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ABSTRACT

Presented is the final report of a project designed to examine the nature of educational and socialization programs within 90 institutions serving emotionally disturbed (ED) children (primarily 6-18 years old). In an introductory section, study goals and objectives are noted to include determination of what educational programs are available to institutionalized ED children and youth and identification of particularly innovative and effective model programs. Covered in section 2 on methodology are the following project tasks: literature search, selection of the advisory panel, sampling procedures, respondent categories, instrument development, pretest and Office of Management and Budget clearance, data collection procedures, document editing, coding and keypunching, data analysis, and report preparation. The bulk of the document is devoted to survey results and analysis which are summarized as indicating major problem areas relating to the behavioral and academic problems of the students; the conflict between the clinical and educational staff as to who will control the philosophy and direction of the educational program; lack of funds, staff, and space; and unavailability of special facilities, staff, and electives. Reviewed in section 4 are such model program components as no-fail grading systems, outdoor education, orientation brochures, and family modules. Discussed in section 5 are recommendations made by project staff for research and demonstration activities in teacher training, information dissemination, formation of a professional association, development of community involvement programs, implementation of a vocational education program, and development of assessment instruments. Appended materials include an analysis of the state laws governing educational programs offered by institutions for the emotionally disturbed, sample survey instruments, and an interviewer's manual. (SBH)

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FINAL REPORT

THE EDUCATION AND SOCIALIZATION OF INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

July 30, 1976

Prepared for:

The Bureau of Education for the Handicapped

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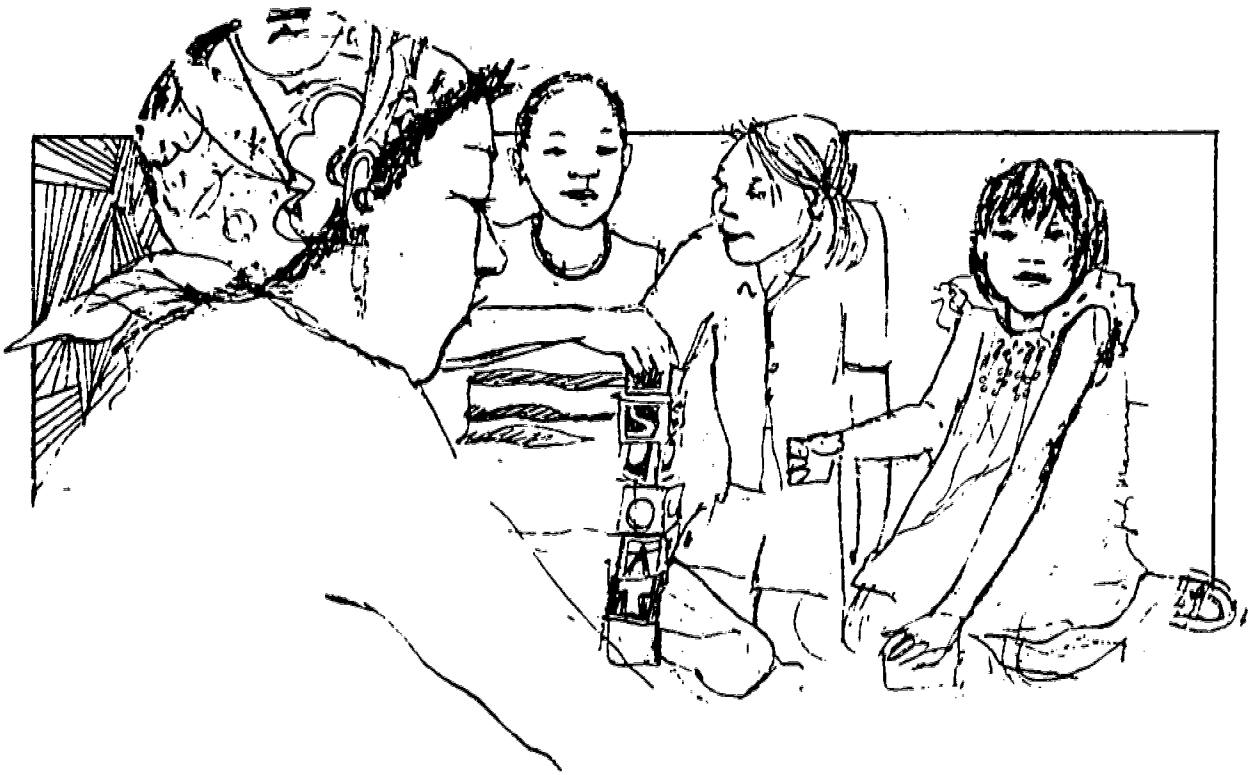

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EXECUTIVE SUMMARY

1. INTRODUCTION

According to estimates published by the Joint Commission on Mental Health of Children, the number of institutionalized emotionally disturbed children has more than doubled in the last ten years. While this represents a significant advance in the delivery of therapeutic services to such children, it creates a need to seriously examine the nature of educational and socialization programs within these institutions to determine their effectiveness in promoting an easy transition to independent adulthood.

Much has been written recently on the education of emotionally disturbed children within the public school environment, but little data exists on the quality of educational service delivery within institutions. This study, therefore, was designed as a "state of the art" report on education and socialization programs available to institutionalized emotionally disturbed children and youth. In addition to describing current services, it identifies model program components and suggests research and demonstration activities for BEH consideration.

A sample of ninety (90) institutions was selected representing both residential treatment centers and in-patient hospital units. Within each institution, a core group of professionals was personally interviewed. This group included the Administrator of the facility, the Educational Program Director and a Psychiatric Nurse or Child Care Worker. When applicable, the Principal of an outside school receiving institutionalized children was also interviewed.

2. SUMMARY RESULTS AND ANALYSIS

Major findings include the following:

- Institution Characteristics
  - .. Survey results indicate that hospitals are dealing with a population which is more profoundly disturbed, more potentially violent, and more problematic educationally than that of the residential treatment center.
  - .. The average length of stay for hospitals (9 months) is considerably shorter than that of residential treatment centers (22 months).
  - .. A deficiency in services provided to the pre-school emotionally disturbed child and to the emotionally disturbed adolescent over the age of 18 exists in both residential treatment centers and in-patient hospital units.

- Teaching Staff Characteristics

  .. The majority of teachers who instruct emotionally disturbed children within institutions are female, between the age of 20-29, work full-time, have earned a B.A. or higher degree and are certified in elementary or secondary education.

  .. Findings indicate that 41 percent of these teachers have provisional or permanent special education certification.

  .. The average teacher/student ratio is 1:7.

- Education Program Characteristics

  .. Approximately 80 percent of these educational programs are accredited.

  .. The most common criteria for grouping students is level of academic achievement.

  .. Residential treatment centers offer a wider variety of electives than do hospitals.

  .. A deficiency in vocational education services exists in both residential treatment centers and in-patient hospital units.

  .. There appears to be no continuity across institutions concerning the selection of diagnostic educational assessment instruments.

  .. Less than half (41%) of all institutions utilize a task analysis format to conduct evaluations.

  .. Teacher observations and anecdotal records remain the most common evaluation techniques.

  .. In general, very little is done in the area of follow-up of discharged students.

- Placement of Institutionalized Students in Outside Schools

  .. Survey results indicate that 54 percent of residential treatment centers and 74 percent of in-patient hospital units have children attending outside public or private schools.

  .. Approximately one-half of the institutions report that the number of children they have enrolled in public school has remained the same over the past five years, while approximately 25 percent report the number increased and approximately 25 percent report a decrease.

- .. Geographic proximity is the main outside school selection criteria.
- .. In the majority of cases, the institution itself assumes the responsibility for transporting the child to an outside school.
- .. Outside schools are likely to receive greater numbers of institutionalized children per school from residential treatment centers than from hospitals.
- .. Most outside schools receiving children from institutions do so solely on the basis of the recommendations of institution staff.
- .. On the whole, outside schools did not have to make any special accommodations in order to integrate the institutional child into the program.

- Adequacy of Teacher Training
  - .. Less than half (48%) of all educational program directors interviewed feel that their teaching staff was adequately trained prior to employment at the institution.
  - .. Approximately 60 percent of institutions provide a formal in-service training program.
  - .. Just over half (51%) of outside school principals feel that their staff was adequately trained to teach emotionally disturbed children prior to employment.
  - .. Little additional training is provided to public school teachers who instruct institutionalized emotionally disturbed children.

- Socialization "Program" Characteristics

Socialization "programs" do not exist. Socialization tends to be a pervasive part of the total institutional experience.

Most commonly emphasized goals included:

- .. ability to wash without assistance
- .. recognition of the misuse of drugs
- .. ability to look after personal hygiene
- .. ability to cope with anxiety
- .. demonstration of pride in one's achievement
- .. acceptance of reasonable rules of the group
- .. opportunity to succeed socially
- .. development of techniques for controlling aggression
- .. development of confidence in one's ability to succeed
- .. ability to constructively interact with peers

- ,, respect for other people's property
- .. awareness of own and others' roles
- .. respect for adults in authority
- .. appreciation of individual rights of family members
- .. recognition of relationships among family members

Many institutions which emphasized social interaction goals did not offer a course in family life and sex education or a big brother/big sister program.

- Perceived Problems and Suggestions for Improvement

  .. Major problem areas in the delivery of educational services to emotionally disturbed children center around the behavioral and academic problems of the students, the conflict between the clinical and educational staff as to who will control the philosophy and direction of the educational program, lack of funds, space and staff, and unavailability of special facilities, materials and electives.

  .. Suggestions for improvement within the institutions and outside schools involve the provision of more specialists, staff and electives, improved teacher training (including internship program), more individualized instruction, more vocational education, more funds, space and materials, and greater integration of therapy and education.

  .. Suggestions for improvement in the country at large again include improved teacher training, but add earlier identification and treatment, less labeling and stigma, more mainstreaming, more community based programs and alternative living situations such as group homes and more community education and preventive psychology.

3. MODEL PROGRAM COMPONENTS

The majority of the educational programs approached by project staff during the course of this study shared a broad base of common objectives, strategies and concerns. Major innovations tended to focus on the application of existing educational strategies to this population. The following innovative individual program components were identified.

- Institutionally Developed Assessment Instruments

Generally assessment instruments covered specific content areas, general attitudes, behavior and test scores. Sample instruments are presented in the text of this report which represent realistic attempts to apply task analysis and behavioral objective techniques to the problems specific to emotionally disturbed children.

- Innovative Teaching Techniques

The variety of teaching techniques used in these institutions tends to reflect the need for providing comfortable, individualized learning situations which permit instruction while developing more acceptable interaction patterns. Included were a student-tutoring-student approach, an interchangeable child care and teaching staff, and tutoring-counseling workshops in which therapeutic goals are addressed using academic content as a basis for interaction.

- No-Fail Grading Systems

Several institutions have eliminated some of the stress inherent in classroom situations by eliminating failing grades for students. The emphasis then is on mastering skills, and students who cannot complete work are given additional instruction and an opportunity to repeat the task.

- Creative Electives

In general, the range of electives available to emotionally disturbed children within institutions is not as wide as that available to other children. In some cases, however, popular interests in the outside community are reflected in the provision of elective courses in the institutional setting.

The more innovative of these elective courses included therapeutic judo, drafting, dance therapy, photography, horticulture, ceramics, animal husbandry, woodworking, black history, and cosmetology.

- Outdoor Education

Outdoor education is an interdisciplinary approach to education which provides opportunities to reinforce and enrich all areas of the school curriculum. Through direct involvement, students actually see, touch, hear, smell, and often taste the subject matter being studied.

- Mainstreaming

Mainstreaming in itself is a relatively new concept with operational procedures and admissions criteria still in a state of flux. One institution provided written admissions criteria for placement in a public school setting. Another educational program used a behavior management schema which allowed the child to assume responsibility for placement. Finally, the most important innovation in mainstreaming is the recent practice of preventing the identification of institutionalized emotionally disturbed children who are enrolled in public schools.

- Transitional Programs

Institutional staff are concerned with the contrast between the regimented nature of the institutional setting and the level of responsibility required for outside life. Therefore, a definite trend exists among the residential treatment centers toward organizing more independent settings for adolescents. The most successful alternative has been the group home where youngsters live in an unmarked home in the community under the supervision of a qualified house parent. These children usually attend public school, but are eligible for all the medical and psychological services provided by the institution.

- Expanding the Learning Environment

Most schools have made some attempts to expand the educational setting beyond the walls of the classroom. These efforts include teaching math students to tally bowling scores, applying newly acquired maintenance and gardening skills to institutional facilities, and teaching basic academic survival skills (reading, math) by requiring small groups of students to be responsible for their own cooking, laundry and homemaking needs.

- In-House Publications

During the course of this study, project staff identified several extensive in-house publications which had been written by institutional staff. These included a needs assessment manual, a foster parent training manual, a manual of philosophy, policies and procedures and several detailed treatment plans.

- Orientation Brochures

Project staff were able to identify one institution which published a descriptive brochure for incoming youngsters explaining rules, procedures and expectations.

- Family Modules

A family module is an apartment which is maintained within the institution to house about-to-be-released children and their families. This arrangement allows for extensive professional observation of family interaction patterns. Maladaptive interaction is identified and corrective therapy given on an immediate and specific basis.

4. RECOMMENDATIONS FOR FUTURE RESEARCH AND DEMONSTRATION ACTIVITIES

- Improved Training for Teachers of Emotionally Disturbed Children

Lack of appropriate teacher training and conflict between the educational and clinical staff were the two problems most frequently

reported by administrators and educational program directors. One possible solution is to re-structure special education training programs using the clinical psychology/social work model. This model involves a minimum number of courses in the chosen discipline plus a one-year supervised internship in an appropriate setting.

A second suggestion frequently offered by institution staff involves the use of personality criteria to screen aspiring teachers.

- Development of a Clearinghouse to Collect and Disseminate Information on Emotional Disturbance

One problem noted by project staff in the course of the literature search was the lack of printed information addressing the educational needs of these children.

The institution of a clearinghouse aimed at identifying, organizing and disseminating appropriate research materials would not only simplify the process of locating the information needed for policy decisions but would also encourage additional publications by providing a needed forum.

- Development of a Professional Association of Residential Treatment Center Directors

Project staff recommend the creation of a professional association of residential treatment center directors. Such an association would open lines of communication between centers and promote more organized planning.

- Community Involvement and Community Education Programs in the Area of Emotional Disturbance

The stigma of institutionalization can be reduced in two ways. First, the number of institutionalized children can be decreased by providing individual and family therapy services in the schools to correct problem behavior before it develops to the point where the child must be removed from the classroom. Also of importance here is the establishment of alternative living situations for children and adolescents whose family situation is contributing to their emotional disturbance.

The second approach involves a concerted effort to educate the community as to the nature and incidence of emotional disturbance.

- Development of Vocational Education Programs for Institutionaized Emotionally Disturbed Children and Youth

Institutionalized children who reach the age of 18 are no longer eligible for state-funded education through the institution,

but may still be academically unprepared to enter an outside higher education program. These adolescents are unable to continue their studies or to obtain a job and support themselves. Institutions must, therefore, include pre-vocational and vocational education in their curriculum in order to prepare these adolescents to enter the work force.

- Development of Appropriate Tests and Measurements

The lack of testing instruments and strategies geared exclusively to institutionalized emotionally disturbed children has seriously complicated the problems of individual diagnosis and program evaluation. Most published tests currently in use in these institutions are not responsive to the specific needs of this population. Valid, reliable instruments that allow researchers to compare the effects of various teaching techniques and curricula with specific groups would permit more meaningful policy-making on all levels.

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FINAL REPORT

THE EDUCATION AND SOCIALIZATION OF INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

July 30, 1976

Prepared for:

The Bureau of Education for the Handicapped

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APPLIED MANAGEMENT SCIENCES

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INTRODUCTION

1.1 Study Background

The Bureau of Education for the Handicapped (BEH) has as one of its principal objectives:

> To enable the most severely handicapped children and youth to become as independent as possible, thereby reducing their requirement for institutional care and providing opportunity for self-development.

In 1966, according to the "Report of the Joint Commission on Mental Health of Children, Inc." "...slightly over 27,000 children under 18 were under care in State and county mental institutions ..."[1/] The National Institute of Mental Health estimated that by 1970, the number of children aged 10-14 hospitalized in these institutions would double.[2/] In 1974, it appears that there were approximately 71,000 to 107,000 emotionally disturbed children and youth in residential facilities.

In the past, the education which handicapped children received was of questionable benefit. Many children identified as disturbed or deviant were excluded from regular classrooms or placed in special classes that were more custodial than educative in nature.. Youngsters who were institutionalized were further

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1/ Report of the Joint Commission on Mental Health of Children, Inc., pp. 8.

2/ Ibid, pp. 8-9.

impaired by inadequate and irrelevant educational programs, if they received any education at all. Educators realized that greater effort was needed to maintain handicapped children within the regular classroom and to provide an appropriate educational program for those who must be placed in a special setting. The Joint Commission recommended that "there should be facilities for a first-rate school and a rich evening activity program" in residential treatment programs for disturbed children.[1/] This recommendation has been implemented only recently.

One of the most consistent and pervasive problems in discussing educational services for emotionally disturbed children is the lack of educationally meaningful definitions or categorizations of the population. As Balow notes:

> "Emotionally and socially maladjusted children are not homogeneous in characteristics or needs. Probably the sole reason they are all thrown into one general category is that they are causing problems for adults."[2/]

Numerous attempts have been made to categorize these children in ways that would be useful in formulating teaching strategies. Quay, Morse and Cutler,[3/] for example, posit three symptomatic

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[1/] Report of the Joint Commission on Mental Health of Children, Inc. p. 69.

[2/] Bruce Balow, "A Program of Preparation for Teachers of Disturbed Children," Educating the Emotionally Disturbed, ed., by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc. 1969, p. 475.

[3/] Herbert C. Quay, William C. Morse and Richard Cutler, "Personality Patterns of Pupils in Special Classes for the Emotionally Disturbed," in Educating the Emotionally Disturbed, ed., by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc. 1969, pp. 43-49.

groups - conduct disorders, personality problems and inadequacy/ immaturity - with appropriate educational approaches. The more common distinction, however, is between "acting out" and "withdrawn"[1/] students, a distinction that is more responsive to the social organization of the classroom than to the educational needs of individual children. There is considerable evidence to suggest that teachers tend to perceive "acting out" students as more in need of services than "withdrawn" students. As Trippe[2/] points out, diagnosis in practice is generally based on two criteria: professional opinion and violation of classroom norms with no readily available explanation. The function of the diagnosis is more to provide the child with access to needed services than to assist in defining the nature of those services. In addition, the diagnosis itself relies on mental health rather than educational concepts. This disagreement over definitions leads to problems in structuring meaningful research to define the nature of special education services and the range of effective approaches. For example, a 1972 study solicited estimates of the percentage of children receiving special education services within each state. Estimates ranged from 10 percent to 80 percent.[3/] Clearly, this reflects a difference in definitions of the population to be served as well as the nature of appropriate services. Such differences make it difficult, if not impossible to assess the usefulness of findings for supposedly comparable groups.

[1/] Herbert C. Quay, "Some Basic Considerations in the Education of Emotionally Disturbed Children" in Educating the Emotionally Disturbed, ed., by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, p. 37.

[2/] Matthew J. Tripe, "Educational Therapy," in Educational Therapy, ed., by Jerome Hellmuth, Bernie Straub and Jerome Hellmuth, Co-Publishers, Seattle, Washington, 1966, p. 37.

[3/] Gene Hensley, "Special Education: No Longer Handicapped," in Compact, v. VII, No. 4, September/October 1973, p. 5.

The definition of the educational needs of these students tends to be even more sketchy:

> "Most children who are admitted to a residential treatment center are at least one to two years retarded educationally, sometimes considerably, more, even though they are of average or even very superior intellectual ability."1/

Articles concerned with diagnostic approaches (Maes,2/ Westman,3/) tend to concentrate on early identification of mental health problems, rather than educational assessment. Normal academic testing instruments form the basis for most educational diagnosis, despite the fact that this is clearly not a "normal" population. Christoplos'4/ work suggests some very basic ways in which these students may differ from other groups, with profound implications for the usefulness of traditional aptitude and achievement testing.

As Knoblock5/ notes, the lack of research substantiating effective teaching techniques leaves little basis for formulating

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1/ Povl W. Taussieng, "The Role of Education in a Residential Treatment Center for Children" in Educating the Emotionally Disturbed, ed., by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, p. 286.

2/ Wayne R. Maes, "The Identification of Emotionally Disturbed Elementary School Children," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, pp. 50-54.

3/ Jack C. Westman, Barbara B. Ferguson and Richard N. Wolman, "School Adjustment Patterns of Children Using Mental Health Services," in Educating the Emotionally Disturbed, ed., by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, pp. 83-92.

4/ Florence Christoplos, "Understanding Social Expectations: Evaluation and Programming," unpublished paper delivered at the 1972 ACLD Convention in Atlantic City.

5/ Peter Knoblock, "Critical Factors Influencing Educational Programming for Disturbed Children" in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, p. 466.

empirically based teacher education programs. Similarly, the nature and objectives of the therapeutic classroom, are much debated in the literature. Redl summarizes the conflict:

> "How are we to provide for Johnny a classroom experience with only two other children present and a highly trained teacher who also has time and skill to sit out five tantrums in a school hour without becoming punitive or disillusioned and at the same time to provide for the youngster the fascinating experience of watching more well-adjusted children happily at work, cheerfully succeeding, and smilingly accepting criticism if they fail, and at the same time taking all the aggression and disturbance he is liable to put out?" 1/

In addition, Quay2/ has noted that research has not proved the effectiveness of special class placement for the mentally handicapped and the implications of this finding for the emotionally disturbed have yet to be explored.

In terms of teacher education strategies, Dorward's study was able to distinguish only two variables that characterized effective special education teachers from other good teachers, "the ability to accept pupils who are violent" and "experience on a clinical team with psychiatrists, psychologists and social workers in studying disturbed pupils."3/ While both suggest possible approaches to teacher education and certification, the process of relating specific teaching strategies to types of student needs is as much a psychiatric as an educational question at present.

1/ Fritz Redl, "The Concept of a 'Therapeutic Milieu'," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, p.121.

2/ Quay, op cit., p. 35.

3/ Barbara Dorward, "A Comparison of the Competencies for Regular Classroom Teachers and Teachers of the Emotionally Disturbed," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, p. 451.

In sum, it appears that many significant issues relating to teaching methodologies, teacher qualifications needs and nature of the student population and methods of evaluation remain unresolved.

An abundance of unresolved issues clouds the area of socialization as well. What is clear, however, is that there is an obvious effect due to withdrawal from the school setting and the academic and social environment provided by the school. The institutional environment is not modeled after the world outside and differs considerably in terms of its social structure, and the social roles/expected behaviors demanded of its patients. The survivial behaviors and ways of interacting with others learned within an institution may be inadequate for eventual readjustment outside the institution. Consequently, a residential facility for children and youth should make a knowledgeable attempt to structure socilaization activities which mirror those of society at large. Specific programs must be intentionally operationalized within the institution to provide a background of normalizing social experiences for young patients. Such experiences will be of value to those patients requiring institutionalization for a long period of time as well as for those whose stay is somewhat shorter.

Thus, institutional programs for emotionally disturbed children have a responsibility to foster both appropriate social functioning and educational growth. Depending on the age group and extent of a child's handicap, program emphasis may vary from the acquisition of basic academic skills and competencies, to preparation for a specific vocational area. The critical issue here is that time spent within the institution should not be time-out from educational and socializing experiences. Current educational law mandates the education of handicapped youngsters of all types; the quantity and quality of this experience is more difficult to legislate.

1.2: Study Scope and Objectives

Although much has been written on the education of these children within the public school environment, little data exist on the quality of educational service delivery to those who have had to be institutionalized. The study is unique, therefore, in its focus on the institutionalized emotionally disturbed child. The analysis of the data gathered forms the basis for this "state-of-the-art" report on the education and socialization programs available to institutionalized emotionally disturbed children and youth.

The major goals and objectives of this study can be outlined as follows:

1) determine what educational programs are available to institutionalized emotionally disturbed children and youth.

2) determine the major emphasis of current efforts toward socialization of emotionally disturbed children and youth.

3) determine the nature of efforts toward integrating the institutionalized emotionally disturbed children and youth.

4) identify and describe particularly innovative and effective model programs.

5) determine the research and demonstration activities which will help to improve the delivery of educational services to emotionally disturbed children and youth.

The first phase of this effort involved a literature search to answer as many questions as possible. The bulk of the literature dealing with residential programs for this population was found to be focused on case studies of therapy techniques and socialization approaches. Most articles dealt with individual cases with little attempt to isolate or

evaluate effective program elements. The research of Rigothe[1] and Sabatino and Hayden[2] falls into this category.

While such studies do indicate much about the structure and purposes of educational programs for emotionally disturbed children, it is doubtful that results can be generalized to any great extent. Even in cases when individual academic progress can be substantiated with test results, the applicability of such standardized tests to this population as a whole is suspect. More often, however, successes are documented as descriptions of the social and emotional progress of individual students. Thus, many programs with academic content are considered by staff to be primarily therapeutic in objectives. As Morse points out this is not surprising, since schools are themselves based on this model of controlled interaction:

> "For many disturbed children the treatment of choice is activity group therapy-doing and making things in the company of peers. If not a peer society, school is nothing."[3]

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[1] Anthony Rigothe, ed., A Residential School's Outdoor Education Program for Emotionally Handicapped Adolescents, Rhinecliff Uncon Free School District, New York, 1974.

[2] David Sabatino and David L. Hayden, "Prescriptive Teaching in a Summer Program for Children with Learning Disabilities," unpublished paper.

[3] William C. Morse, Classroom Disturbance: The Principal's Dilemma, the Council for Exceptional Children, Arlington, Virginia, 1971, p. 5.

In contrasting various approaches to the education of emotionally disturbed children, Hewitt[1] points out that only behavior modification is based on firm empirical evidence. However, since evaluation can only be conducted in the case of very simple behavior and reward systems, it is not clear that even these findings can be generalized and related to other settings. Hewitt[1] also posits a useful hierarchy of skills for emotionally disturbed children, beginning with attention and response and working toward academic mastery. Again, the objectives of both systems are primarily therapeutic, though Hewitt's offers more possibility for integration with standard academic curricula.

Concerning socialization, the literature reflects the difficulty experienced in efforts to breakdown complex social skills into easily identifiable components. Christoplos,[2] for example, suggests a need to address the following rudimentary social skills:

1) accurate interpretation and expression of non-verbal emotional communication;

2) accurate prediction of past and future events based on inferences from situational cues, and

3) accurate estimation of time duration as well as use of mechanical time.

In summary, the most useful articles were found not to be research oriented, but theoretical in nature. Wood[3] for example, provides the following criteria for evaluating programs:

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[1] Hewitt, op. cit., p.55

[2] Florence Christoplos, "Understanding Social Expectations: Evaluation and Programming," unpublished paper delivered at the 1972 ACLD Convention in Atlantic City.

[3] Frank H. Wood, "The Educator's Role in Team Planning of Therapeutic Educational Placement for Children with Adjustment and Learning Problems," Exceptional Children, January, 1968, pp. pp. 337-340.

- teacher's specific skills
- diagnosis of child's needs
- characteristics by which children are grouped (age, sex and diagnostic labels can lead to unnecessarily stressful situations)
- regularity of evaluation of each child's program

In addition, the literature provided a sense of the range of program elements, assessment techniques and pedagogical approaches.

A number of research questions also emerged from the literature. Cruickshank[1/], for example, points out the relationship between social and occupational adjustment, which is an especially significant consideration for this population. In light of this observation and the recurrent suggestion that one major rationale for special education is to remove the necessity for long-term finanancial support, the project team decided to investigate the extent to which vocational education was made available to these children.

Teacher education was still another important issue raised through the review of the literature. One incidental finding of the Dorward[2/] study, for example was the fact that teachers in residential centers tended to be less experienced than public school teachers. In attempting to define parameters for evaluating teacher qualifications a number of approaches were evident, with

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1/ William B. Cruickshank, "Current Educational Practices with Exceptional Children," in Education of Exceptional Children and Youth, ed. by William B. Cruickshank and G. Orville Johnson, Englewood Cliffs, New Jersey, Prentice-Hall, Inc. 1967, p.46

2/ Barbara Dorward, "A Comparison of the Competencies for Regular Classroom Teachers and Teachers of Emotionally Disturbed Children," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc. 1969, p. 449

criteria ranging from "objectivity, flexibility, structure, resourcefulness, social reinforcement, curriculum expertise and intellectual modeling"[1/] to "experience on a clinical team with psychiatrists, psychologists and social workers in studying distubed pupils."[2/]

In general, the literature search provided a useful context for formulating research issues. However, as many experts have noted, residential programs have two, sometimes conflicting major goals:

1) They have to support the total residential treatment program, by helping to create the emotional climate needed by any child at any given time, and

2) They have to teach the child or to help him in such a way that he can resume learning. [3/]

In the past, the emphasis given to the educational and therapeutic program aspects has not been balanced. Liton notes this deficiency in his statement that "the lack of experimental research on the education of children with emotional illness stands in sharp contrast to the extensive interest in mental health."[4/]

1/ Frank M. Hewitt, "A Heirarchy of Competencies for teachers of Emotionally Handicapped Children," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc., 1969, pp. 424-429.

2/ Dorward, op. cit., p. 451

3/ Povl W. Tons[illegible] "The Role of Education in a Resident Treatment Center fo[illegible] Children," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y.Crowell Co., Inc. 19[illegible]9 p. 285.

4/ Donald A. Liton, "Differential Teaching Techniques for Emotionally Disturbed Children," in Educating the Emotionally Disturbed, ed. by Hardwick W. Harshman, New York, Thomas Y. Crowell Company, Inc. 1969, p. 362

In order to fill this research gap, an exploratory study designed to provide baseline data on the kinds of education and socialization programs offered to institutionalized emotionally disturbed children and youth has been conducted. The results of the data collection and analysis are presented in the text of this report. The information obtained by Applied Management Sciences will be useful to professionals who work with these children as well as to federal and state planners who can contribute toward the improvement of educational service delivery to the emotionally disturbed.

1.3: Methodology Summary

The study methodology was organized into three major phases: Planning, Data Collection and Compilation, and Analysis and Reporting. The Planning Phase began with a literature search to identify existing documentation relating to the education and socialization of institutionalized emotionally disturbed children and youth. An exhaustive search of secondary data sources conducted both manually and through data bases produced little directly relevant literature.

Next an Advisory Panel was selected, comprised of experts in the fields of special education and emotional disturbance, to review all phases of planning and data collection and analysis. Finally, a sample of institutions was selected to ensure both regional representation and cost-effective travel, and appropriate respondent categories were identified. It was decided that the administrator of the institution, the educational program director, and a child care worker or psychiatric nurse would be personally interviewed in order to determine the parameters of the educational programs and socialization efforts currently in the process of implementation within each institution in our sample. In addition, principals of outside schools in which institutional children were enrolled were interviewed concerning their efforts toward mainstreaming the emotionally disturbed child.

The Data Collection and Compilation Phase began with the development of four (4) instruments containing both closed and open-ended questions, to be personally administered to each of the four (4) respondent categories. The instruments were pre-tested, revised and submitted for BEH internal review and subsequent OMB clearance. Next, an interviewer's manual was developed interviewer training sessions held and site visits scheduled, and conducted. As survey instruments were completed, they were submitted to project staff for editing, coding and keypunching.

The Analysis and Reporting Phase began after all questionnaires had been processed. Frequency distributions were compiled for each response and selected variables were cross-tabulated. Additionally, project staff presented an analysis of the implications of the results in the form of two chapters dealing with model program components and research and development projects needed to improve educational service delivery to emotionally disturbed children.

Reporting was an on-going process. Progress reports were prepared weekly and monthly to discuss overall work accomplished during the reporting period, proposed activities for the coming period and any problems encountered during the course of the study. An outline was developed for the final report and approved by the BEH Project Officer.

2

METHODOLOGY

2.1: Chapter Overview

The methodology for sample design, data collection and processing, and data analysis was organized into the following project tasks.

- Literature Search
- Selection of the Advisory Panel
- Sampling Procedures
- Respondent Categories
- Instrument Development
- Pretest and OMB Clearance
- Data Collection Procedures
- Document Editing
- Coding and Keypunching
- Data Analysis
- Report Preparation

The study design was developed in the first month of the contract, and approved by both the BEH Project Officer and the Advisory Panel. It was later modified slightly, to accomodate changes in scope suggested by the pretest. The resulting research methodology is described in the sections which follow.

2.2: Literature Search

A comprehensive literature search was conducted to explore definitions of such abstract concepts as "emotional disturbance" and "socialization" and to locate previous relevant research. This baseline data was used to specify informational needs and design the survey instruments. Procedures used in conducting the literature search included the utilization of computerized bibliographic data bases and review of manual indexing systems. Some of the information sources consulted through the on-line computerized literature search capability included the following:

- American Psychological Association (APA)
  1200 Seventeenth Street, NW
  Washington, DC 20036
  Phone: (202) 833-7600

  The contents of Psychological Abstracts, published by the APA, have been placed on magnetic tape since 1967. Recently, these tapes were loaded in a computer and made accessible for research and information purposes as part of the developing National Information System for Psychology. These services permit complex searches of approximately 800 psychological journals and related publications. The abstracts were scanned by the Applied Management Sciences computer terminal for the material containing the search parameters, producing titles and, in most cases, abstracts.

- Educational Resources Information Center (ERIC)
  Office of Education
  Department of Health, Education, and Welfare
  Washington, DC 20202
  Phone: (202) 962-0104

- Medical Literature Analysis and Retrieval System (MEDLARS-MEDLINE)
  National Library of Medicine
  8600 Rockville Pike
  Bethesda, Maryland 20014
  Phone: (301) 496-6193

  The MEDLARS-MEDLINE computer information system is used to prepare various bibliographies and indexes such as Index Medicus. The system permits systematic search of 2,300 journals published since mid-1963.

In addition to the above search and retrieval services, project staff utilized Sociological Abstracts and the Social Science and Humanities Index.

Over 100 citations were identified through various research procedures (See Appendix E: Bibliography). However, these documents tended more towards discussions of theoretical constructs rather than substantive research on educational programs for institutionalized emotionally disturbed children and youth.

2.3: Selection of the Advisory Panel

With the approval of BEH, the following three (3) professionals prominant in the areas of special education and emotional disturbance were selected to serve as an Advisory Panel:

- Dr. Nicholas Long - is the Chairman of the Department of Special Education at American University. He has extensive experience in the evaluation of emotionally disturbed children and has developed a psychoeducational instrument used to identify such children in the first three years of school. Dr. Long has also published several books and articles in the area of educating the emotionally disturbed child.
- Dr. Althea Marshall - is a teacher for the emotionally disturbed at Christ Child Institute in Rockville, Md. Dr. Marshall has conducted considerable research in the area of institutionalized emotionally disturbed children
- Dr. Lawrence Frost - is the Director of the Adolescent In-Patient Unit at St. Elizabeths Hospital in Washington, DC. Dr. Frost has served as a consultant to BEH on several projects dealing with emotionally disturbed children and youth.

They offered advice on research goals, potential problems, and effective analysis of data. Draft survey instruments were presented to this panel for review prior to pre-testing. Their suggestions were incorporated and appropriate revisions made in each of the instruments.

2.4: Sampling Procedures

According to an update of the 1974 National Institute of Mental Health survey of hospital in-patient units and residential treatment centers[1/] there are approximately 475 patient care facilities for the emotionally disturbed child in the United States. Of these facilities approximately 325 are residential treatment centers and 150 are hospital in-patient units. A sample of ninety (90) institutions was selected from this source to represent the following four (4) categories:

- Public residential treatment centers
- Private residential treatment centers
- Public hospitals with in-patient facilities for emotionally disturbed children and youth
- Private hospitals with in-patient facilities for emotionally disturbed children and youth

In addition to ownership, geographic area was determined to be an important criteria. Thus, the sample was selected to ensure that each HEW region would be adequately represented. Since these facilities are not evenly distributed throughout the country, the decision was made to survey at least 25 percent of the institutions for the emotionally disturbed within each of the four HEW regions. Finally, natural clustering and the necessity for insuring cost-effective travel plans dictated the choice of one or two major metropolitan areas within each State as survey sites. Figures 2.1 and 2.2 depict the sample of institutions chosen.

Since the study objectives required information dealing with the integration of institutionalized children into regular public or private schools in the community, it was imperative that the sample plan include procedures for identifying and visiting at

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1/ National Institute of Mental Health-Mental Health Statistics National Clearinghouse for Mental Health Information 1973-74, Residential Treatment Centers for Emotionally Disturbed Children.

H.E.W. Region	Selected State	Number of Institutions Surveyed
I	Massachusetts	6
II	New York	11
III	Washington, D.C. Area	14
IV	Georgia	4
	Florida	3
V	Illinois	9
	Wisconsin	11
VI	Texas	10
VII	Missouri	4
VIII	Colorado	5
IX	California	10
X	Washington	3
Total	12 States	90

FIGURE 2.1: SITE DISTRIBUTION

H.E.W. REGION	STATE	Public and Private Residential Treatment Centers	Public and Private In-Patient Hospital Units
I	Massachusetts	5	1
II	New York	5	6
III	Washington, D.C. Area	7	7
IV	Georgia	2	2
	Florida	2	1
V	Wisconsin	9	2
	Illinois	5	4
VI	Texas	5	5
VII	Missouri	3	1
VIII	Colorado	3	2
IX	California	8	2
X	Washington	2	1
Total	12 States	56	34

FIGURE 2.2: SAMPLING MATRIX

least one outside school for each institution selected. Educational Program Directors were asked to identify an appropriate school. If the institution has enrolled children in more than one outside school, contact was made with the school in which the largest number of institutionalized children were being educated. It is important to note, however, that visits were not made to institutions which did not offer an educational program, i.e., an institution in which all of the children were being sent to a public or private school in the area. The task was to examine the educational programs being offered within institutions for the emotionally disturbed, not to examine the educational services provided within the public or private school sector. Included in the sample, however, were those institutions in which on-site educational programs were conducted by teachers who were contracted with and salaried by the public school system. Such programs, held on the premises of the institution and directed by institutional staff, were indeed within the purview of this study.

2.5: Respondent Categories

Within each institution, a core group of professionals was personally interviewed. This group included the Administrator of the facility, the Educational Program Director and a Psychiatric Nurse or Child Care Worker. When applicable, the Principal of an outside school was also interviewed. Thus, there were four (4) respondent categories as follows:

(1) Administrator - This category refers to that person who is in charge of the entire residential treatment center or hospital. In the case of a large hospital, the person in charge of the in-patient unit for emotionally disturbed children and/or adolescents was interviewed. Various professional titles for this respondent category included Administrator, Hospital Administrator, Superintendent, Director, Executive Director.

(2) Educational Program Director - This category refers to that person who is in charge of the educational program within the institution. Large residential treatment centers often contained a fully accredited school, while a small in-patient hospital unit sometimes employed the services of a single teacher to perform individual tutoring. In the former case, the Principal was interviewed in the latter, the teacher. Occasionally, due to the nature of the administrative structure or size of the facility, the Educational Program Director was given both the Administrator questionnaire and the Educational Program Director questionnaire. Various professional titles for this respondent category included Principal, Assistant Principal, School Administrator, Educational Coordinator, Educational Consultant, Supervisory Teacher, Head Teacher, Teacher.

(3) Child Care Worker or Psychiatric Nurse - This category refers to those people who supervise the institutionalized emotionally disturbed child during the time that the child is neither in school nor in therapy. These individuals were determined to be best able to describe the major emphasis of current efforts towards socialization within the institution. Various professional titles for this respondent category included: Child Care Worker, Psychiatric Nurse, Psychiatric Aide, Mental Health Technician.

(4) Outside School Personnel - Most of the time interviewers spoke with the Principal or Assistant Principal of the regular public or private school in which institutionalized children were enrolled. If that was not possible, a teacher currently instructing a child from the institution was interviewed. Various professional titles for this respondent category included: Principal, Assistant Principal, Special Education Teacher, Crisis Resource Teacher, Teacher.

2.6: Instrument Development

The first step in developing a survey instrument was to identify the data elements which related to each study objective. These desired pieces of information were then related to best

sources and expanded into specific questionnaire items. Each item was examined to determine the appropriate wording and form (open-ended response, multiple choice, etc.) which would make the question understandable and easy to administer. Figure 2.3 presents the data elements arrayed by research objectives and instrument. Four instruments were developed corresponding to the four respondent categories and addressed to the following areas:

1) Administrator Instrument - This instrument focused on admission criteria, resident/in-patient characteristics, demographic variables concerning teaching staff, accreditation status and perceived problems in the delivery of educational services.

2) Educational Program Director Instrument - This instrument focused on program length, grades covered, co-curricular facilities, grouping criteria, curriculum, teaching techniques, staff training, diagnostic assessment, evaluation, integration of institutional students into regular schools, and perceived problems in the delivery of educational services.

3) Child Care Worker/Psychiatric Nurse Instrument - This instrument focused on the social, emotional and behavioral skills needed for adequate functioning (re-socialization) emphasized at the institution.

4) Outside School Instrument - This instrument focused on the number of children residing at an institution while attending that public/private school, special arrangements made to accomodate these children, staff training, and perceived problems in the delivery of educational service.

(A copy of each instrument is found in Appendix B.)

An interviewer's manual was designed to serve as a guide for training sessions, and as a ready reference for interviewers should questions arise during the data collection period. The manual contained an introduction to the study explaining BEH objectives and emphasizing Applied Management Sciences' standards for high quality interviewing. General survey procedures were then outlined, including suggestions for interview preparation and techniques for establishing initial contacts with

	INSTRUMENT			
OBJECTIVE: Determine what educational programs are currently available to institutionalized emotionally disturbed children and youth	Administrator	Educational Program Director	Child Care Worker/ Psychiatric Nurse	Outside School
What are some of the characteristics of emotionally disturbed residents or inpatients which may relate to the educational program?	1,2,3,4,5			
What type of staff are involved in educational programs in institutions?	6,7,8			
Are educational programs accredited and degrees awarded?	9,10,11			
What is the average length of time (hrs. per day/days per week/months per year) covered by educational programs?		1		
What grades are covered by these programs?		2		
What equipment and facilities are used?		3		
What grouping criteria are utilized?		5		
What course offerings are available?		6,7,8		

FIGURE 2.3: DATA ELEMENTS ARRAYED BY RESEARCH QUESTION

OBJECTIVE: Determine what educational programs are currently available to institutionalized emotionally disturbed children and youth	INSTRUMENT			
	Administrator	Educational Program Director	Child Care Worker/ Psychiatric Nurse	Outside School
What teaching techniques are used in educational programs?		9		
Is teacher training adequate?		10, 11		6,7,8
What methods of diagnostic educational assessment are used?		12, 13, 14		
What methods are used to assess the effectiveness of educational programs?		15, 16, 17, 18, 19, 20		
What efforts are currently under way to place children residing at an institution in regular public or private schools?		21, 22, 23 24, 25, 26 27, 28, 29		1,2,3,4,5
What follow-up procedures are utilized?		19, 28		
What needs are expressed by institutional/outside school staff to improve educational service delivery?	12, 13	31, 32		9, 10

FIGURE 2.3: (CONTINUED)

	INSTRUMENT			
OBJECTIVE: Determine the extent to which specified emotional, social and behavioral goals are emphasized in efforts toward socialization of emotionally disturbed children	Administrator	Educational Program Director	Child Care Worker/ Psychiatric Nurse	Outside School
What types of emotional, social and behavioral goals are emphasized in the area of health?			1,2,3,4,5,6,7	
What types of emotional, social and behavioral goals are emphasized in the area of social maturity?			8,9,10, 11, 12 13, 14, 15	
What types of emotional, social and behavioral goals are emphasized in the area of social initiative?			16, 17, 18	
What types of emotional, social and behavioral goals are emphasized in the area of attitudes?			19, 20, 21, 22 23, 24, 25	
What types of emotional, social and behavioral goals are emphasized in the area of leisure time?			30, 31, 32, 33 34, 35, 36	
What types of emotional, social and behavioral goals are emphasized in the area of human relations?			37, 38, 39 40, 41, 42	
What techniques are utilized in efforts toward socialization?			43	

FIGURE 2.3: (CONTINUED)

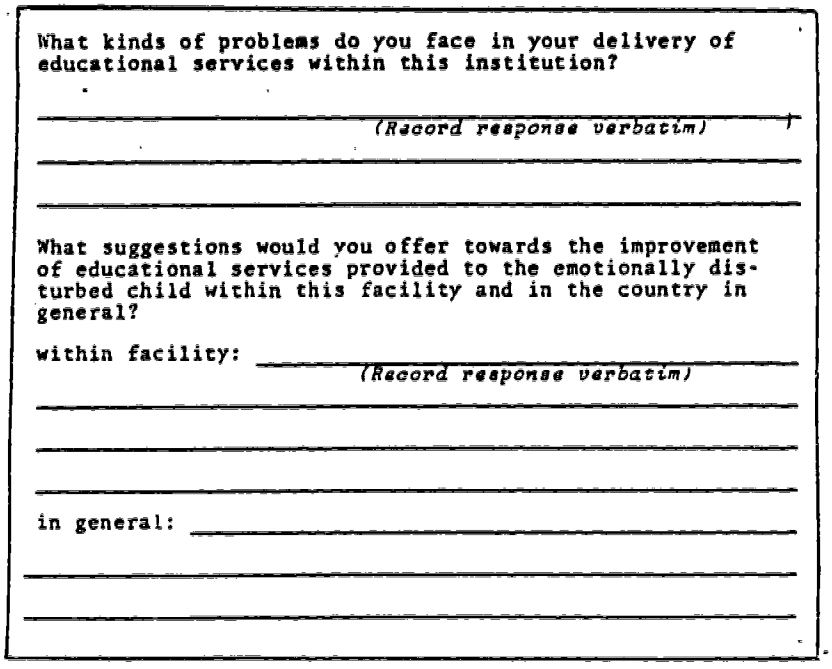
respondents. Finally, the manual presented explicit question-by-question instructions for each of the survey instruments as well as a glossary which included definitions of technical terms found in the questionnaires. (A copy of the interviewer's manual is included in Appendix D.)

2.7: Pretest and OMB Clearance

The survey instruments were pretested at five (5) institutions in the Washington, D.C. area during October, 1975. As a result of this pretest the questionnaires were revised, and additional open-ended questions were included.

For example, the initial short question on the demographic characteristics of the teaching staff was found to produce unwieldy responses. In the final version it was expanded into a full, detailed chart (see Figure 2.4).

Also, a checklist of potential problems and suggestions was included in the initial questionnaire. This format was found to limit responses unnecessarily. It was replaced by an open-ended question more responsive to the actual variety of needs expressed.



What kinds of problems do you face in your delivery of educational services within this institution?

(Record response verbatim)

What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child within this facility and in the country in general?

within facility:

(Record response verbatim)

in general:

Please check boxes across one row for teacher.

Teachers	SEX		AGE					LEVEL OF EDUCATION				EMPLOY-MENT STATUS			CERTIFICATION				AREA OF SPECIALIZATION														
	Male	Female	20-29	30-39	40-49	50-59	60-69	Less than B.A.	B.A.	M.A.	Ph.D.	Full-time (Salaried)	Part-time (Salaried)	Volunteer	Elementary	Secondary	Special Education - Provisional	Special Education - Permanent	Math	Language Arts - Reading	Language Arts - English	Social Studies/ History	Science	Art	Music	Physical Education	Media	Foreign Language	Diagnostic - Prescriptive	Crisis Resource	Vocational Education	Business
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FIGURE 2.4: DEMOGRAPHIC CHARACTERISTICS OF TEACHERS

Subsequent to questionnaire revision, Applied Management Sciences prepared a supporting statement for OMB Clearance which outlined the study objectives, sample design, methodology, and tabulation and analysis plans. In addition, the statement included a time schedule for completion of major study tasks, and listed contract deliverables and estimated cost. Finally, the statement presented plans for assurance of respondent confidentiality.

The instruments and supporting statement were submitted to BEH for internal review and forwarded to OMB. Clearance was granted on January 16, 1976.

2.8: Data Collection Procedures

A letter of introduction was prepared by the Bureau of Education for the Handicapped, explaining the purpose of the study and asking for cooperation. This was mailed to the ninety (90) institutions in the sample during the first week of February, 1976. (See Figure 2.5.) Allowing one week for receipt of the letter, project staff telephoned each institution in order to confirm cooperation and to identify appropriate respondents. Institution administrators were told that they would be contacted by interviewers in the near future to schedule appointments. All ninety (90) institutions agreed to participate in the survey and expressed enthusiasm for upcoming site visits. Thus the project was fortunate in obtaining a 100% response rate for institutions. However, only 49 of the 55 public or private schools in which institutional children were enrolled, agreed to participate in the survey. The second step in the data gathering process was the selection and training of the interviewing staff. Executive interviewers with a background in education/special education were selected from interviewing

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

February 2, 1976

Dear Administrator:

The Bureau of Education for the Handicapped, a division of the United States Office of Education, has funded a study concerned with the education and socialization of institutionalized emotionally disturbed children and youth.

Staff members of residential treatment centers for the emotionally disturbed and in-patient units of hospitals will be interviewed in order to determine the availability of education and socialization programs. Our sample will include a total of 90 facilities located within twelve states throughout the country. In each of these facilities we will want to speak with the Administrator, the Educational Program Director, and a Psychiatric Nurse or Child Care Worker. In addition, if some of the students who live at the facility attend a regular public or private school in the daytime, we will wish to contact a representative of this outside school as well. In this way, we hope to gain an accurate picture of what type of education and socialization programs are offered to institutionalized emotionally disturbed children.

We have found that these interviews take no longer than one-half hour to complete, except in the case of the Educational Program Director, which may take one hour. Let us assure you that no individual facilities nor persons will be named in our final report.

The purpose of this letter is to let you know, with as much notice as possible, that our contractor, Applied Management Sciences, will be calling soon to schedule these interviews with you and members of your staff.

We wish to thank you in advance for your cooperation. Only by careful analysis of the programs now in operation can we plan effectively for the future.

Cordially,

Edwin W. Martin, Ph.D.
Director, Bureau of Education
for the Handicapped

FIGURE 2.5: INTRODUCTORY LETTER

services located in cities close to each cluster of sites. The interviewer training sessions consisted of a short introduction to the study, a review of general interviewing techniques, and a question-by-question analysis of the study instruments.

Efforts were made to arrange appointments with the administrator, educational program director and psychiatric nurse or child care worker in consecutive time periods on the same day. In some cases, however, several trips were required to interview all appropriate respondents at a given institution. It should be noted that occassionally the administrator of the institution also served as the educational program director and then completed both Instrument #1 and #2.

It should also be noted that for larger hospitals, project staff selected those administrators with clear responsibility for children or adolescents. This emphasis may have produced a bias in the sample, since in several hospitals, we were directed toward the "adolescent unit" and collected data from this source alone. The hospital may well have treated younger children, although not in a separate unit.

The executive interviewers visited 55 institutions (61% of the sites) while Applied Management Sciences project staff interviewed respondents at 35 institutions (39% of the sites).

2.9: Document Editing, Coding and Keypunching

Completed questionnaires were edited by project staff in order to resolve any inconsistencies and fill in missing information. When necessary, telephone calls were made to institutions to facilitate the editing process. Next, responses to open-ended questions were assigned codes, and these codes were transferred to the otherwise pre-coded survey instruments. Coded responses were transferred from the questionnaire to punch data cards and all cards were key verified to ensure at least 99.5 percent level of keypunching accuracy. The remaining keypunch errors were corrected during routine machine edit procedures.

2.10: Data Analysis

Responses to the variables measured by the four survey instruments were tabulated and the results presented in frequency tables. Selected responses were aggregated by type of institution - residential treatment center or in-patient hospital unit.

A preliminary analysis, based on frequency distributions, was conducted to provide a quantitative base for describing the nature of existing education and socialization services for institutionalized emotionally disturbed children and youth. In addition, these response frequencies were interpreted, in light of research and more qualitative interview responses, to analyze a) factors which impinge on each variable, b) comments and recommendations of instructional staff with regard to each variable and c) general and specific complexities of each response. Thus, Applied Management Sciences' project staff combined direct experience and expertise with the response frequencies for each question to produce an in-depth analysis of the quantity and quality of education and socialization program available to institutionalized emotionally disturbed children.

Using this data base, project staff has prepared chapters describing student, teacher, and educational program characteristics. In addition, the analysis includes the identification and description of a)model programs and b) research and demonstration programs needed to improve educational service delivery. The model program chapter catalogues creative and innovative techniques currently employed by the institutions in the sample. The research and demonstration chapter deals with perceived problems and suggestions for improvement presented by institution administrators, educational program directors and outside school principals, as well as those identified by project staff through related research.

2.11: Report Preparation

Throughout the course of the contract, progress reports were submitted to BEH on a monthly basis. These reports documented project implementation and outlined the plans for the month to

come. In addition, in-house weekly reports were prepared, documenting tasks completed, anticipated problems, and work to be accomplished.

The final report follows the outline developed during February 1976 and approved by the BEH project officer. This report presents Applied Management Sciences' view of the study goals and objectives, methodology and results. Throughout, project staff has maintained close contact with BEH in order to insure the relevance of this research effort to BEH objectives and to develop an analysis which will serve as a useful aid to BEH's policy determination.

3

SURVEY RESULTS AND ANALYSIS

3.1 Introduction

The primary objective of this study was to determine what type of education and socialization programs are available to institutionalized emotionally disturbed children and youth. In order to meet this objective, questionnaires were developed and personally administered to a core group of professionals at each of ninety (90) institutions located within 12 states. Both public and private residential treatment centers and in-patient hospital units were included within the sample. At each institution the administrator, educational program director and a child care worker or psychiatric nurse were interviewed. In addition, if some of the institutionalized children were attending an outside public or private school the principal of that receiving school was interviewed as well. The remainder of this chapter is devoted to a discussion of the findings and an interpretation of those findings.

3.2 Student Characteristics

A clear delineation of the target population is of primary importance to the discussion of education and socialization programming. The first section of the administrator questionnaire was, therefore, concerned with selected parameters of this student population, including age of those receiving treatment, ages for admission, admission criteria, length of stay, and percent receiving educational services.

3.2.1 Number of Emotionally Disturbed Individuals Between the Ages of 0 to 25 Receiving Treatment

The majority of residential treatment centers (69%) serve between 11 and 50 children on a resident (in-patient) basis. More specifically, 19 percent of residential treatment centers serve between 11 and 20 emotionally disturbed children, 14 percent serve 21 to 30 children, 19 percent serve 31 to 40 children and 17 percent serve 41 to 50 children. Only 3 percent of the residential treatment centers serve less than 10 children and 28 percent of these centers serve more than 50 children.

Thus, 74 percent of all in-patient hospital units serve between 11 to 50 children as compared to 64 percent of residential treatment centers. Specifically, approximately one-third of in-patient hospital units serve 11 to 20 children, with an additional 23 percent serving between 21 and 30 children, 6 percent serving 31 to 40 children, and 13 percent serving 41 to 50 children.

NUMBER OF CHILDREN SERVED	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
1-10	2	3%	1	3%	3	3%
11-20	11	19%	10	32%	21	23%
21-30	8	14%	7	23%	15	17%
31-40	11	19%	2	6%	13	14%
41-50	10	17%	4	13%	14	16%
51-60	3	5%	3	10%	6	7%
61-70	3	5%	-	-	3	3%
71-80	2	3%	1	3%	3	3%
81-90	3	5%	2	6%	5	6%
91-100	2	3%	-	-	2	2%
Over 100	4	7%	1	3%	5	6%
	(n=59)		(n=31)		(n=90)	

TABLE 3.2.1: NUMBER AND PERCENT OF INSTITUTIONS BY NUMBER OF EMOTIONALLY DISTURBED CHILDREN AND YOUTH SERVED BY TYPE OF INSTITUTION

In addition to residents and in-patients, included within the scope of the study, many institutions also accept children on a day care basis. These children attend the institution in the daytime but return to their families in the evening. Finally, several residential treatment centers sponsor group homes. These homes are usually undistinguishable residences in a community which house 5 to 10 emotionally disturbed adolescents under the care and supervision of a house parent. All the psychiatric facilities of the institution are available to these group-home residents. Children living in group homes usually attend a regular public school; in fact, the ability to attend public school is often a criteria for acceptance into a group home.

3.2.2 Minimum Age for Admission

The lowest age at which an institution will accept an emotionally disturbed child appears to differ significantly for residential treatment centers as compared to in-patient hospital units. A full 27 percent of residential treatment centers require that a child have reached 6 years of age before he can be considered for admission while 25 percent of these centers required that a child be 12-13 years of age upon admission. More specifically, only 18 percent of residential treatment centers will accept a child under the age of 6, 53 percent of these centers accept children between the ages of 6-11, and 27 percent of these centers accept children between the ages of 12-15.

This structure parallels that of the public school system where children are admitted to elementary school at age 6 and to junior high school at age 12-13. The reason for these cutoffs is twofold. First, most children are not identified as emotionally disturbed until they are attending school. "Acting out" or aggressive behavior and severe withdrawal, identified by the classroom teacher, remain the most common reasons for a recommendation for institutionalization. Secondly, many residential treatment centers are hesitant to accept children under 6 years of age due to the difficulty in obtaining funds for these children. In many states

there are no public funding mechanisms for educating the pre-school child. Thus, residential treatment centers would not be reimbursed for the education of these children and in most cases the institutions themselves cannot absorb this financial loss.

In-patient units of state hospitals, however, are often required to accept any patient regardless of age. Hence, 28 percent of in-patient hospital units will accept a child under 6, with 16 percent setting no minimum age requirement at all. While providing somewhat more service to the pre-school child (28% of hospitals as compared to 17% of residential treatment centers serving the pre-school child), it appears that in-patient hospital units are geared primarily toward serving the adolescent. Almost half (49%) of the in-patient hospital units specify 12-13 years of age as the minimum for acceptance. However, this figure (49%) may reflect a bias in the sampling. In several hospitals we were directed toward the "adolescent unit" and gathered data from this source alone. The hospital may well have treated younger children, although not in a separate unit. Therefore, questions as to minimum age were sometimes interpreted to mean minimum age for the adolescent unit rather than for the hospital as a whole. It is quite possible that younger children were in fact being served elsewhere in the hospital.

The important finding here is the fact that a deficiency in services provided to the pre-school emotionally disturbed child exists in both residential treatment centers and in-patient hospital units. Table 3.2.2: Number and Percent of Institutions by Minimum Age for Admission by Type of Institution presents a frequency distribution of these data.

3.2.3 Maximum Age for Admission

Almost half of all institutions serving the emotionally disturbed child have a maximum age for admission of 17-18 (46% of residential treatment centers and 48% of in-patient hospital units). There are, of course, hospital facilities available to those over

MINIMUM AGE	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
No minimum	-	-	5	16%	5	6%
1	-	-	-	-	-	-
2	1	2%	1	3%	2	2%
3	3	5%	1	3%	4	4%
4	2	3%	-	-	2	2%
5	5	8%	2	6%	7	7%
6	16	27%	2	6%	18	20%
7	4	7%	-	-	4	4%
8	3	5%	2	6%	5	6%
9	2	3%	-	-	2	2%
10	2	3%	-	-	2	2%
11	5	8%	1	3%	6	7%
12	9	15%	8	26%	17	19%
13	6	10%	7	23%	13	14%
14	-	-	1	3%	1	1%
15	1	2%	-	-	1	1%
16	-	-	1	3%	1	1%
	(n=59)		(n=31)		(n=90)	

TABLE 3.2.2: NUMBER AND PERCENT OF INSTITUTIONS BY MINIMUM AGE FOR ADMISSION BY TUPE OF INSTITUTION

18 years of age but residential treatment centers are uncommon for this population. Those individuals over the age of 18, therefore, who do not require hospitalization, but are in need of help rely on community mental health centers, out-patient units of hospitals and private psychologists and psychiatrists.

Alternate living situations, such as group homes and half-way houses do exist, but they are few in number and for the large part unavailable to most individuals in this category. Educators point to the fact that most emotionally disturbed children and youth are several years behind their peers in academic achievement. Even when this cycle is broken and learning begins to occur at an accelerated rate there is still considerable "catch-up" time to consider. Sometimes, individuals reach the age of 18 and are in the midst of learning junior high school material when suddenly funds are cut off and educational services cease to be delivered. This age limit is viewed by most educators as a barrier to meeting the educational needs of emotionally disturbed adolescents.

MAXIMUM AGE	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
10	4	7%	-	-	4	4%
11	-	-	1	3%	1	1%
12	4	7%	1	3%	5	6%
13	3	5%	1	3%	4	4%
14	8	14%	-	-	8	9%
15	5	8%	-	-	5	6%
16	4	7%	5	16%	9	10%
17	13	22%	4	13%	17	19%
18	14	24%	11	35%	25	28%
19	-	-	-	-	-	-
20	-	-	3	10%	3	3%
21	3	5%	3	10%	6	7%
22	-	-	-	-	-	-
23	-	-	-	-	-	-
24	1	2%	-	-	1	1%
No maximum	-	-	2	6%	2	2%
	(n=59)		(n=31)		(n=90)	

TABLE 3.2.3: NUMBER AND PERCENT OF INSTITUTIONS BY MAXIMUM AGE FOR ADMISSION BY TYPE OF INSTITUTION

3.2.4: Admission Criteria

Administrators were asked if they would accept children whose primary diagnosis was emotional disturbance but who were also either developmentally disabled, neurologically impaired, phsyically handicapped, psychotic, suicidal, aggressive, drug abusers, learning disabled or delinquent. Every institution (100%) said that they accept children who are aggressive. This is not surprising, since aggression is usually a component of emotional disturbance. Likewise, most institutions (98% of residential treatment centers and 93% of in-patient hospital units) accept children who are learning disabled and most accept delinquent children (91% of residential treatment centers and 87% of in-patient hospital units). These results are also to be expected given the academic problems and anti-social behavior which are often symptoms of emotional disturbance.

There are also many differences in those children accepted for residential treatment centers as opposed to in-patient hospital units. The most obvious difference concerns physically handicapped children.

Of in-patient hospital units, 74 percent report that they will accept and can accomodate children whose primary diagnosis is emotional disturbance but who are physically handicapped as well, while only 25 percent of residential treatment centers will accept these children. Hospitals also more often accept developmentally disabled children (71% as compared to 56% of residential treatment centers), suicidal children (97% as compared to 73% of residential treatment centers), and drug abusers (93% as compared to 64% of residential treatment centers). Finally, and perhaps most important, is the fact that 97 percent of the hospitals will accept overtly psychotic children as compared to only 66 percent of the residential treatment centers. It must be inferred from this comparison, that hospitals are dealing with a population which is more profoundly disturbed, more potentially violent, and more problematic

educationally than that of the residential treatment center. The education and socialization programs run by these hospitals (described later in this chapter) must, therefore, be appraised in light of their more difficult population. Table 3.2.4: Number and percent of institutions Accepting Children with Specified Diagnoses by Type of Institution displays these data.

ADMISSION CRITERIA	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Developmentally Disabled	33	56%	22	71%	55	61%
Neurologically Impaired	48	81%	26	84%	74	82%
Physically Handicapped	15	25%	23	74%	38	42%
Psychotic	39	66%	30	97%	69	77%
Suicidal	43	73%	30	97%	73	81%
Aggressive	59	100%	31	100%	90	100%
Drug Abusers	38	64%	29	93%	67	74%
Learning Disabled	58	98%	29	93%	87	97%
Delinquent	54	91%	27	87%	81	90%
Behavior Disorders	6	10%	2	6%	8	9%
	(n=59)		(n=31)		(n=90)	

TABLE 3.2.4: NUMBER AND PERCENT OF INSTITUTIONS ACCEPTING CHILDREN WITH SPECIFIED DIAGNOSES BY TYPE OF INSTITUTION

It should be noted here that there appears to be much variance both within and between the two types of institutions in terms of the severity of the mental illness of their populations. Unfortunately, emotional disturbance remains a "catch-all" category. Some institutions contain children who are merely behavior problems and who are more in need of alternative living situations than intensive psychotherapy. These children have often been identified as status offenders or juvenile delinquents and a major factor in their disturbance is an unstable family situation characterized by abuse, alcoholism, drug addiction, etc. Given the unhealthy atmosphere of many juvenile correctional institutions, courts sometimes place these children in residential treatment centers or hospitals for the emotionally disturbed. In contrast, many hospital wards serve children who are autistic or schizophrenic. Although profoundly different in their behavior than the children with behavior disorders described earlier, these psychotic children are also labeled "emotionally disturbed." The fact that two such discrepant types of behavior are both labeled emoticnal disturbance makes a comparison of education and socialization programs across institutions quite difficult. An institution with a preponderance of autistic children may be concentrating on non-verbal communication techniques while an institution with many aggressive children of normal intelligence may have a program which approximates or even excels that of a regular public school.

3.2.5 Average Length of Stay

Residential treatment centers are characterized by an average length of stay of one year or more. These average lengths cluster at 12 months (12%), 18 months (17%), 24 months (20%), and 36 months (12%) with a mean of 22 months. In-patient units of hospitals, however, characteristically reported an average length of stay of one year or less. The most commonly reported average lengths of stay were 2 months (13%), 3 months (23%), 6 months (16%) and 12 months (10%). The mean length of

LENGTH OF STAY IN MONTHS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
1-6	3	5%	20	65%	23	26%
7-12	9	15%	7	23%	16	18%
13-18	19	32%	-	-	19	21%
19-24	14	24%	2	6%	18	20%
25-36	10	17%	1	3%	11	12%
37-72	4	7%	1	3%	5	6%
	(n=59)		(n=31)		(n=90)	

TABLE 3.2.5a: THE NUMBER AND PERCENT OF INSTITUTIONS BY AVERAGE LENGTH OF STAY BY TYPE OF INSTITUTION

TYPE OF INSTITUTION	LENGTH OF STAY IN MONTHS ($\bar{x}$)
Residential Treatment Centers (n=59)	22
In-Patient Hospital Units (n-31)	9
All Institutions (n=90)	18

TABLE 3.2.5b: MEAN LENGTH OF STAY BY TYPE OF INSTITUTION

Stay for in-patient hospital units is 9 months. Furthermore, hospitals reported a significantly shorter average length of stay than residential treatment centers (9 months as compared to 22 months). A full 64 percent of in-patient hospital units have an average length of stay of 6 months or less, as compared to only 6 percent of residential treatment centers. This short length of stay has many implications for education and socialization programming. The hospital unit is at an advantage regarding socialization since their students are away from their regular school for a shorter period of time and therefore require less readjustment and deinstitutionalization. Hospitals are at a disadvantage educationally, however, since it is hard to ensure continuity of an educational program when there is a short length of stay and a high turnover rate for patients.

It must be noted that this short length of stay is not necessarily indicative of a higher success rate with emotionally disturbed children. Discharge from a hospital does not always mean that a child is going home. Often he is transferred to a residential treatment center or to another hospital. These children tend to "make the rounds" of available institutions. Hospitals consider themselves a last resort for the emotionally disturbed child and are therefore anxious to return him to a residential treatment center or a community health facility. Table 3.2.5a: The Number and Percent of Institutions by Averager Length of Stay by Type of Institution presents a frequency distribution of these data, while Table 3.2.5b: Mean Length of Stay by Type of Institution presents the means for residential treatment centers and in-patient hospital units discussed above.

3.2.6 Percent of Residents Receiving Educational Services

Residential treatment centers educate 89 percent of their residents while in-patient hospital units educate 92 percent of their residents. The remaining number of emotionally disturbed children are either: 1) enrolled in a regular public or private school, 2) already graduated from high school, 3) over the age of 18 and

not eligible for educational services, or 4) too mentally ill to benefit from education. Table 3.2.6: Mean Percent of Residents Receiving Educational Services by Type of Institution, displays these data.

TYPE OF INSTITUTION	MEAN % OF RESIDENTS RECEIVING EDUCATIONAL SERVICES
Residential Treatment Centers (n=59)	89%
In-patient Hospital Units (n=31)	92%
All Institutions (n=90)	90%

TABLE 3.2.6: MEAN PERCENT OF RESIDENTS RECEIVING EDUCATIONAL SERVICES BY TYPE OF INSTITUTION

3.3: Teaching Staff Characteristics

The demographic characteristics of teachers who instruct emotionally disturbed children within institutions have long been of interest to educators. Several significant variables were measured and will be discussed in turn. Table 3.3: Teaching Staff Characteristics by Type of Institutions presents the data for each demographic variable measured. Please note that the percentages in this table were computed on the basis of the total number of teachers in each category.

3.3.1: Sex of Teachers

The teaching staff of the residential treatment centers in our sample was 42 percent male and 58 percent female, while that of in-patient hospital units was 38 percent male and 62 percent female. On the whole, therefore, the majority of teachers who work in institutions for the emotionally disturbed are female (59% female, 41% male for all institutions).

3.3.2: Age of Teachers

Both residential treatment centers and in-patient hospital units tend to employ young teachers. In fact, 49 percent of teachers in residential centers and 38 percent of teachers in hospitals are between 20-29 years of age; 31 percent and 25 percent respectively are between 30-39 years of age. Thus, 75 percent of the teachers employed by institutions are under 40 years of age. The exact breakdown of teachers by age is presented in Table 3.3.

3.3.3: Level of Education of Teachers

Only 6 percent of teachers working in residential treatment centers and 4 percent of teachers in hospitals have less than a B.A. degree. A full 56 percent and 47 percent respectively have earned their B.A. and 36 percent and 47 percent respectively, have earned their Masters degree. Doctorates have been earned by 2 percent of teachers in both types of institutions. In sum, 94 percent of the teachers who instruct institutionalized

emotionally disturbed children have a B.A. degree or a higher degree; 40 percent of these teachers have a M.A. degree or higher degree. (See Table 3.3.)

3.3.4: Employment Status of Teachers

Approximately 89 percent of teachers in both types of institutions are full-time employees, 10 percent part-time, and 1 percent volunteers (See Table 3.3). It is important to note, however, that many teachers working in institutions for the emotionally disturbed are actually provided and salaried by the local school district.

These teachers are generally under the supervision and direction of the educational program director of the institution but they are not employees of the institution. They are instead public school teachers on the county payroll who happen to teach within an institution. Although not a formal question on the survey instrument, nearly one-third of the institutions visited volunteered that their teachers were not direct employees but were instead salaried by the local school district.

3.3.5: Certification of Teachers

The percentage of teachers who have obtained each type of certification is presented in Table 3.3. Please note that the percentages do not add up to 100 percent because a given teacher may have more than one type of certification, e.g., elementary and special education.

According to the survey, 84 percent of the teachers in residential treatment centers have either an elementary or secondary education certificate as compared to 97 percent of the teachers in in-patient hospital units. In addition, 10 percent of teachers in residential treatment centers and 9 percent of teachers in hospitals have provisional special education certification, and 26 percent and 44 percent respectively have permanent special education certification. Thus, 86 percent of teachers in both

types of institutions have elementary or secondary education certification, and 41 percent have either a provisional or permanent certificate in special education.

Concerning a comparison of the two types of institutions, the figures indicate that in-patient hospital units employ significantly more teachers permanently certified in special education (44%) then do residential treatment centers (26%). (See Table 3.3.)

3.3.6: Area of Specialization

Educational Program Directors were asked to indicate the area of specialization of each of their teachers. This presented problems in some cases either because teachers had several areas of specialization or because they were considered to be generalists and had no specific areas of specialization. In the former case, educational program directors were instructed to check one box for each area of specialization of a given teacher, and in the latter case a separate category of "general elementary" was created. It must be noted, however, that teachers of several subjects at the elementary level were sometimes entered as having more than one area of specialization and sometimes entered under the "general elementary" category.

Looking at institutions as a whole, the highest percentages of teachers instruct their pupils in Reading (16%), Social Studies/History (16%), English (15%), general elementary school material (14%) and Math (12%). Areas of specialization for remaining teachers are rather evenly distributed except for music media, foreign language and business teachers of which there are low numbers in both types of institutions. (See Table 3.3.)

Comparing types of institutions we find that hospitals have more english teachers, (20% as compared to 13% for residential centers), social studies teachers (22% as compared to 13%),

science teachers (13% as compared to 4%), diagnostic-prescriptive teachers (13% as compared to 6%) and crisis-resource teachers (14% as compared to 3%).

In conclusion, it appears that while the core curriculum (math/english-reading/social studies) is well represented in terms of the areas of specialization of nearly one-half of the teachers in the sample, other subject areas are given considerably less emphasis. This lack of availability of electives will be further discussed in section 3.8.

TEACHING STAFF CHARACTERISTICS		TYPE OF INSTITUTION					
		RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
SEX	Male	234	42%	83	38%	317	41%
	Female	325	58%	138	62%	463	59%
AGE	20-29	272	49%	85	38%	357	46%
	30-39	174	31%	56	25%	230	29%
	40-49	73	13%	39	18%	112	14%
	50-59	28	5%	25	12%	53	7%
	60-69	12	2%	16	7%	28	4%
LEVEL OF EDUCATION	Less than B.A.	37	6%	9	4%	46	6%
	B.A.	313	56%	105	47%	418	54%
	M.A.	200	36%	103	47%	303	38%
	Ph.D.	9	2%	4	2%	13	2%
EMPLOYMENT STATUS	Full-time (Salaried)	493	88%	197	89%	690	89%
	Part-time (Salaried)	59	11%	24	10%	80	10%
	Volunteer	7	1%	3	1%	10	1%
CERTIFICATION	Elementary	232	42%	99	45%	331	42%
	Secondary	231	42%	116	52%	347	44%
	Special Education-Provisional	57	10%	20	9%	77	10%
	Special Education-Permanent	145	26%	98	44%	243	31%
AREA OF SPECIALIZATION	Math	57	10%	39	18%	96	12%
	Language Arts-Reading	79	14%	42	19%	121	16%
	Language Arts-English	72	13%	44	20%	116	15%
	Social Studies/History	73	13%	49	22%	122	16%
	Science	22	4%	28	13%	50	6%
	Art	39	7%	15	7%	54	7%
	Music	23	4%	7	3%	30	4%
	Physical Education	44	8%	12	5%	56	7%
	Media	9	2%	8	4%	17	2%
	Foreign Language	9	2%	3	1%	12	2%
	Diagnostic-Prescriptive	34	6%	28	13%	62	8%
	Crisis Resource	15	3%	30	14%	45	6%
	Vocational Education	29	5%	22	10%	51	7%
	Business	15	3%	9	4%	24	3%
	Special Education	49	9%	6	3%	55	7%
	General Elementary	81	14%	31	14%	112	14%
		(n=559)		(n=221)		(n=780)	

TABLE 3.3: TEACHING STAFF CHARACTERISTICS BY TYPE OF INSTITUTION

3.4 Educational Program Characteristics

The following section discusses selected parameters of the educational programs offered by both residential treatment centers and in-patient hospital units.

3.4.1 Special Education Certification Requirements

41 percent of residential treatment centers and 55 percent of in-patient hospital units require that the teachers they employ to instruct their emotionally disturbed children and youth be certified in special education. Table 3.4.1: Number and Percent of Institutions which Require that Teachers be Certified in Special Education by Type of Institution presents these data.

TYPE OF INSTITUTION	INSTITUTIONS REQUIRING SPECIAL EDUCATION CERTIFICATION	
Residential Treatment Centers (n=59)	24	41%
In-Patient Hospital Units (n=31)	17	55%
All Institutions (n=90)	41	46%

TABLE 3.4.1: NUMBER AND PERCENT OF INSTITUTIONS WHICH REQUIRE THAT TEACHERS BE CERTIFIED IN SPECIAL EDUCATION BY TYPE OF INSTITUTION

The fact that only one-half of the institutions require teachers to be certified in special education is a significant finding. Some administrators and educational program directors deplore this lack of required certification and would like to see special education certification a criteria for employment of teachers within institutions. Others, however, feel that special education certification is irrelevant to effective teaching. They point to the strong personality characteristics needed to teach aggressive children who have had successive experience of failure in the public school system. In their opinion, personality characteristics such as firmness, patience, high self-esteem, compassion, etc., are more important than formal training to the successful education of the emotionally disturbed child.

3.4.2 Teacher=Student Ratio

The average teacher-student ratio for residential treatment centers is 1:7.4 and that for in-patient hospital units is 1:6.9. Table 3.4.2a: Mean Teacher-Student Ratio by Type of Institution presents these data while Table 3.4.2b: Number and Percent of Teacher-Student Ratios by Type of Institution presents a more detailed description. These ratios of approximately 1:7 are significantly

TYPE OF INSTITUTION	TEACHER STUDENT RATIO ($\bar{x}$)
Residential Treatment Centers (n=59)	1:7.4
In-Patient Hospital Units (n=31)	1:6.9
All Institutions (n=90)	1:7.2

TABLE 3.4.2a: MEAN TEACHER-STUDENT RATIO BY TYPE OF INSTITUTION

lower than those stipulated in most State laws (1:10 or 1:12) but are usually higher than the educational program directors would like.

The need for individualized instruction, "one on one," has long been recognized but is difficult to implement in reality. In those cases where the teachers instructing within the institutions are provided and salaried by the public school system, only a certain number of teachers (based on the number of students) can be obtained. Likewise, where teachers are direct employees of the institution, financial considerations often mediate against hiring enough teachers to obtain a low teacher-student ratio. It should be noted, however, that the overwhelming majority of institutions employ teacher aides and volunteers to help fill this gap and to provide more individual attention to their emotionally disturbed children.

TEACHER-STUDENT RATIO	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
1:2	1	2%	1	3%	2	2%
1:3	1	2%	2	6%	3	3%
1:4	4	7%	3	10%	7	8%
1:5	12	20%	4	13%	16	18%
1:6	7	12%	4	13%	11	12%
1:7	4	7%	5	16%	9	10%
1:8	14	24%	5	16%	19	21%
1:9	5	8%	2	6%	7	8%
1:10	7	12%	4	13%	11	12%
1:12	4	7%	-	-	4	4%
1:17	-	-	1	3%	1	1%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.2b: NUMBER AND PERCENT OF INSTITUTIONS BY TEACHER-STUDENT RATIOS BY TYPE OF INSTITUTION

3.4.3 Accreditation Status

The great majority of educational programs offered within institutions are accredited by the appropriate State Department of Education. More specifically, 80 percent of programs run by residential treatment centers and 71 percent of programs run by in-patient hospital units are accredited by the State Department of Education. Table 3.4.3: Number and Percent of Institutions Whose Educational Programs are Accredited by State Departments of Education by Type of Institution presents these data.

TYPE OF INSTITUTIONS	PROGRAMS ACCREDITED BY STATE DEPARTMENTS OF EDUCATION	
Residential Treatment Centers (n=59)	47	80%
In-Patient Hospital Units (n=31)	22	71%
All Institutions (n=90)	69	77%

TABLE 3.4.3: NUMBER AND PERCENT OF INSTITUTIONS WHOSE EDUCATIONAL PROGRAMS ARE ACCREDITED BY STATE DEPARTMENTS OF EDUCATION BY TYPE OF INSTITUTION

It is important to realize that the educational programs within some institutions (especially hospitals) do not fall under the jurisdiction of the State Department of Education. Some states require instead that certification be granted by the State Department of Mental Health or a related agency. Therefore, the percentage of accredited educational programs offered by institutions for the emotionally disturbed is actually higher than that reflected by State Education Department Accreditation alone (Table 3.4.3).

3.4.4 Carnegie Unit Awards

Carnegie Units are credits assigned to approved courses at the high school level which are required for graduation. For example, a student may need 2 units of English, 2 units of Math, 2 units of Science, etc., to be eligible for an academic diploma. According to the survey, 54 percent of residential treatment centers and 68 percent of in-patient hospital units award Carnegie Units for academic achievement. Table 3.4.4: Frequency of Institution Which Award Carnegie Units by Type of Institution displays these data.

TYPE OF INSTITUTION	INSTITUTIONS AWARDING CARNEGIE UNITS	
Residential Treatment Centers (n=59)	32	54%
In-Patient Hospital Units (n=31)	21	68%
All Institutions (n=90)	53	59%

TABLE 3.4.4: NUMBER AND PERCENT OF INSTITUTIONS WHICH AWARD CARNEGIE UNITS BY TYPE OF INSTITUTION

There are two reasons for these low percentages. First, many institutions do not offer high school level courses due to a younger population and therefore Carnegie Unit Awards are not given. Second, it was apparent that several administrators did not understand what Carnegie Units were, despite repeated explanation by the interviewer, resulting in underreporting. Therefore, the percentage of institutional educational programs awarding Carnegie Units is believed to be higher than that reflected in Table 3.4.4.

3.4.5 Diploma Eligibility

Administrators were asked whether their students were eligible for a high school diploma upon completion of the educational program, and if so, was this diploma awarded by the institution itself or by the school last attended by the child. Approximately 8 percent of residential treatment centers reported granting diplomas directly, while 36 percent prepare the child to receive a diploma from the school he last attended. Comparable figures emerged for in-patient hospital units, with 10 percent granting diplomas directly and 48 percent enabling student to obtain high school dimplomas from the school they last attended. Table 3.4.5: Number and Percent of Institutions Which Grant Diplomas Directly and Through Last Attended School by Type of Institution displays these data.

TYPE OF INSTITUTION	DIPLOMA GRANTED BY:			
	INSTITUTION		LAST ATTENDED SCHOOL	
Residential Treatment Centers (n=59)	5	8%	21	36%
In-Patient Hospital Units (n=31)	3	10%	15	48%
All Institutions (n=90)	8	9%	36	40%

TABLE 3.4.5: NUMBER AND PERCENT OF INSTITUTIONS WHICH GRANT DIPLOMAS DIRECTLY AND THROUGH LAST ATTENDED SCHOOL BY TYPE OF INSTITUTION

3.4.6 Length of Educational Programs

Residential treatment centers and in-patient hospital units are almost identical in the lengths of their educational programs. Both types of institutions usually hold classes five hours a day, five days a week over a ten and a half month period each year. The exact means are presented in Table 3.4.6: Mean Length of Educational Program by Type of Institution.

TYPE OF INSTITUTION	LENGTH OF EDUCATIONAL PROGRAM		
	HOURS PER DAY ($\bar{x}$)	DAYS PER WEEK ($\bar{x}$)	MONTHS PER YEAR ($\bar{x}$)
Residential Treatment Centers (n=59)	5.11	5.03	10.67
In-Patient Hospital Units (n=31)	4.77	5.00	10.45
All Institutions (n=90)	5.00	5.02	10.60

TABLE 3.4.6: MEAN LENGTH OF EDUCATIONAL PROGRAM BY TYPE OF INSTITUTION

Although not a formal question on the survey instrument, many educational program directors mentioned that their institutions ran summer programs of 5-10 weeks duration. These programs were basically recreational in nature but often had an academic component as well.

3.4.7 Grades Covered by the Educational Program

Hospitals tend to have grade organizations which parallel the public school system (K-12, 1-12, 7-12, etc.) which enables them to best serve a short-term, rapidly changing population. Residential treatment centers, on the other hand, have more specialized grade spans that reflect the needs of their more stable population.

The mean grade span for residential treatment centers is 3.9 to 10.5. For in-patient hospital units, the mean grade span is 6.1 to 11.2. The difference in lower grades may, however, not be as great as these figures suggest. As explained earlier, our interviewers tended to deal more often with administrators in adolescent units rather than children's units in hospitals and this bias in the sampling may account for the difference in mean lowest grade covered.

Interestingly 29 percent of both residential treatment centers and in-patient hospital units report that their educational programs are essentially ungraded. In these types of programs each child is individually instructed at his or her level of academic achievement. No attempt is made to group children together and teach a grade oriented curriculum.

Table 3.4.7a: Frequency of Grade Spans by Type of Institution describes the precise grades covered by the 90 institutions in our sample, while Table 3.4.7b: Mean Grades Span by Type of Institution presents the mean lowest and highest grades discussed above.

3.4.8 Co-curricular Resources Available

The majority of both residential treatment centers and in-patient hospital units provide their children with a gymnasium, outdoor recreational area, reading center, library, art center, and industrial arts area. However, only 19 percent of residential treatment centers and 16 percent of in-patient hospital units have a drama center; only 42 percent and 35 percent respectively,

TABLE 3.4.7a: NUMBER AND PERCENT OF INSTITUTIONS BY GRAD SPAN BY TYPE OF INSTITUTION

GRADE SPAN	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
preschool - 7	1	2%	1	3%	2	2%
preschool - 11	-	-	1	3%	1	1%
preschool - 12	6	10%	1	3%	7	8%
K-6	3	5%	-	-	3	3%
K-8	3	5%	-	-	3	3%
K-9	1	2%	-	-	1	1%
K-12	3	5%	5	16%	8	9%
1-8	3	5%	-	-	3	3%
1-11	2	3%	-	-	2	2%
1-12	3	5%	4	13%	7	8%
2-12	-	-	2	6%	2	2%
6-12	3	5%	1	3%	4	4%
7-12	5	8%	4	13%	9	10%
Other, elementary only	1	2%	-	-	1	1%
Other, secondary only	2	3%	2	5%	4	4%
Other, combined	6	10%	1	3%	7	8%
Ungraded	17	29%	9	29%	26	29%
	(n=59		(n=31)		(n=90)	

TYPE OF INSTITUTION	GRADES COVERED BY PROGRAM	
	LOWEST GRADE ($\bar{x}$)	HIGHEST GRADE ($\bar{x}$)
Residential Treatment Centers (n=59)	3.9	10.5
In-Patient Hospital Units (n=31)	6.1	10.5
All institutions (n=90)	4.5	10.7

TABLE 3.4.7b: MEAN GRADE SPAN BY TYPE OF INSTITUTION

provide a laboratory; and only 41 percent and 23 percent respectively provide a swimming pool. Music and drama seem to be low priorities in most educational programs and science laboratory equipment is deemed too dangerous for an emotionally disturbed student population. While the figures for hospital units are lower than those for residential treatment centers, it is important to realize that, unlike residential treatment centers, units of hospitals have other resources at their disposal. These in-patient units can utilize the facilities of other departments within the hospital. For example, they may use the swimming pool in the physical therapy department, the music room in the recreational therapy department and the woodworking shop in the occupational therapy department. Therefore, the low percentage of co-curricular resources reported by the in-patient units of the hospitals in our sample may under-estimate the true availability of these resources.

The "other" response refers to such things as a TV studio, farm, photography laboratory, sheltered workshop, speech laboratory, and Activities for Daily Living laboratory. Only 10 institutions had one of these other resources available to its students. Table 3.4.8: Number and Percent of Institutions by Co-curricular Resources by Type of Institution presents these data.

3.4.9 Grouping Criteria

The most common criteria for grouping appears to be the level of academic achievement of the students (68 percent of residential treatment centers and 84 percent of in-patient hospital units use this criteria). The frequent use of this grouping criteria is an outgrowth of a general commitment to individualized instruction (see section 3.4.13). Thus children of different ages with the same level of academic achievement sit together and learn together, each at his own pace.

CO-CURRICULAR RESOURCES	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Gymnasium	39	66%	20	65%	59	66%
Outdoor Recreational Area	58	98%	28	90%	86	96%
Reading Center	37	63%	17	55%	54	60%
Library	48	81%	21	68%	60	67%
Drama Center	11	19%	5	16%	16	18%
Art Center	50	85%	24	77%	74	82%
Music Center	25	42%	11	35%	36	40%
Science Laboratory	17	29%	6	19%	23	26%
Industrial Arts Area	32	54%	17	55%	49	54%
Pool	24	41%	7	23%	31	34%
Other	6	10%	4	13%	10	11%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.8: NUMBER AND PERCENT OF INSTITUTIONS BY CO-CURRICULAR RESOURCES BY TYPE OF INSTITUTION

Residential treatment centers are more likely to group on the basis of chronological age (59 percent as compared to 39 percent for hospitals), whereas hospitals tend to use severity of the disability as a basis for grouping more often than residential centers (52 percent as compared to 37 percent for residential centers) and social adjustment (61 percent as compared to 49 percent). On the other hand, it appears that the sex of the child bears little relation to his placement in learning situations. Only 12 percent of residential treatment centers and 6 percent of in-patient hospital units use sex as a grouping criteria.

"Other" in this case refers to groupings on the basis of teacher preference for a type of student or interest of the student, and finally, two institutions reported that they had totally individualized instruction with no grouping whatsoever. Table 3.4.9: Number and Percent of Institutions by Grouping Criteria by Type of Institution displays these data.

GROUPING CRITERIA	TYPE OF INSTITUTION					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		TOTAL	
Chronological Age	35	59%	12	39%	47	52%
Sex	7	12%	2	6%	9	10%
Level of Achievement	40	68%	26	84%	66	73%
Type of Disability	20	34%	12	39%	32	36%
Severity of Disability	22	37%	16	52%	38	42%
Social Adjustment	29	49%	19	61%	48	53%
Emotional Adjustment	28	47%	17	55%	45	50%
Other	7	12%	1	3%	8	9%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.9: NUMBER AND PERCENT OF INSTITUTIONS BY GROUPING CRITERIA BY TYPE OF INSTITUTION

3.4.10 Curriculum Utilization

Significant difference in the source of educational curricula was reported by the two types of institutions under study. Seventy-six percent of the residential treatment centers in the sample reported developing their own curriculum as compared to 84 percent of in-patient hospital units. Thirty-four percent of residential treatment centers utilize the state curriculum and 31 percent utilize the county curriculum. In contrast, approximately the same percentage of hospitals as residential centers use the state curriculum (32%) but only 19 percent of hospitals use the county curriculum. However, even when the state or county curriculum is adopted for use, it is modified considerably to accommodate the educational needs of the emotionally disturbed children within these institutions. Table 3.4.10: Number and Percent of Institutions by Curriculum Utilization by Type of Institution presents these data.

TYPE OF INSTITUTION	AGENCY RESPONSIBLE FOR DEVELOPMENT OF CURRICULUM					
	COUNTY		STATE		INSTITUTION	
Residential Treatment Centers (n=59)	18	31%	20	34%	45	76%
In-Patient Hospital Units (n=31)	6	19%	10	32%	26	84%
All Institutions (n=90)	24	27%	30	33%	71	79%

TABLE 3.4.10: NUMBER AND PERCENT OF INSTITUTIONS BY CURRICULUM UTILIZATION BY TYPE OF INSTITUTION

3.4.11 Subject Areas Offered

Virtually all institutions offer Mathematics, Language Arts, Reading, English, and Social Studies. In addition to this core curriculum, the vast majority of both residential treatment centers and in-patient hospital units offer History, Science, Art and Physical Education. Beyond this, residential treatment centers and in-patient hospital units differ significantly in their provision of other courses.

In all cases, a greater variety of courses are offered by residential treatment centers than by hospitals. These centers are more likely to offer:

- activities for daily living (80% as compared to 65%);
- money management (78% as compared to 39%);
- community resources (75% as compared to 48%);
- family life and sex education (65% as compared to 42%);
- drugs and behavior (63% as compared to 48%);
- foreign language (20% as compared to 13% for hospitals).

In response to questions as to what other courses are offered, a small number of institutions reported that they offered homemaking, outdoor education, pre-vocational training, geography, typing, psychology/sociology, and perceptual motor activities. The exact breakdown for these and the other courses discussed earlier appears in Table 3.4.11: Number and Percent of Institutions by Subject Areas Offered by Type of Institution.

3.4.12 Vocational Education Programs

In general, very few vocational education programs are offered by institutions for emotionally disturbed children. Only 39 percent of residential treatment centers and 26 percent of in-patient hospital units offer vocational education to their students. Of those that do offer vocational programs, the areas

TABLE 3.4.11: NUMBER AND PERCENT OF INSTITUTIONS BY SUBJECT AREAS OFFERED BY TYPE OF INSTITUTION

SUBJECT AREAS	TYPE OF INSTITUTION					
	RESIDENTIAL TREATMENT		IN-PATIENT HOSPITAL		ALL INSTITUTIONS	
Mathematics	59	100%	31	100%	90	100%
Language Arts	59	100%	31	100%	90	100%
Reading	59	100%	31	100%	90	100%
English	59	100%	30	97%	89	99%
History	59	100%	26	84%	82	91%
Social Studies	58	98%	29	94%	87	97%
Science	53	90%	27	87%	80	89%
Art	56	95%	27	87%	83	92%
Music	30	51%	15	48%	45	50%
Physical Education	54	92%	23	74%	77	86%
Foreign Language	12	20%	4	13%	16	18%
Activities for Daily Living	47	80%	20	65%	67	74%
Family Life and Sex Education	38	64%	13	42%	51	57%
Drugs and Behavior	37	63%	15	48%	52	58%
Money Management	46	78%	23	39%	69	77%
Community Resources	44	75%	15	48%	59	66%
Homemaking	9	15%	6	19%	15	17%
Outdoor Education	2	3%	-	-	2	2%
Pre-vocational	5	8%	-	-	5	5%
Geography	1	2%	-	-	1	1%
Typing	4	7%	2	6%	6	7%
Psychology/sociology	1	2%	1	3%	2	2%
Perceptual Motor	2	3%	-	-	2	2%
	(n=59)		(n=31)		(n=90)	

that receive the greatest emphasis appear to be business and office occupations (27 percent for residential treatment centers and 16 percent for hospitals), construction occupations (20 percent and 10 percent respectively), consumer and homemaking occupations (20 percent and 23 percent respectively), and marketing and distribution occupations (15 percent and 6 percent respectively). The remaining occupational areas are taught in 10 percent or less of the institutions.

Many institutions do not have children of high school age and therefore feel that vocational education is irrelevant for their population. Several institutions with younger children take the opposing view and endeavor to provide pre-vocational education for their students. An exact breakdown of the number and types of vocational education programs offered by institutions for the emotionally disturbed is presented in Table 3.4.12: Frequency of Vocational Education Programs Offered by Type of Institution.

3.4.13 Teaching Techniques Utilized

Almost all of the institutions for the emotionally disturbed in the sample utilize small group classrooms, tutoring and individually prescribed instruction. Seventy-three percent of residential treatment centers and 61 percent of in-patient hospital units utilize team teaching. Seventy-eight percent of residential centers and 61 percent of hospitals utilize teacher aides in the classroom, and 46 percent of residential centers and 52 percent of hospitals provide their students with automated teaching aides. The low number of institutions which use automated teacher aides can be accounted for by the financial pressure exerted upon a great many institutions. These teaching machines are a low priority budget item in comparison to the many pressing needs of these children.

TYPE OF VOCATIONAL EDUCATION	TYPE OF INSTITUTION					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
Business and Office	16	27%	5	16%	21	23%
Marketing and Distribution	9	15%	2	6%	11	12%
Communications and Media	5	8%	2	6%	7	8%
Construction	12	20%	3	10%	15	17%
Manufacturing	4	7%	3	10%	7	8%
Transportation	2	3%	1	3%	3	3%
Agri-Business and Natural Resource	7	12%	2	6%	9	10%
Marine Science	1	2%	-	-	1	1%
Environmental Control	2	3%	1	3%	3	3%
Public Service	3	5%	2	6%	5	6%
Health	3	5%	2	6%	5	6%
Hospitality and Recreation	4	7%	2	6%	6	7%
Personal Service	6	10%	1	3%	7	8%
Fine Arts and Humanities	7	12%	1	3%	8	9%
Consumer and Homemaking	12	20%	7	23%	19	21%
Any Type of Vocational Education	23	39%	8	26%	31	34%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.12: NUMBER AND PERCENT OF INSTITUTIONS BY VOCATIONAL EDUCATION PROGRAMS OFFERED BY TYPE OF INSTITUTION

The "Other" category in Table 3.4.13 includes such teaching techniques as student tutoring student, value clarification and high interest-low difficulty consumable texts. Table 3.4.13: Frequency of Teaching Techniques Utilized by Type of Institution displays these data.

TEACHING TECHNIQUES	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Small Group Classroom	58	98%	31	100%	89	99%
Tutor Program	55	93%	31	100%	86	96%
Team Teaching	43	73%	19	61%	62	69%
Teacher Aides in Classroom	46	78%	19	61%	65	72%
Automated Teaching Aides	27	46%	16	52%	43	48%
Individually Prescribed Instruction	54	91%	26	84%	80	89%
Other	4	7%	1	3%	5	6%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.13: FREQUENCY OF TEACHING TECHNIQUES UTILIZED BY TYPE OF INSTITUTION

3.4.14 Timing of Diagnostic Educational Assessment

Concerning the occurrence of diagnostic educational assessment, 54 percent of the residential treatment centers and 58 percent of the in-patient hospital units report that assessment occurs after admission, 27 percent and 35 percent respectively report that assessment occurs both prior to and after admission, and 17 percent and 3 percent respe ively report that assessment occurs prior to admission.

The difference in the amount of prior assessment between hospitals (3%) and residential treatment centers (17%) probably reflects discrepant admission criteria. There must be tangible evidence of emotional disturbance in the form of test scores, psychiatric opinion, etc., before a child will be admitted to a residential treatment center, while a child may be admitted to a hospital for a specified period of time without prior assessment for the express purpose of evaluation and diagnosis. This role of the hospital as evaluator is relevant to all emotionally disturbed children, but is particularly evident in the case of children who have been adjudicated and subsequently committed to a hospital for observation.

Table 3.4.14: Timing of Diagnostic Educational Assessment by Type of Institution presents these data.

TYPE OF INSTITUTION	TIMING OF DIAGNOSTIC EDUCATIONAL ASSESSMENT					
	PRIOR TO ADMISSION		AFTER ADMISSION		BOTH	
Residential Treatment Centers (n=59)	10	17%	32	54%	16	27%
In-Patient Hospital Units (n=31)	1	3%	18	58%	11	35%
All Institutions (n=90)	11	12%	50	56%	27	30%

TABLE 3.4.14: TIMING AND DIAGNOSTIC EDUCATIONAL ASSESSMENT BY TYPE OF INSTITUTION

3.4.15: Professionals Responsible for Conducting Diagnostic Educational Assessments

The majority of diagnostic educational assessments are conducted by teachers (59% of residential treatment centers and 68% of in-patient hospital units). The second most frequent response was that of psychologist (31% and 35% respectively). Educational program directors conduct evaluations in 25 percent of residential treatment centers and 26 percent of in-patient hospital units. Remaining responses were divided between psychiatrist, and consulting school psychologist or special education teacher with particularly low percentages reported for diagnostic prescriptive teachers, resource teachers, reading specialists, speech therapists and social workers. Table 3.4.15: Number and Percent of Institution by Professionals Responsible for Diagnostic Education Assessment by Type of Institution presents the exact percentages for each occupational category.

PROFESSIONALS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Psychologist	18	31%	11	35%	29	32%
Teachers	35	59%	21	68%	56	62%
Educational Director Academic Coordinator or Principal	15	25%	8	26%	23	26%
Diagnostic - Prescription Teacher	-	-	1	3%	1	1%
Psychiatrist	7	12%	5	16%	12	13%
Resource Teacher	1	2%	-	-	1	1%
Contulting School Psychologist or Special Education Teacher	10	17%	4	13%	14	16%
Reading Specialist	4	7%	1	3%	5	6%
Speech Therapist	6	10%	-	-	6	7%
Social Worker	2	3%	1	3%	3	3%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.15: NUMBER AND PERCENT OF INSTITUTIONS BY PROFESSIONALS RESPONSIBLE FOR DIAGNOSTIC EDUCATIONAL ASSESSMENTS BY TYPE OF INSTITUTION

3.4.16 Tests and Measures Utilized

The most frequently used tests across both types of institutions were the WISC and WIPPSI (70%), the Bender Visual Motor Gestalt Test (75%), the Wide Range Achievement Test (73%), the Draw-a-Person Test (71%), the Rorschach Test (66%), the Peabody Picture Vocabulary Test (57%), the Thematic Apperception Test (56%) and the Stanford Binet (55%). The remaining tests are used by less than 50 percent of the institutions.

The wide diversity of tests used, illustrated in Table 3.4.16: Number and Percent of Tests and Measurements Used in Diagnostic Educational Assessment, reflects the difficulty experienced by educators in trying to find tests and measures which will accurately assess emotionally disturbed children. Many educators feel that achievement tests that are normed on a population of normal children are inappropriate and invalid for use with exceptional children. Since only normal children participate in the development of most standardized tests, the test scores of exceptional children cannot be interpreted. The Measurement Theory underlying the development of these tests clearly specifies that scores are valid only to the extent that the children to be tested in the future exhibit the same characteristics as those children who participated in the development of the test.

Secondly, since achievement tests usually require standardized administration procedures that are appropriate for normal children, the emotionally disturbed child is immediately at a disadvantage. For example, the hyperactive child does not have the control necessary to permit him to concentrate on test items long enough to respond correctly. Consequently, his low achievement test score reflects his hyperactivity and not his true achievement level.

Finally, should administrators of several institutions using different tests get together and try to compare their

INSTITUTIONS USING TEST		NAME OF TEST
Percent	Number	
70% or more	63 - 96	WISC/WIPPSI Bender Visual Motor Gestalt Test Wide Range Achievement Test Draw-a-Person Test
50% - 69%	45 - 62	Rorschach Test Peabody Picture Vocabulary Test Thematic Apperception Test Stanford Binet
40% - 49%	32 - 44	Frostig Developmental Test of Visual Perception Illinois Test of Psycholinguistic Abilities Peabody Achievement Test
30% - 39%	27 - 31	Wepman Test of Auditory Perception Vineland Scab of Social Maturity Stanford Achievement Test California Achievement Test
20% - 29%	18 - 26	Beery Developmental Test of Visual-Motor Integration
10% - 19%	9 - 17	Valley Psychoeducational Inventory of Basic Skills OTIS Quick Score Reading Metropolitan Achievement Test Key Math Detroit Test of Learning Aptitude Durrell Reading Analysis Test
less then 10%	1 - 8	Dorean Diagnostic Englement Self-Concept Inventory Burke's Behavior Rating Scale Spache Reading Scale Gates-McGinite Self-Developed Needs Assessment Kutan Battery Myklebust Screening Device San Diego Quick Assessment SRA Reading Diagnostic Exam Silent Reading Diagnostic Exam Iowa Test of Basic Skills Mosaic Woodcock Reading Mastery Stanford Science Botel Reading Gray Oral Carrow Auditory Comprehension of Language Carrow Elicited Language Bryant Concept Confusion Bryant Decoding Test Rosewell Chall Reading Jansky Screening Shiffman/Daniel Reading Inventory Ammons Quck Test Michigan Pictures Gilmore Reading Rotter Ayres Sensory-Motor Integration Goldman-Woodcock Auditory MMPI Spontaneous Sentence Kuder Personal and Vocational Strong Vocational Interest Blank Walker Effective Development Larsen Hammel Spelling Test Haak Barbe STEP Achievement ABEL Vocational IRI Sucher Already Reading and Spelling Inventory Sentence Completion Slosson Reading Test Malcomesius Screening for Learning Disabilities Monroe Group Achievement Test Purdue Perceptual Motor Inventory Minnesota Apperceptive Test Harris Test of Lateral Dominance Kinetic Family Drawing Pierce-Harris Self-Concept Scale Spache Diagnostic Reading Test

FIGURE 3.4.16: NUMBER + PERCENT OF INSTITUTIONS BY TESTS + MEASUREMENTS USED IN DIAGNOSTIC EDUCATIONAL ASSESSMENT

students on the basis of achievement test scores, they would find it impossible to do so. These tests are generally not comparable in terms of what they measure and how they measure it. Before any comparison could be made, the interested parties would have to examine such factors as the dates the testing occurred, the population upon which each test was developed, the level of each test, and the conditions under which each was administered. These types of information would be necessary in order to determine whether there is any real significance to an apparent discrepancy between scores.

3.4.17 Frequency of Educational Evaluation

Approximately one-third (31%) of residential treatment centers evaluate their students every 3 months, 19 percent every month or less, 17 percent every six months, 14 percent every two months and 12 percent every 4 months.

Educational evaluations conducted within in-patient hospital units show less variation in their cycles. They tend to occur every month or less (29%), every 3 months (26%) or every 6 months (26%). Looking at the average percentage for all institutions we find that 29 percent of the institutions perform evaluations every 3 months, 22 percent every month or less, and 20 percent every 6 months, with the remainder equally distributed. Table 3.4.17: Number and Percent of Institutions by Frequency of Educational Evaluation by Type of Institution displays these data.

3.4.18: Professionals Responsible for Conducting Educational Evaluations

Teachers are responsible for conducting educational evaluations in 85 percent of residential treatment centers and 84 percent of in-patient hospital units. Evaluations are conducted by Educational Program Directors or Principals in 27 percent of the residential treatment centers and 39 percent of the hospitals.

FREQUENCY OF EDUCATIONAL EVALUATION	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Not evaluated	1	2%	-	-	1	1%
Every month or less	11	19%	9	29%	20	22%
Every two months	8	14%	3	10%	11	12%
Every three months	18	31%	8	26%	26	29%
Every four months	7	12%	1	3%	8	9%
Every five months	1	2%	-	-	1	1%
Every six months	10	17%	8	26%	18	20%
Every nine months	1	2%	-	-	1	1%
Every year	2	3%	2	6%	4	4%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.17: NUMBER AND PERCENT OF INSTITUTIONS BY FREQUENCY OF EDUCATIONAL EVALUATION BY TYPE OF INSTITUTION

Residential treatment centers seem to make more use of psychologists in the role (24% as compared to 16% for hospitals) and social workers (10% and 3% respectively), while hospitals appear to utilize the services of a consulting school psychologist more frequently than residential treatment centers (10% and 3% respectively). Table 3.4.18: Frequency of Professionals Responsible for Conducting Educational Evaluations by Type of Institution presents these data.

PROFESSIONALS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Teachers	50	85%	26	84%	76	84%
Principal	16	27%	12	39%	28	31%
Psychiatrist	5	8%	4	13%	9	10%
Social Worker	6	10%	1	3%	7	8%
Child Care Worker	8	14%	3	10%	11	12%
Psychologist	14	24%	5	16%	19	21%
Consulting School Psychologist	2	3%	3	10%	5	6%
Other	4	7%	-	-	4	4%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.18: FREQUENCY OF PROFESSIONALS RESPONSIBLE FOR CONDUCTING EDUCATIONAL EVALUATIONS BY TYPE OF INSTITUTION

3.4.19 Utilization of Task Analysis

One of the current innovations in the field of education has been the development of the task analysis. For purposes of definition, a task analysis is a listing of the behavioral components necessary to the development of specific education skills. Survey results indicate that 36 percent of residential treatment centers and 52 percent of in-patient hospital units are now using a task analysis format when conducting student evaluations. Table 3.4.19: Number and Percent of Institutions Using Task Analysis as an Evaluative Tool by Type of Institution displays these data.

TYPE OF INSTITUTION	USE OF TASK ANALYSIS	
Residential Treatment Centers (n=59)	21	36%
In-Patient Hospital Unit (n=31)	16	52%
All Institutions (n=90)	37	41%

TABLE 3.4.19: NUMBER AND PERCENT OF INSTITUTIONS USING TASK ANALYSIS AS AN EVALUATIVE TOOL BY TYPE OF INSTITUTION

A partial example of a task analysis in the area of arithmetic is presented on the following page.

ARITHMETIC SKILLS	
1. Knows number concepts from 1-10	
Knows numbers from 1-10	
Knows numbers from 10-100	
2. Can add one digit + one digit whose sums equal 1 through 9	
3. Can use zero addend	
4. Can add two digit + one digit whose sums are 10 through 19	

ARITHMETIC SKILLS (Continued)	
16. Multiply a three digit factor by a two digit factor with carrying	
17. Find the quotient: combination related to products through 5x5 with no remainders	
18. Find the quotient: combinations related to products 5x5 through 9x9 with no remainders	
19. Find the quotient by dividing one place divisor into three digit number with no remainders	

25. Can add per cents	
Can subtract per cents	
Can multiply per cents	
Can divide per cents	
26. Can read and solve problems: explain on what level	
a. problem involving addition, subtraction, multiplication, divsion of whole numbers	
b. addition, subtraction, multiplication, division - fractions	
c. addition, subtraction multiplication, division - decimals	
d. addition, subtraction multiplication, division - per cents	
e. problems involving [illegible] one step	

3.4.20 Educational Evaluation Techniques

The overwhelming majority of both types of institutions use teacher observations (98% for residential treatment centers and 100% for in-patient hospital units), and anecdotal records (93% and and 94%). It appears that residential treatment centers rely more on achievement test scores (83%) than do hospitals (61%). Attitude inventories as an evaluative tool are not stressed at either type of institution (44% for residential treatment centers and 35% for in-patient hospitals). Number and Percent of Institutions by Evaluation Techniques Utilized by Type of Institution, Table 3.4.20, displays these data.

EVALUATION TECHNIQUES	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Teacher Observations	58	98%	31	100%	89	99%
Achievement Tests	49	83%	19	61%	70	78%
Attitude Inventories	26	44%	11	35%	37	41%
Psychologist Observations	50	85%	27	87%	77	86%
Anecdotal Records	55	93%	29	94%	84	93%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.20: NUMBER AND PERCENT OF INSTITUTIONS BY EVALUATION TECHNIQUES UTILIZED BY TYPE OF INSTITUTION

3.4.21: Follow-up Procedures for Discharged Students

Table 3.4.21: Follow-up Procedures for Discharged Students by Type of Institution presents data which indicate that on the whole very little is done in the area of follow-up of discharged students. Only 10 percent of residential treatment centers and 19 percent of in-patient hospital units have a formal after care program. Such a program might include individual and family therapy, conferences with school personnel, and regularly scheduled phone contact and personal visits. However, 25 percent of residential treatment centers and 10 percent of hospitals do telephone the discharged student occasionally, and 3 percent of both types of institutions make personal visits on an as needed basis.

It appears that residential treatment centers are more committed to some type of follow-up procedure than are hospitals (65% as compared to 44%) more residential centers (12% as compared to 3% of hospitals) have either engaged the services of a local university or consulting firm to institute a formal tracking of former students, or have instituted this type of longitudinal study on their own. In addition, 8 percent of residential centers have developed a questionnaire to be sent to discharged students at a specified time after their release. Thus, a full 20 percent of residential centers attempt to document the adjustment of their former students in order to determine what factors influence successful adaptation to the mainstream environment and what factors may lead to renewed problems and recidivism.

FOLLOW-UP PROCEDURES FOR DISCHARGED STUDENTS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
After Care Program	6	10%	6	19%	12	13%
Questionnaire	5	8%	-	-	5	6%
Phone Contact	15	25%	3	10%	18	20%
Pre and Post-Test Survey Instrument	-	-	1	3%	1	1%
Out-Patient Therapy	3	5%	2	6%	5	6%
Foster Care	1	2%	-	-	1	1%
Research and Tracking	7	12%	1	3%	8	9%
Personal Visits	2	3%	1	3%	3	3%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.21: NUMBER AND PERCENT OF INSTITUTIONS BY FOLLOW-UP PROCEDURES FOR DISCHARGED STUDENTS BY TYPE OF INSTITUTION

3.4.22 Self-Assessment Procedure

Almost half of the educational directors interviewed stated that they measure the success of their educational program by the academic progress of individual students. Achievement test scores are used as a measure (25% residential treatment centers and 29% of in-patient hospital units) as well as the number of children in public schools (36% and 23% respectively) and informal feedback and peer review (20% and 29% respectively). The behavior of the students is used as a self-evaluative measure by approximately 12 percent of both types of institutions and the remaining responses include: a low recidivism rate (stressed more by hospitals than by residential centers); the presence of a waiting list for admission; a formal State Department of Education Evaluation; research projects (sometimes conducted through universities) annual evaluation; case conferences; how it feels; measurement against an intake checklist; and evaluations by other agencies.

Interestingly, as a self-assessment procedure residential treatment centers make greater use of measurement against a checklist of problem behaviors and academic weaknesses compiled through formal intake procedures. Thus the child is initially evaluated upon admission and a list of problems and goals developed. At the end of a specified period of time the child is re-evaluated and his progress toward overcoming problem behavior and academic weaknesses noted on this checklist. Such a comparison, used as a self-assessment procedure enables the educational program director of the residential treatment program to gauge the success of his program.

The second most frequently utilized self-assessment procedure centers on the number of children enrolled in outside schools. Many educational program directors seem to feel that the primary goal of their program is to get the child back into public school and "see that he makes it there." Therefore, they gear their efforts toward this goal and measure their success by the number of children successfully attending outside schools.

Table 3.4.22: Number and Percent of Institutions by Self-Assessment Procedures Utilized by Type of Institution presents the exact percentages of institutions using each type of self-assessment procedures.

SELF-ASSESSMENT PROCEDURES	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Academic Progress of Students	29	49%	14	45%	43	48%
Behavior of Students	7	12%	4	13%	11	12%
Test Scores	15	25%	9	29%	24	27%
Number of Students in Public Schools and Success Rate	21	36%	7	23%	28	31%
Low Redicivism Rate	1	2%	3	10%	4	4%
State Department of Education	2	3%	2	6%	4	4%
Formal Research Projects	2	3%	1	3%	3	3%
Case Conferences and Team Meetings	4	7%	1	3%	5	6%
Informal Feedback and Peer Review	12	20%	9	29%	21	23%
Measurement against In-take Checklist	4	7%	-	-	4	4%
Other	3	5%	1	3%	4	4%
	(n=59)		(n=31)		(n=90)	

TABLE 3.4.22: NUMBER AND PERCENT OF INSTITUTION BY SELF-ASSESSMENT PROCEDURES UTILIZED BY TYPE OF INSTITUTION

3.4.23: Enrollment of Institutionalized Children In Outside Public or Private Schools

Many institutions for the emotionally disturbed are now engaged in efforts to mainstream their students. "Mainstreaming", i.e., integration of exceptional children into normal school programs, has become a very popular concept. In the November, 1973, issue of Exceptional Children, published by the Council for Exceptional Children, the basic intent of the concept is lucidly explained. According to the Council:

Mainstreaming is:

- Providing the most appropriate education for each child in the least restrictive setting.
- Looking at the educational needs of children instead of clinical or diagnostic labels such as mentally handicapped, learning disabled, physically handicapped, hearing impaired, or gifted.
- Looking for and creating alternatives that will help general educators serve children with learning or adjustment problems in the regular setting. Some approaches being used to help achieve this are consulting teachers, methods and materials specialists, itinerant teachers, and resource-room teachers.
- Uniting the skills of general education and special education so that all children may have equal education opportunity.

Mainstreaming is not:

- Wholesale return of all exceptional children in special classes to regular classes.
- Permitting children with special needs to remain in regular classrooms without the services they need.
- Ignoring the need of some children for a more specialized program than can be provided in the general education program.
- Less costly than serving children in special self-contained classrooms.

Until the last few years, however, educators were attempting to create viable alternatives to the public school system, rather than make the accommodations necessary to keep the child with special needs in his neighborhood school. This policy of creating separate classes or schools for the physically and mentally handicapped has come under attack due to the following factors:

- The segregation of exceptional children from regular classrooms and activities;
- The failure to meet the needs of some exceptional children in special classes (e.g., some of the gifted and the emotionally disturbed);
- The failure to serve a large proportion of the population with special needs;
- Poor or improper diagnostic techniques and placement reevaluation which resulted in the mislabeling of children, the misuse of special-education classrooms for racial or ethnic segregation and discipline problems, and the confinement of children to "dead-end" educations.

Thus, the idea of enrolling an institutionalized emotionally disturbed child in a public school is relatively new, and progress toward that goal must be viewed with this in mind. According to the survey, 54 percent of residential treatment centers and 74 percent of in-patient hospital units have children attending outside public or private schools. Table 3.4.23: Number and Percent of Institutions with Children Enrolled in Outside School by Type of Institution.

TYPE OF INSTITUTIONS	FREQUENCY OF INSTITUTIONS	
Residential Treatment Centers (n=59)	32	54%
In-Patient Hospital Units (n=31)	23	74%
All Institutions (n=90)	55	61%

TABLE 3.4.23: NUMBER AND PERCENT OF INSTITUTIONS WITH CHILDREN ENROLLED IN OUTSIDE SCHOOLS BY TYPE OF INSTITUTION

3.4.24: Number of Institutionalized Children Attending Outside Schools

In the case of residential treatment centers with children attending outside programs, the number of children enrolled appears to be rather evenly distributed between 1 and 35 students per center. The number of children who are residing at hospitals but attending outside schools tends to cluster at 1-2 children per hospital (47% of those hospitals having children enrolled in outside schools), 5-6 per hospital (17%), with the remaining hospitals having between 1 and 16 children enrolled. It is interesting to note the difference in the range of numbers of children enrolled for both types of institutions; 24 percent of the residential treatment centers had more than 10 children enrolled in outside schools, while only 4 percent of hospitals had more than 10 children so enrolled. Therefore, even though a larger percentage of hospitals had children enrolled in public school (74% as compared to 54% for residential treatment centers), a larger percentage of residential treatment centers had more than 10 children so enrolled (24% as compared to 4% for hospitals).

Table 3.4.24a: Number and Percent of Institutions by Number of Students Enrolled in Outside Institutions by Type of Institution

NUMBER OF STUDENTS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
1-2	7	22%	11	47%	18	33%
3-4	4	12%	2	8%	6	11%
5-6	6	19%	4	17%	10	19%
7-8	5	15%	3	13%	8	14%
9-10	2	6%	2	9%	4	7%
11-19	3	9%	1	4%	4	7%
20-25	3	9%	-	-	3	6%
26-35	2	6%	-	-	2	4%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.24a: NUMBER AND PERCENT OF INSTITUTIONS BY NUMBER OF STUDENTS ENROLLED IN OUTSIDE INSTITUTIONS BY TYPE OF INSTITUTION

TYPE OF INSTITUTION		Number of Students Attending Outside School ($\bar{x}$)
Residential Treatment Centers	(n=32)	4.74
In-Patient Hospital Units	(n=23)	3.29
All Institutions	(n=55)	4.13

TABLE 3.4.24b: MEAN NUMBER OF INSTITUTIONALIZED CHILDREN ATTENDING OUTSIDE SCHOOLS BY TYPE OF INSTITUTION

presents this distribution of students who have been "mainstreamed." Please note that this table is computed on the basis of the number of institutions with children enrolled in outside schools rather than the total number of institutions.

If we calculate the mean number of institutionalized children attending outside schools by type of institution, it appears that residential treatment centers have approximately 5 children enrolled per center, while in-patient hospital units have approximately 3 children enrolled per hospital. The exact means are presented in Table 3.4.24b: Mean Number of Institutionalized Children Attending Outside Schools by Type of Institution.

3.4.25: Criteria for Placing Institutionalized Children in Outside Schools

The great majority of institutions place a child in an outside school when they feel that he is academically (78% of residential treatment centers and 65% of in-patient hospital units) and behaviorally (75% and 74% respectively) ready. Social readiness was reported to be an influential factor in placement in 34 percent of residential centers and 22 percent of hospitals. This difference in emphasis on social readiness may not be as significant as it would appear due to the fact that many educational program directors considered social readiness a component of behavioral and emotional readiness.

In a few isolated instances, educational program directors stated that their major criteria for placement of children in outside schools centered around the lack of appropriate facilities at the institution, the boredom of the student, the availability of funds, the availability of suitable placements and the fact that the child had become too institutionalized and needed to be placed in a mainstream environment. One institution utilized a behavior management schema by which a child can earn enough points through good school work and behavior to qualify for placement in a public school. This type of system shifts the control to the child and allows him to determine when he will begin a public school program.

Table 3.4.25: Number and Percent of Institutions by Criteria Used for Placing Institutionalized Children in Outside Schools gives the exact breakdown of criteria; it is computed on the basis of the number of institutions with children enrolled in outside schools, not the total number of institutions.

CRITERIA FOR PLACING CHILD IN OUTSIDE SCHOOL	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Academically Ready	25	78%	15	65%	40	73%
Behaviorally and Emotionally Ready	24	75%	17	74%	41	75%
Socially Ready	11	34%	5	22%	16	29%
Other	4	13%	4	17%	8	15%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.25: NUMBER AND PERCENT OF INSTITUTIONS BY CRITERIA USED FOR PLACING INSTITUTIONALIZED CHILDREN IN OUTSIDE SCHOOLS BY TYPE OF INSTITUTION

3.4.26: Increase or Decrease in the Number of Institutionalized Children Attending Outside Schools

Educational Program Directors were asked if during the past five years the number of students from their institution enrolled in outside schools had decreased, increased or remained the same. Concerning residential treatment centers with children enrolled in outside schools, 47 percent reported that the number of students had remained the same over the past five years, with the remaining institutions evenly divided between increases and decreases. In the case of hospitals, a similar pattern was reported; 43 percent said that the number of students enrolled in outside schools had remained the same, 30 percent increased, and 26 percent decreased. Table 3.4.26: Frequency of Change in the Number of Institutionalized Students Attending Outside Schools by Type of Institution displays these data. This table is computed on the basis of the number of institutions with children enrolled in outside schools, not the total number of institutions.

CHANGE IN NUMBER OF STUDENTS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Decreased	8	25%	6	26%	13	25%
Remained the Same	15	47%	10	43%	24	46%
Increased	9	28%	7	30%	15	29%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.26: FREQUENCY OF CHANGE IN THE NUMBER OF INSTITUTIONALIZED STUDENTS ATTENDING OUTSIDE SCHOOLS BY TYPE OF INSTITUTION

3.4.27: Number of Receiving Schools

Even though an institution may have access to any school in the county in which it is established, both residential treatment centers and in-patient hospital units actually send their children to approximately three schools each regardless of the number of institutionalized children enrolled. Table 3.4.27: Mean Number of Receiving Schools by Type of Institution presents the exact means based on the number of institutions which actually send students to outside schools.

As can be seen from a comparison with Table 3.4.24b: Mean Number of Institutionalized Children Attending Outside Schools by Type of Institution, it appears that in most cases only one child is enrolled in each school.

TYPE OF INSTITUTION	RECEIVING SCHOOLS ($\bar{x}$)
Residential Treatment Centers (n=32)	3.27
In-patient Hospital Units (n=23)	2.96
All Institutions (n=55)	3.12

TABLE 3.4.27: MEAN NUMBER OF RECEIVING SCHOOLS BY TYPE OF INSTITUTION

3.4.28: Outside School Selection Criteria

The most frequent reason for selecting a particular school in which to enroll institutionalized children was that the school was located near the institution (72% of residential treatment centers with children enrolled in outside schools and 70% of in-patient hospital units gave this reason). Cooperation of the outside school staff and a welcoming attitude toward institutionalized children served as a criteria for 19 percent of residential treatment centers and 22 percent of hospitals. Interestingly, residential treatment centers seem to place a higher value on a good educational program and competent teaching in the outside school than do hospitals (34% as compared to 26% for hospitals).

Only two residential centers and one hospital reported trying to return the child to his neighborhood school. Placing the child in the school he last attended may be a burden for the institution in terms of transportation, but it obviates the necessity for two adjustment periods on the part of the child. As it now stands the child must adjust to a public school near the institution while he remains a resident, and then readjust to his neighborhood school upon his release. This would be a difficult transition for any child but is especially trying for a child with emotional problems.

Refer to Table 3.4.28: Number and Percent of Institutions by Outside School Selection Criteria by Type of Institution, for an exact breakdown of these data. This table is computed on the basis of the number of institutions with children enrolled in outside schools, and not the total number of institutions.

WHY WERE SCHOOLS SELECTED?	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Geographic Proximity	23	72%	16	70%	39	71%
Cooperation of Principal Staff	6	19%	5	22%	11	20%
Good Teaching Staff, Good Program	11	34%	6	26%	17	31%
Only Available School	-	-	1	4%	1	2%
Prefer Religious School	1	3%	2	9%	3	5%
Child's Neighborhood School	2	6%	1	4%	3	5%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.28: NUMBER AND PERCENT OF INSTITUTIONS BY OUTSIDE SCHOOL SELECTION CRITERIA BY TYPE OF INSTITUTION

3.4.29: Providers of Transportation to Outside Schools

In the case of residential treatment centers which have children enrolled in outside schools, 16 percent report that the outside school furnishes transportation, 9 percent report that their students use school buses provided by the county, and 56 percent report that the residential center itself assumes the responsibility for transporting the child to the outside school. The corresponding figures for hospitals are quite similar. Of in-patient units with children in outside schools, 17 percent rely on those schools for transportation, 9 percent utilize county bus services, and 57 percent provide their own transportation to outside schools. Remaining institutions either use public transportation or are located close enough to the outside school for their children to walk. Table 3.4.29: Number and Percent of Institutions of Providers of Transportation to Outside Schools by Type of Institution presents these data computed on the basis of the number of institutions with children enrolled in outside schools.

PROVIDERS OF TRANSPORTATION	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Outside School	5	16%	4	17%	9	16%
County	3	9%	2	9%	5	9%
Institution	18	56%	13	57%	31	56%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.29: NUMBER AND PERCENT OF INSTITUTIONS BY PROVIDERS OF TRANSPORTATION TO OUTSIDE SCHOOLS BY TYPE OF INSTITUTION

3.4.30: Institution - Outside School Liaison Personnel

The professional most frequently selected to serve as a liaison between the institution and the outside school is the educational program director or principal (37% of residential treatment centers and 39% of hospitals). Interestingly, teachers serve as liaisons in 19 percent of the residential treatment centers but in none of the hospitals. It appears that instead of teachers, in-patient hospital units use child care workers to serve as liaisons with outside schools (17% of hospitals as opposed to 6% of residential treatment centers). Social workers fulfill this function in 9 percent of residential treatment centers and in one reporting hospital, and clinical psychologists serve as liaisons in nine percent of in-patient hospital units but no residential treatment centers. It seems logical that hospitals, with their medical orientation, would place greater emphasis on the use of clinical psychologists and social workers as liaisons but it is rather surprising that so many child care workers perform this function within hospitals as opposed to teachers.

The institutions who have children enrolled in outside schools but who are not included in Table 3.4.30: Institution - Outside School Liaison Personnel by Type of Institution, either use a combination of personnel (22%) or do not specify any professional for this role (7%). Please note that Table 3.4.30 is computed on the basis of the number of institutions that have children enrolled in outside school programs.

LIAISON TO OUTSIDE SCHOOLS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Educational Director or Principal	12	37%	9	39%	21	38%
Child Care Worker	2	6%	4	17%	6	11%
Teacher	6	19%	-	-	6	11%
Clinical Psychologist	-	-	2	9%	2	4%
Social Worker	3	9%	1	4%	4	7%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.30: NUMBER AND PERCENT OF INSTITUTIONS BY TYPE OF OUTSIDE SCHOOL LIAISON PERSONNEL BY TYPE OF INSTITUTION

FOLLOW-UP PROCEDURES FOR CHILDREN ENROLLED IN OUTSIDE SCHOOLS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Phone Contact	21	66%	13	57%	34	61%
Regularly Scheduled Conferences	6	19%	7	30%	13	24%
Conferences as Needed	13	40%	11	48%	24	44%
Institution Calls Every Day to See that Child Arrives	3	9%	-	-	3	5%
Written Reports from Outside Research	2	6%	3	13%	5	9%
Questionnaires and Formal Research	1	3%	-	-	1	2%
	(n=32)		(n=23)		(n=55)	

TABLE 3.4.31: NUMBER AND PERCENT OF INSTITUTIONS BY FOLLOW-UP PROCEDURES FOR INSTITUTIONALIZED CHILDREN ENROLLED IN OUTSIDE SCHOOLS BY TYPE OF INSTITUTION

3.4.31: Follow-up Procedures for Institutionalized Children Enrolled in Outside Schools

Institutional liaison personnel most frequently monitor the progress of children enrolled in outside schools by frequent, informal telephone calls (66% of residential treatment centers and 57% of in-patient hospital units). Approximately 45 percent of all institutions meet with outside school staff on an as needed basis, but only 19 percent of residential treatment centers and 30 percent of hospitals hold regularly scheduled conferences with outside school personnel. More hospitals than residential centers require that the outside school submit written reports on each child's progress (13% as compared to 6%), but more residential treatment centers have instituted formalized, concrete follow-up procedures such as daily phone calls to check on attendance (9%) and questionnaires to be filled out by outside school personnel (one center). Table 3.4.31: Number and Percent of Institutions by Follow-up Procedures for Institutionalized Children Enrolled in Outside Schools by Type of Institution displays these data. Note that this table is computed on the basis of the number of institutions with children enrolled in outside schools, not the total number of institutions.

3.5: Socialization Program Characteristics

Socialization is a difficult concept to define. In discussions with professionals during the pilot test phase it was found that "socialization" means different things to different people. To some, it was the global internalization of the mores of the society, to others, the ability to relate to other people and to still others it meant "activities of daily living" such as bathing, dressing, eating, etc. For the purposes of this study socialization has been defined as the emotional, social and behavioral skills needed to function adequately in society.

The study of the development of these skills is of crucial importance because children maturing in an "artificial" institutional environment are often isolated from the socialization processes that are available to their peers. It was found, however, that socialization, as defined, is not a "program." It is instead a pervasive part of the institutional experience. Each person who comes in contact with the emotionally disturbed child is trying to help him obtain these skills. Therefore, socialization of the child is the goal of both therapy and education. Through their separate ideologies and techniques, both the therapist and the educator work towards enabling the child to develop the emotional, social and behavioral skills he will need to function adequately in society.

The Child Care Worker/Psychiatric Nurse Questionnaire was designed to identify the extent to which certain emotional, social and behavior goals were emphasized at a given institution. The respondent was asked to indicate whether each of a series of goals was of high, moderate or low importance to the institution's efforts toward socialization. The results of this portion of the survey are discussed in the following sections.

3.5.1: Health Goals

Over one-half of the institutions for the emotionally disturbed in the sample felt that the health goals which received the greatest emphasis (and were, therefore, rated highest) in their institutions included: The ability to wash without assistance (64% of all institutions rated this goal high); recognition of the misuse of drugs (64%) and the ability to look after personal hygiene adequately (59%). However, it appears that residential treatment centers place greater emphasis on personal hygiene (63% of residential centers rated these goals high as compared to 52% for hospitals) and the ability to wash without assistance (73% and 48% respectively) than do in-patient hospital units. Table 3.5.1a:

Health Goals	TYPE OF INSTITUTION												ALL INSTITUTIONS					
	RESIDENTIAL TREATMENT CENTERS						IN-PATIENT HOSPITAL UNITS											
	High		Moderate		Low		High		Moderate		Low		High		Moderate		Low	
Looks after personal hygiene adequately	37	63%	22	38%	-	-	16	52%	14	45%	1	3%	53	59%	36	40%	1	1%
Has ability to wash regularly & completely without assistance	43	73%	13	22%	3	5%	15	48%	13	42%	3	10%	58	64%	26	29%	6	7%
Has ability to choose correct clothing, according to weather	25	42%	28	48%	6	10%	13	42%	15	48%	3	10%	38	42%	43	48%	9	10%
Has ability to choose appropriate foods to maintain good health	22	37%	31	52%	6	10%	9	29%	18	58%	4	13%	31	34%	49	53%	10	11%
Recognizes the importance of exercise to maintain good health	23	40%	28	46%	8	14%	10	32%	18	58%	3	10%	33	38%	46	50%	11	12%
Recognizes the misuse of drug or medication	38	64%	12	20%	9	15%	20	65%	11	35%	-	-	58	64%	23	26%	9	10%
Has ability to look after own personal health	24	41%	31	52%	4	7%	15	48%	14	45%	2	6%	39	44%	45	50%	6	6%
	(n=59)						(n=31)						(n=90)					

TABLE 3.5.1a: NUMBER AND PERCENT OF INSTITUTIONS BY EMPHASIS PLACED ON HEALTH GOALS BY TYPE OF INSTITUTION

Number and Percent of Institutions by Emphasis on Health Goals by Type of Institution, presents the exact percentages of responses in the high, moderate, or low category for each health goal.

Tables 3.5.1b and 3.5.1c present cross tabulations indicating the relationship between responses to two separate questions by type of institution. For example, the first cell in Table 3.5.1b represents the percentage of residential treatment centers which rate "looks after personal hygiene adequately" highly and also indicated that they offered a program in activities for daily living. Interestingly, although a large percentage of residential treatment centers (41%) felt that the ability to look after one's own personal health was given high emphasis in their institution, 15 percent of these residential centers did not offer a program in activities for daily living. Similarly, course work in activities for daily living was not offered by 19 percent of the in-patient hospital units which gave the highest rating to the ability to look after one's own personal health. Tables 3.5.1b and 3.5.1c present cross tabulations indicating the relationship between responses to 2 separate questions by type of institution.

3.5.2: Social Maturity Goals

Table 3.5.2: Emphasis on Social Maturity Goals by Type of Institution, indicates that social maturity goals are of the greatest importance in both types of institutions. Except for "demonstrates pride in personal appearance," which was given a high rating by 55 percent of the institutions, each of the other social maturity goals was rated highly by between 62 percent and 84 percent of all institutions.

LOOKS AFTER PERSONAL HYGIENE ADEQUATELY	PROGRAM IN ACTIVITIES FOR DAILY LIVING			
	YES		NO	
High	28	47%	9	15%
Moderate	18	31%	3	5%
Low	1	2%	-	-

TABLE 3.5.1b: RELATIONSHIP BETWEEN HYGIENE GOALS AND ACTIVITIES FOR DAILY LIVING PROGRAMS FOR RESIDENTIAL TREATMENT CENTERS (n=59)

LOOKS AFTER PERSONAL HYGIENE ADEQUATELY	PROGRAM IN ACTIVITIES FOR DAILY LIVING			
	YES		NO	
High	8	26%	8	26%
Moderate	11	35%	2	6%
Low	1	3%	1	3%

TABLE 3.5.1b: RELATIONSHIP BETWEEN HYGIENE GOALS AND ACTIVITIES FOR DAILY LIVING PROGRAMS FOR IN-PATIENT HOSPITAL UNITS (n=31)

ABILITY TO LOOK AFTER PERSONEL HEALTH	PROGRAM IN ACTIVITIES FOR DAILY LIVING			
	YES		NO	
High	21	36%	3	5%
Moderate	22	37%	9	15%
Low	4	7%	-	-

TABLE 3.5.1c: RELATIONSHIP BETWEEN RESPONSIBILITY FOR PERSONAL HEALTH AND ACTIVITIES FOR DAILY LIVING PROGRAMS FOR RESIDENTIAL TREATMENT CENTERS (n=59)

ABILITY TO LOOK AFTER PERSONAL HEALTH	PROGRAM IN ACTIVITIES FOR DAILY LIVING			
	YES		NO	
High	9	29%	6	19%
Moderate	9	29%	5	16%
Low	2	6%	-	-

TABLE 3.5.1c: RELATIONSHIP BETWEEN RESPONSIBILITY FOR PERSONAL HEALTH AND ACTIVITIES FOR DAILY LIVING PROGRAMS FOR IN-PATIENT HOSPITAL UNITS (n=31)

The most highly rated goals involved the ability to be able to cope with anxiety producing situations and to demonstrate pride in one's achievements. These goals appear to be central to the therapeutic philosophy of both types of institutions. Anxiety and stress have long been recognized as problems for emotionally disturbed children and many educators and therapists have described their major efforts as imparting coping mechanisms to children with emotional problems. The ability to demonstrate pride in one's achievements, is a necessary but difficult task for emotionally disturbed children. These children have had so many experiences of failure that they have often given up trying to achieve. Institutional staff, therefore, see their role as providing experiences of success for these children, upon which they can build the healthy, positive self-image that will facilitate further personal growth.

SOCIAL MATURITY GOALS	TYPE OF INSTITUTION												ALL INSTITUTIONS					
	RESIDENTIAL TREATMENT CENTERS						IN-PATIENT HOSPITAL UNITS											
	High		Moderate		Low		High		Moderate		Low		High		Moderate		Low	
Be comfortable with most people and respond readily to them	37	63%	17	29%	5	8%	18	58%	13	42%	-	-	55	62%	30	32%	5	6%
Respond constructively to praise and criticism	43	73%	15	25%	1	2%	22	71%	8	25%	1	3%	65	73%	23	25%	2	2%
Undertake and complete tasks with a positive attitude	33	56%	21	36%	5	8%	24	77%	7	23%	-	-	57	64%	28	30%	5	6%
Be able to cope with anxiety-producing situations	48	81%	7	12%	4	7%	25	81%	6	19%	-	-	73	82%	13	13%	4	4%
Demonstrate pride in personal appearance	31	52%	28	48%	-	-	18	58%	13	42%	-	-	49	55%	41	44%	-	-
Demonstrate pride in own achievements	49	83%	10	17%	-	-	26	84%	5	16%	-	-	75	84%	15	16%	-	-
Demonstrate self-reliance within own capabilities	38	65%	19	32%	2	3%	27	87%	4	13%	-	-	65	73%	23	25%	2	2%
Recognize own strengths and weaknesses	43	73%	13	23%	3	5%	25	81%	6	19%	-	-	68	77%	19	20%	3	3%
	(n=59)						(n=31)						(n=90)					

TABLE 3.5.2: EMPHASIS ON SOCIAL MATURITY GOALS BY TYPE OF INSTITUTION

3.5.3: Social Initiative Goals

"Accepting reasonable rules of the group" and "having the opportunity to succeed socially" were given a high rating by both types of institutions (80% and 72% for each goal respectively). "Having the opportunity to perform as a leader", however, was only given a high rating by 32 percent of residential treatment centers and 29 percent of in-patient hospital units. This de-emphasis on leadership reflects a corresponding de-emphasis on competition as a mode of social interaction. These emotionally disturbed children are being taught, instead, to value themselves and each other as individuals worthy of respect and consideration. Cooperation has replaced competition as a measure of success. Students continue to strive, but they are evaluated in terms of progress toward their individual behavioral and academic goals, not on the basis of the performance of their peers. Finally, given that the "acting out" behavior of many emotionally disturbed children is designed to attract the attention and gain the respect of the peer group, these efforts of institution staff to lessen competition for leadership among students should lessen the amount of aggressive behavior as well.

The exact percentages for each of these goals is presented in Table 3.5.3: Emphasis on Social Initiative Goals by Type of Institution.

3.5.4: Attitudinal Goals

Responses to attitudinal goals seem to divide themselves into four categories. The most highly rated goals involve the development of techniques for controlling aggression in culturally acceptable patterns (89% of all institutions) and the development of confidence in one's ability to succeed (83% of all institutions). The second category of attitudinal goals includes the recognition that there is more than one acceptable point of view (rated highly by 74% of all institutions) and the recognition that family members and peers have needs and interests of their own (rated highly by 67% of all institutions). The third category of attitudinal

SOCIAL INITIATIVE GOALS	RESIDENTIAL TREATMENT CENTERS (n=59)					
	HIGH		MEDIUM		LOW	
Be given opportunities to perform as a leader	19	32%	36	61%	4	7%
Accept reasonable rules of the group	47	80%	12	20%	-	-
Be given opportunities to succeed socially	42	71%	15	25%	2	3%
SOCIAL INITIATIVE GOALS	IN-PATIENT HOSPITAL UNITS (n=31)					
	HIGH		MEDIUM		LOW	
Be given opportunities to perform as a leader	9	29%	17	55%	5	16%
Accept reasonable rules of the group	25	81%	6	19%	-	-
Be given opportunities to succeed socially	22	71%	8	26%	1	3%
SOCIAL INITIATIVE GOALS	ALL INSTITUTIONS (n=90)					
	HIGH		MEDIUM		LOW	
Be given opportunities to perform as a leader	28	31%	53	58%	9	10%
Accept reasonable rules of the group	72	80%	18	20%	-	-
Be given opportunities to succeed socially	64	72%	23	24%	3	3%

TABLE 3.5.3: EMPHASIS ON SOCIAL INITIATIVE GOALS BY TYPE OF INSTITUTION

goals are only rated highly by approximately half of the institutions. These goals center on the child assuming full responsibility for making major life choices (53% of all institutions). The fact that these last two goals were only rated highly by half of the institutions is quite understandable. Often the maladaptive family interaction patterns serve as one of the primary reasons for the child's emotional problems and, therefore, the healing process is dependent on disengaging from the family rather than more intense involvement. Secondly, institution staff seem to feel that the child has not had the benefit of enough familial support, successful learning experiences and personal growth to accept the primary responsibility for making major life choices. The emotionally disturbed child must be given the means to attain a positive self-image, as well as the guidance of a qualified staff versed in the growth potential of these children, before the child can even begin to consider the direction of his future life.

The ability to judge people of various races, cultures, national origins and occupations as such, was given a high rating, and thus emphasized to a high degree in only 38 percent of all institutions. Perhaps institution staff feel that the absence of prejudice is dependent upon a secure personality and a positive self-regard and that if these attributes are established first the emotionally disturbed child will naturally grow to be an open-minded adult.

When we compare the emphasis on attitudinal goals with whether or not family life and sex education are offered at a given institution we find some interesting patterns. For example, 74 percent of in-patient hospital units give a high degree of emphasis to the ability to recognize family members and peers as individuals with needs and interests of their own but 42 percent of these hospitals do not offer family life and sex education (as compared to 17% for residential treatment centers). Likewise 32 percent of in-patient hospital units which gave a high rating to assuming responsibility

for duties as a family member, but fail to include family life and sex education as part of the curriculum (as compared to 10% for residential treatment centers).

Table 3.5.4a: Emphasis on Attitudinal Goals by Type of Institution presents the exact percentages of high, moderate and low ratings for each goal, while Table 3.5.4b, 3.5.4c, 3.5.4d, and 3.5.4e presents the relationship between the ratings of specified goals and the provision of family life and sex education

3.5.5: Leisure Time Goals

The most highly rated leisure time goal involves the development of personal satisfaction in constructive activities (80%) of all institutions). The ability to identify and develop skills in a variety of leisure time activities was also rated highly (60% of all institutions). Only one-half of the institutions strongly emphasized the ability to entertain one's self (50%) and the ability to organize leisure time adequately (49%). It appears that in-patient hospital units emphasize the organization of leisure time more than residential treatment centers (61% of hospitals as compared to 42% of residential centers gave this goal a high rating). Table 3.5.5: Emphasis on Leisure Time Goals by Type of Institution displays these data.

ATTITUDINAL GOALS	RESIDENTIAL TREATMENT CENTERS (n=59)					
	HIGH		MEDIUM		LOW	
Recognize that there may be more than one acceptable point of view	40	68%	18	30%	1	2%
Recognize family members and peers with needs and interests of their own	36	61%	19	32%	4	7%
Assume full responsibility for his duties as a member of a family	29	49%	23	39%	7	12%
Accept primary responsibility for making major life choices	27	46%	20	34%	12	20%
Be able to judge people of various races, cultures, national origins, and occupations as such	20	34%	28	47%	11	19%
Be able to develop techniques for controlling aggression in culturally acceptable patterns	54	92%	5	8%	-	-
Develop confidence in his ability to succeed	47	80%	11	18%	1	2%

TABLE 3.5.4a: EMPHASIS ON ATTITUDINAL GOALS BY TYPE OF INSTITUTION

ATTITUDINAL GOALS	IN-PATIENT HOSPITAL UNITS (n=31)					
	HIGH		MEDIUM		LOW	
Recognize that there may be more than one acceptable point of view	26	84%	5	16%	-	-
Recognize family members and peers with needs and interests of their own	23	74%	8	26%	-	-
Assume full responsibility for his duties as a member of a family	17	55%	13	42%	1	3%
Accept primary responsibility for making major life choices	21	68%	5	16%	5	16%
Be able to judge people of various races, cultures, national origins, and occupations as such	14	45%	14	45%	3	10%
Be able to develop techniques for controlling aggression in culturally acceptable patterns	25	81%	6	19%	-	-
Develop confidence in his ability to succeed	27	87%	4	13%	-	-

TABLE 3.5.4a: (Continued)

ATTITUDINAL GOALS	ALL INSTITUTIONS (n=90)					
	HIGH		MEDIUM		LOW	
Recognize that there may be more than one acceptable point of view	66	74%	23	25%	1	1%
Recognize family members and peers with needs and interests of their own	59	67%	27	29%	4	4%
Assume full responsibility for his duties as a member of a family	46	51%	36	40%	8	9%
Accept primary responsibility for making major life choices	48	53%	25	28%	17	19%
Be able to judge people of various races, cultures, national origins, and occupations as such	34	38%	42	46%	14	16%
Be able to develop techniques for controlling aggression in culturally acceptable patterns	79	89%	11	12%	-	-
Develop confidence in his ability to succeed	74	83%	15	16%	1	1%

TABLE 3.5.4a: (Continued)

RECOGNITION OF FAMILY MEMBERS AND PEERS WITH NEEDS AND INTERESTS OF THEIR OWN	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	26	44%	10	17%
Moderate	10	17%	9	15%
Low	2	3%	2	3%

TABLE 3.5.4b: RELATIONSHIP BETWEEN ATTITUDINAL GOALS AND FAMILY LEFE AND SEX EDUCATION FOR RESIDENTIAL TREATMENT CENTERS

RECOGNITION OF FAMILY MEMBERS AND PEERS WITH NEEDS AND INTERESTS OF THEIR OWN	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	10	32%	13	42%
Moderate	3	10%	5	16%
Low	-	-	-	-

TABLE 3.5.4c: RELATIONSHIP BETWEEN ATTITUDINAL GOALS AND FAMILY AND SEX EDUCATION FOR IN-PATIENT HOSPITAL UNITS

ASSUMES RESPONSIBILITY FOR DUTIES AS A FAMILY MEMBER	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	23	39%	6	10%
Moderate	11	19%	12	20%
Low	4	7%	3	5%

TABLE 3.5.4d: RELATIONSHIP BETWEEN ATTITUDINAL GOALS AND FAMILY LIFE AND SEX EDUCATION FOR RESIDENTIAL TREATMENT CENTERS

ASSUMES RESPONSIBILITY FOR DUTIES AS A FAMILY MEMBER	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	7	23%	10	32%
Moderate	6	19%	7	23%
Low	-	-	1	3%

TABLE 3.5.4e: RELATIONSHIP BETWEEN ATTITUDINAL GOALS AND FAMILY LIFE AND SEX EDUCATION FOR IN-PATIENT HOSPITAL UNITS

LEISURE TIME GOALS	RESIDENTIAL TREATMENT CENTERS (n=59)					
	HIGH		MEDIUM		LOW	
Identify and develop skills in a variety of leisure time activities	35	59%	21	36%	3	5%
Organize leisure time adequately	25	42%	29	49%	5	8%
Develop personal satisfaction in constructive activities	47	80%	10	17%	2	3%
Know how to entertain him/ herself	29	50%	24	41%	6	10%

LEISURE TIME GOALS	ALL INSTITUTIONS (n=90)					
	HIGH		MEDIUM		LOW	
Identify and develop skills in a variety of leisure time activities	54	60%	33	37%	3	3%
Organize leisure time adequately	44	49%	40	44%	6	7%
Develop personal satisfaction in constructive activities	71	80%	17	18%	2	2%
Know how to entertain him/ herself	45	50%	38	42%	7	8%

LEISURE TIME GOALS	IN-PATIENT HOSPITAL UNITS (n=31)					
	HIGH		MEDIUM		LOW	
Identify and develop skills in a variety of leisure time activities	19	62%	12	38%	-	-
Organize leisure time adequately	19	62%	11	35%	1	3%
Develop personal satisfaction in constructive activities	24	77%	7	22%	-	-
Know how to entertain him/ herself	16	52%	14	45%	1	3%

TABLE 3.5.5: EMPHASIS ON LEISURE TIME GOALS BY TYPE OF INSTITUTION

3.5.6: Human Relations Goals

The ability to constructively interact with peers and respect for other people's property are the two most highly rated human relations goals (83% and 80% of all institutions respectively). Given the close living arrangements in most residential centers and in-patient hospital units, positive peer interaction and respect for property must, of necessity, be emphasized to a high degree.

Constructive interaction with adults was rated highly by 76 percent of all institutions, yet apart from interactions with institution staff and family visits, institutionalized emotionally disturbed children do not get much chance to interact with adults on a one-to-one basis. It is interesting to note that 49 percent of the residential treatment centers and 55 percent of the in-patient hospital units which gave a high rating to constructive interaction with adults did not sponsor a big brother/big sister program whereby the children could learn to relate positively to an adult outside their therapeutic setting (See Table 3.5.6b and 3.5.6c).

Between 61-69 percent of all institutions gave the following human relations goals a high rating: display socially acceptable manners (69%); work cooperatively (68%); respect authority (64%); and understand the concept of sharing (61%). In regards to this last goal of sharing, it appears that in-patient hospital units emphasize this goal to a greater degree than residential treatment centers (74% of hospitals gave this goal a high rating as compared to 53% of residential treatment centers). Table 3.5.6a: Emphasis on Human Relations Goals by Type of Institution displays these data.

3.5.7: Home and Family Goals

Over 60 percent of all institutions strongly emphasized an awareness of own and others roles (71% gave this goal a high rating), respect for adults in authority (66%), appreciation of the individual rights of family members (62%), and recognition of relationship among family members (60%). Apparently of lesser emphasis are

HUMAN RELATIONS GOALS	RESIDENTIAL TREATMENT CENTERS (n=59)					
	HIGH		MEDIUM		LOW	
Display socially acceptable manners	38	64%	20	34%	1	2%
Respect other people's property	44	75%	12	20%	3	5%
Understand the concept of sharing	31	52%	25	42%	3	5%
Work cooperatively	37	63%	20	34%	2	3%
Constructively interact with peers	48	81%	9	15%	2	3%
Constructively interact with adults	44	74%	15	26%	-	-
Respect authority (Police, Firemen, etc.)	38	64%	16	27%	5	9%

TABLE 3.5.6a: EMPHASIS ON HUMAN RELATIONS GOALS BY TYPE OF INSTITUTIONS

ONS

HUMAN RELATIONS GOALS	IN-PATIENT HOSPITAL UNITS (n=31)					
	HIGH		MEDIUM		LOW	
Display socially acceptable manners	23	75%	7	22%	1	3%
Respect other people's property	27	87%	3	10%	1	3%
Understand the concept of sharing	23	74%	7	22%	1	3%
Work cooperatively	23	74%	7	22%	1	3%
Constructively interact with peers	26	84%	4	13%	1	3%
Constructively interact with adults	23	74%	8	26%	-	-
Respect authority (Police, Firemen, etc.)	19	62%	10	32%	2	6%

TABLE 3.5.6a: (Continued)

HUMAN RELATIONS GOALS	ALL INSTITUTIONS (n=90)					
	HIGH		MEDIUM		LOW	
Display socially acceptable manners	61	69%	27	29%	2	2%
Respect other people's property	71	80%	15	16%	4	4%
Understand the concept of sharing	54	61%	32	35%	4	4%
Work cooperatively	60	68%	27	29%	3	3%
Constructively interact with peers	74	83%	13	13%	3	3%
Constructively interact with adults	67	76%	23	24%	-	-
Respect authority (Police, Firemen, etc.)	57	64%	26	28%	7	8%

TABLE 3.5.6a: (Continued)

CONSTRUCTIVE INTERACTION WITH ADULTS	BIG BROTHER/BIG SISTER PROGRAM OFFERED			
	YES		NO	
High	15	25%	29	49%
Moderate	5	8%	10	17%
Low	-	-	-	-

TABLE 3.5.6b: RELATIONSHIP BETWEEN HUMAN RELATION GOALS AND BIG BROTHER/BIG SISTER PROGRAM FOR RESIDENTIAL TREATMENT CENTERS

CONSTRUCTIVE INTERACTION WITH ADULTS	BIG BROTHER/BIG SISTER PROGRAM OFFERED			
	YES		NO	
High	6	19%	17	55%
Moderate	2	6%	6	19%
Low	-	-	-	-

TABLE 3.5.6c: RELATIONSHIP BETWEEN HUMAN RELATIONS GOALS AND BIG BROTHER/BIG SISTER PROGRAM FOR IN-PATIENT HOSPITAL UNITS

goals concerned with recognition of individual family living patterns and life styles (42%) and participation in family activities (34%). These low ratings are explained, perhaps, by the frequent maladaptive family interaction patterns present in the homes of many emotionally disturbed children alluded to earlier, and the lessened opportunity for family participation that is a concomitant of institutional life. Table 3.5.7a: Emphasis on Home and Family Goals by Type of Institution presents the exact percentages of high, medium and low responses for each goal.

Comparing ratings on home and family goals and course offerings, we find that approximately 15 percent of residential treatment centers and in-patient hospital units give a high rating to recognition of individual family living patterns but do not offer family life and sex education (See Tables 3.5.7b and 3.5.7c); 15 percent of residential treatment centers and 42 percent of hospitals give a high rating to recognition of relationships among family members but do not offer family life and sex education (See Tables 3.5.7d and 3.5.7e); 17 percent of residential treatment centers and 45 percent of in-patient hospital units give a high rating to appreciation of the individual rights of family members but do not offer family life and sex education (See Tables 3.5.7f and 3.5.7g); and finally, 22 percent of residential treatment centers and 45 percent of in-patient hospital units give a high rating to awareness of own and other's roles but do not offer family life and sex education (See Tables 3.5.7h and 3.5.7i).

Ratings of the goal concerned with participation in family activities were compared with socialization techniques (See Table 3.5.8) and findings indicate that approximately 5 percent of residental treatment centers gave a low rating to participation in family activities but encouraged family visits to the institution (See Table 3.5.j), (See Table 3.5.71) and children spending weekends at home (See Table 3.5.7n). Likewise, 16 percent

HOME AND FAMILY GOALS	RESIDENTIAL TREATMENT CENTERS (n=59)					
	HIGH		MEDIUM		LOW	
Recognize and understand relationships among family members	32	54%	19	32%	8	14%
Gain an awareness of own and other's roles	41	70%	16	27%	2	3%
Appreciate the individual rights of family members	34	58%	22	37%	3	5%
Participate in family activities	21	36%	34	58%	4	7%
Recognize and respect adults in authority	39	66%	16	27%	4	7%
Recognize that every family has its own living pattern and style	30	51%	24	41%	5	8%

TABLE 3.5.7a: EMPHASIS ON HOME AND FAMILY GOALS BY TYPE OF INSTITUTION

HOME AND FAMILY GOALS	IN-PATIENT HOSPITAL UNITS (n=31)					
	HIGH		MEDIUM		LOW	
Recognize and understand relationships among family members	21	68%	9	29%	1	3%
Gain an awareness of own and other's roles	23	74%	7	23%	1	3%
Appreciate the individual rights of family members	21	68%	7	23%	3	10%
Participate in family activities	10	32%	16	52%	5	16%
Recognize and respect adults in authority	19	61%	10	32%	2	6%
Recognize that every family has its own living pattern and style	12	39	14	45%	5	16%

TABLE 3.5.7a: (Continued)

HOME AND FAMILY GOALS	ALL INSTITUTIONS (n=90)					
	HIGH		MEDIUM		LOW	
Recognize and understand relationships among family members	53	60%	28	30%	9	10%
Gain an awareness of own and other's roles	64	71%	23	24%	3	3%
Appreciate the individual rights of family members	55	62%	29	30%	6	7%
Participate in family activities	31	34%	50	56%	9	10%
Recognize and respect adults in authority	58	66%	26	28%	6	7%
Recognize that every family has its own living pattern and style	42	47%	38	41%	10	11%

TABLE 3.5.7a: (Continued)

RECOGNITION OF INDIVIDUAL FAMILY LIVING PATTERNS	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	21	36%	9	15%
Moderate	14	24%	10	17%
Low	3	5%	2	3%

TABLE 3.5.7b: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR RESIDENTIAL TREATMENT CENTERS

RECOGNITION OF INDIVIDUAL FAMILY LIVING PATTERNS	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	7	23%	5	16%
Moderate	4	13%	10	32%
Low	2	6%	3	10%

TABLE 3.5.7c: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR IN-PATIENT HOSPITAL UNITS

RECOGNITION OF RELATIONSHIPS AMONG FAMILY MEMBERS	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	23	39%	9	15%
Moderate	10	17%	9	15%
Low	5	8%	3	5%

TABLE 3.4.7d: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR RESIDENTIAL TREATMENT CENTERS

RECOGNITION OF RELATIONSHIPS AMONG FAMILY MEMBERS	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	8	26%	13	42%
Moderate	4	13%	5	16%
Low	1	3%	-	-

TABLE 3.5.7e: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR IN-PATIENT HOSPITAL UNITS

APPRECIATION OF THE INDIVIDUAL RIGHTS OF FAMILY MEMBERS	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	24	41%	10	17%
Moderate	13	22%	9	15%
Low	1	2%	2	3%

TABLE 3.5.7f: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR RESIDENTIAL TREATMENT CENTERS

APPRECIATION OF THE INDIVIDUAL RIGHTS OF FAMILY MEMBERS	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	7	23%	14	45%
Moderate	5	16%	2	6%
Low	1	3%	2	6%

TABLE 3.5.7g: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR IN-PATIENT HOSPITAL UNITS

AWARENESS OF OWN AND OTHER'S ROLES	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	28	47%	13	22%
Moderate	8	14%	8	14%
Low	2	3%	-	-

TABLE 3.5.7h: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR RESIDENTIAL TREATMENT CENTERS

AWARENESS OF OWN AND OTHER'S ROLES	FAMILY LIFE AND SEX EDUCATION OFFERED			
	YES		NO	
High	9	29%	14	45%
Moderate	4	13%	3	10%
Low	-	-	1	3%

TABLE 3.5.7i: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY LIFE AND SEX EDUCATION FOR IN-PATIENT HOSPITAL UNITS

PARTICIPATION IN FAMILY ACTIVITIES	FAMILY VISITS TO INSTITUTION			
	YES		NO	
High	21	36%	-	-
Moderate	32	54%	2	3%
Low	3	5%	1	2%

TABLE 3.5.7j: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY VISITS TO INSTITUTION FOR RESIDENTIAL TREATMENT CENTERS

PARTICIPATION IN FAMILY ACTIVITIES	FAMILY VISITS TO INSTITUTION			
	YES		NO	
High	10	32%	-	-
Moderate	16	51%	-	-
Low	5	16%	-	-

TABLE 3.5.7k: RELATIONSHIP BETWEEN FAMILY GOALS AND FAMILY VISITS TO INSTITUTION FOR IN-PATIENT HOSPITAL UNITS

PARTICIPATION IN FAMILY ACTIVITIES	FAMILY TAKES CHILD OUT OF INSTITUTION FOR A VISIT			
	YES		NO	
High	21	36%	-	-
Moderate	31	53%	3	5%
Low	3	5%	1	2%

TABLE 3.5.7.1: RELATIONSHIP BETWEEN FAMILY GOALS AND CHILD TAKEN OUT OF INSTITUTION FOR VISIT FOR RESIDENTIAL TREATMENT CENTERS

PARTICIPATION IN FAMILY ACTIVITIES	FAMILY TAKES CHILD OUT OF INSTITUTION FOR A VISIT			
	YES		NO	
High	10	32%	-	-
Moderate	16	51%	-	-
Low	5	16%	-	-

TABLE 3.5.7m: RELATIONSHIP BETWEEN FAMILY GOALS AND CHILD TAKEN OUT OF INSTITUTION FOR A VISIT FOR IN-PATIENT HOSPITAL UNITS

PARTICIPATION IN FAMILY ACTIVITIES	CHILD SPENDS WEEKENDS AT HOME			
	YES		NO	
High	21	36%	-	-
Moderate	34	58%	2	3%
Low	2	3%	-	-

TABLE 3.5.7n: RELATIONSHIP BETWEEN FAMILY GOALS AND CHILD SPENDING WEEKENDS AT HOME FOR RESIDENTIAL TREATMENT CENTERS

PARTICIPATION IN FAMILY ACTIVITIES	CHILD SPENDS WEEKENDS AT HOME			
	YES		NO	
High	10	32%	-	-
Moderate	16	51%	-	-
Low	5	16%	-	-

TABLE 3.5.7o: RELATIONSHIP BETWEEN FAMILY GOALS AND CHILD SPENDING WEEKENDS AT HOME FOR IN-PATIENT HOSPITAL UNITS

of in-patient hospital units gave a low rating to participation in family activities but encouraged family visits to the institution (See Table 3.5.7k), family taking the child out of the hospital for a visit (See Table 3.5.7m) and children spending weekends at home (See Table 3.5.7o).

3.5.8: Socialization Techniques

Over 80 percent of all institutions provide field trips (99%), allow the child to spend weekends with his family (97%), encourage the family to take the child out of the institution for a visit (94%), have a formal evening and weekend recreation program (91%), facilitate the participation of institutionalized children in outside group sporting events (86%), facilitate the participation of institutionalized children in outside group social events (83%) and have a regular system of peer review group sessions where these emotionally disturbed children constructively criticize each others behavior (83%). It appears, however, that residential treatment centers provide more outside sports activities for their children (90% as compared to 77% for hospitals) as well as more participation in outside group social events (90% as compared to 71% for hospitals).

Only 76 percent of all institutions have a full-time, salaried activities director or recreation therapist and even fewer (31%) sponsor a big brother/big sister program whereby adult volunteers from the community can serve as friends and role models to these institutionalized emotionally disturbed children. Table 3.5.8: Frequency of Socialization Techniques Used by Type of Institution displays these data.

SOCIALIZATION TECHNIQUES	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Family visits to facility	56	95%	30	97%	86	96%
Family taking child out of facility for a visit	55	93%	30	97%	85	94%
Child spending weekends with his family	57	97%	30	97%	87	97%
Field trips	59	100%	30	97%	89	99%
Participation in outside group sporting events	53	90%	24	77%	77	86%
Participation in outside group social events	53	90%	22	71%	75	83%
Big brother/big sister program	20	34%	8	26%	28	31%
Peer review group sessions	52	88%	23	74%	75	83%
Formal recreation program	55	93%	27	87%	82	91%
On-staff activities director	44	75%	24	77%	68	76%
	(n=59)		(n=31)		(n=90)	

TABLE 3.5.8: FREQUENCY OF SOCIALIZATION TECHNIQUES USED BY TYPE OF INSTITUTION DISPLAYS THESE DATA

3.6: Outside School Program Characteristics

According to a previous section of this report (3.4), institutions tend to enroll children who are academically and behaviorally "ready" in public schools located near the institution. Additional characteristics of these outside schools are discussed in the following sections. A total of 49 outside schools were interviewed, (36 schools receiving children from residential treatment centers and 13 schools receiving children from in-patient hospital units). Please note that each table in this section (3.6) is computed on the basis of the number of outside schools receiving children from institutions.

3.6.1: Number of Institutionalized Children Enrolled in Outside School Programs

Looking at outside schools as a whole, 24 percent of outside schools who receive children from institutions have only 1 institutionalized child enrolled, 18 percent have 2 institutionalized children enrolled, and 10 percent have 3 institutionalized children enrolled. If these figures are compared to those of outside schools that receive children from each of the two types of institutions, however, it is found that 44 percent of schools that receive children from residential centers have between 1 and 3 institutionalized children enrolled, while 77 percent of schools that receive children from hospitals have between 1 and 3 institutionalized children enrolled. Thus, outside schools are likely to receive greater numbers of institutionalized children per school from residential treatment centers than from hospitals. The exact percentages for each number of children enrolled are displayed in Table 3.6.1: Number and Percent of Outside Schools by Number of Institutionalized Children Received by Outside School Programs by Type of Institution.

NUMBER OF CHILDREN RECEIVED	SCHOOLS RECEIVING CHILDREN FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
1	5	14%	7	54%	12	24%
2	7	19%	2	15%	9	18%
3	4	11%	1	8%	5	10%
4	4	11%	-	-	4	8%
5	3	8%	-	-	3	6%
6	4	11%	1	8%	5	10%
7	1	3%	1	8%	2	4%
8	2	5%	-	-	2	4%
10	1	3%	-	-	1	2%
13	2	5%	-	-	2	4%
14	1	3%	-	-	1	2%
17	1	3%	-	-	1	2%
23	-	-	1	8%	1	2%
26	1	3%	-	-	1	2%
	(n=36)		(n=13)		(n=49)	

TABLE 3.6.1: NUMBER AND PERCENT OF OUTSIDE SCHOOLS BY NUMBER OF INSTITUTIONALIZED CHILDREN RECEIVED BY TYPE OF SCHOOL

3.6.2: Increase or Decrease in the Number of Institutionalized Children Received by Outside Schools

The majority of outside schools receiving children from institutions of both types reported that the number of these children enrolled in their school has remained the same during the past 5 years (61% of outside schools). Of these schools, 67 percent of those receiving children from residential treatment centers and 46 percent of those receiving children from in-patient hospital units reported that enrollment had remained constant.

It appears significant that while 11 percent of the schools receiving children from residential centers reported a decrease in the number of children, and 22 percent reported an increase, no schools receiving children from hospitals reported a decrease and a majority of 54 percent reported an increase. Thus, outside schools receiving children from in-patient hospital units have experienced a greater increase in enrollment of institutionalized children during the past five years than outside schools receiving children from residential treatment centers. Table 3.6.2: Frequency of the Change in Number of Institutionalized Children Received by Outside Schools, displays these data.

These data do not agree precisely with figures provided by the institutions themselves. (See Section 3.4.26.) This is because not all outside schools were contacted and the schools selected for interviews were generally those which enrolled the greatest number of children. Hence, these schools had a greater tendency to report that the number of students enrolled had increased or remained the same.

3.6.3: Criteria for Acceptance of Institutionalized Children

Most outside schools receiving children from institutions as a whole, do so on the basis of the recommendations of institution staff (61% of all outside schools). However, the percentage is greater for those schools receiving children from residential treatment centers (69%) as compared to those which receive

CHANGE IN NUMBER OF CHILDREN RECEIVED	SCHOOLS RECEIVING CHILDREN FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
Decreased	4	11%	-	-	4	8%
Remained the Same	24	67%	6	46%	30	61%
Increased	8	22%	7	54%	15	31%
	(n=36		(n=13)		(n=49)	

TABLE 3.6.2: FREQUENCY OF THE CHANGE IN NUMBER OF INSTITUTIONALIZED CHILDREN RECEIVED BY OUTSIDE SCHOOLS BY TYPE OF SCHOOL

children from hospitals (38%). The academic and behavioral readiness of the student influenced decisions on acceptance in 30 percent of the schools receiving children from residential centers and 38 percent from hospitals.

Interestingly, schools receiving children from residential centers offer only 5 criteria, while schools receiving children from hospitals offer 10 criteria. It seems to be more important to the schools receiving children from hospitals that the children be controlled by medication, not psychotic, and have some demonstrable learning ability. In two instances acceptance depended on the recommendations of an Admission Discharge Review Committee or a formal entrance exam. One outside school was a vocational training program which required that the child be diagnosed as handicapped in order to be eligible for admission. The percentage of schools using each criteria is presented in Table 3.6.3: Frequency of Criteria for Acceptance of Institutionalized Children by Type of Institution.

3.6.4: Providers of Transportation

The survey results indicate that 19 percent of outside schools as a whole provide transportation for institutionalized children, 18 percent rely on county school buses and 64 percent report that the institution assumes the responsibility for transporting the child to the outside school. However, 74 percent of schools receiving children from residential treatment centers report that the centers transport the children as compared to 40 percent of the hospital associated schools. Schools receiving children from hospitals appear to utilize county bus service to a larger degree (40% as compared with 9% for schools receiving children from residential treatment centers). The remaining schools are close enough to the institution for the children to walk or rely on public transportation. Please refer to Table 3.6.4: Providers of Transportation by Type of School and note the figures in this

CRITERIA FOR SELECTING STUDENTS	SCHOOLS RECEIVING CHILDREN FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
Academically Ready	7	19%	2	15%	9	18%
Behaviorally Ready	4	11%	3	23%	7	14%
Controlled by Medication	-	-	1	8%	1	2%
Not Psychotic	-	-	1	8%	1	2%
Some Learning Ability	-	-	1	8%	1	2%
Must be Handicapped	-	-	1	8%	1	2%
Recommendations of Institution Staff	25	69%	5	38%	30	61%
Recommendation of ADR	-	-	1	8%	1	2%
Socially Ready	-	-	1	8%	1	2%
Depends on Individual Child	-	-	1	8%	1	2%
Contractual Agreement	1	3%	-	-	1	2%
Entrance Exam	1	3%	-	-	1	2%
	(n=36)		(n=13)		(n=49)	

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TABLE 3.6.3: FREQUENCY OF CRITERIA USED FOR ACCEPTANCE OF INSTITUTIONALIZED CHILDREN BY TYPE OF SCHOOL

PROVIDERS OF TRANSPORTATION	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
School	4	17%	2	20%	6	18%
County	2	9%	4	40%	6	18%
Instruction	17	74%	4	40%	21	64%
	(n=23)		(n=10)		(n=33)	

TABLE 3.6.4: PROVIDERS OF TRANSPORTATION BY TYPE OF SCHOOL

table are based on the number of outside schools which rely on some form of transportation other than public transportation or walking, and not on the total number of outside schools receiving institutionalized children.

Since we interviewed only a sample of outside schools, these figures do not agree precisely with those reported by the institutions themselves. (See Section 3.4.29.)

3.6.5: Special Accommodations Made by Outside Schools to Integrate Institutionalized Children Into the Program

Schools receiving children from hospitals found that these children required more flexible scheduling (8%), had to be placed in intermediate classes (usually special education or learning disabilities classes) - (15%) or made greater use of the resource room than normal children (8%).

More flexible scheduling, more counseling, and more teachers or aides than are required by children who are not emotionally disturbed, were reportedly instituted in 11 percent of the schools which received children from residential treatment centers. A smaller percentage of these schools placed these children in an intermediate class (2 schools), adjusted the classwork (one school) or had to order special materials (one school). These data are displayed in Table 3.6.5: Number and Percent of Outside Schools by Special Accommodations Made to Integrate Institutionalized Children Into Their Program.

3.6.6: Special Education Certification Requirements

Principals of outside schools were asked if they require that the teachers in whose classes these emotionally disturbed students were placed be certified or eligible for certification in special education. Results indicate that 38 percent of schools receiving children from in-patient hospital units have this requirement as opposed to 14 percent of schools receiving children from residential treatment centers. This greater percentage probably reflects the more frequent placement of institutionalized children

SPECIAL ACCOMMODATIONS	SCHOOLS RECEIVING CHILDREN FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
More Flexible Scheduling	4	11%	1	8%	5	10%
Special Intermediate Class or Center	2	6%	2	15%	4	8%
More Counseling	4	11%	-	-	4	8%
More Teachers or Aides	4	11%	-	-	4	8%
Other	2	6%	1	8%	3	6%
	(n=36)		(n=13)		(n=49)	

TABLE 3.6.5: NUMBER AND PERCENT OF OUTSIDE SCHOOLS BY SPECIAL ACCOMMODATIONS MADE TO INTEGRATE INSTITUTIONALIZED CHILDREN INTO THEIR PROGRAM BY TYPE OF SCHOOL

in intermediate special education classes by schools which receive children from hospitals (15% as compared to 6% for schools which receive children from residential centers - See Table 3.6.5). These special education classes are, in turn, taught by teachers who are required to be certified. Please refer to Table 3.6.6: Number and Percent of Outside Schools that Require that Teachers of Institutionalized Children be Certified in Special Education by Type of Sending Institution.

SPECIAL EDUCATION CERTIFICATION	SCHOOLS RECEIVING CHILDREN FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
Certification Required	5	14%	5	38%	10	20%
	(n=36)		(n=13)		(n=49)	

TABLE 3.6.6: NUMBER AND PERCENT OF OUTSIDE SCHOOLS THAT REQUIRE THAT TEACHERS OF INSTITUTIONALIZED CHILDREN BE CERTIFIED IN SPECIAL EDUCATION BY TYPE OF SENDING INSTITUTION

3.7: Teacher Training

The qualifications of teachers who instruct emotionally disturbed children within institutions has long been of great concern to educators. Therefore, both educational program directors and outside public and private school principals (of schools in which institutionalized children were enrolled) were asked if they felt that their teaching staff was adequately trained to teach emotionally disturbed students prior to their employment at the institution or school. Secondly, project staff determined the quantity and quality of additional training provided by institutions and outside schools.

3.7.1: Educational Program Director's View

Survey results indicate that 51 percent of educational program directors of residential treatment centers and 42 percent of educational program directors of in-patient hospital units feel that their teaching staff was adequately trained prior to employment at the institution. (See Table 3.7.1a: Number and Percent of Educational Program Directors Who Felt That Their Staff Was Adequately Trained Prior to Employment at the Institution by Type of Institution). Thus, for all institutions less than half (48%) of educational program directors feel that prior training for their teachers was sufficient to help them deal with the special needs of these emotionally disturbed students.

Concerning additional training provided by the institution, 61 percent of all institutions reported a formal in-service training

TYPE OF INSTITUTION	PERCEIVED ADEQUACY OF TEACHER TRAINING	
Residential Treatment Centers (n=59)	30	51%
In-patient Hospital Units (n=31)	13	42%
All Institutions (n=90)	43	48%

TABLE 3.7.1a: NUMBER AND PERCENT OF EDUCATION PROGRAM DIRECTORS WHO FELT THAT THEIR STAFF WAS ADEQUATELY TRAINED PRIOR TO EMPLOYMENT BY TYPE OF INSTITUTION

program for their teaching staff. An additional 32 percent of all institutions provide seminars, workshops and guest lectures. Topics covered in these seminars and workshops include:

- class management
- behavior modification
- curriculum development
- medication
- testing
- diagnostic - prescriptive teaching
- task analysis
- remedial reading
- motivation
- conflict management
- transactional analysis
- reality therapy
- systems therapy

- family therapy
- operant conditioning
- behavioral objectives
- individualized instruction
- drug abuse
- educational rhythm
- specialized materials

Aside from in-service programs and seminars and workshops, little else in the way of training is provided to teachers. Only 17 percent of all institutions utilize county training programs, 13 percent allow teachers time off for conventions, 12 percent pay teachers tuition for outside courses, 11 percent allow teachers access to clinically oriented in-service training and 9 percent allow the teachers time off for courses at local colleges and universities. Table 3.7.1b: Frequency of Types of Additional Training Provided by Type of Instruction displays these data.

3.7.2: Outside School Principal's View

Findings indicate that 47 percent of principals from outside schools that receive children from residential treatment centers feel that their teaching staff was adequately trained to teach emotionally disturbed children prior to their employment at the school, while 61 percent of the principals from schools that receive children from in-patient hospital units perceive the prior training of their teaching staff to be adequate (See Table 3.7.2a: Frequency of Outside School Principals Who Felt That Their Staff Was Adequately Trained Prior to Employment at the School by Type of School.)

In sum, just over half (51%) of outside school principals felt that their staff was adequately trained to teach emotionally disturbed children prior to employment. However, it must be realized that the great majority of students who are instructed by public school teachers are not emotionally disturbed and therefore public school teachers can not be expected to have this specialized training.

ADDITIONAL TRAINING	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
In-Service Program	39	66%	16	52%	55	61%
Seminars, Workshops and Guest Lectures	19	32%	10	32%	29	32%
Institution Pays Tuition	8	14%	3	10%	11	12%
Time Off for Outside Courses	5	8%	3	10%	8	9%
Time Off for Conventions	9	15%	3	10%	12	13%
County Training Program	10	17%	5	16%	15	17%
Title I Funded Training	1	2%	-	-	1	1%
Access to Clinical In-Service Training	7	12%	3	10%	10	11%
	(n=59)		(n=31)		(n=90)	

TABLE 3.7.1b: FREQUENCY OF TYPES OF ADDITIONAL TRAINING PROVIDED BY TYPE OF INSTITUTION

TYPE OF SCHOOL	PERCEIVED ADEQUACY OF TEACHER TRAINING	
Schools Receiving Children from Residential Treatment Centers (n=36)	17	47%
Schools Receiving Children from In-Patient Hospital Units (n=13)	8	61%
Total Outside Schools (n=49)	25	51%

TABLE 3.7.2a: FREQUENCY OF OUTSIDE SCHOOL PRINCIPALS WHO FELT THAT THEIR STAFF WAS ADEQUATELY TRAINED PRIOR TO EMPLOYMENT AT THE SCHOOL BY TYPE OF SCHOOL

It appears that little additional training is provided to public school teachers who instruct institutionalized emotionally disturbed children. Only 15 percent of outside schools receiving children from all institutions sponsor seminars, workshops and guest lecturerers, 12 percent have a formal in-service training program, 7 percent utilize the county training program, 6 percent have teachers meet with a consulting psychiatrist to discuss class management, and 1 percent pay tuition for outside courses. (See Table 3.7.2b: Frequency of Types of Additional Training Provided by Type of School).

ADDITIONAL TRAINING	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
In-Service Program	6	10%	5	16%	11	12%
Seminars, Workshops and Guest Lectures	11	19%	3	10%	14	15%
Facility Pays Tuition	-	-	1	3%	1	1%
Utilize County Training Program	4	7%	2	6%	6	7%
Meetings with Psychiatrist About Class Management	3	5%	2	6%	5	6%
Title I	1	2%	-	-	1	1%
	(n=59)		(n=31)		(n=90)	

TABLE 3.7.2b: FREQUENCY OF TYPES OF ADDITIONAL TRAINING PROVIDED BY TYPE OF SCHOOL

3.8: Perceived Problems and Suggestions for Improvement

Administrators, educational program directors, and outside school principals were asked to describe the kinds of problems they faced in their delivery of educational services and to provide suggestions towards improved education of emotionally disturbed children within their facility and in the country at large. The content of their responses is discussed in the sections to follow.

3.8.1 Administrators' View

The most frequently reported problem involved the behavior of these emotionally disturbed children (38% of all institutions). Persistent problems in this area include resistance to authority, school phobia, alienation, lack of motivation, fear of failure, violent outbursts, etc. In other words, even though this type of behavior is the reason the child was institutionalized in the first place, such behavior remains the major obstacle to educational progress. Several administrators spoke at length of the despair and hopelessness of these children--children who have been sent from one institution to another, falling further and further behind academically, fearing that they will never catch up and therefore ceasing to try. It is interesting to note that survey results indicate that residential treatment centers are experiencing more difficulty with the behavior of their children than are hospitals (34% of residential treatment centers as compared to 13% of hospitals).

Inadequate funds were considered a problem by 23 percent of the administrators of all institutions, and academic problems of the children, such as a short attention span, learning disabilities, etc., were mentioned by 21 percent of the administrators interviewed.

Of particular importance is the reported conflict between clinical and educational staff. It appears that each group seeks

to control the philosophy and direction of the educational program. Clinical staff tend to view education as a therapeutic tool--i.e., a means to an end, while educational staff view education as a self-contained endeavor, i.e., an end in itself. Conflict arises as to the method and degree of discipline within the classroom, the firmness with which attendance requirements are enforced and the content of the work itself. Permissiveness and a lack of pressure are often favored by clinical staff, while educational staff feel that structure must be imposed for these children to succeed. Overt disagreements as to the goals and objectives of the educational program--indeed the importance of education itself--are often reinforced by covert conflict such as the scheduling of therapy sessions during school hours. Survey results indicate that in-patient hospital units, with their more medical orientation, experience this conflict to a greater degree than residential treatment centers (35% of hospitals as compared to 12% of residential treatment centers).

Between 10-17 percent of the administrators interviewed report a lack of specialists, such as reading specialists, speech therapists, audiologists, learning disabilities specialists, crisis resource teachers, etc. (17%); an inadequate physical plant (often a section of an institution not originally designed as a school - 12%); and a lack of special facilities, materials, and electives (10%). The remainder of the problems reported by administrators are presented in Table 3.8.1a: Number and Percent of Administrators Reporting Perceived Problems by Type of Institution.

Concerning suggestions for improvement, administrators most often recommend additional specialists, staff and electives (32%), improved teacher training (24%), and more funds (20%). Comparing both types of institutions, survey results indicate that in the administrator's view residential treatment centers feel the need for more behavior management techniques (19% as compared

PERCEIVED PROBLEMS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Behavioral Problems of the Children	20	34%	14	45%	34	38%
Inadequate Funds	17	29%	6	19%	23	23%
Academic Problems of the Children	11	19%	8	26%	19	21%
Conflict Between Clinical and Educational Staff	7	12%	11	35%	18	20%
Lack of Specialists	10	17%	5	16%	15	17%
Inadequate Physical Plant	6	10%	5	16%	11	12%
Lack of Facilities/ Materials/Electives	7	12%	2	6%	9	10%
Lack of Vocational Education and Job Placement	6	10%	2	6%	8	9%
Management Problems	4	7%	3	10%	7	8%
Lack of Cooperation from Receiving Schools for Mainstreaming	4	7%	2	6%	6	7%
Lack of Teacher Expertise	2	3%	3	10%	5	6%
No Control Over Hiring and Firing of Teachers	4	7%	1	3%	5	6%
Low Attendance	3	5%	1	3%	4	4%
Problems of Adjustment to Discharge	3	5%	1	3%	4	4%
Self-Concept Problems	3	5%	-	-	3	3%
High Turnover/Lack of Continuity	1	2%	2	6%	3	3%
Difficulty Obtaining Tutor from Public School	1	2%	1	3%	2	2%
	(n=59)		(n=31)		(n=90)	

TABLE 3.8.1a: NUMBER AND PERCENT OF ADMINISTRATORS REPORTING PERCEIVED PROBLEMS BY TYPE OF INSTITUTION

to 0% for hospitals) and individualized programs than do hospitals (28% as compared to 0% for hospitals). In regard to this latter suggestion of more individualized programs, administrators of residential treatment centers often spoke of the need for one-on-one instruction, where both the content of the program and the evaluation procedures are entirely individually referenced, i.e., the child is instructed according to his own academic strengths and weaknesses and measured against his own goals and objectives. Ideally, administrators would like to provide one teacher for every student, but financial constraints made this impossible. Instead, each teacher tries to individualize the program by tailoring the instructional material to the educational and emotional needs of each child.

Additional suggestions include a large physical plant (14% of administrators of all institutions); better coordination of the clinical and educational staff (13%); more vocational education and practical experience (13%); and smaller classes (10%), among others. Also of interest are suggestions to increase the experiential learning of these emotionally disturbed children by providing more recreation and field trips--a form of the "classroom without walls" concept popular in current educational literature. Table 3.8.1b: Number and Percent of Administrators Reporting Suggestions for Improvement Within the Institution by Type of Institution displays these data.

Suggestions for improved educational service delivery to emotionally disturbed children in the country at large differ from suggestions directed toward programs within institutions in that greater emphasis is placed on less labeling (12% of administrators of all institutions); more mainstreaming (13%); earlier identification and treatment (16%); improved teacher training (22% plus 13% recommended the establishment of intership programs);

SUGGESTIONS FOR IMPROVEMENT WITHIN THE INSTITUTION	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
More Specialists, Staff, and Electives	20	34%	9	29%	29	32%
Improved Teacher Training	17	29%	5	16%	22	24%
More Funds	13	22%	5	16%	18	20%
Large Physical Plant	5	8%	8	26%	13	14%
Better Coordination of Clinical and Educational Staff	5	8%	7	23%	12	13%
More Vocational Education/ Practical Experience	8	14%	4	13%	12	13%
More Behavior Management Techniques	11	19%	-	-	11	12%
More Materials and Equipment	8	14%	4	13%	12	13%
Smaller Classes	7	12%	2	6%	9	10%
More Individualized Program	16	28%	-	-	16	18%
More Recreation and Field Trips	3	5%	4	13%	7	8%
More Control Over Hiring, Firing, and Monitoring of Teachers	3	5%	-	-	3	3%
Less Labeling/Stigma	-	-	1	3%	1	1%
More Community Education	1	2%	-	-	1	1%
More Mainstreaming	2	3%	-	-	2	2%
More Gray Homes	2	3%	-	-	2	2%
More Sheltered Workshops	1	2%	-	-	1	1%
	(n=59)		(n=31)		(n=90)	

TABLE 3.8.1b: NUMBER AND PERCENT OF ADMINISTRATORS REPORTING SUGGESTIONS FOR IMPROVEMENT WITHIN THE INSTITUTION BY TYPE OF INSTITUTION

more community based programs, such as community mental health centers to provide an alternative to institutionalization (12%); and more community education and preventive psychology (17%).

One particularly interesting suggestion for improvement in the country centers on the formation of a national association of residential treatment directors to facilitate the exchange of useful information and innovative techniques for dealing with emotionally disturbed children (7%). Also of interest, is the suggestion that personality criteria accompany educational criteria when hiring teachers for the population (6%). Finally, several administrators (9%) felt that the establishment of a child advocate within the federal government would further the cause of adequate treatment for emotionally disturbed children nationwide. Table 3.8.1c: Number and Percent of Administrators Offering Suggestions for Improvement in the Country at Large by Type of Institution lists the total number of suggestions made by administrators in both types of institutions.

GENERAL SUGGESTIONS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Less Labeling/Stigma	6	8%	5	16%	11	12%
More Mainstreaming	8	14%	4	13%	12	13%
Less Mainstreaming	3	5%	-	-	3	3%
Earlier Identification and Treatment	9	15%	5	16%	14	16%
Internship Programs for Teachers and Hospital Staff	7	12%	5	16%	12	13%
Coordination of Clinical and Education Staff	5	8%	4	13%	9	10%
Improved Teacher Training	11	19%	9	29%	20	22%
More Individualized Program-	6	10%	3	10%	9	10%
Association of Residential Treatment Center Directors	6	10%	-	-	6	7%
Personality Measures for Teacher Effectiveness	2	3%	3	10%	5	6%
More Vocational Education and Practical Experience	6	8%	3	10%	9	10%
More Community-Based Programs	6	8%	5	16%	11	12%
More Community Education and Preventive Psychology	10	17%	5	16%	15	17%
Child Advocate in Government	6	8%	2	6%	8	9%
Return to 3 R's	4	7%	-	-	4	4%
Smaller Classes	6	8%	4	13%	10	11%
More Specialists, More Staff	2	3%	3	10%	5	6%
More Funds	6	8%	2	6%	8	9%
More Special Schools	6	8%	1	3%	7	8%
	(n=59)		(n=31)		(n=90)	

TABLE 3.8.1c: NUMBER AND PERCENT OF ADMINISTRATORS OFFERING SUGGESTIONS FOR IMPROVEMENT IN THE COUNTRY AT LARGE BY TYPE OF INSTITUTION

3.8.2 Educational Program Director's View

According to the educational program directors, the behavioral problems of the students constitute the most serious impediment to academic progress (34% of educational directors gave this response). Also frequently mentioned were the academic problems of the children (23%); inadequate funds (26%); the conflict between the clinical and educational staff discussed earlier (21%); the lack of specialists (21%); the inadequacy of the physical plant (20%); and the lack of facilities, materials and electives (16%). Although not mentioned by administrators, 4 percent of the educational program directors interviewed report that their teachers feel isolated from the mainstream of education. These teachers are sometimes salaried by the public school system, but because they are dealing with a specialized population within an institution they are removed from communication channels apprising teachers of new educational techniques and materials.

Survey results indicate that educational program directors of in-patient hospital units are more likely to see the academic difficulties of their students as a serious problem than are educational program directors of residential treatment centers (45% of educational directors of hospitals report this problem as compared to 11% of directors of residential treatment centers).

This difference in perceived problems between in-patient hospital units and residential treatment centers probably reflects the more difficult population of the former rather than any substantial difference in philosophy or technique. Table 3.8.2a: Number and Percent of Educational Program Directors Reporting Perceived Problems by Type of Institution displays these data.

Concerning suggestions for improvement within the institution, the most frequent response involves more specialists, staff and electives (36%). More funds (18%), a larger physical plant (17%), more individualized programs (17%) and more education (15%) are also needed. As was the case with administrators, educational program directors suggest improved teacher training (15 percent of all

PERCEIVED PROBLEMS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Conflict Between Clinical and Educational Staff	12	20%	7	22%	19	21%
Problems of Academic Children	7	11%	14	45%	21	23%
Problems of Adjustment to Discharge	-	-	2	6%	2	2%
Inadequate Funds	19	32%	4	13%	23	26%
Lack of Specialists	13	22%	6	19%	19	21%
Inadequate Physical Plant	11	19%	7	23%	18	20%
Behavioral Problems of Children	21	36%	10	32%	31	34%
Management Problems	4	7%	4	13%	8	9%
Lack of Teacher Certification and Expertise	2	3%	2	6%	4	4%
Self-Concept Problems of Students	5	8%	-	-	5	6%
Lack of Cooperation from Receiving Facilities for Monitoring	4	7%	-	-	4	4%
No Control over Hiring and Firing of Teachers	3	5%	1	3%	4	4%
Lack of Facilities, Materials or Electives	11	19%	3	10%	14	16%
Lack of Vocational Education or Job Placement	4	7%	3	10%	7	8%
Lack of Continuity, High Turnover	3	5%	-	-	3	3%
Isolation of Teachers Salaried by School System but Working in Institution	3	5%	1	3%	4	4%
	(n=59)		(n=31)		(n=90)	

TABLE 3.8.2a: NUMBER AND PERCENT OF EDUCATIONAL PROGRAM DIRECTORS REPORTING PERCEIVED PROBLEMS BY TYPE OF INSTITUTION

educational directors suggest improved training - plus 4% suggest increased experience and certification).

As far as mainstreaming is concerned, some educational program directors feel that institutionalized emotionally disturbed children should be integrated into the public school system in preparation for their eventual discharge. Ohters, however, voice the opinion that if the child can function in a public school setting, he is not ill enough to be institionalized. The issue is further complicated by the fact that the educational program within the institution sometimes has greater resources for dealing with emotionally disturbed children than does the public school. Educational program directors must decide if the experience of interacting with "normal" children in the public school setting counteracts the lack of specialized educational services for the emotionally disturbed.

Also of interest is the suggestion made by 37 percent of the educational program directors that more realistic goals be set for these students. In their opinion, a sad but necessary realization must occur concerning the future of these children. That realization is that these children are often so far behind academically and socially that college placement is out of reach. Instead, goals must be redirected toward occupational training programs, junior college programs, etc. To try to prepare these children for college, when acceptance is not a realistic possibility, does a disservice to these people. They must instead be given the means to support themselves and function as independent adults in the larger society. Table 3.8.2b: Number and Percent of Educational Program Directors Offering Suggestions for Improvement Within the Institution by Type of Institution displays these data.

SUGGESTIONS FOR IMPROVEMENT WITHIN THE INSTITUTION	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Improved Teacher Training	10	17%	4	13%	14	15%
Coordination of Clinical and ducational Staff	5	8%	6	19%	11	12%
Larger Physical Plant	10	17%	6	19%	16	17%
More Funds	13	22%	4	13%	17	18%
More Specialists, Staff, Electives	21	36%	11	35%	32	36%
More Individualized Program	11	18%	5	16%	16	19%
Teachers Certified in ED, More Experienced	3	5%	1	3%	4	4%
More Behavior Management Techniques	2	3%	-	-	2	2%
More Vocational Education and Practical Experience	11	19%	3	10%	14	15%
Less Labeling, Stigma	-	-	1	3%	1	1%
More Realistic Goals for Students	3	5%	-	-	3	3%
More Community Education	2	3%	1	3%	3	3%
Earlier Identification	1	2%	-	-	1	1%
More Control of Hiring, Firing and Monitoring of Teachers	2	3%	-	-	2	2%
Smaller Classes	7	12%	3	10%	10	11%
More Mainstreaming	4	7%	1	3%	5	6%
More Alternate Housing	1	2%	-	-	1	1%
More Materials and Equipment	5	8%	7	23%	12	13%
More Recreation, Trips and Learning Experiences	6	10%	2	6%	8	9%
More Structure	3	5%	1	3%	4	4%
	(n=59)		(n=31)		(n=90)	

TABLE 3.8.2b: NUMBER AND PERCENT OF EDUCATIONAL PROGRAM DIRECTORS OFFERING SUGGESTIONS FOR IMPROVEMENT WITHIN THE INSTITUTION BY TYPE OF INSTITUTION

The most frequent suggestion for improved educational service delivery to emotionally disturbed children in the country at large, centers on the improvement of teacher training. Approximately 43 percent of the educational program directors interviewed suggested an improvement in training, either directly (26%) or through the establishment of an internship program for teachers (17%). Such an internship program would give the teachers first hand experience in dealing with emotionally disturbed children prior to their obtaining certification. In fact, many educational directors feel that an internship for teachers should indeed be a requirement for certification.

Additional suggestions include: more individualized programs (16%); more community education (16%); greater integration of Therapy and education (13%); less labeling (12%); and more mainstreaming (12%). The remaining suggestions and the frequencies with which they were offered by educational program directors are presented in Table 3.8.2c: Number and Percent of Educational Program Directors Offering Suggestions for Improvement in the Country at Large by Type of Institution. A pattern seems to emerge in several of these remaining suggestions.

As mentioned earlier, 12 percent of educational directors recommend more mainstreaming. If we combine this with the 2 percent who feel that public schools should provide therapy for emotionally disturbed children, the 10 percent who suggest more community based program and alternate living situations such as group homes, and the 11 percent who suggest more special schools for the emotionally disturbed, we can conclude that there is a strong feeling on the part of educational directors that give appropriate community resources and support, a great number of these children would not have to be institutionalized.

GENERAL SUGGESTIONS	TYPE OF INSTITUTION				ALL INSTITUTIONS	
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS			
Less Labeling, Stigma	8	14%	3	10%	11	12%
More Mainstreaming	7	12%	4	13%	11	12%
Less Mainstreaming	4	7%	2	6%	6	7%
Earlier Identification and Treatment	5	8%	3	10%	8	9%
Internship Program for Teachers and Hospital Staff	9	15%	6	19%	15	17%
Coordination of Clinical and Educational Staff	7	12%	5	16%	12	13%
Better Training for Teachers	13	22%	10	32%	23	26%
Schools Should Provide Therapy	2	3%	-	-	2	2%
Parents Should Be Treated	2	3%	1	3%	3	3%
More Individualized Programs	11	18%	3	10%	14	16%
Association of Residential Treatment Center Directors	6	10%	1	3%	7	8%
Personality Measures for Teacher Effectiveness	5	8%	6	19%	11	12%
More Vocational Education and Practical Experience	5	8%	2	6%	7	8%
More Community-Based Programs	6	12%	3	10%	9	10%
More Community Education	11	18%	3	10%	14	16%
Parent Training	5	8%	-	-	5	6%
More Research on ED	2	3%	1	3%	3	3%
Child Advocacy	4	7%	2	6%	6	7%
Return to 3 R's	-	-	3	10%	3	3%
Smaller Classes	9	15%	1	3%	10	11%
More Specialists and Staff	5	8%	3	10%	8	9%
More Funds	7	12%	2	6%	9	10%
More Attention to Depressed Children vs. Acting Out	2	3%	-	-	2	2%
More Special Schools	7	12%	3	10%	10	11%

TABLE 3.8.2c: NUMBER AND PERCENT OF EDUCATIONAL PROGRAM DIRECTORS OFFERING SUGGESTIONS FOR IMPROVEMENT IN THE COUNTRY AT LARGE BY TYPE OF INSTITUTION

3.8.3 Outside School Principals' View

The behavior of the institutionalized children enrolled in public schools presents a problem for 20 percent of the outside school principals interviewed. Academic problems of these children such as learning disabilities are also a problem but apparently only for schools receiving children from residential treatment centers (12%).

It is interesting to note, that unlike institutions where the children are homegeneous at least as far as diagnosis is concerned and where the parents play a minimal role in the education of the children, 4 percent of outside schools have difficulty developing peer approval for the child probably due to the stigma associated with institionalization and 6 percent report that parents tend to sabotage learning. Table 3.8.3a: Number and Percent of Outside School Principals Reporting Perceived Problems by Sending Institution displays these data.

As was the case with institutional staff, outside school principals suggest improved training of teachers (14%); more specialists, staff and electives (12%); and more individualized instruction. Additional suggestions include more coordination between institution and outside school staff (6%), more funds (6%), more parent involvement (4%), earlier identification (3%), and more vocational education (3%). The remaining suggestions are included with those discussed above in Table 3.8.3b: Number and Percent of Outside School Principals Offering Suggestions for Improvement Within the School by Sending Institutions.

PERCEIVED PROBLEMS	SCHOOLS RECEIVING CHILDRED FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
Children's Academic problems	7	12%	-	-	7	8%
Developing Peer Approval for Child	2	3%	2	6%	4	4%
Lack of Specialists	1	2%	-	-	1	1%
Inadequate Physical Plant	-	-	1	3%	1	1%
Children's Behavioral Problems	11	19%	7	23%	18	20%
Parents Sabotage Learning	2	3%	3	10%	5	6%
Self-Concept Problems	-	-	1	3%	1	1%
Low Attendance	1	2%	1	3%	2	2%
Lack of Facilities, Materials, Electives	1	2%	1	3%	2	2%

TABLE 3.8.3a: NUMBER AND PERCENT OF OUTSIDE SCHOOL PRINCIPALS REPORTING PERCEIVED PROBLEMS BY SENDING INSTITUTION

SUGGESTIONS FOR IMPROVEMENT WITHIN THE SCHOOL	SCHOOLS RECEIVING CHILDREN FROM:					
	RESIDENTIAL TREATMENT CENTERS		IN-PATIENT HOSPITAL UNITS		ALL INSTITUTIONS	
Staff Training	10	17%	3	10%	13	14%
Coordination of Institutional and School Staff	3	5%	2	6%	5	6%
More Funds	5	8%	-	-	5	6%
More Specialists, Staff, Electives	9	15%	2	6%	11	12%
More Individualized Program	6	10%	5	16%	11	12%
More Vocational Education and Practical Experience	2	3%	1	3%	3	3%
More Realistic Goals for Students	-	-	1	3%	1	1%
More Community Education	1	2%	1	3%	2	2%
Earlier Identification	3	5%	-	-	3	3%
More Mainstreaming	1	2%	2	6%	3	3%
More Parent Involvement	3	5%	1	3%	4	4%
More Recreation, Trips and Educational Experiences	2	3%	-	-	2	2%
	(n=36)		(n=13)		(n=49)	

TABLE 3.8.3b: NUMBER AND PERCENT OF OUTSIDE SCHOOL PRINCIPALS OFFERING SUGGESTIONS FOR IMPROVEMENT WITHIN THE SCHOOL BY SENDING INSTITUTIONS

Concerning suggestions for improvement in the country at large, outside school principals appear to agree with institutional staff that there should be improved teacher training (6%), an internship program for teachers (8%), more specialists (9%) etc. In addition, outside school principals add to the list of general suggestions better screening and evaluation procedures to insure that children are not mis-diagnosed and inappropriately institutionalized (5%). Table 3.8.3c: Number and Percent of Outside School Principals Offering Suggestions for Improvement in the Country at Large by Sending Institution presents these suggestions.

GENERAL SUGGESTIONS	TYPE OF SCHOOL					
	SCHOOLS RECEIVING CHILDREN FROM RESIDENTIAL TREATMENT CENTERS		SCHOOLS RECEIVING CHILDREN FROM RESIDENTIAL TREATMENT CENTERS		SCHOOLS RECEIVING CHILDREN FROM ALL INSTITUTIONS	
Less Labeling, Stigma	3	5%	3	10%	6	7%
More Mainstreaming	5	8%	-	-	5	6%
Less Mainstreaming	-	-	1	3%	1	1%
Earlier Identification and Treatment	2	3%	-	-	2	2%
Internship Program for Teachers and Hospital Staff	6	10%	1	3%	7	8%
Coordination between Clinical and Education Staff	1	2%	1	3%	2	2%
Improved Teacher Training	3	5%	2	6%	5	6%
More Individualized Program	2	3%	-	-	2	2%
Personality Measures for Teacher Effectiveness	5	8%	-	-	5	6%
More Vocational Education and Practical Experience	1	2%	2	6%	3	3%
More Community-Based Programs	4	7%	2	6%	6	7%
More Community Education	4	7%	2	6%	6	7%
Better Screening Procedures	3	5%	-	-	3	3%
More Specialists and Staff	6	10%	2	6%	8	9%
More Funds	4	7%	2	6%	6	7%
More Special Schools	5	8%	1	3%	6	7%
	(n=56)		(n=33)		(n=43)	

TABLE 3.8.c: NUMBER AND PERCENT OF OUTSIDE SCHOOL PRINCIPALS OFFERING SUGGESTIONS FOR IMPROVEMENT IN THE COUNTRY AT LARGE BY SENDING INSTITUTION

To summarize, major problem areas in the delivery of educational services to emotionally disturbed children center around the behavioral and academic problems of the students, the conflict between the clinical and educational staff as to who will control the philosophy and direction of the educational program, lack of funds, space and staff and unavailability of special facilities, materials and electives. Suggestions for improvement within the institutions and outside schools involve the provision of more specialists, staff and electives, improved teacher training (including internship program), more individualized instruction, more vocational education, more funds, space and materials, and greater integration of therapy and education. Suggestions for improvement in the country at large again include improved teacher training, but add earlier identification and treatment, less labeling and stigma, more mainstreaming, more community based programs and alternative living situations such as group homes and more community education and preventive psychology.

4

MODEL PROGRAM COMPONENTS

4.1 Introduction

The majority of the educational programs approached by project staff during the course of this study shared a broad base of common objectives, strategies and concerns. It was difficult, therefore, to identify any programs as representing totally revolutionary approaches to delivering educational services to emotionally disturbed children since major innovations tended to focus on the application of existing educational strategies to this population. Although educational programs within institutions were generally traditional in nature, a wide variety of innovative individual program components were identified for discussion here.

The review of program descriptions and related documents indicated that many programs were involved in isolated attempts to develop more meaningful evaluation mechanisms and to identify effective curriculum and teaching strategies. In several cases, this was supported (or possibly stimulated) by the institution's linkage to graduate programs encouraging research activities. In other cases, the instruments or strategies developed were credited to institutional staff members with knowledge of more sophisticated educational approaches (behaviorial objectives, tests and measurements, task analysis, etc.). Occasionally the innovation was suggested by a staff member who perceived the application of seemingly unrelated interests (camping, bowling, gardening, etc.) to the educational process. While none of these innovative program components are new in the sense that they have never been applied to educational settings before, they are not generally

thought of in terms of this group of children, either because they present potential risks with an unstable population or because they are expensive. A more detailed analysis of these selected program components follows.

4.2 Institution Developed Assessment Instruments

Of the assessment documents supplied by individual programs, the single most common type was concerned with educational assessment. Generally these assessment instruments covered specific content areas, general attitudes, behavior and test scores. The most striking aspect of these instruments is the difference in level of specificity from one institution to another. For example, the following two rating scales measure proficiency in language arts for two different institutions:

EXAMPLE A

LANGUAGE ARTS	VERY MUCH	OFTEN	SOME-TIMES	NOT AT ALL
1. Demonstrates Listening Ability				
2. Expresses Ideas Clearly in Conversation				
3. Demonstrates Knowledge of Vocabularies Taught				
4. Is Able to Work Out New Words				
5. Understands and Remembers What He Reads				
6. Reads Orally With Accuracy, Fluency and Expression				
7. Demonstrates Interest in Books And Independent Reading				
8. Uses Reference Skills				
9. Applies Rules of Good English				
10. Expresses Himself Creatively in Oral and Written Work				
11. Applies Good Spelling Habits in Written Work				
12. Writes Neatly and Forms Letters Correctly				

EXAMPLE B

Language Skills Checklist

I. Word Identification and Analysis

A. Word Meaning

—— 1. Recognizes common synonyms
—— 2. Recognizes common antonyms
—— 3. Recognizes common homonyms

B. Structural Analysis

—— 1. Can divide words into syllables
—— 2. Knows common prefixes, suffixes
—— 3. Understand function of prefixes, suffixes
—— 4. Can expand root words to make new words
—— 5. Can interpret accent marks
—— 6. Uses contractions
—— 7. Uses compound words
—— 8. Can interpret possessives
—— 9. Can interpret plurals
——10. Can discriminate between words that look similar but are pronounced differently.

II. Word Sensitivity

— A. Recognizes multiple meanings
— B. Associates words with feelings
— C. Interprets figurative, idiomatic expressions
— D. Can derive meaning from non-verbal expression
— E. Can interpret and convey word meaning verbally and non-verbally
— F. Sees relationships between words
— G. Can classify words of like quality
— H. Searches out and uses new words to replace over-used or familiar words
— I. Can use words to manipulate feeling, create mood or emotional appeal
— J. Develops lasting appreciation of words, the power of words
— K. Derives personal pleasure, satisfaction and enjoyment from using and dealing with words.

III. Comprehension

— A. Can classify material read
— B. Can summarize
— C. Can generalize
— D. Can make comparisons, associations

IV. Work Study Skills

— A. Can alphabetize
— B. Can choose appropriate definitions
— C. Can locate information in reference materials.
—— 1. Dictionary
—— 2. Thesaurus
—— 3. Encyclopedia
—— 4. Catalog
—— 5. Atlas
—— 6. Card catalog
—— 7. Magazine
—— 8. Newspapers
—— 9. Table of Contents
——10. Index
——11. Glossary

Despite the difference in the level of skills discussed, it is clear that the second instrument, supported by appropriate skill inventories, is more effective for use in designing an individualized educational program geared to diagnosed academic deficiencies. It is significant to note that neither instrument is in any way specific to an emotionally disturbed population. Both are more appropriate to structuring remedial work for students who have in fact developed some ability to deal with normal class work.

Rating scales which attempt to deal with emotional and behavorial problems as related to classroom management strategies are relatively scarce and occasionally seem more related to therapeutic than educational needs. Student self-ratings and sentence completions fall into this category:

EXAMPLE C

My parents understand me.
never/sometimes/often/always

I tell the truth.
never/sometimes/often/always

I know what to say to people.
never/sometimes/often/always

I am nice looking.
never/sometimes/often/always

The direct applicability of this type of information to development of appropriate educational goals and teaching strategies is dubious. Project staff did, however, identify several types of behavioral checklists which appeared to be more appropriate to formulating pre-academic objectives and structuring meaningful learning situations. Two examples are presented on the following page.

EXAMPLE D

Classroom Behavior

1. Makes disruptive noise (tapping, humming, etc.)
2. Leaves seat (unexcused)
3. Speaks out of turn
4. Destructive to property
5. Disturbs others (provokes others nearby)
6. Does not attend to classroom instruction
7. Does not complete expected classwork
8. Gets into fights
9. Sad or sullen
10. Nervous under stress of an examination
11. Restless or overactive
12. Overly sensitive (easily hurt)
13. Has a short span of attention
14. Becomes easily frustrated

EXAMPLE E

Attitude

1. Shows concern for his academic progress.
2. Is enthusiastic in classroom activities
3. Shows confidence that he can succeed
4. Likes to complete tasks
5. Likes tangible rewards (candy, points, etc.).
6. Likes praise and attention as a reward
7. Likes to come to class - looks forward to it.
8. Has a positive attitude toward most areas of school life
9. Likes books or written materials
10. Likes physical activity
11. Likes tasks that require tools or object-manipulation
12. Admits mistakes and shortcomings without blaming others
13. Gets along without complaining or griping
14. Has good grooming habits-not sloppy, stinky or dirty.
15. Has good grooming habits without being meticulous (primping).

The second example in particular deals with potential problems and effective strategies for control. Such an approach begins to address those classroom behaviors which necessarily precede academic learning. Clearly the problem is complex, particularly given the diversity of the population. Examples such as those cited above represent realistic attempts to apply task analysis and behavioral objective techniques to the problems specific to emotionally disturbed children. A wider dissemination of this type of self-developed instrument would enable teachers and evaluation specialists with common concerns to benefit from each other's perspectives.

In this regard, one final assessment document will be presented. Example F is an individualized educational program developed for one child. It demonstrates a clarity of objectives and strategies that encourage an organized teaching approach.

4.3 Innovative Teaching Techniques

The variety of teaching techniques used in these institutions tends to reflect the need for providing comfortable, individualized learning situations which permit instruction while developing more acceptable interaction patterns. Most institutions have low student-teacher ratios, supplemented by teacher aides. However, one institution is using a student-tutoring-student approach to increase individualization and stimulate constructive peer interaction. Another institution has an interchangeable child care and teaching staff, insuring maximum continutiy between therapeutic and educational programming. Still another institution accomplishes this same goal through tutoring-counseling workshops in which therapeutic goals are addressed using academic content as a basis for interaction.

4.4 No-Fail Grading Systems

Several institutions have eliminated some of the stress inherent in classroom situations by eliminating failing grades for students. The emphasis then is on mastering skills, and students who cannot complete work are given additional instruction and an opportunity to repeat the task. In this regard, one related consideration must be noted. Many of these students are far behind expected grade levels in many subjects and often the necessity for such extensive

EXAMPLE F

NEEDS ASSESSMENT - 10/75

Problems with motivation and attitude and adult relationships

WISC and Bender-Gestalt given 6/71

STRENGTHS:

1) Aware of activity in her immediate environment.
2) Very inquisitive.
3) Can work independently within a group situation.
4) Attends regularly, seems to enjoy school.
5) Best learning modalities are visual, tactile, kinesthetic.

NEEDS:

1) To improve her relationships with authority figures.
2) To verbalize observations and impressions.
3) To develop a repertoire of reading skills.
4) To develop a knowledge of time and money.
5) To develop a better understanding of the material world and the functions around her.

PROGRAM OBJECTIVES:

1) To teach the student acceptable verbal, facial, attitudal responses to authority figures.
2) To relate a 3-step event concisely and in sequence.
3) To recognize instructional and directional written words on a functional basis.
4) To recognize the value of coins in relation to one another and be able to tell time to the half hour.
5) To gain a basic method of scientific concepts; example, catagoration of animals and their eating habits; seasonal weather and appropriate clothing.
6) To develop an appreciative concept of community helpers and important places in the community.

STRATEGIES FOR MEETING PROGRAM OBJECTIVES:

1) a. Demonstration to student by teacher the correct acceptable responses.
   b. Verbal reinforcement for acceptable responses exhibited by student.
   c. Ignoring unacceptable responses which were elicited.
2) Only accept complete sentence accounts of events.
3) Exposure to functional sight words through Second Step to Reading Books A, B & C Learning Steps (signs and field trips).
4) Manipulative exercises with money and time; learning steps (store) directed experiences. Reinforce with work sheet.
5) Science demonstrations and catagorizing games (description posters, weather flannel board, teacher-made games that demonstrate concept of classification.
6) Social Studies (Books 1 & 2, Hayes Publishing Co.; Living Together in the Neighborhood; field trips, films, Peabody discussion pictures; environment).

ENVIRONMENT:

Self-contained classroom, TMR to EMR level, low level of external stimuli, concentration on visual and tactile-kinesthetic presentations and experience.

SUPPORT SERVICES:

1972 County Department of Social Services (foster care placement).

FOLLOW-UP:

Supervisor of Special Education
Department of Social Services
Classroom teacher

remedial work creates an attitude which assumes that the child cannot really "progress" until he has "caught up". The use of norm-referenced tests as a basis for evaluation can be demoralizing to a student who has progressed one grade level in one year, but who is still five or six years behind expected grade level. Some institutions avoid this situation by relying entirely on individually referenced evaluations. The child is given credit for those skills he masters and comparisons to "normal"children are eliminated.

4.5 Creative Electives

In general, the range of electives available to emotionally disturbed children within institutions is not as wide as that available to other children. In some cases, however, popular interests in the outside community are reflected in the provision of elective courses in the institutional setting. One suspects that these electives may reflect the incidental interests and expertise of individual staff members as well as more defined goals. Regardless of the motivation, these courses provide a novel, topical basis for constructive interaction.

The more innovative of these elective courses include:

- therapeutic judo
- dance therapy
- horticulture
- animal husbandry
- black history
- drafting
- photography
- ceramics
- woodworking
- cosmetology

The provision of a variety of electives to institutionalized emotionally disturbed children not only widens their range of growth experiences but insures that each child will find some area of endeavor in which he can be successful. Experiences of success are, in turn, necessary to the development of the positive self-image which forms the foundation of sound mental health.

4.6 Outdoor Education

One specific example of these attempts to expand the learning environment is the outdoor education program.

> Outdoor education involves direct learning experiences which utilize the outdoors to achieve the goals of education. Outdoor education is an interdisciplinary approach to education and provides opportunites to reinforce and enrich each area of the school curriculum. Through learning and living in an outdoor environment, children and adults are able to better understand and appreciate the world in which they are a part.

Three affiliated outdoor education centers were identified during the course of the study. These centers serve as a resource to various types of schools and are designed to accomodate a range of special needs students. The basic philosophy of these centers is well expressed in their brochure:

> There is no substitute for experience in the learning process. Through direct involvement, students actually see, touch, hear, smell, and often taste the subject matter being studied. Direct contact with the real subject improves the mind, generates interest, stimulates the imagination and increases curiosity. The learning process becomes as it should be, enjoyable and exciting. This type of learning is beneficial for students and teachers, and that is why outdoor education experiences should be an essential part of the school curriculum.
>
> The instructional programs of each of the Centers operate throughout the school year, as well as during the summer months. Teachers who bring their classes to a Center receive assistance from the Center's staff in planning and conducting outdoor education experiences that use a variety of resources in the natural environment to teach students not only science and ecological studies, but also subjects such as language arts, social studies, mathematics, foreign languages, the humanities, home economics, health education, physical education, and career education related to the outdoors.
>
> Programs at the Centers are designed to meet the specific educational needs of all students. Learning experiences are structured, as well as informal, and the health and safety of all participants are an essential part of every program.

The Centers also provide an opportunity for teachers to participate in professional improvement programs through outdoor education workshops, seminars and conferences. Courses in outdoor education, with academic credit, are also taught at the Centers in cooperation with college and university extension programs.

The professional staff at each of the Centers is available to assist teachers in acquiring the skills and knowledge necessary to plan outdoor experiences that will fulfill the educational needs and interest of children. Through planned outdoor learning experiences, students gain a greater understanding and appreciation of the interrelationship of all subjects in the school curriculum and the learning process becomes enjoyable for both teachers and students.

The success of an outdoor education program is directly related to the participation of teachers. The staff provides teachers with instruction in the techniques and procedures for teaching in the outdoors, and teachers apply these skills with their students in the natural environment of the Centers. Many of the activities taught at the Centers possess carry-over value, and teachers are encouraged to incorporate these learning experiences into the curriculum when they return to their school and community.

The setting at each center offers a variety of interesting features, including ponds, streams, woods, swamps, fields, forests, nature trails, cemetaries, livestock, farm equipment, green houses, gardens and laboratory facilities.

One of the institutions interviewed had contracted with such a center for instructional programs and teacher training services. Another institution was providing a similar program using its own staff and facilities.

4.7 Mainstreaming

Mainstreaming in itself is a relatively new concept with operational procedures and admissions criteria still in a state of flux. The following was the only written example of Admissions Criteria located by project staff.

OFF CAMPUS SCHOOL

Responsibility for recommending students for public school resides with the therapist and teachers. The list of recommended referrals is compiled by the director of education who in turn submits same list to a public school referral committee for discussion and review. This committee is headed by the psychiatrist-director and includes the associate director, director of education, residence therapists and teachers.

CRITERIA: The following criteria developed by a teacher-therapist committee is used as a guide for establishing which students will be going to public school. Students should have a clear understanding that recommendations from therapists and teachers are necessary before enrollment in public school.

1. Sufficient amount of time in on-campus to allow adjustment to group-living and academic and emotional evaluation.

   A. Academic (Applicable the majority of classtime)

      1. Follow instructions
      2. Work independently
      3. Do assignments without constant force.
      4. Acquire basic skills for age and grade level.
      5. Punctuality
      6. Non-absenteeism except legitimate illness.

   B. Social

      1. Minimum ability to tolerate peers
      2. Ability to cooperate and work with group
      3. Take mild behavior corrections without disproportionate reaction.
      4. Control of inappropriate language.
      5. Appropriate dress and hygiene habits.

2. Public School placement is a treatment tool-- an ego-builder treatment technique which is used to strengthen a student at the time in treatment when this seems indicated.

3. Classroom, residence, individual and group off-campus activities (areas of strength and problem) -- It is important to recognize that stresses and structure differ here and off-campus and a student's on-campus behavior is not always indicative of public school functioning. In a treatment setting the limits on behavior are different, much as they would be different in a child's home as compared to public school.

4. Obvious improvement from entry in on-campus school until time for consideration for off-campus.

Another educational program within an institution went further by defining academic and behavioral placement criteria for each child on the basis of his or her individual performance. Placement in an outside school then becomes the responsibility of the child. By earning a specified number of points through a behavior management system, the child can decide the point at which he will be mainstreamed into a regular public school setting.

Finally, the most important innovation in mainstreaming is the recent practice of preventing the identification of institutionalized emotionally disturbed children who are enrolled in public schools. Children who are ready for such placement are enrolled by institution staff as regular transfer students, and public school officials are not informed of the child's institutional status. Therefore, they cannot prescribe only specialized educational or counseling services which would call attention to the institutionalized child. The degree to which the procedure allows the child a "fresh start," free of stigma or labeling, is worthy of further examination.

4.8 Transitional Programs

In reviewing exemplary programs, it should be noted that a definite trend exists among the residential treatment centers toward organizing less institutional, more independent settings for emotionally disturbed adolescents. Program descriptions and rationales for several of these transitional programs follow.

Program staff in one institution, for example, were concerned with the contrast between the regimented, impersonal, public nature of the institutional setting and the sense of responsibility required for outside life.

> The old-style open dormitory left a great deal to be desired when results were measured. Today, the boys are organized into "group living units" which combine a comfortable, home-like atmosphere with an essential measure of privacy. To an adolescent boy, this latter is every bit as vital as the former. He must have opportunity to retreat from the group to an area that is all his own, however simple its furnishings may be. Thus given responsibility to act as an individual, he can be encouraged to develop resourcefulness, initiative and healthy pride. At the same time, he can feel completely relaxed within the structure of the group setting, and participate in a program designed to meet the needs of a number of boys. He can exercise considerable self-control ... but if he needs help, it is close at hand from the counselor in charge of his group.
>
> Not every boy is ready to go directly home when he has completed his re-adjustment. Sometimes conditions at home are the basic cause of the problems he has had. Sometimes he simply wants to extend his stay until he feels real confidence in a new set of circumstances. A variety of such reasons led to a trial of the idea and the results were sufficiently encouraging to justify the new facilities. If a boy's situation is such that a transfer to the Transition House is approved, he moves into an almost completely home-like atmosphere. The building is designed like a residence, has individual bedrooms, home-like kitchen, laundry and family rooms ... and resident house mother and father. The boys remain under the direction and guidance of the institution as they move through this final stage of establishing a rightful place for themselves in the community.

The students were allowed a much higher level of interaction with the outside community than is common among institutions serving emotionally disturbed children. They attended outside schools, were encouraged to participate in extra-curricular activities and were permitted free access to the telephone.

A similar program for girls is described below:

1. Group Living

Our girls live in separate groups of 8 to 10 in number under the care of houseparents. Each unit has its own kitchen, recreation room, bedroom, and bathroom facilities. The group interaction fostered in a group living situation among the girls and the houseparents is a key element in strengthening and forming a new pattern in behavioral and social interaction.

2. Group Therapy

At least once a week, formal group therapy is conducted by the Social Work Therapists; frequently impromptu group meetings are called by the houseparents or girls. These group meetings deal with individual problems and any problems and concerns expressed by the girls and the houseparents around group living areas. Frequently through these meetings the girls learn to express their feelings about others and themselves in a socially appropriate manner, and in so doing they dissolve some of their anxiety and hostility.

3. Individual Therapy

Each girl is seen in treatment sessions, on a scheduled basis according to her needs. If additional sessions are needed they ar also provided. The Social Work Therapists, besides their n competence, are guided by our experienced Director of Treatment and by Psychiatric Consultants. It is through this psychotherapy that the girls gain insight into their problems and can better deal with their feelings and emotions.

4. Family Therapy

On a weekly basis, professional help is offer to families of girls in residence. Most of the girls will be returning to their home and it is of utmost necessity that the families become involved with group and/or individual therapy provided by our staff. Such areas as family interaction, family communication, and marital disharmony are often the focus of family therapy.

5. Education

On-Ground School is provided for girls who cannot function in a regular school setting because of behavioral, academic, or social difficulties. Specialized teachers work with the students on an individual and group basis. For any girl who can socially and educationally succeed, community schools, both public and parochial, are utilized. School counselors are contacted frequently concerning the progress of students attending outside schools.

6. Cultural, Social and Recreational Needs

Each living unit provides for its own recreational needs. A variety of recreational activities are provided including summer water sports, hiking, bicycling, and other outdoor and indoor sports.

In the Child's Interest .... a Social Work Therapist provides therapy, arranges for proper school placement, coordinates institutional services in the child's interest and maintains liaison with the referring agency. The therapist also keeps a record of the girl's progress and arranges for further examination and testing, if necessary. At least every six months, a psychiatric evaluation is held and all interested personnel join with the psychiatrist in determining the course of treatment to be followed.

Obviously, the procedure just outlined, as well as the program described, calls for a group of trained and devoted persons - Director of Treatment, Social Work Therapists, Special Education Teachers, Psychiatric Consultant, Houseparents, Supervisor of Houseparents, Administrator, and Executive Director -- all working together as a team for the growth of the child.

The institution also operates two satellite homes. These homes provide shelter, therapy and living experience for fifteen girls, most of whom are attending local high schools. Here the girls find the structure they need, together with a life style much like that of a family living in a residential neighborhood. Some of these girls will eventually be returning to their own homes; others will move into independent living.

Each of these satellite homes is staffed by two houseparents and supervised by the institutions social service and administrative staff.

It is clear from this program description that a good deal of variance was possible in this setting with respect to the level of support and control for individual students. As students demonstrated more responsibility, greater amounts of freedom were

available to them within the therapeutic setting. This was true of the student's living situation and academic context.

A third program provided a similar range of services:

> The total effort of the staff is to prepare a boy to return to his parental home, to be placed with foster parents, or depending on age, for living independently.
>
> The staff family consists of five social workers, one social work student in field placement and seven house parents, men and women, who have been carefully screened to ascertain their emotional stability. As adjuncts to our staff family, we have the services of a psychiatrist four hours each week for staff meetings and group therapy sessions, the services of two consulting psychologists and the services of two remedial tutors.
>
> We restrict our intake to forty boys. This is done to provide a home rather than an institutional atmosphere and to allow our staff family to provide each boy with the professional and personal attention that he needs to prepare him to return to a normal home situation.
>
> The boys are divided into three groups; senior, intermediate and junior. Although age is a factor in the unit grouping, special attention is given to the needs and problems of the individual boy. Each group has its own living quarters area including recreational facilities and program.
>
> Each boy is respected for his uniqueness as a person. He is given the equivalent of a private room. This provides him with a sense of independence and pride and enables him to have personal possessions which have meaning for him.
>
> The boys attend the schools in the neighborhood that will best fill their individual needs. They are urged to participate in the social, recreational and sports programs of the school they are attending. Plans are under study to begin a school on the premises for those boys who would have serious difficulty fitting into a school in the surrounding community. If this plan is adopted, its aim would be to prepare a boy to take his place in a neighborhood school as soon as possible. The staff at all times and in all areas emphasizes a policy of having the boys live as an integral part of the neighborhood community.

We require a personal interview with each boy, a family history, school report, psychological test and a recent psychiatric evaluation. These intake requirements help our staff family decide if we can give a boy the assistance he needs to return to a normal home environment.

When a boy is accepted, he is assigned to the senior, intermediate or junior group and to a social worker. Some boys see their social worker for longer or shorter periods every day depending on the existant problem. They must see him at least once each week. Each unit has a weekly group therapy session with our consulting pschiatrist, a social worker and the house parents.

One member of our staff family works with any parents of our boys where there is a home situation that needs to be resolved before the boys can safely return home. We also have meetings for the parents of all of our boys on a regular monthly basis. These parent meetings are both educational and therapeutic. They help the parents understand the problem the boy is facing and increase their cooperation with our treatment program. They also are helpful in resolving home problems.

Our staff family has short meetings each day to discuss immediate problems and their solution. Each week the staff family meets with the consulting psychiatrist. One boy is given a complete staffing at each of these meetings and recommendations are made with the assistance of the psychiatrist for future treatment.

Where family situations permit, our boys are encouraged to make home visits. These home visits increase in frequency and length before a boy returns permanently to his family. This helps the family adjust to the boy and the boy adjust to the family on a gradual basis.

In each case, our concern is for the welfare of the individual boy and our total effort is to help him return to a normal home situation as quickly as possible. Every possible precaution is taken to prevent a boy from becoming institutionalized.

An additional example involves a group living situation which utilized a physical facility built to function as separate apartment settings where girls were responsible for dealing with their own day-to-day needs:

GROUP LIVING

The center of the treatment program is the apartment. In addition to providing for the girls' physical needs, the apartment atmosphere furnishes opportunities for socialization, practicing self discipline and the secure support of a professional youth care staff. One youth care staff person, the group living coordinator, a teacher and the therapist make up the apartment "treatment team" which is responsible for overseeing the girls' programs.

Each of the six apartments consists of living, dining and family rooms, kitchen and twin bedrooms. All the rooms are spacious and comfortably furnished.

EDUCATION

The tools of independence are, of course, education and skill. Most of the residents are below their grade level initially because of truancy and repeated school failure. The goal of our education program - making it possible for the girl to attend public school again or to get a job - is reached through small ungraded classes, individual curriculum planning and the services of special teachers and consultants. Preparation for the GED (General Education Diploma) is offered also for those girls who seem to be unlikely candidates for traditional school. In-depth psychological and career counseling is offered to the girls as well as vocational training.

All of these programs used related strategies (organization of physical living space, outside school placement and varying levels of responsibility for meeting one's own needs) as a way of easing the transition back into the outside community.

As is evident from the description of several of these transitional arrangements, one major emphasis was the youngster's need to acquire the basic skills needed to function independently in the outside world. Several institutions offered courses in "bachelor survival skills" or provide "daily living labs" similar to the apartment arrangements described above.

In addition, one institution conducted an "emancipation program" for students nearing adulthood who were being prepared for release. These students were provided with the financial resources needed to support themselves in the community. They were then assisted in

locating suitable living arrangements and in securing other needed goods and services. For a while they maintained daily contact with the institution, but their instructional programs focused on assisting them in addressing day-to-day problems and in planning for their future. As they became more self-reliant, contact with the institution was reduced.

4.9: Expanding the Learning Environment

Most schools have made some attempts to expand the educational setting beyond the walls of the classroom. These efforts include teaching math students to tally bowling scores, applying newly acquired maintenance and gardening skills to institutional facilities, and teaching basic academic survival skills (reading, math) by requiring small groups of students to be responsible for their own cooking, laundry and homemaking needs.

Several institutions of the emotionally disturbed must be credited with using all of their internal resources - office, grounds and maintenance crews - to provide the students with some exposure to occupational skills. Given the high cost of occupational education programs and the obvious lack of such programs in most institutions, utilization of the full range of institutional staff for vocational instruction demonstrates a willingness to address an obvious need within the context of available resources.

In one program examined by the project staff, the training offered assisted at least one student in securing summer employment. Evaluating such an approach, however, is a complicated issue, since the employability of individual adolescents depends greatly on their social adjustment, community attitudes and related factors in addition to the skill level of the student. Further, it is clear that there are many complications to this approach. The teachers used in this program were not certified vocational education teachers; they were hospital maintenance personnel. While it is by no means certain that this would reduce the quality of

the instruction, it would, in some states, render the program ineligible for future state reimbursement. In more sophisticated trades it might also effect students' eligibility for licensing. Thus, while the intent of the program is well directed, a broader perspective is needed to insure that institutionalized emotionally disturbed children receive high quality vocational instruction in a wide variety of occupational fields.

4.10: In-House Publications

During the course of this study, project staff identified several extensive in-house publications which had been written by institutional staff. These included a needs assessment manual, a foster parent training manual, a manual of philosophy, policies and procedures and several detailed treatment plans. While these documents are too lengthy to be reproduced in full, a brief overview of their contents will indicate their potential usefulness.

The assessment manual, for example, begins with a description of the objectives of assessment and a general description of the procedure. It also includes an overview of standardized tests used and all self-developed rating scales and inventories. Administration and scoring procedures are presented for these instruments followed by a reporting form to record results and recommendations.

The manual for the foster parent training program serves as an orientation guide and course text for prospective foster parents. It outlines course content and spells out expectations for both parent and child. Information covered during the course includes child care, legal implications and responsibilities, behavior management, education and growth and development.

The manual of policies and procedures was designed to describe existing services and clinical, administrative and supportive responsibilities. It includes sections on patient rights, services, staff organization and staff duties. In addition, it defines limits

and controls, community relationships, daily routines and staff development policies.

The final series of documents, the treatment plans, focus more specifically on therapeutic techniques, though they include a good deal of policy information as well. The education section usually includes a brief component on testing that discusses strategies for testing children whose scores on standardized instruments fall below meaningful levels. In addition, general considerations in specifying educational goals and selecting appropriate procedures are discussed. These plans sometimes include a sample evaluation and educational plan and a list of appropriate curriculium materials.

For the most part, the training and informational needs that these manuals were designed to address are shared by most institutions. Since, it is unlikely that any institutions would have the resources to develop more than one such extensive documents independently, considerable time, energy and money could be saved if models such as those discussed above were available for general distribution.

4.11: Orientation Brochures

Project Staff were able to identify one institution which published a descriptive brochure for in-coming youngsters explaining rules, procedures and expectations. This brochure is quoted in its entirety below:

> Before you ask any questions, here are some answers:
>
> We ask you to actively participate in the counseling services provided.
>
> We expect you to participate in daily individual and group activities.
>
> We encourage you to help yourself by striving for better social skills and personal care.

There are planned home visits which are arranged by your referral agency upon recommendation of all those concerned.

You and your family shall be asked to participate in plans for treatment

You may make phone calls to your family from your cottage, and send and receive mail, as long as this is not misused.

The best way to return to your home and neighborhood is by demonstrating to yourself and concerned others that you are able to deal with everyday situations and by assuming responsibility for your actions.

You will have a social worker, called a therapeutic coordinator who will help you get acquainted at the Center. Your principal or supervisor will arrange times for you to see your therapeutic coordinator.

If you need to see a doctor or nurse, your supervisor will make the appropriate appointment.

You will get to talk to a psychiatrist at scheduled times.

You will be asked to meet with your doctor and staff to discuss your problems and review your progress.

You will be assigned to either our regular Center or Maximum Care Unit, depending upon the program best suited to meet your needs.

The cottages are residential homes where you will be living with 8 to 10 other students your own age, under the care of houseparents.

We do go in groups on field trips to public parks, beaches and movies.

We have swimming pools in the Maximum Care Unit, the Ranch and the Sea Camp.

We have basketball courts.

You need permission to leave our campus.

The word campus means all property of the center and sidewalks in front of or beside those properties.

All students are to be in their cottages by 7:30 p.m. unless specific okay has been given by the Residential Director for special activities.

The boys have fun swimming, boating, etc. at the Sea Camp.

Some older boys go to day school on a Ranch where there are ponies and other animals to care for during the day.

There is an 11:00 p.m. city curfew which is enforced by the local police.

There is supervised co-ed visiting in cottages as well as supervised co-ed activities such as parties and field trips.

We do celebrate your birthday with a cake!

It is true that the use of drugs and alcoholic beverages by our staff and students is prohibited.

It is true we never give you permission to smoke, but if your family or agency permits, smoking is allowed only in designated areas, and never in the bedroom.

You receive a weekly allowance based on your acceptance of personal and cottage responsibilities.

A savings program is available to all students.

We have a laundry service on campus.

You have the right to wear your own clothing and the responsibility of caring for personal clothing and items properly.

It is true we do not permit our children and adolescents to lend, borrow, sell or destroy their clothes or the personal property of others.

We expect you to label all clothing and personal items before arrival at the center.

We ask you to keep an up to date list of your clothing.

We make an all-out effort to protect your personal property when you leave without express permission; however, it is your ultimate responsibility.

We ask you to strive to be the "best" in school or vocational classes.

Your class schedule will be flexible, placing importance on your growth as a person, rather than mastery of subject matter.

You may go to neighborhood religious services of your choice.

You will eat breakfast and dinner in the cottage, prepared under the direction of a dietician. Lunch is served in the classroom.

It is true we take responsible precautions but are not responsible for breakage or theft of expensive, personal items such as cameras, stereos, radios, etc. We recommend to all students and staff that these items remain at home.

We welcome a pre-admission visit to get to know you and your family or agency.

We hope to see you soon!

This brochure is significant in two respects. First, it addresses the student's anxieties in entering an unfamiliar situation. Second, it clearly defines the institution's expectations for appropriate behavior.

4.12: Family Modules

Several institutions stipulate family involvement as a criteria for the child's acceptance. The nature and extent of this involvement varies from required therapy sessions to participation in social events sponsored by the institution. In most cases the objective is both to identify and treat family pathologies, and to encourage the family in maintaining close ties to the child, hopefully assisting his eventual re-integration as a full-time family member. This approach is more common among residential treatment centers which have somewhat more control over the children they accept.

One institution has formalized this type of program as a release requirement for each child. An apartment module is maintained within the institution to house about-to-be released children and their families. Families move into this apartment for a specified period of time prior to the discharge of the child. Thus the child is reintegrated into the family before he is released from the institution. This arrangement allows for extensive professional observation of family interaction patterns. Maladaptive interaction is identified and corrective therapy given on an immediate and specific basis.

Thus, re-adjustment to family life is conducted at the institution under the watchful eyes of trained staff. Hopefully such a system will ease the transition into the community and reduce the recidivism rate for these emotionally disturbed children.

4.13: Conclusion

In general, we found few differences between the residential treatment centers and the in-patient hospital units with regard to the nature or extent of innovative program elements. It was apparent, however, that in cases where a specific age group was targeted, this was most often an adolescent group. The transitional programs, for example, dealt entirely with older adolescents. Clearly this is related to age limits on funding and the immediacy of these students' need for normal living skills. Most other program elements identified (evaluation materials, teaching techniques, etc.) are applicable to students of a variety of ages, and a wide range of levels of adjustment.

5

RESEARCH AND DEMONSTRATION ACTIVITIES

5.1 Introduction

This chapter presents several research and demonstration activities designed to improve educational service delivery to institutionalized emotionally disturbed children and youth. After discussions with 270 professionals at 90 institutions and 49 outside public or private school principals, project staff has combined their suggestions, the survey results and the information gathered during the literature review phase of the project to formulate the research and demonstration activities discussed in the following sections.

It is the opinion of project staff that BEH-sponsored research and demonstration activities should include:

- The development of a training program for aspiring teachers of emotionally disturbed children which includes a one-year supervised internship and personality criteria
- The establishment of a clearinghouse to gather and disseminate data on emotional disturbance
- The formation of a professional association of residential treatment center directors to facilitate information exchange
- The development of a community involvement and community education project to include the establishment of alternative living situations for emotionally disturbed children and adolescents

- The planning and implementation of a vocational education program geared towards the needs and abilities of emotionally disturbed children
- The development of assessment instruments specifically designed for an emotionally disturbed population to be used in individual assessment and program evaluation

The broad range of projects suggested is intended to stimulate interest on the part of planners, administrators and educators in the field of emotional disturbance.

5.2 Improved Training for Teachers of Emotionally Disturbed Children

Lack of appropriate teacher training and conflict between the educational and clinical staff were the two problems most frequently reported by administrators and educational program directors of both residential treatment centers and in-patient hospital units. Upon reflection, it becomes clear that these problems are, in fact, related. Current teacher training programs instill an orientation towards education which is quite discrepant from that of psychiatrists, psychologists and social workers. Teachers tend to stress content - the acquisition of basic educational skills, while mental health personnel are more interested in the implications of learning - the effect of successful learning experiences on the development of a positive self-regard, for example. This difference in orientation, with teachers viewing education as an end in itself, and therapists viewing education as a means to an end, is not merely the result of a lack of communication between the two groups. It is, instead, a result of different types of training programs.

One possible solution to this dilemma is to re-structure special education training programs using the clinical psychology-social work model. This model involves a minimum number of courses in the chosen discipline plus a 1-year supervised in-internship in an appropriate setting. For teachers who intend to instruct emotionally disturbed children, residential treatment centers and in-patient hospital units would provide such a setting. Under the supervision of educational psychologists or other qualified personnel, aspiring teachers could gain first-hand experience in dealing with emotionally disturbed children. Techniques for handling acting-out behavior, engaging a withdrawn child, calming a hyperkinetic youngster, etc. would be acquired prior to formal employment. Indeed, time lost during the transition phase where teachers currently must integrate their classroom training experiences with the realities of instructing

an emotionally disturbed population would be eliminated.

A second suggestion frequently offered by institution staff involves the incorporation of some type of personality criteria for aspiring teachers of emotionally disturbed children. It has long been realized that the rapport established between teacher and student is the critical factor in any learning situation. Good teachers are those that relate well to the student; those that can motivate emotionally disturbed children who have experienced one failure after another to try one more time. The formal training of these teachers and their knowledge of their content area are irrelevant to their ability to reach these children. Personality characteristics such as warmth, compassion, and patience combined with the strength to set and enforce firm guidelines for behavior, seem to play a greater role in effective teaching. One educational program director went so far as to suggest that potential teachers be subjected to the same battery of diagnostic personality tests as are the students. While such a suggestion may never be implemented, it serves to underline the need for some personality criteria to be included in the selection process of teachers for emotionally disturbed children.

In sum, project staff recommend that BEH consider a demonstration teacher training program for potential teachers of emotionally disturbed children which includes: 1) a one-year supervised internship in a residential treatment center or inpatient hospital unit and 2) measurable personality criteria relevant to dealing with emotionally disturbed children.

5.3 Development of a Clearinghouse to Collect and Disseminate Information on Emotional Disturbance

One of the primary problems noted by project staff in the course of the literature search phase of the study was the lack of printed information addressing the educational needs of institutionalized emotionally disturbed children and youth. The avenues through which existing research articles, manuals and instruments are shared are primarily psychological and educational associations. Of necessity, the specific interests of these groups affect the number and nature of articles published and places the burden for locating such articles on the individual teacher or program director.

The institution of a clearinghouse aimed at identifying, organizing and disseminating appropriate research materials would not only simplify the process of locating the kinds of information needed for policy decisions but would also encourage additional publications by providing a needed forum. In this regard, project staff has identified five basic principles which should govern the development of such a clearinghouse:

1. The clearinghouse should have an active out-reach component. Such a system must take the initiative in sensing user needs and in cultivating both users and contributors. In the early stages, this would probably include the necessity for identifying in-house publications of more general value, or, in some cases, approaching potential authors.
2. Several methods of packaging and potential dissemination of information should be available. Two major considerations are operative here: First, information must reach the appropriate person in an accessible form in order to be used effectively. This report has identified a wide variety of persons with direct involvement in the educational services for emotionally disturbed children - administrators, teachers, social workers, psychologists, child care workers, etc. It is imperative that any information mechanism locate and assess information needs for as many of these groups of interested professionals as possible, within institutions, the public school systems, community mental health agencies and educational

research. Second, the cost limitations so apparent in the delivery of services to this population argues for a packaging strategy that considers cost as well as the nature of the user's needs. For example, a system of standard format searches, geared to specific populations, on topics of general interest would address both these objectives.

3. Secondary methods of providing information should be considered which utilize resources beyond the clearinghouse itself. Specifically, this should include linkages to other information systems, as well as referrals to individuals or institutions with particular expertise. The governing principle here should be that the clearinghouse itself will be responsible for information specific to delivering educational services to emotionally disturbed youngsters. Information of a more general nature concerning education, psychology, program management, etc., should be made accessible through other sources so as to avoid unnecessary overlap with existing information retrieval systems.

4. The procedures for cataloging and summarizing publications should be linked to procedures for monitoring user needs. This system is designed to insure maximum accessibility of articles to all appropriate groups.

5. The system should also include a Quality Assessment for all major articles to assist institutions in selecting the best and most cost-effective materials. This is particularly significant insofar as the in-house publications collected by project staff varied widely in their quality. Thus, the extent to which any publication represents a significant advance and the nature of its innovation is as important as the general subject area.

As can be seen from the above, the major objectives of this clearinghouse would be to provide interested parties with the best and most current publications in their area of interest. It is important to note, however, that the education of emotionally disturbed children is only beginning to define itself as a field of interest separate from education or psychology. Thus, the demands placed on such a clearinghouse are likely to differ significantly from similar services in more established fields. The clearinghouse will have to identify and interest its own

clientele, in addition to occasionally soliciting written reports on programs or techniques of special significance. In fulfilling these objectives, it is important that the range of services offered address several levels of informational needs from casual interest to formal academic research.

5.4 Development of a Professional Association of Residential Treatment Center Directors

The question most frequently asked of project staff at the conclusion of an interview was: "Have you been to other centers? What are they doing there?" This lack of communication between centers seriously hampers the sharing of innovative techniques and materials dealing with emotionally disturbed children. It seems logical that an assessment instrument or socialization technique developed and found to be useful in one institution, would be applicable to the students in another institution as well.

Therefore, project staff recommend the creation of a professional association of residential treatment center directors. Such an association would serve the following purposes:

- Open lines of communication between centers
- Allow the sharing of innovative education and socialization techniques and materials
- Sponsor workshops and seminars on topics of interest to the professionals dealing with emotionally disturbed children
- Engage in planning activities for future care of the emotionally disturbed child
- Develop a self-assessment procedure whereby centers can evaluate the success of their education and socialization efforts
- Pool information as to much needed funding sources
- Lobby for legislation benefitting institutionalized emotionally disturbed children and youth

5.5 Community Involvement and Community Education Programs in the Area of Emotional Disturbance

Despite the popularity of the mental health field in recent years, there remains a considerable stigma attached to institutionalization. A "label" of emotional disturbance has often been applied to a child so that he will qualify for appropriate educational and social services. This label, however, does him great damage as well. Long after discharge the child is considered "abnormal" by his peers and by the adults in his community. His record of institutionalization travels with him through each successive step in his life; more specifically, through each school and job application. No one wants to make an investment in an unstable individual, as these youngsters are unfortunately characterized.

The stigma of institutionalization can be reduced in two ways. The first avenue is obviously to lessen the number of children who have to be institutionalized. This can be accomplished by providing individual and family therapy services in the schools to try to correct problem behavior before it develops to the point where the child must be removed from the classroom. Also of importance here is the establishment of alternative living situations for children and adolescents whose family situation is contributing to their emotional problems. The most successful alternative living situation has been the group home where a small group of youngsters live in an unmarked home in the community under the supervision of a qualified house parent. These children usually attend public school, but are eligible for all the medical and psychological services provided by the institution. Community residents are often unaware that these children are "special" in any way and therefore an easy rapport is established and maintained.

The second approach involves a concerted effort to educate the community as to the nature and incidence of emotional disturbance. Such a campaign would include seminars and workshops

open to the public, informed speakers provided to local community organizations such as the PTA, brochures distributed to teachers, parents and children containing information about where to get help, an information and referral service created to match those who need help with those who provide service, and perhaps a hot-line staffed by qualified volunteers to answer questions and provide support for children and youth with emotional problems.

To summarize, project staff recommend that BEH sponsor a demonstration project designed to lessen the stigma of institutionalization through community education and community involvement.

5.6 Development of Vocational Education Programs for Institutionalized Emotionally Disturbed Children and Youth

It is a well known fact that emotionally disturbed children within institutions are academically several years behind their chronological peers. It is not uncommon, for example, for an institutionalized child to be as much as 5 years below grade level in reading ability. Even with optimum therapeutic care, excellent instruction and high motivation these children need a great deal of time to catch up. Therefore, an institutionalized child having reached the age of 18 and no longer eligible for state-funded education through the institution, may still be academically unprepared to enter an outside higher education program. These adolescents are then unable to continue their studies and unable to obtain a job and support themselves. The institution has thus neither prepared them for college nor equipped them to deal with the occupational realities of the outside world.

The first thing that must be realized by institutions for the emotionally disturbed is that given the emotional, behavioral and academic problems of these children, many will never be able to meet college admissions criteria. They will, however, have to function in society as independent adults. Institutions must, therefore, include pre-vocational and vocational education in their curriculums in order to prepare these children to enter the work force.

In order to assess the effectiveness of an existing pre-vocational or vocational program, or plan for the development of a new program, administrators, educational program directors and teachers must ask themselves a series of questions such as the following:

Career Concept: Personal & Career Development

Do your students:

Demonstrate abilities to capitalize on special skills and competencies?
Understand personal abilities and limitations?
Formulate values to judge personal worth?

Understand values influence decisions, feelings, realities, options?
See work as a means to achieve satisfaction?
Understand occupational environments and personality classifications?
Understand careers and lifestyles are interrelated and change by achievement?
Understand attitudes and interpersonal relations influence lifestyle and achievement?
Understand that career selection is a self-defined procedure?
Demonstrate effective work habits and positive work attitudes?
Realize that personal and social needs are met through work and leisure?

Career Concept: Society and Technology

Do your students:

Value human dignity? Realize that there is dignity and worth in every occupation?
Understand that technology feeds on knowledge - causes continuous interaction and change?
Realize that people must learn to cope with challenge?
Understand that society must control the challenge of change?
Understand that society reflects the creative force of work?
Understand that technology has dehumanized work?
Possess skills generally useful to society and the world of work?

Career Concept: Economics and Society

Do your students:

Understand that livelihood depends upon production, distribution and consumption of goods and services?
Recognize that jobs exist to satisfy the needs of self and society?
Recognize a productive economy makes mobility necessary?
Understand that supply and demand is a continuous process?
Understand the personal, social and economic significance of work?
Value work in terms of society's goals?
Understand that working people produce goods and services?

Career Concept: Education and Human Resources

Do your students:

Realize that there are many ways to reach excellence?
Understand that operations learned in the classroom contribute to the well-being of society?

Understand that education prepares people for work, leisure, retirement?
Recognize the work force as a product of education and career preparation?
Realize that employment skills are interrelated to all subject areas?
Understand that education provides people with a variety of job skills related to many careers?
Understand that education will help us control and use technology creatively?
See work and lifestyle as intensely related?

Career Concept: Home, Work & Leisure Involvements

Do your students:

Appreciate the reasons people use to select certain careers?
Understand people can relate to their work regardless of educational level?
Realize family, health, peers, personality and institutions influence career decisions?
Recognize leisure time promotes career applications - life-style?
Realize work is people, places, and things oriented?
Recognize and relate education environments to occupational environments and personality classifications - realistic, intellectual, social, enterprising, conventional, and aesthetic?

Career Concept: Career Preparation and Career Skills Development

Do your students:

Integrate knowledge of self and career into decisions?
Possess employment seeking skills?
Understand many occupations have a variety of similar performance patterns?
Understand characteristics and requirements of a variety of careers?
Become familiar with occupations where the same operation is performed in the classroom?
See career choice as an expression of individual personality factors and interest?
Understand job market trends project occupational needs?
Have specific vocational skills and knowledge?
Demonstrate proficiency in selecting high school programs suited to their needs and desires?
Plan strategies to include alternative choices?
Display a knowledge of career clusters?
Demonstrate a knowledge of the major responsibilities involved in a wide range of careers?

These questions can only be answered affirmatively if the institution has developed a formal, structured vocational education program. Such a program would include both theoretical and concrete learning experiences which would lead to proficiency in one or more career clusters. The following example of this type of systematized approach is taken from an 9th grade career education program:

BUSINESS COMMUNICATIONS

Specific Objectives

In order to explore the learning activities related to the careers of:

Clerk-Typist	Stencil-Cutter Operator
Receptionist	Duplication Machine Operator
Secretary	Advertising Illustrator
Stenographer	Reporter
Correspondence Clerk	Feature Editor
	Business Education Teacher

The student will:

- Explore the typewriter using the "Whole Word Method" of "The Short Course for the IBM Selectric Typewriter"
- Compose a business letter, personal letter following directions in placement of home address, date, inside address, salutation, body and complimentary close
- Discuss form letters, memos and their uses in today's business office
- Receive visitors, screen calls, take messages, and answer the telephone, utilizing the tele-trainer unit, typewriter, film strips and given information on human interaction with visitors and clients
- Complete a Learning Activity Package on "Telephone Techniques"
- Illustrate acceptable choice of words, tone inflection, and sentence structure by engaging in and recording a brief telephone conversation
- Begin exploration of shorthand to achieve a dictation rate of _____ words per minute
- View a demonstration of IBM Transcriber and record a message

- Transcribe the message with 75% accuracy
- Collect and analyze facts on a current event from which he will compose and type a news story or subjective newspaper article
- Explore duplicating by preparing stencils and masters and setting up and operating the duplicating and mimeograph machines
- Provide instructional and tutorial assistance to fellow classmates if he has completed assigned activities satisfactorily and was a keen observer of procedures used by teacher
- Illustrate advertisements which effectively gets across a message and is eye appealing, using own design and customer (Teacher) specifications
- Design advertising layouts and plan advertising programs and brochures to advertise products or services
- Prepare layout of pages selecting appropriate illustrative material to be included in the newspaper
- Edit newspaper copy using standard copy reading symbols, and write headlines and captions

Thus, project staff recommend that one interesting and important research and demonstration activity considered by BEH involve the development of a vocational education program specifically designed to meet the needs of institutionalized emotionally disturbed children and youth.

5.7 Development of Appropriate Tests and Measurements

The lack of testing instruments and strategies geared exclusively to institutionalized emotionally disturbed children has seriously complicated the problems of individual diagnosis and program evaluation. Most published tests currently in use in these institutions are not responsive to the specific needs of this population. Since they are normed on groups of children who have already developed basic and necessary classroom adaptations, they fail to address the extent to which the lack of these skills prevents academic progress. Thus, as the child becomes more normal, the tests are more useful; but for the severely disturbed child they do little to measure early but meaningful progress.

The issue is significant on two levels. First, norm-referenced instruments standardized on this population and dealing with a range of pre-academic skills are necessary to permit any meaningful program evaluation and to provide a basis for making comparisons between programs. Existing educational instruments provide gross measures of progress, but more specific instruments are needed to assess levels of expectation, to provide a basis for comparing the extent to which specific emotional disturbances effect academic accomplishments, to allow for the formation of control groups for research purposes and to accurately measure short-term progress. Development of such instruments necessarily implies a clarification of educational goals for these children and an organization of skills hierarchies and behavior indicators that address these objectives.

Valid, reliable instruments that allow researchers to compare the effects of various teaching techniques and curricula with specific groups would permit more meaningful policy-making on all levels. They would also permit empirical study of many of the assumptions about effective program techniques that are prevalent in the literature, currently supported only by anecdotal

records and vague impressions.

The second major need is for a series of criterion-referenced diagnostic instruments that encourage the development of specific, individualized programs of instruction. Like the norm-referenced instruments, these will, to some extent, reflect standard academic content, but they should also define useful behavioral patterns that precede academic success. Hewitt, for example, suggests "attention" as the most basic of these skills and the extent to which the child is able to develop an ability to screen out minor distractions is likely to be at least as significant in his continued academic success as his ability to learn in an isolated setting that screens out distractions for him. Similarly, Christoplos suggests several basic skills (ability to judge time, ability to read emotion) which tend to increase the predictability of the child's environment. The extent to which such factors influence learning and the extent to which these skills can be taught need to be investigated more thoroughly. In this respect, the criterion-referenced test development will rely heavily on the norm-referenced instruments to provide a means for verifying useful skills hierarchies.

Thus, it is the suggestion of the project staff that BEH provide funding to support a variety of research and development projects aimed at providing needed assessment instruments.

APPENDIX A

ANALYSIS OF THE STATE LAWS GOVERNING EDUCATIONAL PROGRAMS OFFERED BY INSTITUTIONS FOR THE EMOTIONALLY DISTURBED

ANALYSIS OF THE STATE LAWS CONCERNING EDUCATIONAL PROGRAMS OFFERED BY INSTITUTIONS FOR THE EMOTIONALLY RETARDED

The following analysis of state laws is based on the third edition of the Digest of State and Federal Laws: Education of Handicapped Children published by the Council for Exceptional Children, 1920 Association Drive, Reston, Virginia 22091.

The purpose of this analysis is to document the extent to which state laws insure educational services to emotionally disturbed children, and to examine strategies for encouraging and regulating the delivery of appropriate programs.

RIGHT TO AN EDUCATION

All state constitutions contain clauses mandating the establishment of a system of free public schools. However, two types of general limitations are placed on the provision of educational services to state residents. First, thirty-five states and the District of Columbia specify a minimum and maximum age of eligibility for public educational services, as in Alabama:

> The Legislature shall establish, organize and maintain a liberal system of public schools throughout the state for the benefit of the children thereof between the ages of seven and 21 years... (Art. XIV, Sec. 256, Ala. Const.)

Twenty-nine specify a minimum annual time period during which public education must be available. Such is the case in California:

> The Legislature shall provide for a system of common schools by which a free school shall be kept up and supported in each district at least six months in every year. (Art. IX, Sec. 5, Cal. Const.)

In addition to state constitutional clauses mandating free public education, each state has developed a compulsory attendance law. These laws usually specify the ages during which a child must attend a public school; in addition, they define those situations and circumstances which would qualify the child for exemption or

exclusion from full school attendance. The compulsory attendance law of Montana, for example, specifies age requirements but is vague concerning the conditions necessary for exemptions:

> A child between the ages of 7 and 16 (and who has completed the eighth grade) will be exempted from the compulsory school attendance provisions upon satisfactorily showing that the bodily and mental condition of the child does not permit his attendance at school. (Sec. 75-2901 RCM)

Other states, such as Florida, are more explicit in defining their policy and procedures regarding exemption from compulsory attendance:

> Children who are within the compulsory attendance limits and who have certificates of exemption issued by a county superintendent are exempt from attending school for the school year specified in the exemption. Children whose physical, mental or emotional condition prevents their successful participation in regular education or programs for exceptional children may be exempted. Before issuing a certificate of exemption, the county superintendent requires a statement from the county health officer, if he is a licensed practicing physician in other counties, or from a qualified psychological examiner designated by the county. This statement must certify that the child is physically or mentally incapacitated for school attendance. (Sec. 232.06 Fla. Stat.)

The most common rationale for exclusion is the presumption that the child's instability may constitute a potential hazard to himself or others. This is particularly appropriate to emotionally disturbed children.

All states now have special education laws which more clearly define state and local responsibilities in providing educational services to those students who may be eligible for exemptions or exclusions. The primary issue here is the delineation of responsibility for providing appropriate programs and, more importantly, for financing them.

In nearly all cases, the responsibility for providing special education programs for handicapped students falls to the local school boards or other administrative units with jurisdiction over individ-

ual children. Such laws mandate that all local school districts shall provide an appropriate program of special construction, facilities, and related services for exceptional children. In 10 states, however, these special education laws are either written to exclude emotionally disturbed children (particularly those who are institutionalized) or else the provision of appropriate services is encouraged, but not mandated.

In Arkansas, South Carolina, Utah and Virginia, the State Departments of Education maintain direct responsibility for the establishment of special education programs, though in practice this often means providing funds to local school districts for these services or contracting with state agencies (Department of Social and Rehabilitative Services, for example) or private institutions. Since all states provide some level of funding for these purposes, and all State Departments of Education maintain responsibility for approving public education programs, it is not clear that this difference in definition of responsibilities results in differences in the nature or extent of services available.

See Table 1 (Compulsory Attendance Laws and Responsibility for Implementing Special Education Programs) for a summary of this data.

POPULATION

In order to establish special school education programs, a target population must be clearly defined. Most state laws do provide a definition of exceptional children who are eligible for special programs. South Dakota, for example, uses the following general definition:

> Exceptional children means all children under the age of 21 years who are residents of the State of South Dakota and because of their physical or mental condition, are not adequately provided for through the usual facilities and services of public schools. (SDCL 13-37-1)

Of concern here is the number of states which provide not only a general definition of exceptionality but a specific definition of emotional disturbance. For example, the statutes of Nebraska include such a detailed definition:

> Emotionally disturbed shall mean children with behavioral disorders variously designated as neurotic, psychotic or character disordered, and whose inabilities may manifest themselves in school accomplishment, social relationships, or feelings of self inadequacy and may result from experience or biological limitations. (RNS 79-1414)

As illustrated in Table 2 (Definitions, Age of Eligibility, Identification and Screening), 12 states provide detailed definitions of emotional disturbance, while the remaining states have only broad definitions of exceptional children.

As Hensley[1/] points out, to the extent that such categories and definitions have an impact on the appropriateness of educational programs provided to students, they should be looked upon as progress.

Since these legal definitions are used primarily to determine eligibility for special educational services and levels of state reimbursements for such programs, it may be that more general definitions permit school systems to group exceptional children inappropriately, unless state regulations address this issue in more detail. On the other hand, Mississippi, Montana and Ohio define categories of exceptional children for the purpose of absolving local school districts of the responsibility of developing special programs for any one category having less than a specified number of students in the district at one time. Thus, existing programs may be more appropriate, but the strategy may well increase the number of exceptional children in certain categories who do not have access to any educational services at

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1/ Gene Hensley, "Therapeutic Teachers of Exceptional Children," in Educational Therapy, ed. by Jerome Hellmuth, (Seattle, Washington: Bernie Straub & Jerome Hellmuth, Co-Publishers, 1966), p. 123.

all. In this respect, Crabtree[2/] notes that Massachusetts' single designation of "special needs" may be the most far-reaching because it insures the child's access to services without imposing categorial limitations on those services.

In addition to defining the parameters of exceptionality each state designates the minimum and maximum age of eligibility for special education programs. These ages are listed by state in Table 2. In all cases, eligible children receive at least as many years of education as are required under compulsory education laws. In some cases, pre-school and adult education is also reimbursable.

2/ Robert K. Crabtree, "Breakthrough in Massachusetts: Getting it Together for the Handicapped," in Compact, vol. VII, no. 4, September/October 1973, p. 9.

IDENTIFICATION, EVALUATION AND PLACEMENT

Screening programs may be informal (some states direct teachers to watch for symptoms of mental or physical handicaps) or may be formal (fourteen states require health examinations for school children, nine on a regularly scheduled basis). Connecticut, for example, mandates the following:

> The Board of Education requires that all public school pupils have health examinations by a licensed medical practicioner or by the school medical advisor at least once every three years to discover if children suffer from any physical disability which would prevent them from receiving the full benefit of school work (Sec. 10-206 Conn. Gen. Stat.)

Evaluation and placement is variously the responsibility of local school boards (5 states); the State Board of Education (4 states); a special committee or diagnostic team (9 states); an administrative official (8 states); or a division of special education (2 states). See Table 3 (Responsibility for Special Education Evaluation). An example of the committee format is as follows:

> "The determination that a child is handicapped and the recommendation for placement of that child in a special education program shall be made by a committee of professionally qualified personnel designated by the Board of Education of the school district. The composition of the committee shall be prescribed by the State Board and may be composed of but not limited to the following: a psychologist, a social worker, a physician, a school administrator, and a teacher of the handicapped."

For planning and funding purposes, 26 states and the District of Columbia require that local school boards conduct a census. In 3 states the Department of Health assumes this responsibility. Such a census generally includes information on all school-age children in the district, including a separate listing of all students who have enrolled in or applied for special programs. Information collected usually includes the name of the child, the parent or guardian's name and address, the birth date and age of the child, and the nature of the handicapping conditions as far as it is known.

ADMINISTRATIVE RESPONSIBILITY

In all states, the State Department of Education provides some level of funding to public school systems implementing special programs and thus maintains some control over the type and extent of services offered within the public schools. Most often this involves setting of certification requirements for teachers, definitions of reimbursable services, and maintenance of related educational standards.

In 13 states, however, educational programs offered in state institutions fall under the same administrative structure as do the health care and therapeutic programs of that institution. The responsible agencies include the Department of Health in 7 states; the Department of Hospitals or the Department of Mental Institutions in 4 states and the Department of Social Services or Social Welfare in 2 states. See Table 4 (Administrative Responsibility for Programs for the Emotionally Disturbed). While some state laws contain provision for cooperation between such administrative units and the Department of Education, it is not clear what level of control is possible in reality. In some cases, all services to institutionalized emotionally disturbed children are provided through the regular hospital administration and budget; in other cases, local school districts provide tuition, and are reimbursed (in whole or in part) by the state. Controls over educational programs in private institutions, which must be certified to permit direct or indirect state reimbursement, are at least more clearly enforceable.

ADMINISTRATIVE STRUCTURE, ORGANIZATION AND SERVICES PROVIDED

In states where the responsibility for special education programs falls to local school boards, it is often the case that the number of handicapped children does not justify the establishment of a special education program in each district. In such a case, two or more school boards may wish to enter into a joint agreement to provide services. Illinois, for example, offers the following provision:

> "Two or more school boards may enter into joint agreement to provide needed special education facilities and to employ a director and other professional workers. Provisions of the agreement shall include administration, staff, programs, financing, housing, transportation, an advisory body, and the withdrawal of districts from joint agreement." (Sec. 10-22.31a III. Stat.)

Thirty-one states allow this option. A related solution involves the contracting of services of another school district (36 states). South Dakota statutes state that:

> "School districts may contract with each other to share the services of a superintendent of schools, a business administrator, supervisors, specialists, teachers and any other employees." (SDCL 13-15-1.1)

The states of Alaska, California, Georgia, Idaho, Indiana, Iowa, Maryland, North Carolina, South Carolina, Vermont and Wisconsin provide for the contracting of an out-of-state provider of special educational services. In addition, 42 states provide for the reimbursement of special educational services provided by private school facilities. These laws appear to reflect a lack of appropriate services on the local, regional or state level. More recent legislation has tended to stress provision of services on a local level to the maximum extent possible.

Conditions on such arrangements generally relate to the number of children in a specific category within the school district and the level at which the state will permit reimbursement for such services. A variety of formulas are used, but, in general, states will not allow total or partial reimbursement if educational costs in a private institution exceed the cost of educating the same child within the district. There are also various strategies for dividing the cost of such services between the local school district and the state. Most commonly, the local school district pays a share equivalent to its per-pupil expenditure for an average student. The state will reimburse the excess to a set maximum amount.

Most state statutes (38) enumerate what services shall be considered "special education services" for the purposes of such contracts. For example, Section 281.4 of the Iowa Code specifies the following:

> When providing special services to children requiring special education, the board of directors of any school or county board of education may provide transportation; maintain one or more suitable special classes; provide for instruction of children in regular classes; special schools or have instruction as part of the local or county school system. The board may also prescribe the use of other aids to special education such as physical therapy, corrective gymnastics, rest periods, warm lunches, social or vocational counseling and training. (Sec. 281.4 Iowa Code)

A few states (4) describe procedures for obtaining special education materials, as illustrated by the following Alabama statute:

> The state superintendent of education is authorized to purchase and arrange for distribution to school boards previously adapted text books, equipment, and materials prepared in various resource and media centers for use by certain children. (Sec. 10, Act 106 Laws of 1971)

TEACHER CERTIFICATION REQUIREMENTS

Table 6 (Teacher Certification Requirements) presents those requirements needed in various states for a special education certificate with an emphasis in emotional disturbance. Thus, courses listed in Table 6 are required above and beyond those courses needed for standard teacher certification. They are also in excess of the general requirements such as birth certificates, fee, evidence of citizenship, etc.

Courses needed for certification in emotional disturbance are presented in code form which may be translated by using the appended course listings. It should be noted that many of these requirements have been revised or are in the process of revision since the writing of this report.

Eleven states have laws which include specific descriptions of the function and certification requirements for special education personnel. In other states, the State Department of Education develops appropriate regulations. As can be seen from Table 7, the certification standards developed by the states vary widely. It is important to note also that these standards apply only to educational programs under the jurisdiction of the State Departments of Education. It is not clear if all state-run institutional programs that fall under the jurisdiction of other state agencies do in fact comply with these requirements.

PERSONNEL

Training grants and scholarships for special education teachers are offered by 11 states. Michigan statutes for example, contain the following provision:

> The Department of Education may make traineeship and fellowship grants available to persons interested in part time or full time study in programs designed to qualify them as teachers and other workers in special education. To qualify for a traineeship persons must have earned at least 60 semester hours of college credit, and to qualify for a fellowship one must be a graduate of a recognized university. (Senate Bill 1182, Public Acts of 1966)

In addition, Connecticut and Florida specifically provide scholarships for teachers to out-of-state colleges and universities, since no in-state schools provide such programs. States providing both training grants and out-of-state scholarships are listed in Table 7 (Personnel).

FINANCE

As stated previously, all State Departments of Education provide some level of funding to local school districts for special education programs. Similarly, even in those states where the State Department of Education retains full responsibility for the provision of such services, contributions from local school districts

are required in proportion to the number of exceptional students in the district.

In practice, this means that most laws dealing with financing set up categories for reimbursement or formulas for determining the local district's share of funds allocated by the state. Reimbursable categories generally include:

- transportation (for teachers or students)
- personnel (teachers; administrators; psychologists; social workers or related professional personnel, and aides)
- facilities (including maintenance)
- equipment
- materials

Transportation and teachers' salaries are the most common. Some states (for example, Illinois) reimburse local school districts for expenditures in such categories beyond a defined minimum, or reimburse for a percentage of the total cost.

Other states (for example, Iowa and Mississippi) pay all costs in excess of the district's normal per-pupil expenditures. More complicated formulas include estimates of base student costs across the state, weighting factors for particular categories of students (reflecting recommended class sizes) and number of students (sometimes expressed as Average Daily Attendance or Full-Time Equivalency).

Reimbursement formulas for states are highly individualistic. Not only do they differ from state to state, but often within a state the funds available to support a program for a specific child will be different depending on what type of agency provides the services. This difference in funding regulations for local school districts, public institutions and private schools may well have more effect on a placement decision than the child's needs.

SUMMARY

As can be seen from the preceeding analysis, state laws dealing with the provision of educational services to the handicapped, and particularly to the emotionally disturbed, vary widely in terms of intent, specificity and range of concerns. Trippe[1] points out that in the field of special needs the direction of recognition has depended greatly on the visibility of the handicap. This has worked to the detriment of emotionally disturbed children in that the more visible their problems are, the better the case that can be made for removing them from educational to institutionalized settings.

The special education laws almost uniformly restored some level of educational services to emotionally disturbed children and thus represent a considerable advance over compulsory education laws which for the most part outlined mechanisms for their exclusion from regular educational programs. Nonetheless, suits pending against several states demonstrate that parents have not been consistently satisfied with the extent or content of "appropriate programs" provided for their children.

There are several related reasons for suspecting that program options for emotionally disturbed children are not as encouraging as a review of state legislation might at first suggest. The existence of provisional certification options suggests that the shortage of trained personnel is still acute. In a 1973 article, Hensley[2] estimated that there was a need for some 500,000 specialists to deal adequately with all handicapped children, but only 175,000 trained professionals were available. In response to this issue, eleven states provide funds to assist teachers in completing appropriate

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1/ Matthew J. Trippe, "Educational Therapy" in Educational Therapy, ed. by Jerome Hellmuth, Seattle, Washington: Bernie Straub and Jerome Hellmuth, Co-Publishers, 1966. p. 35

2/ Jene Hensley, "Special Education: No Longer Handicapped," in Compact, vol. VII, no. 4, September/October 1973, p.4.

teacher training programs. California maximizes its special education personnel by including administrative and resources management components as part of its certification requirements in special education, thereby encouraging the use of such personnel as managers for broad-based educational teams.

As interim responses, all of these strategies are valid, but the real issue is the extent to which this shortage of personnel is borne by state and private residential institutions, where the need is greatest. A cursory look at working conditions and pay scales suggests that resident institutions may, in fact, not be able to compete with public schools unless funding criteria take this kind of problem into account. Since teacher certification requirements appear to be one major level of control that states exercise over local programs, the extent of enforcement is crucial.

Obviously this issue of enforcement is more far-reaching. None of the state laws are written in such a way as to categorically prevent emotionally disturbed students from having access to educational services. For the individual child, however, the issue is often the availability of funds to support an appropriate program. If responsibility, in this sense, has not been delineated, then the problem is how effectively the parent can use available legislation to force state or local officials to supply a meaningful educational experience. In at least 10 states it is not clearly specified that the child has such rights (though recent federal court decisions "insure that no handicapped child can be denied access to public education services without a due process hearing").[5/] Pending class action suits in several states illustrate the difficulties involved in this process.

For institutionalized children, the problem is compounded in two respects: First, the diagnosis of the severity of the child's condition which permits institutionalization may be a strong argument for substituting therapy for educational programs. Second, in several states, the educational programs which are available in

5/ Crabtree, op. cit., p.8.

programs must be traded for needed psychiatric services.

Staff qualifications, meaningful program evaluation criteria, access to up-to-date research and technical assistance, adequate funding levels, parental and community involvement, and availability of accurate planning information are all program aspects which can be manipulated through state intervention to improve quality. As this analysis suggests, the legal basis for such state leadership and regulation is in place in most states. The extent to which this leadership is exercised is highly dependent on the committment and creativity of those involved in planning, monitoring and implemeting programs.

> The state is finally responsible for acceptable levels of quality programs of instruction within its borders.[6/]

6/ Council of Chief State School Officers, State and Federal Relationships in Education, (Washington, D.C., 1971), p. 10.

STATES	State Constitution Specifies Min. & Max. Age of Eligibility	State Constitution Specifies Min. & Max. Age of Eligibility	Compulsory Attendance Law Specifies Min. & Max. Age of Eligibility For Attendance	Compulsory Attendance Law Does Not Specify Min. & Max. Age of Eligibility	Professional Certification Required For Exemption From Compulsory Attendance	Professional Certification Not Required For Exemption From Compulsory Attendance	Responsibility For Implementing Special ED Programs Rests with Board of Education	Responsibility For Implementing Special ED Programs Rests with Local School Board	Responsibility For Implementing Special ED Programs Rests with State Dept. of Education	Responsibility For Implementing Special ED Programs Rests with Other Administrative Unit
Alabama	X			X		X				
Alaska		X	X	X		X				
Arizona		X	X		X					X
Arkansas	X		X		X			X		
California		X			X					
Colorado	X		X		X					X
Connecticut		X	X	X						
Delaware		X		X		X		X		
District of Columbia		X	X	X						
Florida		X	X	X		X				
Georgia		X	X		X	X				
Hawaii		X		X		X				
Idaho	X		X	X		X				
Illinois		X	X	X		X		X		
Indiana		X	X	X						
Iowa		X	X		X	X				
Kansas		X	X	X						
Kentucky		X		X						
Louisiana		X	X	X						
Maine		X	X		X					X
Maryland		X	X	X		X				
Massachusetts		X	X		X	X				
Michigan		X		X		X				
Minnesota		X	X		X	X				
Mississippi	X				X	X				
Missouri		X	X		X	X				

TABLE 1: COMPULSORY ATTENDANCE LAWS AND RESPONSIBILITY FOR IMPLEMENTING SPECIAL EDUCATION PROGRAMS

Compulsory Attendance Laws & Responsibility For Implementing Special ED Programs / STATES	State Constitution Specifies Min. & Max. Age of Eligibility	State Constitution Does Not Specify Min. & Max. Age of Eligibility	Compulsory Attendance Law Specifies Min. & Max. Age For Attendance	Professional Certification Required For Exemption From Compulsory Attendance	Professional Certification Not Required For Exemption From Compulsory Attendance	Responsibility For Implementing Special Ed Programs Rests with Local School Board	Responsibility For Implementing Special Ed Programs Rests with State Dept. of Education	Responsibility Rests with Other Administrative Unit
Montana		X	X		X	X		
Nebraska	X			X		X		
Nevada		X	X	X		X		
New Hampshire		X			X			
New Jersey	X		X		X	X		
New Mexico		X	X		X	X		
New York		X	X	X		X		
North Carolina		X		X		X		
North Dakota		X			X	X		
Ohio		X	X	X		X		
Oklahoma		X	X	X				
Oregon		X			X	X		
Pennsylvania		X	X	X		X		
Rhode Island		X	X	X				
South Carolina	X		X	X			X	
South Dakota		X		X		X		
Tennessee		X	X	X		X		
Texas		X			X	X		
Utah		X	X	X			X	
Vermont		X	X	X		X		
Virginia		X	X	X			X	
Washington		X	X		X	X		
West Virginia		X			X	X		
Wisconsin	X		X		X	X		
Wyoming		X	X	X		X		

TABLE 1: (Continued)

STATES	Special Definition of Emotional Disturbance Included in Statutes	Age of Eligibility for Special ED Programs	Census Required for Local School Boards	Census Required of Department of Health	Health Exams Required for Public School Children	Time Frame Specified for Health Exams
Alabama		6-21	X		X	
Alaska	X	3→				
Arizona	X	5-21				
Arkansas		5-21				X each yr.
California		8-18	X			X every 3 yrs.
Colorado		5-21				
Connecticut	X	4-21	X			X every 3 yrs.
Delaware	X	4-21	X			
District of Columbia			X			
Florida		3→		X		
Georgia						
Hawaii		5-20				
Idaho		0-21	X			
Illinois	X	3-21	X			X
Indiana		6-18	X			X each yr.
Iowa		0-21	X			
Kansas						
Kentucky		0-21	X			
Louisiana		3-21				
Maine		5-20				X each yr.
Maryland		0-20	X			X every 2 yrs.
Massachusetts		3-21				X
Michigan		0-25				
Minnesota		6-21	X			
Mississippi		0-21				
Missouri		5-21	X			

TABLE 2: DEFINITIONS, AGE OF ELIGIBILITY, IDENTIFICATION AND SCREENING

STATES	Definitions Age of Eligibility Identification & Screening	Special Definition of Emotional Disturbance Included in Statutes	Age of Eligibility for Special ED Programs	Census Required for Local School Boards	Census Required of Department of Health	Health Exams Required for Public School Children	Time Frame Specified For Health Exams
Montana		X	6-21	X			
Nebraska		X	5-21	X			
Nevada			5 →				
New Hampshire		X	0-21	X			
New Jersey			5-20	X			
New Mexico			6-21	X			
New York			5-21	X			
North Carolina			0-21	X			
North Dakota			5-21	X			
Ohio			5-18			X	
Oklahoma			4-21			X	
Oregon		X	0-21				
Pennsylvania			5 →			X	each yr.
Rhode Island		X	3-21	X		X	each yr.
South Carolina		X	6-21	X			
South Dakota			0-21	X			
Tennessee			4-21	X			
Texas		X	3-21				
Utah			5-21	X			
Vermont			0-21				
Virginia			2-21			X	
Washington			6-21	X		X	each yr.
West Virginia			5-23	X			
Wisconsin			0-21				
Wyoming			6-21				

TABLE 2: (Continued)

STATES	Responsibility For Special Education Evaluation: Responsibility Rests With Local School Board	Responsibility Rests With State Board of Education	Responsibility Rests With Special Committee	Responsibility Rests With Designated Individual	Responsibility Rests With Division of Special ED. or Pupil Personnel Services
Alabama			X		
Alaska				X	
Arizona				X	
Arkansas		X			
California			X		
Colorado			X		
Connecticut	X				
Delaware			X		
District of Columbia					
Florida					
Georgia					
Hawaii					
Idaho					
Illinois				X	
Indiana				X	
Iowa					X
Kansas					
Kentucky				X	
Louisiana	X				
Maine			X		
Maryland					
Massachusetts			X		
Michigan					
Minnesota					
Mississippi					
Missouri		X			

TABLE 3: RESPONSIBILITY FOR SPECIAL EDUCATION EVALUATION

STATES	Responsibility For Special Education Evaluation: Responsibility Rests With Local School Board	Responsibility Rests With State Board of Education	Responsibility Rests With Special Committee	Responsibility Rests With Designated Individual	Responsibility Rests With Division of Special Ed. or Pupil Personnel Services
Montana			X		
Nebraska		X			
Nevada	X				
New Hampshire					
New Jersey			X		
New Mexico					
New York	X				
North Carolina					
North Dakota					
Ohio					
Oklahoma					
Oregon			X		
Pennsylvania		X			
Rhode Island					
South Carolina	X				
South Dakota				X	
Tennessee					
Texas					
Utah					
Vermont			X		
Virginia					
Washington					
West Virginia			X		
Wisconsin			X		
Wyoming					

TABLE 3: (Continued)

STATES	Responsibility Rests with State Board of Education	Responsibility Rests with State Department of Health	Responsibility Rests with Division of Special Education	Responsibility Rests with Department of Hospitals or Institutions	Responsibility Rests with Department of Social Services or Social Welfare	Responsibility Rests with Other Department
Alabama	X					
Alaska	X	X				
Arizona			X			
Arkansas	X					
California	X					
Colorado	X					
Connecticut		X				
Delaware	X					
District of Columbia	X					
Florida		X				
Georgia	X					
Hawaii	X					
Idaho	X					
Illinois	X					
Indiana	X					
Iowa			X			
Kansas					X	
Kentucky		X				
Louisiana				X		
Maine						X
Maryland	X					
Massachusetts	X	X				
Michigan	X					
Minnesota	X					
Mississippi				X		
Missouri	X					

TABLE 4: ADMINISTRATIVE RESPONSIBILITY FOR PROGRAMS FOR THE EMOTIONALLY DISTURBED

Administrative Responsibility For Programs For Emotionally Disturbed / STATES	Responsibility Rests With State Board of Education	Responsibility Rests With State Department of Health	Responsibility Rests With Division of Special Education	Responsibility Rests With Department of Hospitals or Mental Institutions	Responsibility Rests with Department of Social Services or Welfare	Responsibility Rests With Other Department
Montana				X		
Nebraska	X					
Nevada						
New Hampshire	X	X				
New Jersey						
New Mexico				X		
New York	X					
North Carolina	X					
North Dakota	X					
Ohio	X					
Oklahoma		X				
Oregon	X					
Pennsylvania	X					
Rhode Island	X					
South Carolina	X					
South Dakota						X
Tennessee			X			
Texas	X					
Utah	X					
Vermont			X			
Virginia	X					
Washington			X			
West Virginia	X					
Wisconsin					X	
Wyoming						X

TABLE 4: (Continued)

Administrative Structure And Organization & Services Rendered / STATES	Joint Provision of Special ED By 2 or More School Districts	One School District May Contract With Another For Provision of Service	School District May Contract Out-of-State For Provision of Service	Special ED Services Enumerated in Statues	Descriptions of Personnel Enumerated in Statues	Provision of Materials Specified in Statues	Private School May Provide Special ED Services
Alabama	X			X		X	X
Alaska		X	X	X	X		
Arizona	X	X		X			X
Arkansas	X	X					X
California	X	X	X	X	X	X	X
Colorado	X	X		X	X		X
Connecticut		X		X			X
Delaware	X	X					X
District of Columbia							
Florida	X			X	X	X	X
Georgia	X	X	X	X	X		X
Hawaii				X			
Idaho			X	X			X
Illinois	X			X	X	X	X
Indiana	X	X	X	X	X		X
Iowa	X	X	X	X			X
Kansas	X	X					X
Kentucky		X		X			X
Louisiana	X			X			X
Maine	X	X		X			X
Maryland		X	X	X			X
Massachusetts	X			X			X
Michigan	X	X		X	X		X
Minnesota	X	X		X			X
Mississippi	X			X			X
Missouri				X			X
Montana	X	X					

TABLE 5: ADMINISTRATIVE STRUCTURE, ORGANIZATION AND SERVICES PROVIDED

Administrative Structure And Organization & Services Rendered / STATES	Joint Provision of Special Ed By 2 or More School Districts	One School District May Contract With Another For Provision of Service	School District May Contract Out-of-State For Provision of Service	Special ED Services Enumerated Descriptions of Personnel in Statues	Provision Enumerated Specified in Statues	Private School May Provide Special ED Services	
Nebraska		X		X	X		X
Nevada							
New Hampshire		X					X
New Jersey	X	X		X			
New Mexico		X					X
New York	X	X		X			X
North Carolina			X				X
North Dakota	X	X		X			X
Ohio	X			X			X
Oklahoma	X	X					X
Oregon	X	X		X			X
Pennsylvania							X
Rhode Island	X	X		X			X
South Carolina		X	X	X			
South Dakota		X		X			X
Tennessee	X	X		X			X
Texas	X	X		X	X		X
Utah					X		X
Vermont		X	X	X			X
Virginia	X	X		X			X
Washington	X	X					X
West Virginia		X		X			
Wisconsin		X	X	X			X
Wyoming	X	X		X			

TABLE 5: (Continued)

STATE	CERTIFICATION REQUIREMENTS
Alabama-	21 semester hrs. selected from 9.1, 9.4, 9.6, 9.7, 9.8, 9.9, 9.13, 9.34
Alaska-	no information available
Arizona-	18 hrs. to include: 9.1 or 9.2 or 9.3, 9.4 9.45
Arkansas-	no ED certificate available
California-	24 hrs. including: 8.45, 8.47, 8.48 and 8.49; including at least 12 hrs. advanced components of same
Colorado-	masters degree required: courses from the following areas: 8.4, 8.7, 8.8, 8.9, 8.11, 8.12, 8.13, 8.16, 8.23, 8.24, 8.31, 8.35, 8.36
Connecticut-	no information available
Delaware-	at least one course from 9.1, 9.5, 9.6, 9.13, 9.16, 9.17, 9.27, 9.39, 9.44
District of Columbia-	no information available
Florida-	no information available
Georgia-	5 quarter hours in 9.1, 9.20, 9.47 and 9.52, 10 quarter hours in 9.13 and choice 10 quarter hours from 9.16, 9.11 or 8.34
Hawaii-	no information available
Idaho-	no information available as to certificate, but emotionally disturbed endorsement available
Illinois-	32 hrs. including: 9.1, 9.20, 9.52, 9.53, 9.13
Indiana-	24 hrs. selected from 9.4, 9.5, 9.7, 9.8, 9.13, 9.15, 9.45
Iowa-	no information available
Kansas-	no set requirements - individually approved
Kentucky-	elementary education (24) including special education (12 minimum) selected from 9.4, 9.5, 9.13, 9.16, 9.31
Louisiana-	9.4, 9.16, 9.21
Maine-	18 hrs. taken from: 9.2, 9.3, 9.4, 9.5, 9.9, 9.12, 9.13, 9.20, 9.49, 9.50
Maryland-	no information available
Massachusetts-	9.3, 9.4, 9.7, 9.8, 9.11, 9.16, 9.23, 9.27, 9.46
Michigan-	30 hrs. selected from: 9.14, 9.48, 9.36, 9.4, 9.7, 9.8, 9.11, 9.12, 9.16, 9.27, 9.13, 9.46
Minnesota-	30 quarter hours in area approved by the State Department of Education
Mississippi-	24 hrs. selected from 9.2, 9.3, 9.4, 9.11, 9.13, 9.16, 9.17, 9.19, 9.20, 9.21, 9.22, 9.32
Mississippi-	24 hrs. selected from: 9.2, 9.3, 9.4, 9.11, 9.13, 9.16, 9.17, 9.19, 9.20, 9.21, 9.22, 9.32
Missouri-	24 hrs. selected from: 9.2, 9.3, 9.4, 9.11, 9.13, 9.16, 9.17, 9.19, 9.20, 9.21, 9.22, 9.32
Montana-	no information available
Nebraska-	9.13, 9.24, 9.34, 9.43, 9.48, 9.49, 9.51

TABLE 6: TEACHER CERTIFICATION REQUIREMENTS

STATE	CERTIFICATION REQUIREMENTS
Nevada-	9.43 (2 yrs.) plus 12 hrs. selected from: 9.2, 9.3, 9.4, 9.5, 9.12, 9.16, 9.24
New Hampshire-	9.1, 9.4, 9.5, 9.13, 9.16
New Jersey-	same requirements as for handicapped
New Mexico-	no specific requirements
New York-	no information available
North Carolina-	9.1, 9.5, 9.13, 9.14, 9.21, 9.25, 9.34, 9.35
North Dakota-	8.1, 8.4, 8.31, 8.13, 8.14, 8.23, 8.27, 8.34, 8.39, 9.4, 9.27
Ohio-	8.9, 8.13, 8.20, 8.26
Oklahoma-	24 hrs. selected from: 9.1, 9.4, 9.5, 9.11, 9.13, 9.16, 9.19, 9.20, 9.26
Oregon-	no specific requirements
Pennsylvania-	no information available
Rhode Island-	24 approved hours plus 9.13
South Carolina-	elementary math, art, music and 9.4, 9.5, 9.9, 9.15, 9.27, 9.45
South Dakota-	teachers evaluated separately by Department of Public Instruction
Tennessee-	9.4, 9.5, 9.13, 9.14, 9.47, plus 6 hrs. selected from: 9.1, 9.2, 9.9, 9.11, 9.15, 9.22, 9.24, 9.27, 9.28, 9.48
Texas-	3 hours 9.1, 9 hrs. selected from courses re emotionally disturbed (including 9.13)
Utah-	24-27 hrs. in specialization including 9.1 or 9.3 plus instructional recommendation
Vermont-	no specific course requirements
Virginia-	9.1, 9.11, 18 hrs. selected from: 9.13, 9.20, 9.23, 9.32, 9.33, 6 hrs. selected from 9.3, 9.10, 9.17, 9.18, 9.32, 9.39
Washington-	9.2, 9.3, 9.5, 9.10, 9.16
West Virginia-	no certificate available
Wisconsin-	18 hours in general education including 9.14, 9.11, 9.13, 9.7; 6 hours in Sp. ED including 9.3; 15 hours in Education of Emotionally Disturbed, including 8.20, 9.52, 9.13
Wyoming-	no information available

TABLE 6: (Continued)

EMOTIONAL DISTURBANCE

9.1	Introduction to Exceptional Children
9.2	Education of Exceptional Children
9.3	Psychology of Exceptional Children
9.4	Education of the Emotionally Disturbed
9.5	Psychology of the Emotionally Disturbed
9.6	Speech and Language Development and Correction
9.7	Curriculum
9.8	Materials
9.9	Diagnostic and Remedial Reading
9.10	Arts and Crafts
9.11	Tests and Measurements
9.12	Counseling and Guidance for Students and Parents
9.13	Student Teaching
9.14	Child Growth and Development
9.15	Math and Language
9.16	Abnormal Psychology
9.17	Mental Hygiene
9.18	Juvenile Delinquency
9.19	Behavioral Problems and Management
9.20	Characteristics of the Emotionally Disturbed
9.21	Sociology
9.22	Educational Psychology
9.23	Child Psychology
9.24	Characteristics of the Learning Disabled
9.25	Psychology of Human Groups
9.26	Foundations of Reading and Arithmetic
9.27	Theories of Personality
9.28	Physical Education and Recreation
9.29	Characteristics of the Mentally Retarded
9.30	Industrial Arts
9.31	Human Processes
9.32	Remedial Teaching
9.33	Adolescent Psychology
9.34	Prescriptive Analysis and Methods
9.35	Reactions to Illness in Children
9.26	Psychological and Sociolotical Aspects of Environment
9.37	Remedial Reading
9.38	Child Psychiatry
9.39	Social Services
9.40	Occupational Therapy
9.41	Home Economics
9.42	Master's Degree Required
9.43	Experience Required
9.44	Cultural Anthropology
9.45	Electives
9.46	Clinical Experience
9.47	Teaching Reading
9.48	Theories of Learning
9.49	Psychoeducational Techniques for Emotionally Disturbed Children
9.50	Seminar in Education
9.51	Clinical Psychology
9.52	Curriculum Methods for the Emotionally Disturbed
9.53	Psychological Diagnosis

TABLE 6: (Continued)

LEARNING DISABILITIES

8.1	Introduction to Exceptional Children
8.2	Education of Exceptional Children
8.3	Psychology of Exceptional Children
8.4	Education of the Learning Disabled
8.5	Psychology of the Learning Disabled
8.6	Speech and Language Development and Correction
8.7	Curriculum
8.8	Materials
8.9	Diagnostic and Remedial Reading
8.10	Arts and Crafts
8.11	Tests and Measurements
8.12	Counseling and Guidance for Students and Parents
8.13	Student Teaching
8.14	Child Growth and Development
8.15	Math and Language
8.16	Abnormal Psychology
8.17	Mental Hygiene
8.18	Vocational Rehabilitation Techniques
8.19	Perceptual Problems
8.20	Identification, Diagnosis and Remediation of Learning Disabilities
8.21	Psychology of Human Groups
8.22	Characteristics of the Mentally Retarded
8.23	Prescriptive Techniques and Materials
8.24	Characteristics of the Learning Disabled
8.25	Introduction to Speech Pathology
8.26	Behavior Problems and Management
8.27	Teaching Reading
8.28	Occupational Therapy
8.29	Methods of Education for Children with Visual-Motor Integration Problems
8.30	Methods of Education for Children with Verbal Communication Disorders
8.31	Individual Psychological Tests
8.32	Advanced Reading
8.33	Electives
8.34	Behavior Modification
8.35	Theories of Learning
8.36	Educational Psychology
8.37	Physical Education and Recreation
8.38	Introduction to Speech Pathology
8.39	Seminar in Learning Disabilities
8.40	Elementary Education
8.41	Secondary Education
8.42	Sociology
8.43	Media Techniques and Materials
8.44	Administration and Supervision of Special Education
8.45	Health Problems
8.46	Pupil Assessment
8.47	Instruction of Special Education Pupils
8.48	Evaluation of Pupil Progress and Program Effectiveness
8.49	Professional Interpersonal Relationships

TABLE 6: (Continued)

Personnel-Training Grants & Scholarships / STATES	Training Grants Available For Special ED Teachers	Scholarships To Out-of-State Schools Available for Special ED Teachers
Alabama	X	
Alaska		
Arizona		
Arkansas		
California	X	
Colorado		
Connecticut		X
Delaware		
District of Columbia		
Florida	X	X
Georgia	X	
Hawaii		
Idaho		
Illinois	X	
Indiana		
Iowa		
Kansas		
Kentucky		
Louisiana		
Maine		
Maryland		
Massachusetts	X	
Michigan	X	
Minnesota		
Mississippi		
Missouri		

TABLE 7: PERSONNEL-TRAINING GRANTS AND SCHOLARSHIPS

STATES	Personnel-Training Grants & Scholarships: Training Grants Available For Special ED Teachers	Scholarships To Out-of-State Schools Available For Special ED Teachers
Montana		
Nebraska		
Nevada		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Carolina		
North Dakota	X	
Ohio		
Oklahoma		
Oregon	X	
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee	X	
Texas		
Utah		
Vermont		
Virginia	X	
Washington		
West Virginia		
Wisconsin		
Wyoming		

TABLE 7: (Continued)

APPENDIX B

SURVEY INSTRUMENTS

I.D. No. | | | | | 0 | 1 |

O.M.B. No. 51-S75-089
Approval Expires 12/76

1

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

ADMINISTRATOR INSTRUMENT

Name of Institution: _____

Address of Institution: _____
Number Street

_____
City or Town

_____
State Zip Code

Type of Facility: (Check appropriate box)

01' Private In-patient ☐ 1 Public in-patient ☐ 3

Private residential ☐ 2 Public residential ☐ 4

Name of Respondent: _____

Title of Respondent: _____

Name of Interviewer: _____

Date of Interview: _____

Length of Interview: _____

1

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

-ADMINISTRATOR INSTRUMENT-

1. How many emotionally disturbed children and youth (between the ages of 0-25 years old) are currently receiving treatment as in-patients/residents at this facility? _____

2. What is the minimum and maximum age at which individuals diagnosed as emotionally disturbed are eligible for admission?
,16-17

Minimum age _____ Maximum age _____

3. Concerning your criteria for admission to this facility, do you accept children who are: *(Interviewer reads each choice and checks response)*

a.	developmentally disabled (e.g., those with mild, moderate, or severe mental retardation, cerebral palsy, or epilepsy)	Yes ___1 No ___2
b.	neurologically impaired	Yes ___1 No ___2
c.	physically handicapped (including blind and deaf children)	Yes ___1 No ___2
d.	psychotic	Yes ___1 No ___2
e.	suicidal	Yes ___1 No ___2
f.	aggressive/acting out	Yes ___1 No ___2
g.	drug abusers	Yes ___1 No ___2
h.	learning disabled	Yes ___1 No ___2
i.	delinquent	Yes ___1 No ___2
29 j.	other _____ *(Specify)*	Yes ___1 No ___2

4. What is the average length of stay for emotionally disturbed children at this facility? _____ (months)

5. What percentage of the emotionally disturbed children and youth residing here are receiving educational services within this facility? _____ %

6. Concerning your teaching staff, would you please fill out the attached form so that we can get an idea of the demographic and professional characteristics of the teachers working in institutions for the emotionally disturbed. *(Interviewer hands respondent form 2A reproduced on the following page.)*

7. Do you require that your teaching staff be certified in special education?

Yes ☐ 1 No ☐ 2

8. What is your current teacher/student ratio? _____ (xxx.xx)

9. Is your educational program accredited by the State Department of Education?

Yes ☐ 1 No ☐ 2

10. Do the students receive Carnegie Units for academic performance?

Yes ☐ 1 No ☐ 2

11. Are the students eligible for a high school diploma or a high school equivalency certificate upon completion of your program?

Yes ☐ 1 No ☐ 2

→ Is this diploma or certificate awarded by your facility or by the school last attended by the child?

Facility ☐ 1 School ☐ 2

Please check boxes across one row for each teacher.

Teachers	SEX		AGE					LEVEL OF EDUCATION				EMPLOY-MENT STATUS			CERTIFICATION				AREA OF SPECIALIZATION												
	Male	Female	20-29	30-39	40-49	50-59	60-69	Less than B.A.	B.A.	M.A.	Ph.D.	Full-time (Salaried)	Part-time (Salaried)	Volunteer	Elementary	Secondary	Special Education - Provisional	Special Education - Permanent	Math	Language Arts - Reading	Language Arts - English	Social Studies/ History	Science	Art	Music	Physical Education	Media	Foreign Language	Diagnostic - Prescriptive	Crisis Resource	Vocational Education	Business
1																															
2																															
3																															
4																															
5																															
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18																															
19																															
20																															
TOTALS																															

7-8='02' 9 12 15 18 21 24 27 30 33 36 39 42 45 48 51 54 9 12 15 18 21 24 27 30 33 36 39 42 45 48 51 54

Y C='07'

FORM 2A (Referred to in Question 6)

12. What kinds of problems do you face in your delivery of educational services within this institution?

(Record response verbatim)

13. What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child within this facility and in the country in general?

within facility:

(Record response verbatim)

in general:

I.D.No. | | | | | 0 | 2 |

2

O.M.B.No. 51-S75-089
Approval Expires 12/76

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROBLEMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

EDUCATIONAL PROGRAM DIRECTOR INSTRUMENT

Name of Institution: _____

Address of Institution: _____
Number Street

_____
City or Town

_____
State Zip Code

Name of Respondent: _____

Title of Respondent: _____

Name of Interviewer: _____

Date of Interview: _____

Length of Interview: _____

2

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

-EDUCATIONAL PROGRAM DIRECTOR INSTRUMENT-

-8='01' PROGRAM CHARACTERISTICS

1. How many hours per day, days per week, and months per year are classes offered at this facility?

-10,11, hours/day _____ days/week _____ months/year _____

-13

2. What grades are covered by this program?

-15,16-17 grade _____ to grade _____ ungraded ☐

3. Which of the following co-curricular resources are present at your facility? *(Interviewer reads each choice and checks response)*

a.	gymnasium	Yes ☐ 1	No ☐ 2
b.	outdoor recreational area	Yes ☐ 1	No ☐ 2
c.	reading center	Yes ☐ 1	No ☐ 2
d.	multi-media center/library	Yes ☐ 1	No ☐ 2
e.	drama center	Yes ☐ 1	No ☐ 2
f.	art center	Yes ☐ 1	No ☐ 2
g.	music center	Yes ☐ 1	No ☐ 2
h.	laboratory	Yes ☐ 1	No ☐ 2
i.	industrial arts area	Yes ☐ 1	No ☐ 2
j.	pool	Yes ☐ 1	No ☐ 2
k.	Other _____ *(Specify)*	Yes ☐ 1	No ☐ 2

31

_____

4. What percentage of the emotionally disturbed children and youth residing here are receiving educational services within this facility? _____%

2-34

5. Are the students grouped according to any of the following criteria? *(Interviewer reads each choice and checks response)*

5 a. chronological age Yes ☐ 1 No ☐ 2

5 b. sex Yes ☐ 1 No ☐ 2

7 c. level of achievement Yes ☐ 1 No ☐ 2

3 d. type of disability Yes ☐ 1 No ☐ 2

) e. severity of disability Yes ☐ 1 No ☐ 2

) f. social adjustment Yes ☐ 1 No ☐ 2

l g. emotional adjustment Yes ☐ 1 No ☐ 2

? h. other _____ Yes ☐ 1 No ☐ 2
(Specify)

5-44

6. Do you utilize the curriculum developed by the county, the state, or do you develop your own curriculum?

,45,47 County ☐ 1 State ☐ 1 Institution ☐ 1

7. Which of the following subject areas are included in your educational program? (*Interviewer reads each choice and checks response*)

a.	math	Yes	☐ 1	No	☐ 2
b.	language arts	Yes	☐ 1	No	☐ 2
c.	reading	Yes	☐ 1	No	☐ 2
d.	English	Yes	☐ 1	No	☐ 2
e.	history	Yes	☐ 1	No	☐ 2
f.	social studies	Yes	☐ 1	No	☐ 2
g.	science	Yes	☐ 1	No	☐ 2
h.	art	Yes	☐ 1	No	☐ 2
i.	music	Yes	☐ 1	No	☐ 2
j.	physical education	Yes	☐ 1	No	☐ 2
k.	foreign language	Yes	☐ 1	No	☐ 2
l.	activities for daily living	Yes	☐ 1	No	☐ 2
m.	family life and sex education	Yes	☐ 1	No	☐ 2
n.	drugs and behavior	Yes	☐ 1	No	☐ 2
o.	money management	Yes	☐ 1	No	☐ 2
p.	community resources	Yes	☐ 1	No	☐ 2
q.	other _____ (Specify) _____	Yes	☐ 1	No	☐ 2

-66

8='02' 8. Does your program include instruction in vocational education?

Yes ☐ 1 No ☐ 2

→ Which of the following career clusters are the students prepared for?

a. Business and Office Occupations	Yes ☐ 1	No ☐ 2
b. Marketing and Distribution Occupations	Yes ☐ 1	No ☐ 2
c. Communications and Media Occupations	Yes ☐ 1	No ☐ 2
d. Construction Occupations	Yes ☐ 1	No ☐ 2
e. Manufacturing Occupations	Yes ☐ 1	No ☐ 2
f. Transportation Occupations	Yes ☐ 1	No ☐ 2
g. Agri-Business and Natural Resource Occupations	Yes ☐ 1	No ☐ 2
h. Marine Science Occupations	Yes ☐ 1	No ☐ 2
i. Environmental Control Occupations	Yes ☐ 1	No ☐ 2
j. Public Service Occupations	Yes ☐ 1	No ☐ 2
k. Health Occupations	Yes ☐ 1	No ☐ 2
l. Hospitality and Recreation Occupations	Yes ☐ 1	No ☐ 2
m. Personal Service Occupations	Yes ☐ 1	No ☐ 2
n. Fine Arts and Humanities Occupations	Yes ☐ 1	No ☐ 2
o. Consumer and Homemaking Occupations	Yes ☐ 1	No ☐ 2

9. Does your instructional program utilize the following teaching techniques? *(Interviewer reads each choice and checks response)*

a. small group classroom	Yes ☐ 1	No ☐ 2
b. tutor program (individual instruction)	Yes ☐ 1	No ☐ 2
c. team teaching	Yes ☐ 1	No ☐ 2
d. teacher aides in classroom	Yes ☐ 1	No ☐ 2
e. automated teaching aides (computer assisted program, talking typewriter, responsive environment system, etc.)	Yes ☐ 1	No ☐ 2
f. individually prescribed instruction	Yes ☐ 1	No ☐ 2
g. Other _____ *(Specify)*	Yes ☐ 1	No ☐ 2

63

10. Do you feel that your staff was adequately trained to teach emotionally disturbed students prior to their employment here?

Yes ☐ 1 No ☐ 2

11. What kinds of special training, if any, has your facility provided in order to help your staff deal with the special needs of these students?

-36
-38
-40
-42

(Record response verbatim)

DIAGNOSTIC EDUCATIONAL ASSESSMENT

12. Is a diagnostic educational assessment of incoming students usually done prior to admission or shortly after admission?

prior to admission ☐ 1 after admission ☐ 2 both ☐ 3

13. Which individual or team of professionals within the facility is responsible for conducting diagnostic educational assessments?

(Record response verbatim)

45
47
49
51

14. Please look at this card and tell me which tests and measures are utilized as part of your educational diagnostic procedure and who generally administers these tests.

Test	Used (✓)	Administered by	
		Educator	Therapist
a. Stanford Binet		(1)	(2)
b. WISC/WIPPSI			
c. Bender Visual Motor Gestalt Test			
d. Beery (Developmental Test of Visual Motor Integration)			
e. Frostig Developmental Test of Visual Perception			
f. Wepman Test of Auditory Perception			
g. Vallet Psychoeducational Inventory of Basic Skills			
h. Vineland Scale of Social Maturity			
i. ITPA (Illinois Test of Psycho-linguistic Abilities)			
j. Slingerlend Screening for Learning Disabilities			
k. Stanford Achievement Test			
l. California Achievement Test			
m. OTIS Quick Score Reading			
n. Dorean Diagnostic			
o. Wide Range Achievement Test			
p. Englemen Self Concept Inventory			
q. Peabody Picture Vocabulary Test			
r. Peabody Achievement Test			
s. Burke's Behavior Rating Scale			
t. Thematic Aperception Test			
u. Rorschach			
v. Draw-A-Person			
w. Other _____ (Specify) _____			

='03'

EVALUATION OF EDUCATIONAL PROGRESS

15. How often are students evaluated as to their educational progress?

_____ (months)

16. Which individual or team of professionals within this facility is responsible for conducting these evaluations?

_____

(Record response verbatim)

_____

17. Are students evaluated in accordance with a pre-designed task analysis, i.e., a listing of the behavioral component necessary to the development of specific educational skills?

Yes ☐ 1 No ☐ 2

18. Which of the following techniques are utilized in conducting these evaluations? *(Interviewer reads each choice and checks response)*

a.	teacher observations	Yes	1	No	2
b.	achievement/aptitude tests	Yes	1	No	2
c.	attitude/interest inventories	Yes	1	No	2
d.	psychologist observations	Yes	1	No	2
e.	anecdotal records	Yes	1	No	2
f.	other _____	Yes	1	No	2

19. What follow-up procedures do you use to monitor the adjustment and progress of students who have been released from this facility?

_____

(Record response verbatim)

_____

_____

_____

20. How do you evaluate the effectiveness of your educational program as a whole?

(Record response verbatim)

INTEGRATION OF INSTITUTIONAL CHILDREN IN REGULAR PUBLIC OR PRIVATE SCHOOLS

21. Do any of the children or adolescents living here attend a regular public or private school in the community?

Yes ☐ 1 No ☐ 2

→ (Skip to Question 31)

22. How many students are currently enrolled in these outside programs?

23. What criteria do you use when deciding if a child should be placed in a regular public or private school?

(Record response verbatim)

24. During the past five years has the number of students enrolled in these outside programs increased, decreased, or remained the same?

decreased ☐ 1 remained same ☐ 2 increased ☐ 3

25. With how many schools do you have such an agreement?

26. Why were these schools selected?

(Record response verbatim)

7-8='04'

9-10,11

27. Is transportation to these outside schools provided by the schools themselves, the county, or by this facility?

outside schools ☐ 1 county ☐ 1 facility ☐ 1

28. Who within this facility serves as a liaison with these schools?

12-13

29. What follow-up procedures do you use to monitor the adjustment and progress of students who reside here but attend an outside school?

(Record response verbatim)

14-15
16-17
18-19
20-21
22-23

30. Could you please give me the name, address, and principal's name of the school in which the greatest number of children from this facility are enrolled? I would like to interview him concerning his perceptions of your efforts to educate institutional children in a more normal setting.

Name of School

Address

Telephone Number

Name of Principal

PROBLEMS AND SUGGESTIONS

31. What kinds of problems do you face in your delivery of educational services within this institution?

24-25
26-27
28-29
30-31
32-33

(Record response verbatim)

32. What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child within this facility and in the country in general?

within facility:

(Record response verbatim)

34-35
36-37
38-39
40-41

in general:

42-43
44-45
46-47
48-49

I.D.No. | | | | | 0 | 3 |

O.M.B. No. 51-S75-089

Approval Expires 12/76

3

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

CHILD CARE WORKER/PSYCHIATRIC NURSE INSTRUMENT

Name of Institution: _____

Address of Institution: _____
Number Street

_____
City or Town

_____
State Zip Code

Name of Respondent: _____

Title of Respondent: _____

Name of Interviewer: _____

Date of Interview: _____

Length of Interview: _____

3

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

CHILD CARE WORKER/PSYCHIATRIC NURSE INSTRUMENT

I am interested in finding out to what extent certain emotional, social and behavior goals are emphasized here at _____.
Name of institution.

8='01' Please tell me whether each of the following goals is of high, moderate, or low importance to your efforts towards socialization.

In the area of Health: the student:	High (3)	Moderate (2)	Low (1)
1. Looks after personal hygiene adequately.			
2. Has the ability to wash himself regularly and completely without assistance.			
3. Has the ability to choose the correct clothing, according to the weather.			
4. Has the ability to choose appropriate foods to maintain good health.			
5. Recognizes the importance of exercise to maintain good health.			
6. Recognizes the misuse of drugs or medication.			
7. Has the ability to look after own personal health.			
In the area of Social Maturity: the student will:			
8. Be comfortable with most people and respond readily to them.			
9. Respond constructively to praise and criticism.			
10. Undertake and complete tasks with a positive attitude.			
11. Be able to cope with anxiety-producing situations.			
12. Demonstrate pride in personal appearance.			
13. Demonstrate pride in own achievements.			
14. Demonstrate self-reliance within own capabilities.			
15. Recognize own strengths and weaknesses.			

In the area of Social Initiative: the student will:	High	Moderate	Low
16. Be given opportunities to perform as a leader.	(3)	(2)	(1)
17. Accept reasonable rules of the group.			
18. Be given opportunities to succeed socially.			
In the area of Attitudes: the student will:			
19. Recognize that there may be more than one acceptable point of view.			
20. Recognize family members and peers with needs and interests of their own.			
21. Assume full responsibility for his duties as a member of a family.			
22. Accept primary responsibility for making major life choices.			
23. Be able to judge people of various races, cultures, national origins, and occupations in terms as such.			
24. Be able to develop techniques for controlling aggression in culturally acceptable patterns.			
25. Develop confidence in his ability to succeed.			
In the area of Leisure Time: the student will:			
26. Identify and develop skills in a variety of leisure time activities.			
27. Organize leisure time adequately.			
28. Develop personal satisfaction in constructive activities.			
29. Know how to entertain him/herself.			
In the area of Human Relations: the student will:			
30. Display socially acceptable manners.			
31. Respect other people's property.			
32. Understand the concept of sharing.			
33. Work cooperatively.			
34. Constructively interact with peers.			
35. Constructively interact with adults.			
36. Respect authority (Police, Firemen, etc.).			

	In the area of Home and Family: the student will:	High	Moder-ate	Low
		(3)	(2)	(1)
45	37. Recognize and understand relationships among family members.			
46	38. Gain an awareness of own and other's roles.			
47	39. Appreciate the individual rights of family members.			
48	40. Participate in family activities.			
49	41. Recognize and respect adults in authority.			
50	42. Recognize that every family has its own living pattern and style.			

43. Which of the following are included in your treatment program?
(Interviewer reads each choice and checks response)

51	a.	family visits to facility	Yes ☐1	No ☐2	
52	b.	family taking child out of facility for a visit	Yes ☐1	No ☐2	
53	c.	child spending weekends with his family	Yes ☐1	No ☐2	
54	d.	field trips	Yes ☐1	No ☐2	
55	e.	participation in outside group sporting events	Yes ☐1	No ☐2	
56	f.	participation in outside group social events	Yes ☐1	No ☐2	
57	g.	big brother/big sister program	Yes ☐1	No ☐2	
58	h.	peer review group sessions	Yes ☐1	No ☐2	
59	i.	formal recreation program	Yes ☐1	No ☐2	
60	j.	on-staff activities director	Yes ☐1	No ☐2	

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4

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROBLEMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

OUTSIDE SCHOOL INSTRUMENT

Name of Institution: _____

Address of Institution: _____
Number Street

_____
City or Town

_____
State Zip Code

Name of Outside School: _____

Address of Outside School: _____
Number Street

_____
City or Town

_____
State Zip Code

Name of Respondent: _____

Title of Respondent: _____

Name of Interviewer: _____

Date of Interview: _____

Length of Interview: _____

4

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

-OUTSIDE AGENCY INSTRUMENT-
(PUBLIC/PRIVATE SCHOOL)

'01' 1. How many emotionally disturbed children and youth residing at

_____
(Name of Institution)

are presently enrolled in your educational program? _____

2. During the past five years has the number of emotionally disturbed students living at _____
(Name of Institution)
while enrolled in your program increased, decreased, or remained the same?

decreased ☐1 remained same ☐2 increased ☐3

3. What criteria have you established for accepting these students from _____?
(Name of Institution)

6
8
0
2
4 _____
(Record response verbatim)

_____

_____

_____

4. Is transportation from the institution provided by your school, the county, or the institution?

5,27 school itself ☐1 county ☐1 institution ☐

5. What special arrangements have you made here to facilitate the integration of these students into your program?

_____
(Record response verbatim)

_____

_____

_____

6. Do you feel that your staff was adequately trained to teach emotionally disturbed students prior to their employment here?

Yes ☐ 1 No ☐ 2

7. What kinds of special training, if any, has your school provided in order to help your staff deal with the special needs of these students?

-40 -42 -44 -46 -48

(Record response verbatim)

8. Do you require that the teachers in whose classes these emotionally disturbed students are placed be certified or eligible for certification in special education?

Yes ☐ 1 No ☐ 2

9. What kinds of problems do you face in your efforts to educate these emotionally disturbed students?

-51 -53 -55 -57 -59

(Record response verbatim)

10. What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child and adolescent within this school and in the country in general?

within school:

-61 -63 -65 -67

(Record response verbatim)

in general:

69 71 73 75

APPENDIX C

INTRODUCTORY LETTER

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION
WASHINGTON, D.C. 20202

February 2, 1976

Dear Administrator:

The Bureau of Education for the Handicapped, a division of the United States Office of Education, has funded a study concerned with the education and socialization of institutionalized emotionally disturbed children and youth.

Staff members of residential treatment centers for the emotionally disturbed and in-patient units of hospitals will be interviewed in order to determine the availability of education and socialization programs. Our sample will include a total of 90 facilities located within twelve states throughout the country. In each of these facilities we will want to speak with the Administrator, the Educational Program Director, and a Psychiatric Nurse or Child Care Worker. In addition, if some of the students who live at the facility attend a regular public or private school in the daytime, we will wish to contact a representative of this outside school as well. In this way, we hope to gain an accurate picture of what type of education and socialization programs are offered to institutionalized emotionally disturbed children.

We have found that these interviews take no longer than one-half hour to complete, except in the case of the Educational Program Director, which may take one hour. Let us assure you that no individual facilities nor persons will be named in our final report.

The purpose of this letter is to let you know, with as much notice as possible, that our contractor, Applied Management Sciences, will be calling soon to schedule these interviews with you and members of your staff.

We wish to thank you in advance for your cooperation. Only by careful analysis of the programs now in operation can we plan effectively for the future.

Cordially,

Edwin W. Martin

Edwin W. Martin, Ph.D.
Director, Bureau of Education
for the Handicapped

APPENDIX D
INTERVIEWER'S MANUAL

INTERVIEWERS MANUAL FOR G-69:

THE EDUCATION AND SOCIALIZATION OF INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

Sponsored by:

The Bureau of Education for the Handicapped

Contract No.: 300-76-0005

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1

INTRODUCTION TO THE SURVEY

1. Purpose

The Bureau of Education for the Handicapped, a division of the United States Office of Education, has funded a study concerned with the education and socialization of institutionalized emotionally disturbed children and youth. Staff members of residential treatment centers for the emotionally disturbed and in-patient units of hospitals will be interviewed in order to determine the availability of education and socialization programs. Our sample will include a total of 90 facilities located within twelve states throughout the country. In each of these facilities we will want to speak with the Administrator, the Educational Program Director, and a Psychiatric Nurse or Child Care Worker. In addition, if some of the students who live at the facility attend a regular public or private school in the day time, we will wish to contact a representative of this outside school as well. In this way, we hope to gain an accurate picture of what type of education and socialization programs are offered to institutionalized emotionally disturbed children.

2. Data Collection Procedures

a. Sample:

According to an update of the 1974 National Institute of Mental Health survey of hospital in-patient units and residential treatment centers, there are approximately 475 patient care

facilities for the emotionally disturbed child in the United States. Of these facilities approximately 325 are residential centers and 150 are hospital in-patient units. A sample of ninety (90) institutions has been judgmentally selected from the following four (4) categories:

- State or county hospitals with in-patient facilities for emotionally disturbed children
- Public residential treatment centers
- Private hospitals with in-patient facilities for emotionally disturbed children and youth
- Private residential treatment centers

In addition to ownership, geographic area was of prime importance. Thus, we selected our sample to ensure that each HEW region throughout the country would be represented. Since these facilities are not evenly distributed, however, we chose to survey at least twenty-five (25%) percent of the institutions for the emotionally disturbed within each HEW region. Finally, natural clustering and cost-effective travel plans dictated the choice of one (1) or two (2) major metropolitan areas within each state as survey sites.

SITE DISTRIBUTION

H.E.W. Region	Selected State	Number of Institutions To Be Surveyed
I	Massachusetts	10
II	New York	10
III	Washington, D.C. Area	12
IV	Georgia	2
	Florida	3
V	Illinois	10
	Wisconsin	10
VI	Texas	8
VII	Missouri	5
VIII	Colorado	5
IX	California	10
X	Washington	5
Total	12 States	90

b. Instruments and Respondents:

In each of these institutions we will administer the following questionnaires to specified professionals:

Questionnaire	Respondent
Administrator Instrument - 1	Administrator of facility
Educational Program Director Instrument - 2	Principal or director of education program
Psychiatric Nurse/Child Care Worker Instrument - 3	Psychiatric nurse or child-care worker
Outside School Instrument - 4	Principal of regular public or private school in which institutional children are enrolled.

Several points must be made about the respondent categories. In the case of the Administrator Instrument, you will want to interview the director of the residential treatment center. However, when an in-patient unit of a large hospital is to be surveyed you will want to contact the director of the unit for emotionally disturbed children and youth, not the director of the entire hospital. If the director of this unit is not available, the educational program director should be contacted and given both questionnaires 1 and 2.

Concerning the Educational Program Director Instrument, you will want to interview the principal of the facility school. If he is not available, an assistant principal can be interviewed. If both of these professionals are not available or if these positions do not exist, a classroom teacher should be interviewed.

The Psychiatric Nurse/Child Care Worker should be administered to a psychiatric nurse or child care worker. Please note that in some institutions those who spend time with the children when

they are not in class are not called child-care workers, but may instead be called psychiatric aides, mental health technicians, etc. Regardless of the title, you will want to speak to a person who is responsible for the supervision of the children when they are not in therapy or in school.

Finally, the Outside School Instrument should be administered to the principal of a non-institutional school in which children living at the institution are enrolled in the educational program. In other words, we will want to speak with people who deal with institutionalized emotionally disturbed children in a normal public or private school setting. This concept of returning children with special needs to the public school system is known as mainstreaming. If the principal of this school is not available, a classroom teacher who has at least one of these institutional children in her class at the present time, should be interviewed.

Although substitutes are possible, please try to interview the professional for whom the questionnaire was designed.

c. Step-by-step procedure:

1. Make sure you have obtained the following materials:

- Administrator Instrument Forms
- Education Program Director Instrument Forms
- Psychiatric Nurse/Child Care Worker Forms
- Outside School Instrument Forms
- Teaching Staff Forms
- Educational Testing Flash Cards
- List of Institutions in your area
- Copy of Introductory Letter

2. Telephone the first institution on the list, introduce yourself, refer to the introductory letter, and request an appointment for a site visit. Inform the director of the nature of each questionnaire. Please explain that each interview will take less then one-half hour to complete, except in the case of the educational program director instrument which will take approximately one hour to complete. Thus, you will need two hours of interviewing time at each institution and one-half hour at each outside school.

3. During this conversation with the director discuss which staff members at the institution are most appropriate to respond to each questionnaire. Ask the director to arrange these appointments for you.

4. If the director refuses to cooperate, go to the next name on the list and notify Applied Management Sciences of the rejection.

5. Try to complete the interviews at the institution in the morning so that you can visit the outside school in the afternoon. If this is not possible, try to visit the outside school the following day.

6. Please arrange your appointments in a cost-effective manner. All travel plans must be approved by Applied Management Sciences Project Director.

7. When you have completed 10 institutions, mail the questionnaires to Applied Management Sciences. You may have less than 10 outside agency questionnaires completed due to the fact that not all institutions have children enrolled in regular public or private schools.

3. Reasons For and Uses of Forms

A brief description of the purpose and use of each form follows. (For your reference, the forms are in the Appendix of this manual.) Question-by-question detailed instructions are given in Chapter 3.

a. Introductory letter - Approximately two weeks prior to the actual interview, an introductory letter will have been sent to each of the respondents. This letter will have informed them that their facility was selected for this survey, stated the purpose of this survey, and requested their cooperation.

b. Administrator Instrument - This instrument focuses on admission criteria, resident/inpatient characteristics, demographic variables concerning teaching staff, accreditation status and perceived problems in the delivery of educational services. It should take approximately one-half hour to complete this interview.

c. Educational Program Director Instrument - This instrument focuses on program length, grades covered, co-curricular facilities, grouping criteria, curriculum, teaching techniques, staff training, diagnostic assessment, evaluation, integration of institutional students into regular schools, and perceived problems in the delivery of educational services. At least one hour will be required to complete this interview.

d. Child Care Worker/Psychiatric Nurse Instrument - This instrument focuses on the social, emotional and behavioral skills needed for adequate functioning (re-socialization) emphasized at the institution. This instrument will require one-half hour to complete.

e. Outside School Instrument - This instrument focuses on the number of children who presently reside at an institution while attending that public/private school, special arrangements

made to accommodate these children, staff training, and perceived problems in the delivery of educational service. This interview will require one-half hour to complete.

A matrix of the specific objectives to be covered and their corresponding questions appears on the following pages.

4. Use of this Manual

Because of the large number of different questionnaires to be used we are asking you to take a substantial amount of care in the training session and to use this manual as a specific and instant reference.

The balance of this manual deals with the general overall instructions for performing the field work in this survey (Chapter 2), and a question-by-question set of instructions on how the work is to be carried forward (Chapter 3).

In an appendix to this interviewer's manual are copies of all the instruments you will be using. At the back of the manual is a glossary which defines many of the terms used in the various questionnaires. It is intended as a handy reference if you are questioned by a respondent concerning the meaning of a word or term on one of the questionnaires.

OBJECTIVE: DETERMINE WHAT EDUCATIONAL PROGRAMS ARE CURRENTLY AVAILABLE TO INSTITUTIONALYZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH	ADMINISTRATOR INSTRUMENT (Question Numbers)	EDUCATIONAL PROGRAM DIRECTOR (Question Numbers)	CHILD CARE WORKER/ PSYCHIATRIC NURSE INSTRUMENT (Question Numbers)	OUTSIDE SCHOOL IN STRUMENT (Question Numbers)
• What are some of the characteristics of emotionally disturbed residents or inpatients which may relate to the educational program?	1,2,3,4,5			
• What type of staff are involved in educational programs in institutions?	6,7,8		2	
• Are educational programs accredited and degrees awarded?	9,10,11			
• What is the average length of time (hrs. per day/ days per month/months per year) covered by educational programs?		1		
• What grades are covered by these programs?		2		
• What equipment and facilities are used?		3		
• What grouping criteria are utilized?		5		
• What course offerings are available?		6,7,8		
• What teaching techniques are used in educational programs?		9		
• Is teacher training adequate?		10,11		6, 7, 8
• What methods of diagnostic educational assessment are used?		12,13,14		
• What methods are used to assess the effectiveness of education programs?		15,16,17,18,19,20		
• What efforts are currently underway to place children residing at an institution in regular public or private schools?		21,22,23,24,25 26,27,28,29		1, 2, 3, 4, 5
• What follow-up procedures are utilized?		19,28		

Matrix of Objectives and Corresponding Questions

OBJECTIVE: DETERMINE WHAT SOCIALIZATION PROGRAMS ARE AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH	ADMINISTRATOR INSTRUMENT (Question Numbers)	EDUCATIONAL PROGRAM DIRECTOR INSTRUMENT (Question Numbers)	CHILD CARE WORKER PSYCHIATRIC NURSE INSTRUMENT (Question Numbers)	OUTSIDE SCHOOL INSTRUMENT (Question Numbers)
• What types of emotional, social and behavioral goals are emphasized in the area of health?			1,2,3,4,5,6,7	
• What types of emotional, social and behavioral goals are emphasized in the area of social maturity?			8,9,10,11,12,13,14,15	
• What types of emotional, social and behavioral goals are emphasized in the area of social initiative?			16,17,18	
• What types of emotional, social and behavioral goals are emphasized in the area of social initiative?			19,20,21,22,23,24,25	
• What types of emotional, social and behavioral goals are emphasized in the area of attitudes?			26,27,28,29	
• What types of emotional, social and behavioral goals are emphasized in the area of leisure time?			30,31,32,33,34,35,36	
• What types of emotional, social and behavioral goals are emphasized in the area of human relations?			37,38,39,40,41,42	
• What techniques are utilized in the socialization program?			43	

OBJECTIVE: WHAT RESEARCH AND DEMONSTRATION ACTIVITIES WILL HELP TO IMPROVE EDUCATIONAL SERVICES TO EMOTIONALLY DISTURBED CHILDREN	ADMINISTRATOR INSTRUMENT (Question Numbers)	EDUCATIONAL PROGRAM DIRECTOR INSTRUMENT (Question Numbers)	CHILD CARE WORKER? PSYCHIATRIC NURSE INSTRUMENT (Question Numbers)	OUTSIDE SCHOOL INSTRUMENT (Question Numbers)
• Are there any "model" education programs that work best?	To be determined	by project staff	upon completion of	data analysis
• What needs are expressed by institutional staff to help improve education services to children?	12,13	31,32		
• What needs are expressed by agencies outside the institution for improving educational services to children?				9,10
• What are the serious deficiences in educational programs to emotionally disturbed children that will benefit from research?	To be determined	by project staff	upon completion of	data analysis

2

GENERAL INSTRUCTIONS AND PROCEDURES

1. Quality of Work

While substantial effort has been placed on the design and procedures by which this survey will be conducted, one element can never be controlled by anyone but you and that is your personal skill in gathering the data, as requested, in an accurate and complete fashion. The interviewer is the strongest and weakest link in the chain. The information you will gather will form the single base upon which all our conclusions will be built.

2. Approach to the Respondents

While conducting your interviews please be mindful of maintaining a good relationship with your respondents. Since a substantial burden will be placed upon each of the respondents, good rapport is essential. This rapport is best established by showing a professional polite and friendly manner which conveys an interest in the study and the individual.

Before and during the interview you should do everything you can to put the respondent at ease. You will want to search out every possible means to bridge the gap between yourself and the respondent.

Please be tactful - all people who give their time for an interview are entitled to courteous and tactful treatment. Try to leave the respondent with the impression that he has taken part in an interesting and worthwhile experience-one that he would be willing to repeat.

3. Points to Remember

In summary, let us assure you that the respondent will most likely be pleasant and cooperative if:

- You assure him of the confidentiality of the data you are collecting.
- Your manner indicates that the respondent's opinions and facts are important.
- You avoid letting the respondent get the idea that the interview is in any way a test of his/her knowledge or intelligence.
- You spend sufficient time on explaining the purposes of the survey and the instruments to get the respondent at ease.

4. Confidentiality

As was noted in the preceding section, you should assure the respondent of the confidentiality of the data collected. The information being sought is for statistical purposes only and will be reported in an aggregated manner. No individual person or institution will be named in the final report.

5. Preparation for an Interview

Before starting to use these instruments, you should read them through carefully, along with the special instructions in Chapter 3 of this manual. Please ask any questions that come to mind. We would much prefer to clear questions up before the interviewing starts than to have to reject the interview later.

As you read over the questionnaires, try to conjure up the most difficult and perverse set of respondents, and surmise in what ways they will avoid giving satisfactory answers to each of the questions, this will help prepare you to make appropriate probes during the actual interviewing.

Become familiar with specific technical and jargonistic words, phrases, and acronyms related to your interviews. Many of these are listed in the Glossary at the back of this manual. Before you

commence an interview, go back over terms and definitions given during training and in the Glossary. A good background knowledge of these terms is very important in performing a smooth interview because a respondent may have never heard the word or phrase previously.

6. General Instructions for Asking Questions

This section describes some principles which apply to all the questionnaires, that is, to the conduct of the interview as a whole.

a. Impartiality: The interviewer must always remember that his/her job is to get the respondent's own response and only this response. This means that he/she must never allow his/her own views on the subject to influence the respondent in any way. Refrain from expressing your own opinions on the questions, even if asked; you should not convey your own evaluation even by implication (e.g., by frowning or smiling at certain answers, by tone of voice, etc.). You should never, for instance, say anything that would imply, even vaguely, the type of answers you, personnaly, would like to hear. And, you should avoid reacting in a negative manner to any of the views of the respondent. At the beginning of the interview, you should convey the idea that there is no "right" or "wrong" way to answer any of the questions. If at any time during the interview you sense that this position is at all in doubt, you should explain it again in detail. We are interested in the facts as they are.

b. Care in Following Instructions: The interviewer must be careful to follow instructions in every respect. This includes: (a) not skipping questions; (b) asking the questions properly, using the exact wording given on the questionnaire; and (c) recording the responses properly, according to the directions given. This is especially important with the open-ended questions. Occasionally,

you may want to paraphrase a question to explain or define it further. Every experienced interviewer has had to work with questions that sounded awkward to her/him, or whose wording seemed likely to mislead the respondent. You should realize, however, that the design of a questionnaire is always carefully worked out in advance, and that not all of the factors which go into this design can be seen from a casual inspection of the questions.

c. Probing: There will be times when the respondent will not be able to answer a question immediately. It may help his answer if you ask additional questions or give examples or definitions, using the Glossary if necessary.

d. Pausing: Some of the questions which you ask the respondent may be somewhat difficult for him and will take time to answer. It is important that you pause sufficiently often (both during and after reading the questions) to give the person time to think without feeling rushed.

e. Failure to Answer: Occasionally, despite the most patient probing and/or pausing, the respondent may not be able to answer some questions. As a last resort you might try coming back to the same question later in the interview. If you cannot elicit an answer at all do NOT leave the question blank. Use the symbol "NA" for "NO ANSWER" ONLY. Write "NA" for NO ANSWER in large letters in the answer space or in the margin, plus the reason why the respondent did not answer (e.g., "Respondent defensive on this subject," "Could not understand question," "Data not available," etc.) Do not spend too long on any one question.

f. Write Legibly: Remember, your handwritten answers to the open-ended questions will have to be read by others!

g. Comments or Need to Use More Space: If it becomes necessary to continue writing data responses or to add clarifying information, use the blank page opposite each printed page. Be very careful to reference the entry by indicating the question number to which it pertains.

3

DETAILED INTERVIEWING INSTRUCTIONS

Administrator Instrument - 1

The first page of each questionnaire will be used for identification purposes. Before beginning the actual interview, please fill in all the information requested. Also be sure to ask the administrator whether his institution is public or private and whether it is considered on inpatient unit of a hospital or a residential treatment center. An example of a correctly filled out identification page is presented below:

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

ADMINISTRATOR INSTRUMENT

Name of Institution: SAN PABLO HOME FOR YOUTH

Address of Institution: 4001 NORTH 30TH ST.
Number Street

PHOENIX
City or Town

ARIZONA 85016
State Zip Code

Type of Facility: (Check appropriate box)

Private In-patient ☐ Public in-patient ☐

Private residential ☑ Public residential ☐

Name of Respondent: DR. JOHN SMITH

Title of Respondent: ADMINISTRATOR

Name of Interviewer: CAROLE SCHOR

Date of Interview: 2/20/76

Length of Interview: 35 MIN.

Question 1 - If the institution is a hospital, ask the question using the word inpatient. If the institution is a residential treatment center, ask the question using the word resident.

Example of a correctly answered question:

1. How many emotionally disturbed children and youth (between the ages of 0-25 years old) are currently receiving treatment as inpatients/residents at this facility? 25

Question 2 - Question 2 refers only to those persons diagnosed as emotionally disturbed, not to the population of the hospital or residential treatment center as a whole.

Example of a correctly answered question:

2. What is the minimum and maximum age at which individuals diagnosed as enotionally disturbed are eligible for admission?

Minimum age 6 Maximum age 21

Question 3 - Here we are interested in what type of disability qualifies children for admission to this facility, in addition to emotional disturbance. Please note that these choices are not mutually exclusive; in other words, more than one box may be checked as "yes." Please ask each choice in turn and then say something like, "Are there any other admission criteria which we have not already covered?"

Example of a correctly answered question:

3. Concerning your criteria for admission to this facility, do you accept children who are: *(Interviewer reads each choice and checks response)*

a.	developmentally disabled (e.g., those with mild, moderate, or severe mental retardation, cerebral palsy, or epilepsy)	Yes ☐ No ☑
b.	neurologically impaired	Yes ☐ No ☑
c.	physically handicapped (including blind and deaf children)	Yes ☐ No ☑
d.	psychotic	Yes ☑ No ☐
e.	suicidal	Yes ☑ No ☐

f.	aggressive/acting out	Yes ☑	No ☐
g.	drug abusers	Yes ☑	No ☐
h.	learning disabled	Yes ☐	No ☑
i.	delinquent	Yes ☑	No ☐
j.	other _____ (Specify)	Yes ☐	No ☑

Question 4 - Length of stay refers to the period of time between admission and discharge and will be reported in days, weeks, months, or years.

Example of a correctly answered question:

4. What is the average length of stay for emotionally disturbed children at this facility? 8 MONTHS.

Question 5 - Please obtain a percentage, not an actual number.

Example of a correctly answered question:

5. What percentage of the emotionally disturbed children and youth residing here are receiving educational services within this facility? 95%

Question 6 - Please give the administrator a copy of the form included in Question 6. The administrator should check the boxes across one row for each teacher. If the administrator does not have the necessary information at hand, suggest that he give the form to an appropriate person and you will pick it up at the conclusion of your interview. After concluding the interview, attach the completed form to the identical form printed on the survey instrument.

Example of a correctly filled out form:

	SEX		AGE					LEVEL OF EDUCATION				EMPLOY-MENT STATUS			CERTIFICATION				AREA OF SPECIALIZATION														
Teachers	Male	Female	20-29	30-39	40-49	50-59	60-69	Less than B.A.	B.A.	M.A.	Ph.D.	Full-time (Salaried)	Part-time (Salaried)	Volunteer	Elementary	Secondary	Special Education - Provisional	Special Education - Permanent	Math	Language Arts - Reading	Language Arts - English	Social Studies/ History	Science	Art	Music	Physical Education	Media	Foreign Language	Diagnostic - Prescriptive	Crisis Resource	Vocational Education	Business
1		✓		✓						✓		✓			✓					✓												
2	✓				✓				✓			✓			✓							✓										
3		✓			✓				✓			✓			✓	✓							✓									
4		✓		✓						✓		✓			✓									✓								
5		✓	✓							✓		✓			✓			✓												✓		
6																																
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19																																
20																																
TOTALS	1	4	1	2	2				2	3		5		4		1	1		1		1	1	1							1		

FORM 2A (Referred to in Question 6)

Question 7 - We are interested here in whether the institution requires teachers to be certified in special education, not in whether teachers happen to be so certified coincidentally.

Example of a correctly answered question:

7. Do you require that your teaching staff be certified in special education?

Yes ☐ No ☑

Question 8 - Teacher/student ratio refers to the average number of students assigned to each teacher.

Example of a correctly answered question:

8. What is your current teacher/student ratio? 1/4.

Question 9 - Accredited refers to a program which has met all the requirements for staff certification, licensure, and compliance with the facility code and is, therefore, approved by the State.

Example of a correctly answered question:

9. If your educational program accredited by the State Department of Education?

Yes ☑ No ☐

Question 10 - Carnegie units refers to credits assigned to approved courses at the high school level which are required for graduation.

Example of a correctly answered question:

10. Do the students receive Carnegie units for academic performance?

Yes ☑ No ☐

Question 11: We are interested here in whether a student can earn his diploma while institutionalized and if so, who grants this diploma.

Example of a correctly answered question:

11. Are the students eligible for a high school diploma or a high school equivalency certificate upon completion of your program?

Yes [✓] No [ ]

→ Is this diploma or certificate awarded by your facility or by the school last attended by the child?

Facility [✓] School [ ]

Questions 12 & 13 - These questions are very important. They will provide the data we need to complete the research and development section of our final report. Please record the response verbatim using the back of the page if additional space is required. Please encourage the reticent respondent by emphasizing the importance of his answers to the project and in turn to the future educational service delivery to emotionally disturbed children.

Examples of a correctly answered question:

12. What kinds of problems do you face in your delivery of educational services within this institution?

We can't afford enough teachers
(Record response verbatim)

13. What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child within this facility and in the country in general?

within facility: We need a reading specialist, a speech therapist and an activities director.
(Record response verbatim)

in general: There needs to be more emphasis on treating the emotionally disturbed child within the public school sector

2. Educational Program Director Instrument - 2

The educational program director instrument also begins with an identification page. Before beginning the actual interview please fill in all the information requested. An example of a correctly filled out identification page is presented below:

2

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROBLEMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

EDUCATIONAL PROGRAM DIRECTOR INSTRUMENT

Name of Institution: SAN PABLO HOME FOR YOUTH

Address of Institution: 4001 NORTH 30 ST.
Number Street

PHOENIX
City or Town

ARIZONA 85016
State Zip Code

Name of Respondent: MR. BILL JONES

Title of Respondent: PRINCIPAL OF ELEMENTARY SCHOOL

Name of Interviewer: CAROLE SCHOR

Date of Interview: 2/20/76

Length of Interview: 1 hr. & 15 min.

Question 1 - This is a straightforward question designed to measure the length of the educational program.

Example of a correctly answered question:

1. How many hours per day, days per week, and months per year are classes offered at this facility?

   hours/day 6 days/week 5 months/year 10

Question 2 - It is possible that an education program may have both a graded and ungraded component (e.g., a self-contained classroom). In this case you would enter the grades covered and also check the ungraded box.

Example of a correctly answered question:

2. What grades are covered by this program?

   grade K to grade 6 ungraded

Question 3 - This question refers to the special areas or equipment which may be present at the facility. Obviously, these answers are not mutually exclusive. In other words, more than one box may be checked 'yes'. At the conclusion of the question ask if there are any other special resources present at the school which you have not already mentioned. If so, check 'other' and write the name of the resource on the line which reads (specify).

Example of a correctly answered question:

3. Which of the following co-curricular resources are present at your facility? *[Interviewer reads each choice and checks response]*

a.	gymnasium	Yes ☑	No ☐
b.	outdoor recreational area	Yes ☑	No ☐
c.	reading center	Yes ☐	No ☑
d.	multi-media center/library	Yes ☑	No ☐
e.	drama center	Yes ☐	No ☑
f.	art center	Yes ☐	No ☑
g.	music center	Yes ☐	No ☑
h.	laboratory	Yes ☐	No ☑
i.	industrial arts area	Yes ☐	No ☑
j.	pool	Yes ☑	No ☐
k.	Other _____ (Specify) _____	Yes ☐	No ☑

Question 4 - Please obtain a percentage, not an actual number.

Example of a correctly answered question:

4. What percentage of the emotionally disturbed children and youth residing here are receiving educational services within this facility? 95 %

Question 5 - We are interested here in why certain children are placed in the same classroom. Again, the answers are not mutually exclusive - more than one box may be checked 'yes'. At the conclusion of the question, ask if there are any grouping criteria in use at the facility which you have omitted. If so, record them on the line marked (specify).

Example of a correctly answered question:

5. Are the students grouped according to any of the following criteria? *(Interviewer reads each choice and checks response)*

a.	chronological age	Yes ☑	No ☐
b.	sex	Yes ☐	No ☑
c.	level of achievement	Yes ☑	No ☐
d.	type of disability	Yes ☑	No ☐
e.	severity of disability	Yes ☑	No ☐
f.	social adjustment	Yes ☐	No ☑
g.	emotional adjustment	Yes ☐	No ☑
h.	other _____ (Specify)	Yes ☐	No ☑

Question 6 - A curriculum is an outline of approved topics to be covered in the course of a school year. If both the county curriculum and an internally developed curriculum are used, check both boxes.

Example of a correctly answered question:

6. Do you utilize the curriculum developed by the county, the state, or do you develop your own curriculum?

County ☑ State ☐ Institution ☐

Question 7 - This is a rather straightforward question which deals with what topics are included in the curriculum (explained above). Please check 'yes' for all those offered and ask if there are any other topics covered which were not included in our list. If so, record these on the line marked (specify).

Example of a correctly answered question:

7. Which of the following subject areas are included in your educational program? *(Interviewer reads each choice and checks response)*

a.	math	Yes	☑	No	☐
b.	language arts	Yes	☑	No	☐
c.	reading	Yes	☑	No	☐
d.	English	Yes	☑	No	☐
e.	history	Yes	☑	No	☐
f.	social studies	Yes	☑	No	☐
g.	science	Yes	☑	No	☐
h.	art	Yes	☑		☐
i.	music	Yes	☑	No	☐
j.	physical education	Yes	☐	No	☑
k.	foreign language	Yes	☐	No	☐
l.	activities for daily living	Yes	☑	No	☐
m.	family life and sex education	Yes	☐	No	☑
n.	drugs and behavior	Yes	☐	No	☑
o.	money management	Yes	☐	No	☑
p.	community resources	Yes	☐	No	☐
q.	other _____ *(Specify)*	Yes	☐	No	☑

Question 8 - This question concerns courses which help prepare students for occupations upon graduation. More than one area may be offered, therefore, more than one box may be checked 'yes'.

Example of a correctly answered question:

8. Does your program include instruction in vocational education?

Yes ☐ No ☐

Which of the following career clusters are the students prepared for?

a. Business and Office Occupations	Yes ☑	No ☐
b. Marketing and Distribution Occupations	Yes ☐	No ☑
c. Communications and Media Occupations	Yes ☐	No ☑
d. Construction Occupations	Yes ☐	No ☑
e. Manufacturing Occupations	Yes ☑	No ☐
f. Transportation Occupations	Yes ☐	No ☑
g. Agri-Business and Natural Resource Occupations	Yes ☑	No ☐
h. Marine Science Occupations	Yes ☐	No ☑
i. Environmental Control Occupations	Yes ☐	No ☑
j. Public Service Occupations	Yes ☑	No ☐
k. Health Occupations	Yes ☐	No ☑
l. Hospitality and Recreation Occupations	Yes ☐	No ☑
m. Personal Service Occupations	Yes ☐	No ☑
n. Fine Arts and Humanities Occupations	Yes ☑	No ☐
o. Consumer and Homemaking Occupations	Yes ☑	No ☐

Question 9 - Please note that small group classroom may sometimes be called a self-contained classroom. Individually prescribed instruction refers to an educational model formulated at the Learning Research and Development Center in Pittsburgh.

Example of a correctly answered question:

9. Does your instructional program utilize the following teaching techniques? *(Interviewer reads each choice and checks response)*

a. small group classroom	Yes ☑	No ☐
b. tutor program (individual instruction)	Yes ☑	No ☐
c. team teaching	Yes ☑	No ☐
d. teacher aides in classroom	Yes ☑	No ☐
e. automated teaching aides (computer assisted program, talking typewriter, responsive environment system, etc.)	Yes ☐	No ☑
f. individually prescribed instruction	Yes ☐	No ☑
g. Other _____ *(Specify)*	Yes ☐	No ☑

Question 10 - This question is particularly important since we have found through our preliminary dealings with institutions for the emotionally disturbed that the lack of adequate teacher training is one of the most frequent complaints.

Example of a correctly answered question:

10. Do you feel that your staff was adequately trained to teach emotionally disturbed students prior to their employment here?

Yes ☐ No ☑

Question 11 - This is a straightforward question. Please record the response verbatim using the opposite page or back of page if additional space is required.

Example of a correctly answered question:

11. What kinds of special training, if any, has your facility provided in order to help your staff deal with the special needs of these students?

We have had a series of workshops on behavior modification

(Record response verbatim)

Question 12 - We are interested here in the administration of educational tests for the purpose of diagnosis, i.e., identification of areas of academic strengths and weaknesses.

Example of a correctly answered question:

12. Is a diagnostic educational assessment of incoming students usually done prior to admission or shortly after admission?

prior to admission [✓] after admission [ ] both [ ]

Question 13 - Please obtain titles of professionals, not their actual names.

Example of a correctly answered question:

13. Which individual or team of professionals within the facility is responsible for conducting diagnostic educational assessments?

psychologist + teacher

(Record response verbatim)

Question 14 - Hand the testing card to respondent; have him/her tell you the information for each test and record answers on identical listing in the questionnaire booklet.

Example of a correctly answered question:

14. Please look at this card and tell me which tests and measures are utilized as part of your educational diagnostic procedure and who generally administers these tests.

Test	Used (✓)	Administered by	
		Educator	Therapist
a. Stanford Binet	✓		✓
b. WISC/WIPPSI	✓		✓
c. Bender Visual Motor Gestalt Test	✓		✓
d. Beery (Developmental Test of Visual Motor Integration)			
e. Frostig Developmental Test of Visual Perception			
f. Wepman Test of Auditory Perception			
g. Vallet Psychoeducational Inventory of Basic Skills			
h. Vineland Scale of Social Maturity			
i. ITPA (Illinois Test of Psycho-linguistic Abilities)	✓		✓
j. Slingerlend Screening for Learning Disabilities			
k. Stanford Achievement Test			
l. California Achievement Test			
m. OTIS Quick Score Reading			
n. Dorean Diagnostic			
o. Wide Range Achievement Test			
p. Englemen Self Concept Inventory			
q. Peabody Picture Vocabulary Test	✓	✓	
r. Peabody Achievement Test	✓	✓	
s. Burke's Behavior Rating Scale			
t. Thematic Aperception Test	✓		✓
u. Rorschach	✓		✓
v. Draw-A-Person	✓		✓
w. Other _____ (Specify) _____			

Question 15 - Most institutions conduct periodic evaluations of their students. Please obtain the time period for these evaluations at each institution.

Example of a correctly answered question:

15. How often are students evaluated as to their educational progress? Every 6 months

Question 16 - Please obtain titles of professionals, not their actual names.

Example of a correctly answered question:

16. Which individual or team of professionals within this facility is responsible for conducting these evaluations?

psychiatrist, clinical psychologist
(Record response verbatim)

Question 17 - A task analysis is a method of evaluation whereby the educational performance of the student is matched with the behavioral components thought necessary to the development of specific educational skills.

Example of a correctly answered question:

17. Are students evaluated in accordance with a pre-designed task analysis, i.e., a listing of the behavioral component necessary to the development of specific educational skills?

Yes ☐ No ☑

Question 18 - Achievement/Aptitude Tests are tests which measure intellectual capability and academic functioning, e.g., "I.Q." tests.
Attitude/Interest Inventories are tests which measure social and emotional variables by asking the student to agree or disagree with certain indicative statements.

Example of a correctly answered question:

18. Which of the following techniques are utilized in conducting these evaluations? *(Interviewer reads each choice and checks response)*

a.	teacher observations	Yes	☑	No	☐
b.	achievement/aptitude tests	Yes	☑	No	☐
c.	attitude/interest inventories	Yes	☑	No	☐
d.	psychologist observations	Yes	☐	No	☑
e.	anecdotal records	Yes	☑	No	☐
f.	other _____	Yes	☐	No	☑

Question 19 - This is a straightforward question which should provide few problems.

Example of a correctly answered question:

19. What follow-up procedures do you use to monitor the adjustment and progress of students who have been released from this facility?
(Record response verbatim)

We make monthly phone calls to the child's parents and school teachers during the first year.

Question 20 - This is an important question. Please use the opposite blank page or back of page if more space is needed. Be sure to number the answer.

Example of a correctly answered question:

20. How do you evaluate the effectiveness of your educational program as a whole?

(Record response verbatim)

We conduct weekly staff meetings during which time we enumerate our goals and evaluate our progress.

Question 21 - We are interested in those students who live at the institution but attend a regular private or public school in the daytime. We are not interested in day-care patients - those who live at home but attend school at the institution, nor children who have been discharged and now attend a regular school.

Example of a correctly answered question:

21. Do any of the children or adolescents living here attend a regular public or private school in the community?

Yes [✓] No [ ]

→ (Skip to Question 31)

Question 22 - Please get the total number of institutional students attending regular public or private schools.

Example of a correctly answered question:

22. How many students are currently enrolled in these outside programs? 5

Question 23 - By criteria we mean what type of behavior is necessary before a child is considered for placement in a regular school.

Example of a correctly answered question:

23. What criteria do you use when deciding if a child should be placed in a regular public or private school?

We look for such things as emotional self-control, responsibility and growth in educational skills

(Record response verbatim)

Question 24 - Again, we are interested in those students who attend a regular school in the daytime and return to the institution in the afternoon.

Example of a correctly answered question:

24. During the past five years has the number of students enrolled in these outside programs increased, decreased, or remained the same?

increased ☑ decreased ☐ remained ☐

Question 25 - Please obtain a number, not the name of each school.

Example of a correctly answered question:

25. With how many schools do you have such an agreement? 3

Question 26 - Here we are interested in what criteria are utilized for selecting receiving schools from among all the public and private schools in the area.

Example of a correctly answered question:

26. Why were these schools selected? They had special education teachers and resources for the emotionally disturbed

(Record response verbatim)

Question 27 - If more than one answer is correct, check each box as appropriate. For example, one school may utilize county school buses while the facility may drive children to another school.

Example of a correctly answered question:

27. Is transportation to these outside schools provided by the schools themselves, the county, or by this facility?

outside schools ☐ county ☑ facility ☐

Question 28 - Please obtain titles of professionals, not their actual names.

Example of a correctly answered question:

28. Who within this facility serves as a liaison with these schools?

Principal and classroom teacher

Question 29 - In this case, we are interested in the follow-up procedure used to monitor the progress of children who still live at the institution but who attend a regular public or private school in the day time.

Example of a correctly answered question:

29. What follow-up procedures do you use to monitor the adjustment and progress of students who reside here but attend an outside school?

We make weekly phone calls to the classroom teacher

[Record response verbatim]

Question 30 - Be sure to obtain the name and address of the school in which the largest number of institutional children are enrolled. Explain that this interview with the outside school will deal with their perceptions of the problems involved in educating the emotionally disturbed - not with their perceptions of how good a job the institution is doing in this regard. Also remind the respondent that this outside school interview will only last about one-half hour.

Example of a correctly answered question:

30. Could you please give me the name, address, and principal's name of the school in which the greatest number of children from this facility are enrolled? I would like to interview him concerning his perceptions of your efforts to educate institutional children in a more normal setting.

Marin County School for Boys
Name of School

1011 Telegraph Road
Address

451-931-0437
Telephone Number

Tom Jones
Name of Principal

Questions 31 and 32 - Again, these questions are very important and answers should be recorded verbatim using additional space if needed.

Examples of correctly answered questions:

31. What kinds of problems do you face in your delivery of educational services within this institution?

We don't have enough time, money or staff.

(Record response verbatim)

32. What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child within this facility and in the country in general?

within facility: We would do better with more teachers and smaller classes

(Record response verbatim)

in general: Teachers should have better training before being certified as special education teachers

3. Child Care Worker/Psychiatric Nurse Instrument - 3

This instrument also begins with a identification page. Before beginning the actual interview, please fill in all the information requested. An example of a correctly filled out identification page is presented below:

3

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROGRAMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

CHILD CARE WORKER/PSYCHIATRIC NURSE INSTRUMENT

Name of Institution: SAN PABLO HOME FOR YOUTH

Address of Institution: 4001 NORTH 30TH ST.
Number Street

PHOENIX
City or Town

ARIZONA 85016
State Zip Code

Name of Respondent: Ms. Mary Smith

Title of Respondent: Psychiatric Nurse

Name of Interviewer: Carole Schor

Date of Interview: 2/20/76

Length of Interview: 35 min.

Question 1, etc. - For the purpose of this study, socialization is defined as the emotional, social and behavioral skills needed to function adequately in society. It may be necessary to repeat the instructions due to the large number of similarly structured questions. The only acceptable answers are "high, moderage, or low", and a check should be placed in the appropriate box.

Example of a correctly answered form:

Please tell me whether each of the following goals is of high, moderate, or low importance to your efforts towards socialization.

In the area of Health: the student:	High	Moderate	Low
1. Looks after personal hygiene adequately.		✓	
2. Has the ability to wash himself regularly and completely without assistance.		✓	
3. Has the ability to choose the correct clothing, according to the weather.		✓	
4. Has the ability to choose appropriate foods to maintain good health.		✓	
5. Recognizes the importance of exercise to maintain good health.		✓	
6. Recognizes the misuse of drugs or medication.	✓		
7. Has the ability to look after own personal health.			✓
In the area of Social Maturity: the student will:			
8. Be comfortable with most people and respond readily to them.	✓		
9. Respond constructively to praise and criticism.		✓	
10. Undertake and complete tasks with a positive attitude.		✓	
11. Be able to cope with anxiety-producing situations.		✓	
12. Demonstrate pride in personal appearance.			✓
13. Demonstrate pride in own achievements.			✓
14. Demonstrate self-reliance within own capabilities.		✓	
15. Recognize own strengths and weaknesses.	✓		

	High	Moderate	Low
In the area of Social Initiative: the student will:			
16. Be given opportunities to perform as a leader.			✓
17. Accept reasonable rules of the group.	✓		
18. Be given opportunities to succeed socially.	✓		
In the area of Attitudes: the student will:			
19. Recognize that there may be more than one acceptable point of view.			✓
20. Recognize family members and peers with needs and interests of their own.		✓	
21. Assume full responsibility for his duties as a member of a family.			✓
22. Accept primary responsibility for making major life choices.	✓		
23. Be able to judge people of various races, cultures, national origins, and occupations in terms as such.		✓	
24. Be able to develop techniques for controlling aggression in culturally acceptable patterns.	✓		
25. Develop confidence in his ability to succeed.	✓		
In the area of Leisure Time: the student will:			
26. Identify and develop skills in a variety of leisure time activities.			✓
27. Organize leisure time adequately.			✓
28. Develop personal satisfaction in constructive activities.		✓	
29. Know how to entertain him/herself.		✓	
In the area of Human Relations: the student will:			
30. Display socially acceptable manners.		✓	
31. Respect other people's property.		✓	
32. Understand the concept of sharing.		✓	
33. Work cooperatively.			✓
34. Constructively interact with peers.	✓		
35. Constructively interact with adults.		✓	
36. Respect authority (Police, Firemen, etc.).			✓

In the area of Home and Family: the student will:	High	Moderate	Low
37. Recognize and understand relationships among family members.	✓		
38. Gain an awareness of own and other's roles.		✓	
39. Appreciate the individual rights of family members.	✓		
40. Participate in family activities.		✓	
41. Recognize and respect adults in authority.		✓	
42. Recognize that every family has its own living pattern and style.		✓	

Question 43 - These answers are abviously not mutually exclusive; therefore, more than one box may be checked "yes." For your information, a big brother/big sister program is a program in which teenagers and young adults from the community volunteer to spend time with a specific institutionalized child; peer review group sessions, refer to meetings of institutionalized children during which the children evaluate each others behavior; and an activities director is a person who directs a formal recreation program. Such a person usually has a degree in physical education, and is sometimed called a recreation therapist.

Example of a correctly answered question:

43. Which of the following are included in your treatment program?
(Interviewer reads each choice and checks response)

a.	family visits to facility	Yes ☑	No ☐	
b.	family taking child out of facility for a visit	Yes ☑	No ☐	
c.	child spending weekends with his family	Yes ☑	No ☐	
d.	field trips	Yes ☑	No ☐	
e.	participation in outside group sporting events	Yes ☑	No ☐	
f.	participation in outside group social events	Yes ☑	No ☐	
g.	big brother/big sister program	Yes ☐	No ☑	
h.	peer review group sessions	Yes ☐	No ☑	
i.	formal recreation program	Yes ☑	No ☐	
j.	on-staff activities director	Yes ☐	No ☑	

4. Outside School Instrument - 4

Again, this instrument begins with an identification page. Before beginning the actual interview, please fill in all the information requested. An example of a correctly filled out identification page is presented below:

4.

BEH-69

SURVEY OF THE EDUCATION AND SOCIALIZATION PROBLEMS AVAILABLE TO INSTITUTIONALIZED EMOTIONALLY DISTURBED CHILDREN AND YOUTH

OUTSIDE SCHOOL INSTRUMENT

Name of Institution: SAN PABLO HOME FOR YOUTH

Address of Institution: 4001 NORTH 30TH ST.
Number Street

PHOENIX
City or Town

ARIZONA 85016
State Zip Code

Name of Outside School: ORANGE HUNT ELEMENTARY

Address of Outside School: 1020 MESA ST.
Number Street

PHOENIX
City or Town

ARIZONA 85016
State Zip Code

Name of Respondent: Mr. JOHN SMITH

Title of Respondent: PRINCIPAL

Name of Interviewer: CARLE SCHOR

Date of Interview: 2/20/76

Length of Interview: 30 min.

Question 1 - Please remember that we are interested in children who live at the institution while attending this school - we are not interested in children who have been discharged from the institution. Enter the name of the institution before asking the question.

Example of a correctly answered question:

1. How many emotionally disturbed children and youth residing at

SAN PABLO HOME FOR YOUTH
(Name of Institution)

are presently enrolled in your educational program? 3

Question 2 - Again, enter the name of the institution before asking the question.

Example of a correctly answered qu stion:

2. During the past five years has the number of emotionally disturbed students living at SAN PABLO HOME FOR YOUTH
(Name of Institution)
while enrolled in your program increased, decreased, or remained the same?

increased ☑ decreased ☐ remained ☐

Question 3 - Enter name of institution before asking the question. By criteria, we mean what behavioral and/or academic standards must a student meet before they are accepted into the program.

Example of a correctly answered question:

3. What criteria have you established for accepting these students from SAN PABLO HOME FOR YOUTH ?
(Name of Institution)

The student must exhibit self control
(Record response verbatim)
and be able to keep up with the others.

Question 4 - Question 4 is straight forward, and should present few problems.

Example of a correctly answered question:

4. Is transportation from the institution provided by your school, the county, or the institution?

school itself ☑ county ☐ institution ☐

Question 5 - Question 5 is particularly important. Please record the response verbatim using the opposite page or page back if additional space is needed.

Example of a correctly answered question:

5. What special arrangements have you made here to facilitate the integration of these students into your program?

(Record response verbatim)

We hired an additional special education teacher.

Question 6 - This question is important because inadequate teacher training is a major reason why institutions are hesitant to enroll emotionally disturbed children in regular schools.

Example of a correctly answered question:

6. Do you feel that your staff was adequately trained to teach emotionally disturbed students prior to their employment here?

Yes ☐ No ☑

Question 7 - Please record the response verbatim using extra space as needed.

Example of a correctly answered question:

7. What kinds of special training, if any, has your school provided in order to help your staff deal with the special needs of these students?

(Record response verbatim)

We have held workshops on open classroom techniques and behavior modification.

Question 8 - Emphasis here is on the word required. We are not interested in whether or not the teachers coincidentally happen to be certified in special education.

Example of a correctly answered question:

8. Do you require that the teachers in whose classes these emotionally disturbed students are placed be certified or eligible for certification in special education?

Yes ☐ No ☑

Questions 9 & 10 - Once again, these questions are very important and answers should be recorded verbatim using additional space if needed.

Example of a correctly answered question:

9. What kinds of problems do you face in your efforts to educate these emotionally disturbed students?

(Record response verbatim)

Disruptive behavior on the part of the student is usually the greatest problem.

10. What suggestions would you offer towards the improvement of educational services provided to the emotionally disturbed child and adolescent within this school and in the country in general?

within school: We need a resource room and a Crisis resource teacher.

(Record response verbatim)

in general: Teachers need more practicum type training.

GLOSSARY OF TERMS

Accredited - A program which has met all the requirements for staff certification, licensure and compliance with the facility code and is, therefore, approved by the State.

Achievement/Aptitude Tests - Tests which measure intellectual capability and academic functioning, e.g., "IQ" tests.

Attitude/Interest Inventories - Tests which measure social and emotional variables by asking the student to agree or disagree with certain indicative statements.

Activities Director - A person who directs a formal recreation program. Such a person usually has a degree in physical education, and is sometimes called a recreation therapist.

Big brother/Big sister program - A program in which teenagers and young adults from the community volunteer to spend time with a specific institutionalized child.

Carnegie Units - Credits assigned to approved courses at the high school level which are required for graduation.

Crisis Resource Teaching - Technique used with children specifically identified as emotionally disturbed. This technique is characterized by timely intervention and continuing support.

Curriculum - Outline of approved topics to be covered in the course of a school year.

Diagnostic Educational Assessment - Administration of educational/psychological tests for the purpose of determing the students academic strengths and weaknesses.

Diagnostic-Prescriptive Teaching - A technique whereby the student's educational strengths and weaknesses are identified and a program developed to meet his special needs.

Emotionally Distrubed - A person exhibiting behaviors which are developmentally deviant in emotional functioning and which interfere directly with learning.

In-Patient - A person who has been admitted to a hospital and who has been assigned a hospital bed and corresponding services for the duration of his stay.

Individually Prescribed Instruction - An educational model formulated at the Learning Research and Development Center in Pittsburgh.

Mainstreaming - A program whereby children who have been segregated due to their special needs are returned to a regular public or private school.

Peer Review Group Sessions - Meetings of institutionalized children during which the children evaluate each others behavior.

Small Group Classroom - Sometimes called a self-contained classroom, in which children with similar handicapping conditions are grouped together for instruction.

Socialization - The learning of the social, emotional and behavioral skills needed to adequately function in society.

Special Education - A highly individualized educational intervention designed to provide children with handicapping conditions in optimum learning environment in order to develop maximum potential.

Task Analysis - A method of evaluation whereby the educational performance of the student is matched with the behavioral components thought necessary to the development of specific educational skills.

Dear Administrator:

The Bureau of Education for the Handicapped, a division of the United States Office of Education, has funded a study concerned with the education and socialization of institutionalized emotionally disturbed children and youth.

Staff members of residential treatment centers for the emotionally disturbed and in-patient units of hospitals will be interviewed in order to determine the availability of education and socialization programs. Our sample will include a total of 90 facilities located within twelve states throughout the country. In each of these facilities we will want to speak with the Administrator, the Educational Program Director, and a Psychiatric Nurse or Child Care Worker. In addition, if some of the students who live at the facility attend a regular public or private school in the daytime, we will wish to contact a representative of this outside school as well. In this way, we hope to gain an accurate picture of what type of education and socialization programs are offered to institutionalized emotionally disturbed children.

We have found that these interviews take no longer than one-half hour to complete, except in the case of the Educational Program Director, which may take one hour. Let us assure you that no individual facilities nor persons will be named in our final report.

The purpose of this letter is to let you know, with as much notice as possible, that our contractor, Applied Management Sciences, will be calling soon to schedule these interviews with you and members of your staff.

We wish to thank you in advance for your cooperation. Only by careful analysis of the programs now in operation can we plan effectively for the future.

Cordially,

APPENDIX E

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BIBLIOGRAPHY

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