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Residential Treatment for Children and Its Derivatives

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RESIDENTIAL TREATMENT FOR CHILDREN AND ITS DERIVATIVES

A conference on inpatient psychiatric treatment for children was held under _the auspices of the American Psychiatric Association and the American Academy of Child Psychiatry in 1956, with the assistance of the National Institute for Mental Health (NIMH). The inpatient treatment of emotionally disturbed children was as yet a new field of development. The conference was held to share concepts and methods and develop a basis for minimal standards. Yet, and in many ways fortunately, diversity still reigns.

The first inpatient psychiatric services for emotionally disturbed children appeared in the 1920s. The rather basic care function of these institutions was rooted in the Poor Law of 1601 in England, whereby public responsibility for the poor—including many children with physical, cognitive, and emotional handicaps—was established. In the 1800s, there emerged also a view of children as separate and distinct from adults. Amendments to the Poor Law in England in 1868 and 1889 provided for the removal of children from their parents in cases of neglect. At that time, specific hospitals geared to the special needs of children were first established, and children identified as mental retardates were admitted to institutions for custodial care. Then, private voluntary children's aid societies emerged, focused upon the dependent, neglected child. Even so, by 1900, children were generally not to

be found in specialized programs and facilities. They were, rather, in the custodial care environments of almshouses, orphanages, state hospitals, jails, training schools, and group homes. Significant subsequent developments included the evolution of social work to professional status; the contributions of psychoanalysis and psychobiology, indicating the importance of early child development and the environmental influences of child-rearing practices; the preparation of the public for a more positive attitude toward the mentally ill and their need for specialized services by the mental hygiene movement; and the establishment (in 1912) of the Children's Bureau as an arm of the federal government, and (in 1931) of "the first inpatient psychiatric services for children in the United States ... to care for children with post-encephalitic behavior disorders following the encephalitis lethargica epidemic at the close of World War I."

Another stimulus for the growth or conversion of treatment institutions for the emotionally disturbed was added by the passage of the Social Security Act of 1935 with its aid to dependent children provisions. Many children so classed were enabled to remain with their mothers. Institutions formerly geared to group living programs now received increasing referrals of disturbed children, enforcing a change from staffs with many volunteers and laymen to more and more professionals. Overall, there was a progression from custodial care, to modifying behavior by utilizing the environment, to intervening attempts at internal change by forms of psychotherapy. This led

to the addition and various uses of social case workers with a psychiatric orientation, social group workers, educational experts, occupational therapists, clinical psychologists, psychiatric nurses, and psychiatrists, as institutions altered their programs from providing continuing care to that of providing psychiatric treatment and return home. As a result of the addition of such personnel and of programs utilizing them during the 1940s, "it was demonstrated that treatment in a residential setting was possible for children who could not be satisfactorily treated on an out-patient basis."

By the 1950s, residential treatment offered various combinations of approaches and depended greatly on the setting in which the service was offered. There certainly was no standard method, approach, or staffing. The inpatient treatment of emotionally disturbed children has evolved from a wide variety of philosophical viewpoints encompassing different views of children in relation to the adult role, concerns for special needs of children as they develop in a variety of environments from total dependency to relative autonomy in the face of ever-changing demands by rapidly changing environments, and a remarkably rapid growth of a technology of behavioral science with its many diverse theories.

Other factors influencing the manifold diversity of developments have been differing philosophies as to the role of parents (varying from all-important, much to be condemned and shunned etiological factors, to

bewildered victims who both need and can provide help, plus all kinds of versions and mixtures in between). The kinds of children being treated play a large role, as do the expectations of institution and community for either symptomatic improvement or total internal psychological change. Freedom to limit intake and freedom to determine duration of treatment are two among a host of important variables.

Introduction of family therapy, group methods, halfway houses, specialized foster homes, group homes, behavior therapy, and day hospitals all have added to a mix of infinite variety.

Residential Institutions for Children

The Setting

In 1964, the National Association for Mental Health published a *Directory of Facilities for Mentally III Children in the United States.* For criteria of selection they included residential and educational facilities that by "stated policy, function and intake criteria planfully accept mentally ill children and render continued service in facilities which are distinct and separate from adults." In the term "children" they included infancy to eighteen years of age. Many authors limit "children" to age twelve years. No doubt many facilities were omitted, for many reasons. This publication listed 116 such facilities,

with sixteen of the fifty states having no such facility. It was considered that fourteen more facilities might have been included had more information been available.

Only four years later, the NIMH biometry branch cited 149 residential treatment centers. It was admitted that only limited information on children served in such facilities was available. This fact permitted only an estimate of the number of children served, which was placed at 55,400 in 1966.

There is a great variety of facilities, listed under a bewildering variety of names, many of which do not even connote treatment. Reid and Hagan considered that such "specialized institutions . . . have one thing in common—the development of a total approach to therapy." They go on to describe twelve organizations as "a base from which to evaluate and better understand clinical studies and reports from residential treatment centers."

There are four general categories of inpatient treatment facilities for children: (1) the shelter or placement unit; (2) the residential treatment center; (3) the inpatient psychiatric service; and (4) the state hospital unit.

1. The shelter or placement unit is usually under private auspices and finds financial support under contract with a government unit. Generally, shelters provide custody, care, and management of children in residence, are inadequately staffed, and more often offer psychiatric evaluation and

separation from the community and family than continuance of care for emotional aspects. Such facilities tend to draw from children unmanageable in the community and involved in court and child welfare services.

2. The residential treatment center is most often under private auspices with financial support through public agencies. There may be psychiatrists, social workers, educators, or psychologists as administrative directors, with psychiatric and medical directors often in the structure. In addition to custody, care, and management are a therapeutic, structured milieu, routine medical care, individual and group psychotherapies, special school, and an adequate staff-child ratio. The staff is usually multi-disciplined and highly specialized. In contrast to the usual social pathology found in the children in shelters, one finds a large number of emotionally disturbed children, who may have parents who cannot cope with the child. Most of the children in these settings are ten to seventeen years of age; with 1 percent under five years of age and 5 percent in the five-to-nine-year age group. Seventy-three percent of the ten- to seventeen-year-olds are diagnosed as having psychosis, personality disorder, or transient situational disorder. The five- to nine-year-old group are usually diagnosed chronic brain syndrome, personality disorder, or schizophrenia.

An attempt to bring some order out of diversity is provided in our draft of an operational definition for residential treatment centers. A residential

treatment center is an institution or a unit of an institution existing specifically for the round-the-clock, long-term treatment of emotionally disturbed children who have sufficient intellectual potential for responding to active treatment and for whom outpatient treatment is not indicated but for whom inpatient treatment is the treatment of choice at the time. It does not provide custodial care. Children will not be admitted because of central nervous system disorders or other organic difficulties as such. However, the existence of such difficulties will be no bar to admission if they contribute to or complicate emotional disturbance, provided proper medical facilities are available. The staff must have control over intake and discharge, based upon diagnostic and therapeutic study.

The institution must provide a total therapeutically planned group living and learning situation and a milieu within which individual psychotherapeutic approaches are integrated. The living arrangements, physical and personal, should provide a psychologically safe milieu for dynamic maneuvering and experimentation without fear of trauma or retaliation. It should offer support for growth as well as for internal reexamination, with individual psychotherapeutic interviews available in proportion to the needs of each individual child. Schooling may be provided within or outside the institution. Adequate recreational facilities (including gross sports and major muscle activity and hobbies, arts, and crafts) must be available within it.

The institution will usually provide the combined contributions of the disciplines of psychiatry, psychology, education, social casework, and social group work, which must be integrated in a responsible and dynamic interplay with the group living aspects and the personnel who provide these, though there will be no standard pattern for the form of combination or role of each of these. All, however, must have special therapeutic training and orientation for work with children and for work together as a team along with the childcare workers, teachers, nurses, pediatricians, and all who deal with the children. It is hoped that all such institutions would also provide centers for clinical training and for research.

A specific variant, which has been offered as a means of carrying out the task of residential treatment in a more economical, focused and shorter-term manner is the modality known as “Project Re-Ed,” modeled somewhat on the French *educateur.* In this, specially trained teachers, in essence, provide all the needed teaching, group living, and change in emotional status of their charges, with appropriate consultation from other disciplines. Enthusiastic claims for the results and devastating attacks on the concept have both appeared. It is too soon for any definitive evaluation, but it may be expected that with time it will become clear that this can be an excellent approach for many, leaving a residual for which only the classical methods of residential treatment will suffice.

3. The inpatient psychiatric service of the general hospital is under private, public, or university auspices. Such facilities are administered and directed by psychiatrists. Many provide the range of services of the residential treatment center and can provide more totally for the medical needs of the children. Generally, they serve the child for shorter periods of time than the usual residential treatment center. Psychiatrists are more involved in the day to day treatment of the children, with a characteristic emphasis on intrapsychic change and the opportunity for more individual psychotherapy than in the residential centers. It is estimated that in 1966 there were three to four times as many children in this type of facility (20,000) than in a residential treatment center (8,000) and that there are nearly five times as many such units as residential centers. In 1966, 14 percent of the children in these units were under five years of age and 52 percent were older adolescents. Under five the predominant diagnosis is chronic brain syndrome. In the five-to-nine-year age group, convulsive disorder and mental deficiency are the most common diagnoses. Schizophrenia, psychoneurosis, and personality disorder account for more than 50 percent of the ten- to fourteen-year-olds and schizophrenia, neurosis, and transient situational disorders account for more than 60 percent of the fifteen- to seventeen-year-olds.

4. The state hospital unit is under the auspices of a state health or hospital system and utilizes psychiatrists as administrators and directors.

Like the residential treatment centers, these institutions provide for the total needs of the children but generally have insufficient professional staff to adequately carry out long-term treatment and rehabilitation. They serve about the same number of children as the inpatient psychiatric units in general hospitals, have a greater prevalence of children over ten, and more than half have the more severe chronic diagnoses of schizophrenia and chronic brain syndrome. Many children with a poor prognosis, who have failed to benefit sufficiently in other inpatient settings, may be found in these state units.

Reports since that quoted for 1966 have shown a steady rise in the actual numbers and percentages of adolescents admitted to both state and nongovernmental mental hospitals. This is especially true of the latter, with their smaller capacity. Increasingly, the private hospitals are reporting that a majority of their census consists of adolescents.

As the percentage of adolescents increases, the mental hospital tends to take on more and more of the coloration of the residential center (as described and defined here), including the all-important educational aspects and group approaches. Discussions of hospital treatment for adolescents almost always raise the issue of whether it is preferable to have a separate adolescent unit or have them intermingled with the older patients. Articles and arguments on each side abound and neatly cancel each other out. This

being so, it must be concluded that the results depend upon the particular staff and that with which it is comfortable. The same would seem to apply to isolation or mixing of the sexes.

An increasingly vexing issue is the problem of how to deal with adolescent drug users. Many settings are limiting the numbers of such youngsters that they will take. One respected private hospital, which had been quite successful in dealing with alcoholics, finally decided to ban entirely the admission of teenage drug addicts. In essence, it was felt that severe character disorder and a lack of motivation for treatment, along with easy continuing availability of drugs in the community, were what caused this program to fail.

Such observations may have significance for treatment of other patterns of adolescent dysfunctional behavior related to character disorders. It is our opinion that success in treatment in such cases requires the availability of, and initial placement in, a locked ward, with graded and earned increases in "openness" and a readiness to return the adolescent to the locked ward and start all over again, as often as necessary.

The Child

Criteria for placement of a child in an inpatient treatment facility vary from institution to institution. Generally, the children selected for inpatient

treatment are those who cannot be treated on an outpatient basis because of severity of symptoms or breadth of symptoms. Selection is not on the basis of diagnosis or because outpatient treatment is not available. Relevant are the severity of the child's disorder, the family's disturbance, the severity of maladaptive child behavior, and the danger to the child, to other persons, and to property posed by the child's behavior. Institutions may specialize to the point of providing admission for children with specific types of behavior. Age, intelligence, the presence of an intact family, geographic proximity to the child's home, the willingness of the family to participate in casework, the length of inpatient treatment considered to be necessary, and the presence or absence of special sensory and physical disabilities are further factors considered as influencing admission. Individual institutions, such as state hospitals, may have little or no choice (a child may be court committed, for example), or they may feel that they need to offer their services as equally as possible to all comers. Institutions functioning with greater freedom of choice of patient may create a total environment geared to the special needs of a certain behaviorally disturbed group. For example, a highly controlled and structured environment may be created for the aggressive, acting-out child, or the treatment program may be geared to behavior modification principles and applied only to autistic-like children, or it may be permissive and encouraging to the shy, anxious, withdrawn child.

Contraindications also vary from institution to institution. It has been a

rule of thumb that a child under six should not be taken from his family for such a placement. Children under six in placement are relatively few and tend to have serious disorders, such as psychosis, brain syndrome, or retardation. The problem of eventual reentry into the community of a burdensome child, unwanted by his family, may influence admission. Parental opposition to placement or unwillingness to voluntarily give up custody, or lack of motivation for family casework or therapy may be considered as cause for rejection of a child for admission.

Particularly in private residential units, the ability to finance the treatment is a major consideration.

The structure of the setting is more often a matter of chance than design, as it is still true that the majority of residential treatment centers represent the outcome of new uses of old buildings. A recent article by Clemens relates the happy results of being able to plan from the outset as to how a center could be built to meet the needs of the children, and its bibliography gives some further thoughts on the matter.

A frequent question is whether it is best to have a single congregate building with other supporting structures, or to have a cottage system. Experience suggests that the results are more dependent on staff than on structure, there having been outstanding successes and failures with each

plan. Regardless of design, children must feel that the staff care more for them than for the building.

Treatment

Classically present in child inpatient treatment have been individual psychotherapy, milieu treatment, group therapy, parents in therapy, and the use of medications. Family therapy may be employed. It is not currently utilized to the same extent as the above modalities, but is increasingly so. A new approach, assuming increasing prominence, is that of behavior therapy.

Intrinsic to the treatment of a child in residence are the concepts of separation of the child from his environment as not only necessary but as therapeutically useful (and only to the extent that it is); involvement in a milieu, not only promoting desirable development and behaviors but also acting as an agent to change and improve attachment behaviors; and reintegration of the child into his community, not only as necessary to physical termination but as a therapeutic series of actions of an ongoing, not just a terminal, nature. In addition to the specific therapies, these treatment concepts gain support in residential units by employment of controlled and manipulatable groupings of children and parent surrogates, by control over the degree of offered life structure, by variations in the life tasks expectations in terms of frequency, duration, and sequencing, and by control over the

quality and quantity of exposure to the outside world.

Inpatient units specifically offer (1) planned and controlled living, with flexibility for greater responsibility and independence and protection against destructive impulses; (2) an emphasis on health via achievement and work; (3) group living and individualization; (4) identification figures of a positive nature; (5) a medium for treatment and change through child-staff and child-child interaction; (6) a community in which a child feels himself as integral; and (7) integration of a collective effort.

The treatment goals for the child are to build a stronger ego, to enable him to sublimate and modify drives in a socially acceptable manner, and to help him develop more mature defenses, a realistic superego, and new and more useful identifications.

Length of treatment varies widely from institution to institution and from child to child. The depth of the illness, the requirements of ego growth, and the nature of the treatment process are determinants of length of treatment. Some consider that one- or two-year treatment programs are vulnerable to the child's use of compliance, and surface change may be accepted as expressive of deeper change. Some consider that the child needs inpatient placement until he reaches adulthood. Factors leading to a rationale for such long-term treatment are the severity of the child's illness, the nature

and complexity of psychic growth, the length of time required for establishment of a relationship to the ego defective child, the time required for new positive experiences to ward off pernicious effects of earlier traumatic experiences, and the concept of the child setting the treatment pace.

Although it is convenient to state all this in terms of the child, such an orientation leaves out a most important factor, the adult grouping to which the child belongs and to which, hopefully, he will return. In most cases, this represents an existing family. To most workers in the field, an absolute essential is that there be involvement of the total family from the time of consideration of admission, through the actual admission-separation process, throughout the period of residential treatment, with its increasing home and community visiting, and the post-discharge reintegration. This involvement may be developed by individual casework with the parents, but there is an increasing tendency to make use of total family sessions for this purpose. As noted elsewhere, the availability of transitional measures, such as halfway houses and day hospitals, enhances this technique tremendously and may speed the process of reintegration.

Where there is no intact family, or where the child's best interests require continuing separation, experience suggests that work with the sponsoring agency (if the treating agency does not have a network of its own

services) can be crucial and must continue all through the contact with the child.

The kind of thinking previously offered has been based upon psychodynamic premises. It must be recognized that acceptance of behavior therapy concepts and mode of operation may shorten the stay and lead to different goals.

Discharge is considered clinically indicated when the child has sufficient adaptive capabilities for usual life stress. Post-discharge adequacies and the child's institutional performance are relatable only when the situation to which the child returns is taken into account. Slow integration into the community, such as can be accomplished by discharge to a group home or halfway house or day hospital, is useful in gauging the child's readiness for full community life.

Education

One of the major tasks of a growing child is to learn. In this culture, learning is generally done in school.

Most children coming to residential treatment have problems both learning and behaving in a standard learning situation. One of the most important and difficult tasks in a residential treatment center is that of

bringing about improvement in these areas. An all too common tragedy is for a child of normal intelligence to leave at the age of twelve, capable only of second-grade work, despite the best endeavors. This is one of the areas most in need of improvement, generally. Perhaps this is one area where behavioral approaches will be of value.

The Professionals in Residential Units

Perhaps in no other place in mental health facilities will one find such a wide range of professionals as in residential units. Impinging on the daily routines of the children are the child-care personnel, the special educators (subspecialized in some instances), pediatric and psychiatric nursing personnel, the physician (pediatric and psychiatric), the occupational therapist, the recreational specialists, the special skill technician (for example, speech, language, visual-perceptual-motor), social group and case worker, and individual psychotherapist (variously, childcare worker, nurse, social worker, psychologist, psychiatrist). In addition, one finds a widely varied group of consultants, diagnosticians, and treatment personnel as special resources from the fields of child development, child care, education, and medicine.

Although not conceptually a professional in terms of the treatment of children, the supporting staff of the institution (cooks, maintenance and

janitorial personnel, seamstresses, and so on) often spontaneously or by design form important relationships with children and thus become a part of the total treatment program and staff.

There are increasing experiments in using indigenous personnel from a community as treatment agents in settings such as community mental health centers. One special role that commends itself for residential treatment centers is in the two-way communication between parents-community and staff-institution.

Though not professionals, no reference to staff would be complete without consideration of volunteers. They have demonstrated their value in many capacities. Included are the roles of visitors to children who have none; introducing children into community activities; providing special skills not possessed by regular staff; supplementing the work of staff, for instance, as teacher aides. Above all, they bring the warmth and feeling of the community to these children in a most impressive and personal way and make children and staff feel: “We are not alone.”

Outcome

Highly refined data on outcome are lacking, and there are but few follow-up studies available. The concept of success in residential treatment is a difficult one. Current intake criteria lack precision, so as to limit major

comparisons between settings. There is the question of defining how much intrapsychic or environmental change there must be for success. It has been said that progress is best seen in terms of total case modifiability, the components of which include individual modifiability and family involvement in individual circumstances. Maximal success has been said to occur with neurotic, non-acting-out children. Treatment variables and subsequent adjustment following discharge have shown no relationship to each other; however, the presenting symptoms and chief complaints at admission have been found to be the best predictors of post-discharge adjustment.

The Bellefaire follow-up study found the greatest growth in terms of school and relationships with adults, peers, and general living tasks to be evidenced in those admitted before the age of thirteen. Also it found that this growth in and of itself was not useful in predicting post-discharge adaptability and adaptation. The post-discharge environment was found to be a major consideration in determining success or failure.

In nearly every worker's experience there has been little doubt of benefit of inpatient psychiatric treatment for some children. The presence of an intact family that desires a reintegration with the child appears to greatly increase the chances of post-discharge success. Availability of such resources as day hospitals, group homes, and outpatient treatment services, in addition to allowing for a smoother reintegration into a full community life, also allow

for more accurate predictions as the child proceeds to become re-involved in his community in a gradual and stepwise fashion.

Day Hospitals

Although by the mid-1950s the need for some such program as day hospital for children had been seen, as of 1956 no experience had yet been reported in a day hospital program at public psychiatric hospitals for children. Increasingly in the last decade day hospital treatment has been stressed as a vital component in the continuum of services for emotionally disturbed children, but the professional literature concerned with children had yielded relatively few relevant papers up to 1969.

The Setting

A day hospital for children is a therapeutic milieu in which psychotherapeutic, educational, sometimes behavioral, recreational, social work, and other services (for example, nursing, pediatrics, communication skills, and perceptual training) are integrated under the direction of clinically trained staff, on a day basis, with the child returning home for the night.

The distinction between the terms “day hospital” and “therapeutic day school” may at times be difficult to draw. For example, some day schools operate more in the manner typical of a day hospital. One of the distinctions

cited by Dingman is that the day hospital's major programming control is in the hands of clinicians, whereas the day school, though it may have similar facilities and services, operates with the guidance and consultations of clinical staff rather than under its direct supervision.

The term "day care" has often been used to refer to day hospital programs. It has been suggested that the term "day care" might best be restricted to programs intended primarily for children who are not in need of treatment for emotional disturbance but rather in need of day-to-day nurturant care in the absence of parents. With the increasing emphasis on publicly supported day-care centers for young children of working mothers, this distinction may well need to be asserted. This is not to ignore the fact that many youngsters may benefit from a therapeutic milieu under the auspices of day-care programs, but points to a difference in intent, population, and scope of services.

In its emphasis on the integration of a variety of approaches within one program, the day hospital comes to resemble the residential treatment center, with the obvious distinction that the child returns to his family daily and generally spends the entire weekend with his family. The fact of continual daily return to the family means that the parents continue to have major responsibility for fulfilling the nurturing needs of the child, as contrasted with the assumption of virtually total responsibility for the child's needs by the

residential treatment center. The child maintains his status as a family member physically present in the home, and parents continue to fulfill the parental role, so that in this sense the family unity is preserved intact.

In addition to helping maintain the degree of family cohesion already present, there are other advantages of a day hospital as opposed to residential treatment. Fenichel indicated some of the disadvantages often attending residential treatment.

1. Residential treatment centers are usually distant from the child's home, making work with parents more difficult.

2. The family may reorganize in the child's absence so as to exclude the child's reentry.

3. The child may become institutionalized and thus have further difficulties in reintegrating into community life.

4. Removal of the child from his home causes the child to lose whatever positive aspects of family life exist, which harms both child and parents.

To this list may be added the stigmatizing of the child as bad or different, which may serve to mask underlying family problems, and the increased guilt and feelings of failure that many parents experience when the child leaves the home. In addition, the residential placement may allow the child to maintain fantasies (often difficult to work through) of the family

home, quite discrepant from what it actually was.

Clearly, removal of the child from his family is a drastic step, but one that in some instances is necessary. All too often, when guidance clinic services do not meet the needs of a particular child and family, and community educational facilities cannot cope with the child, there is no adequate alternative available except to seek a residential facility. It is this gap, between inpatient and outpatient services, that a day hospital can often fill. In a 1969 survey of needs for children's residential facilities in San Diego County, California, day treatment facilities were listed as most needed for children up to age twelve. Moreover, while the need for residential facilities for adolescents was stressed overall, it was felt most economical to invest in a day treatment facility because it offered services needed for the largest percentage of children in all age groups.

The Child

The day hospital may be the treatment of choice and a useful alternative to full-time hospitalization and to outpatient treatment, both for children and adolescents. With adolescents it has been employed as a flexible service offering rehabilitation of former inpatients, follow-up service for discharged patients, and a testing ground for those long hospitalized. While providing treatment it can also serve a diagnostic function and help to determine the

extent to which a structured day for the child and relief for the parents along with casework will prove sufficient to avoid the need for complete removal of the child from the home. Availability of day hospital programs offers the promise of earlier discharge of children from residential treatment centers. Actually, as a rough rule of thumb, we have surmised that one-third of child referrals for residential treatment can have their needs better met by day hospital; and one-third, as well by day hospital as by residential treatment; and for the final one-third, residential treatment represents by far the treatment of choice.

Studies have indicated that up to two-thirds of adult patients treated in partial hospitalization settings would have required full-time hospitalization had day hospital facilities not been available. Controlled studies in which patients were randomly assigned to inpatient or day hospital programs have shown that approximately two-thirds of those assigned to day hospitals were able to make use of treatment in that modality. Devlin reported on the results of randomly assigning to a day program, children who had met the criteria for residential treatment at the Ittelson Center. Tentative conclusions, based on those children either withdrawn from the program or transferred to the residential program, were that parental factors were the most significant determinants of suitability for either modality, although all children were deemed to have made some gains. Commenting on day hospitals in general, Astrachan et al. stated that rather than any specific patient characteristic, it is

the family's willingness to participate in the treatment program that influences the suitability of day hospital treatment. On the subject of criteria for the differential use of treatment settings, Atkins reported that day treatment programs also served seriously disturbed children with results apparently comparable to those of residential treatment programs, a fact that made the search for differential criteria even more complicated. Schizophrenic children have been treated on a day basis at the League School for more than a decade. On the basis of seven years' experience in day treatment, La Vietes et al. included among criteria for admission to the program the willingness and ability of parents to participate in the program plus a certain amount of basic stability in the home. Psychotic children have been treated directly, on a day basis, and more recently indirectly, through the training of parents to work in the home with the child, with an operant conditioning approach. Lovaas, et al. have recently reported a follow-up study, utilizing operant techniques with autistic children in a variety of programs, including day settings.

It would seem, then, that no diagnostic classification of itself indicates the specific treatment modality of choice. The severity of the disorder as such is also not an absolute indicator, although one might think that a child or adolescent who demonstrates extremely poor impulse control and/or poor judgment and has clearly endangered himself or others may need the controls that only a residential setting can provide. This has not been substantiated in

the literature with regard to day hospitalization. Frequent reference has been made to the need for the child to be removed from the family as an indication for residential treatment. In general, it appears that some degree of parental stability, including parental willingness to support the treatment program of the child, and sufficient parental resources to participate in their own treatment program (be this casework, group therapy, family therapy, or the like) are essential to the success of a day hospital approach. Greater precision with regard to criteria on the part of the child or the parents remains to be delineated. Despite this uncertainty, the need for the day treatment center to maintain control over its intake policy has been stressed.

Treatment Program

The basic elements in most day hospital programs are specialized education, competence-producing recreational activities, group socializing experiences, provision for individual psychotherapy where indicated, and intensive work with parents. The integration of these elements is generally through a multidisciplinary team approach.

Education must be tailored to the special needs of the child, while the content of specific educational activities and their emphasis within the total program will vary. Day treatment center clinical and educational services have been successfully coordinated with classroom experience in a

metropolitan school system. The integration of educational experiences with other therapeutic experiences has been stressed, while maintaining the view that in a day hospital, treatment, rather than modified education, is the primary function.

Psychotherapy is most likely to be offered on an individual basis for the preadolescent in day hospitals and therapeutic day schools. Adolescents may be treated individually as well, but typically much emphasis is placed on group interaction, including frequent, often daily, patient-staff discussion groups. A basic tool recommended for staff to employ in helping children make use of the therapeutic milieu is the "life space interview."

Day treatment programs for psychotic children must be highly modified to cope with the severe limitations of functioning generally present. In a study of the effects of structure on the development of autistic children, results suggested that autistic children responded best to relatively high structure.

The importance of helping the parents of psychotic children in day treatment centers to care for their disordered child in the home, with a more collaborative, rather than analytic approach to the parents, has increasingly been stressed. In recent years, autistic children, for the most part inaccessible to psychodynamic therapies, have been involved in specially modified day treatment approaches, often with the application of principles of operant

conditioning. The most recent findings indicated that the key to maintenance of gains in behavior modification programs for autistic children lies in assisting the parents to assume the training role in the home.

In terms of staffing patterns, experience derived from residential treatment centers in general offers a reliable estimate of types of positions and staff ratios needed Programming of activities and staffing patterns will depend on the age of the children being treated and the types of disorder. Day treatment programs for children span the age range from preschool through adolescence and include children with emotionally based learning problems, those with personality disorders, and those termed psychotic or autistic. D'Amato presented models of types of programs, the staffing of a program complex for fifty children, and corresponding space requirements.

Some clinicians who advocate day hospitalization as the principal treatment resource for a broad range of severely disturbed adolescents and adults cite the disadvantages of the day hospital being physically and organizationally an appendage of a parent institution, and stress the need for institutional autonomy in order to maximize utilization of the day hospital as a treatment modality. Astrachan et al. discussed the problems arising in a given day hospital when it attempts to attain a variety of goals. They pointed out that all secondary tasks will interfere with performance of the primary task and urged that task primacy and priorities be designated to ensure the

survival of the organization. As an example, a day hospital that functions primarily to prevent inpatient hospitalization would be seen as being compromised in this task to the extent that it attempted to provide ongoing follow-up services to former inpatients.

At this point, day treatment programs for children appear to be (1) offshoots of residential treatment or inpatient facilities or (2) attempts at either adding educational programming to outpatient clinical services or bringing these clinical services to existing educational settings.

Where day hospital facilities are developed on the same grounds as residential or inpatient facilities, the question arises whether to integrate or keep separate day hospital and residential patients. Beneficial effects of integrating adolescent day and residential patients have been reported. Arguments in favor of integrating day hospital with residential children, and in favor of separating the two programs, have been presented by Marshall and Stewart. While their institution adopted a compromise resolution (schooling is the major area integrated), they pointed out that although theoretically able to differentiate goals and time factors in the two programs, in practice staff did have difficulty in modifying their patterns of treatment, based as they were on the preexisting residential treatment program.

Outcome

Outcome studies of the results of day treatment for children are sparse and generally lacking in precision. As Wilder et al. reported, research on day hospitalization "has not kept pace with its expanded use." Guy and Gross found in the literature "the almost unanimous opinion that day hospitals are an effective alternative to hospitalization," and cited the success reported with almost every variety of psychiatric disturbance in adults and children. They discussed proposals aimed at reducing confusion in the identification of patient populations, definitions of treatment, treatment effects, and assessment procedures.

An outcome study of a day treatment unit school with a psychoeducational program for primarily nonpsychotic children has been reported by Gold and Reisman. Utilizing information from case records of fifty children treated over a four-year period and comparing this with follow-up data, including parent and teacher ratings, results indicated an approximately two-thirds improvement rate, regardless of the provision of psychotherapy. More favorable outcomes were found for children identified and treated at younger (five to eight) ages. Of the thirty-seven children who enrolled in public school following treatment, twenty-six still required some special class placement. La Vietes et al. reported on thirty-eight children who completed a three-year day treatment program, indicating that 76 percent had "good results," while of the four children who required residential treatment, "the factor chiefly responsible was the parental one." Halpern found that about

one-fourth of autistic patients moved directly from the day treatment unit into a residential facility. As pointed out by Gold and Reisman "reported results of day school programs dealing with primarily non-psychotic youngsters are not as readily available" as are those with psychotic or autistic youngsters. As for the latter, although there is an increased emphasis on quantifiable data, the newness of the programs and the relatively small number of children in them limit statements as to long-term treatment effectiveness.

The cost of day treatment is generally estimated at somewhat less than half that of full residential treatment. Obviously, since the type of program, kinds of children served, and staffing patterns all may vary, there are differences in costs from one program to another. One difficulty that is being overcome in many instances is that of obtaining third-party payment, without which most comprehensive day treatment programs would be beyond the resources of the average family.

There are no exact figures available on the number of day hospitals or therapeutic day schools currently operating. As of April 1970, the National Association of Private Psychiatric Hospitals listed twenty-one private hospitals that offered day treatment programs for children and/or adolescents; in the following year at least two more such programs were known to have been initiated.

In one reported instance, over a two-year period, the number of inpatient children decreased by approximately 16 percent, while the number in day treatment nearly tripled. If day treatment fulfills its promise as an alternative to residential treatment for a significant number of children, it seems likely that similar trends will become prevalent. It is with such an expectation in mind, coupled with the belief that day treatment is a needed and useful treatment of choice in many instances, that those involved in mental health planning for children continue to emphasize the role of day treatment in the spectrum of services.

Group Homes

The concept of the group home has been receiving increasing attention from those concerned with providing services to children. Although definitions vary, since they have been derived for the most part pragmatically, the general structure of the concept and the definite need for such homes, especially for adolescents, are clear enough in the literature. A group home occupies a place in the continuum of services between institutional care and foster home, with some measure of each. Although at times there have been difficulties in the literature in distinguishing between group and foster homes, several authors, especially Herstein have emphasized that the group home is a residential setting that provides professionally guided help for disturbed adolescents while retaining the small-group autonomy of the foster

family for the growth benefits the latter provides. Both Herstein and Gula stressed the need for agency control and supervision of care and treatment (with provisions for casework and/or social group work supervision and psychiatric consultation). The child-care staff are viewed as counselors or house-parents rather than as foster parents, and each group home is limited in size, numbers, and composition of members. The nuclear child-care staff may be either a couple or a group of adults, but neither the staffing patterns nor the degree of openness or closedness to the community is crucial to the definition of a group home.

Group homes are believed to meet the living and treatment needs of many adolescents who (1) may be able to move from residential treatment to community living but have no suitable family or (2) have had multiple unsuccessful foster home placements and cannot meet the demands for intimacy and conformity to family life.

Admission criteria to group homes generally refer to the inability of the adolescent to cope with family or foster home life (or unavailability or unsuitability of the latter). The adolescent's behavioral or emotional problems must not be of such severity as to prevent functioning in the community, including school and peer activities, given the support and treatment that may be available. While some degree of psychiatric disorder may be present, the degree and kind of acting-out behavior must not be of

such nature or severity as to be disruptive of the home itself or of its relationship to the community.

In addition to discussions of the composition and supervision of the child-caring staff of group homes, the overall direction and integration of services has been described. Relationship of the home to its neighborhood, and of preparation to enter the neighborhood, have been discussed.

In view of the diversity of staffing patterns, it is difficult to discuss costs with any generality. Compared to residential treatment in a similar locale, group home costs may be approximately one-third to one-fourth per resident.

The usefulness of small-group homes for adolescents (the need among younger children has not been so much emphasized) may be seen both in terms of ongoing aftercare (following residential treatment) and as a means of providing stability in the lives of those who might otherwise develop more delinquent or other symptomatic behavior. For the adolescent boy or girl who has some emotional disturbance, who is unable to adjust to the foster home or family setting that is available but unsuitable, or who needs an ongoing, supportive living situation that can provide security and consistency, with overall professional direction, supervision, and consultation, the group home may be a placement of choice.

As mental health planning focuses more deservedly on the needs of

adolescents, the concept of the group home may be expected to flourish.

Retrospect and Forecast

Ongoing social changes and concepts have helped to bring about a shift from institutions designed to provide congregate living for orphans or dependent and neglected children, to residential treatment centers, designed to help children and parents reconstruct inner distortions and pathological interaction. The childcare origin of most of these institutions helped to determine a social work orientation, while the hospital origin of others led toward a medical orientation. Various settings have sprung up, reflecting the concepts of psychiatry, casework, group work, education, and the like.

Regardless of this past, it is noteworthy that the best among such settings came to emphasize an integrated approach, utilizing and requiring the contribution of each discipline in an integrated manner. Very often this was exemplified in the treatment team of which the particular child was the unseen but much felt center, in which all who were involved with child or parent or agency met, conferred, planned, and with increasing maturity and independence set and pursued their goals. Not only did this require a heavy concentration of staff per child, but the spoken or unspoken contract of the treatment center was apt to be: “We will cure the child; we will cure the family; and we will cure the society which has afflicted them both, so that we

may guarantee an everlasting successful life after leaving our doors." The consequence is somewhat like analysis interminable. The combination of high staff ratio, heavy cost, and prolonged treatment has placed the classical form of residential treatment in jeopardy.

Owing to the resultant economic pressures from third-party payers; the spirit of the times, which emphasizes a colleague rather than an autocratic approach and stresses flexibility; the felt and asserted need for a comprehensive, integrated network of services readily and locally available, involving community change agents as much as possible; the appearance, often forceful pushing, of behavior therapy and its delimited set of goals—we see today a great ferment.

It is likely that there will be a variety of experiments and hybrid forms of treatment. Goals will be more flexible, realistic, and differentiated. Community involvement, extending into the operation of these facilities, will most likely increase, and many more facilities will become part of a community network rather than stand alone. The next decade will probably record 1972 as the end of that phase of residential treatment and its offshoots which began with the Social Security Act of 1935.

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