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Of the 720 emotionally disturbed children under 18 years of age in state mental institutions, 150 were selected by the Illinois Interdepartmental Committee for intensive study; 35 youths were also selected by the Illinois Youth Commission as being in need of mental treatment. Two schedules were designed for automatic data processing and cases were reviewed by two committee members, two social workers, and two child psychiatrists. The 17.8% who were designated as inappropriately hospitalized more often presented problems in management and training (as from moderate to severe retardation) and none was psychotic. The 8.6% judged hospitalized for an inappropriately long time were characterized by socially unacceptable behavior due to psychotic break. Findings and recommendations considered the institutions' programs, comprehensive treatment plan for each child, release planning and aftercare, the roles of disciplines, case records, and communication between agencies. The lack of community resources, early problem identification and prevention, modification of the child's environment, community programs to handle the acting out child, and guardianship were judged for each child's community; and the institution-community relationship was treated. (SN)

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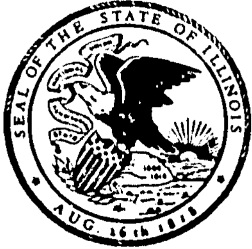

OTTO KERNER, Governor

STUDY OF EMOTIONALLY DISTURBED CHILDREN

BY INTERDEPARTMENTAL COMMITTEE
ON CHILDREN AND YOUTH
of
ILLINOIS COMMISSION ON CHILDREN

November, 1967

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STUDY OF EMOTIONALLY DISTURBED CHILDREN

who were in the State Mental Hospitals of the Department of Mental Health or the Institutions of the Illinois Youth Commission on June 30, 1964

by

INTERDEPARTMENTAL COMMITTEE ON CHILDREN AND YOUTH

of

ILLINOIS COMMISSION ON CHILDREN

Room 1010 Myers Building
101 South Fifth Street
Springfield, Illinois

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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November, 1967

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Miss Naomi Hiett, ACSW, Executive Director

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LETTER OF TRANSMITTAL

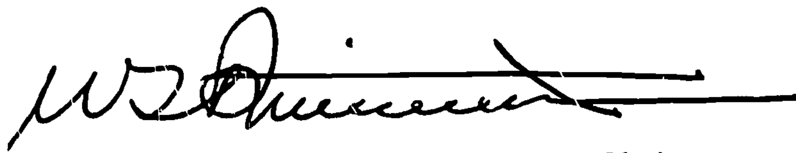
TO: THE HONORABLE OTTO KERNER, GOVERNOR
MEMBERS OF THE GENERAL ASSEMBLY
CONCERNED CITIZENS IN ILLINOIS

This Study, though limited to the emotionally disturbed children in the State hospitals of the Department of Mental Health and the institutions of the Illinois Youth Commission, brings clear indication of weaknesses in programs and services and the urgency of improving the services for emotionally disturbed children both in the institutions and in the community.

Not only must we add new services such as a vitally necessary closed treatment resource for aggressively acting-out emotionally disturbed children, but also there is an imperative need for a clear-cut designation of responsibility for children with varying degrees of disturbance. This Committee has tried to spell out some more appropriate delineations of responsibility for these children and the importance of much closer collaboration between the various departments and agencies involved as well as between the institutions and the community.

Many of the findings of this Study were well known to staff of agencies who have been trying to secure services for individual children. However, this report, for the first time, brings a documentation of what happens to children under our present inadequate system of service—children who are unnecessarily in State mental hospitals or institutions of the Illinois Youth Commission or who are required to stay in those institutions months and even years longer than their treatment requires.

Respectfully submitted,



W. F. BRISSENDEN, Chairman

FOREWORD

Every child has the capacity of becoming a significant member of society. Each child must be carefully nurtured if he is to realize his full potential and society is to create an environment in which future generations may live together in mutual respect and harmony. Therefore, all public and voluntary agencies have responsibility to direct their services to assure the full development of every child.

In Illinois, to meet children's basic needs and to foster physical, emotional, intellectual, social, and spiritual growth and development, services are provided by many governmental and voluntary agencies. To be most effective, all children's programs must be integrated through cooperative planning. When there is not purposeful coordination of services and collaboration between agencies on behalf of individual children and their families, the services are fragmented and wasteful.

Because a broad gamut of services is required in order to meet the particular needs of each child, State Departments and voluntary agencies not only must focus on their specialized areas of knowledge, skill and competency, but act in concert with others.

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SECTION I

INTRODUCTION

Since at least 1955 there has been a very rapid increase in the admission rate and hospital population of children, 17 years of age and under, in the facilities of the Department of Mental Health. A summary of the trend for that period shows

	Admissions Rate	*On-Books Population*
Fiscal year 1954-1955	164	154
Fiscal year 1961-1962	548	531
Fiscal year 1962-1963	535	605
Fiscal year 1966-1967	767	

From July, 1954 to July, 1962 there was an increase in children's admissions of 234%. The On-the-Books population increased during this period by over 244% and for the 1963-1964 fiscal year by over 13%. As of June 30, 1964 there were 720 young patients in all State hospitals. The increase in hospitalization greatly exceeded increase of this age group in the general population. For Illinois the United States Census Report lists 1,428,939 children between 6 - 18 years of age in 1950 and 2,083,034 in 1960, an increase for this decade of 45.7%. In other words this increase in admissions to State hospitals was slightly over five times as great as the increase in the population for this age in the census.

The year 1963 marked the first year during the entire period when there was a decrease in admissions and that was very slight.

The steady climb in the On-the-Books population and the overall increase in admission rate raises many questions. Why such great increase? How well are the needs of these youth being met before institutionalization, while institutionalized and following institutionalization.

The focus in mental health is now being directed toward the development of comprehensive community mental health services. Are existing community mental health and social welfare services for children and adolescents meeting needs adequately or are there gaps in services to children? Are the several specialized programs coordinated and responsibility clearly defined and accepted? How well are the needs of children who are being admitted to State institutions served by such institutionalization or could other services have met their needs better? Could better use of community services have made institutionalization unnecessary?

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THE STUDY

To secure answers to the above questions the Interdepartmental Committee on Children and Youth of the Illinois Commission on Children undertook this study.

The purpose of this study is to ascertain through individual case studies which children, 17 years of age and under who were in State Mental Health and Correctional Institutions as of June 30, 1964, could have remained in the community or could have been returned to the community at an earlier date if comprehensive community services had been available to meet their needs.

The children studied were all child patients, 17 years of age and under, who were hospitalized in the eleven State hospitals of the Department of Mental Health. These were children and adolescents whose behavior and thinking were grossly maladaptive and/or unacceptable to the community and who, by virtue of the clinical picture presented, were accepted for diagnostic, treatment and custodial services by the hospitals. From a clinical standpoint this group of children includes those suffering from psychotic reactions, central nervous system disorders affecting behavior, severe neurotic reactions, and personality and character disorders.

A parallel study was made of children and youth, 17 years of age and under, who were deemed by clinical staff of Illinois Youth Commission to be in need of mental treatment and who were in one of the institutions of the Illinois Youth Commission as of June 30, 1964. These were boys and girls who were institutionalized at the Illinois Industrial School for Boys, Illinois Training School for Boys, Illinois Training School for Girls or the Reception and Diagnostic Center. The same methods and procedures were used to study these youth as were used for the group under care of the Department of Mental Health.

COMMISSION ON CHILDREN

The Commission on Children is a Statutory Commission created by the Legislature to provide the mandate, manpower and machinery for the orderly study, planning, promoting, coordinating, and stimulating of services in behalf of Illinois children.

Members

The membership of the Commission on Children is composed of 15 public members appointed by the Governor for three year staggered terms, 6 Legislative members appointed by the President Pro Tem of the Senate and Speaker of the House, and 9 State Department or Commission Directors which have direct services to families and children. In addition the Chairman of the Illinois Council of Youth, which is a representative body of young people ages 15 to 21, also serves with the Commission.

Function

The law creating the Commission states the Commission shall:

"(a) Study the needs of all children and assist in planning for the improvement and most effective use of voluntary and tax-supported programs at the state and local levels;

(b) Study programs for children in Illinois and in other states, make reports and advise public and private bodies throughout the state on matters relevant to the protection, growth, and development of children;

(c) Assist in the coordination of the administrative responsibility and the services of the State departments and programs as they relate to the well-being of children;

(d) Make recommendations on needed legislative action on behalf of children;

(e) Promote adequate educational services and training programs for children, including exceptional children, in all parts of the state;

(f) Promote social service and vocational guidance, training, and placement for all children who require them, including exceptional children and those youth who leave school prior to high school graduation, and promote adequate special facilities for children maladjusted to their home surroundings;

(g) Promote adequate provisions throughout the state for diagnosis and treatment of children who may require special medical services."

Procedure

The major part of the work of the Commission on Children is carried on through the use of Special Project Committees which are set up to study, assess, develop and make recommendations to the Commission on specific problem areas concerning children which are considered to require the priority attention of the Commission and the citizens of the State. After action on these recommendations has been taken by the Commission on Children, the Commission selects and transmits them to the appropriate group, organization or person for implementation. This may be to the Legislature for necessary legislation, to the Governor for Executive consideration, to public or private agencies, or to citizen or professional organizations.

INTERDEPARTMENTAL COMMITTEE ON CHILDREN AND YOUTH

The Interdepartmental Committee on Children and Youth is the only Committee specifically set out in the Act creating the Commission. The Act states:

"The Commission shall establish a special committee to encourage cooperative planning among state programs for children and such other committees as it may deem necessary."

In compliance with this mandate in the Act, the Commission set up the Interdepartmental Committee on Children and Youth with this elaboration of the purpose and function:

"The Interdepartmental Committee exists to assist state agencies which have programs affecting children and youth to work cooperatively so that the activities of each agency may reinforce and be aided by those of others. It may also serve as a channel for instituting collaboration among two or more agencies.

The meetings of the Committee should provide a forum for the discussion of current or anticipated problems which endanger youth or limit their opportunities. The meetings should provide for an exchange of information about program developments in the member agencies, for reports on new programs and for discussion of areas of unmet needs and legislation."

The Committee is composed of one permanent representative from each of the thirteen State Departments or Commissions with service to families and children. In addition, the Chairman of the Commission has appointed one member of the Commission to this Committee.

The Interdepartmental Committee on Children and Youth selects its own subjects for discussion. The subject of Emotionally Disturbed Children with special reference to interagency relationships was requested by 8 of the 13 members. Out of this concern of so many of the agency representatives and the deliberations in the Interdepartmental Committee came the idea of this study.

SECTION II

PROGRAM DESCRIPTION

A. DEPARTMENT OF MENTAL HEALTH—STATE HOSPITAL PROGRAMS

The Illinois Department of Mental Health is responsible for providing psychiatric services for mentally ill, mentally retarded and emotionally disturbed children and youth or those who are in danger of becoming so, to the end that delinquency, crime, mental disorders and other forms of human maladjustment may be prevented. The Department provides services for such children in the custody of or under the control of State agencies, any court, school, public or private social agency or parent or guardian, providing the latter are residents of the State of Illinois.

On June 30, 1964 the Department's psychiatric services for child and adolescent patients consisted of outpatient and inpatient services for young patients with emotional disturbance or mental disorders and inpatient services for young patients with mental retardation. The Department's outpatient services were provided by the Institute for Juvenile Research in Chicago and in 18 communities throughout the State. Institute staff provided diagnostic and treatment services in regionally based clinics and also provided consultation and education to agencies and individuals from communities in each of the eight State regions or zone. Institute staff, by providing such services at an early time and through collaborating with other agencies serving the child, have been able to obviate the need for hospitalization for the child. Institute staff have also collaborated with hospital staff, before and/or after hospitalization, in facilitating the child's admission and discharge and in providing support and treatment to the child and his parents before and after hospitalization.

Services for mentally retarded children and youth have been provided by the Dixon and Lincoln State Schools and more recently by the Warren G. Murray Center at Centralia. These services consist primarily of educational, medical and nursing services for those patients in need of residential care.

At present inpatient services for the severely emotionally disturbed or mentally ill child are provided by the Department in its 11 State hospitals. As the need for inpatient services has increased and young patients have, out of necessity, been housed with adult patients, hospital staff have developed separate inpatient programs and provided separate housing for these children and youth. The first unit for children, The Grace Abbott Treatment Center, was developed at Peoria State Hospital in 1951. The

first units for adolescents were developed at Chicago State Hospital in 1957. Below is a summary of the Department's inpatient services as of June 30, 1964.

Alton State Hospital—On June 30, 1964 there were 37 young patients on the books of Alton State Hospital. The administration of the hospital had begun to develop a separate program for these young patients and plans had been formulated to remodel an existing building in order to provide separate housing for all patients under 18 years of age. Hospital staff were developing procedures to collaborate with Institute for Juvenile Research staff in the East St. Louis Regional office so that all young patients would be seen by Institute staff prior to hospitalization. Institute staff would collaborate with hospital staff in facilitating the return of young patients to the community and in providing after care.

Anna State Hospital—On June 30, 1964 there were nine young patients on the books of Anna State Hospital. The hospital did not have a separate program or housing for young patients; no plans were being made for developing a separate program.

Chicago State Hospital—On June 30, 1964 there were 263 young patients on the books of Chicago State Hospital. In 1954-55, 29 patients under the age of 18 were admitted to the hospital; ten years later 285 young patients were admitted. In recognition of this need, hospital staff developed three separate programs and allocated separate housing for young patients. The first program was developed for children, between the ages of six and twelve, in 1956. This program was for 36 severely disturbed and mentally ill boys and girls. In May, 1957 and September, 1957 the hospital opened units for disturbed adolescent girls and boys respectively. These units provide separate programing and housing for 36 girls and 36 boys between the ages of 13 and 18. Even with these three programs, however, the need for inpatient services for young patients in the Chicago area greatly exceeded the resources of the hospital and as a result over 60% of the young patients were still being housed and programed with adult patients. Furthermore, these latter facilities and programs were substandard and at best the young patients were getting inadequate custodial care.

East Moline State Hospital—On June 30, 1964 there were 11 young patients on the books of East Moline State Hospital. These patients were housed with adult patients on the diagnostic service of the hospital. When staff determined the disposition of each child or youth he was discharged, or, if he needed continued inpatient treatment, was transferred to the Children and Adolescent Unit of Galesburg or Peoria State Hospitals. Plans have been made to provide a separate and new 30 bed unit for adolescent boys and girls.

Elgin State Hospital—On June 30, 1964 there were 201 young patients on the books of Elgin State Hospital. In January, 1961 hospital staff opened a 48 bed unit for adolescent boys and girls.

Elgin State Hospital, like Chicago State Hospital, became a resource for the entire Chicago area and its capacity to provide separate programs and housing for young patients was greatly exceeded. By June 30, 1964 over 75% of the patients under 18 years of age were housed and programed with adult patients.

Galesburg State Research Hospital—On June 30, 1964 there were 66 young patients on the books of Galesburg State Research Hospital. In April, 1958 a 30 bed unit for adolescent boys and a 25 bed unit for adolescent girls were opened. This has enabled hospital staff to provide separate program and housing for all young patients. In view of the increasing need for inpatient services for young patients, however, plans have been formulated to remodel a section of the hospital through use of Bond issue funds and thereby provide separate housing and programing for 120 children and adolescents.

Illinois Security Hospital—On June 30, 1964 there were five adolescent boys on the books at Illinois Security Hospital. These youth were housed with very disturbed adult male patients and no separate program was being provided for the teenagers.

Jacksonville State Hospital—On June 30, 1964 there were 19 young patients on the books at Jacksonville State Hospital. These young patients were housed with adult patients in the diagnostic service of the hospital and while there was no separate program for the youth, the service provided each one of the young people was individualized. Plans were being considered by hospital staff to establish separate housing and programs for such patients.

Kankakee State Hospital—On June 30, 1964 there were 17 young patients on the books at Kankakee State Hospital. These patients were housed with adults. Staff were implementing plans to provide a separate program for young patients, and they were making plans to provide separate facilities for them. Kankakee State Hospital has been used as a resource for young patients from the Chicago area needing inpatient services.

Manteno State Hospital—On June 30, 1964 there were ten young patients at Manteno State Hospital. These patients were housed with adult patients. There was no separate program for these young patients and no plans were being made to develop separate inpatient services for child and adolescent patients.

Peoria State Hospital—On June 30, 1964 there were 82 young patients on the books of Peoria State Hospital. The need for separate programs and facilities for young patients was recognized and in 1951 The Grace Abbott Center was opened, with inpatient service for 30 children between the ages of six and twelve. In April, 1958 hospital staff opened a 36 bed unit for adolescent boys. Staff have thereby been able to provide separate program and housing for nearly all young patients coming to the hospital.

In addition to the above inpatient services, the Department has formulated and is beginning to implement plans for a compre-

hensive community mental health program on a zone basis. Mental health centers will be developed at Rockford, Peoria, Champaign-Decatur, Springfield and Chicago (The Charles Read Center for Chicago, North and the John Madden Center for Chicago, South). These six centers will provide mental health services for children and adolescents as well as adults. The Centers will provide outpatient services, partial hospitalization and 70 inpatient beds for child and adolescent patients. When these services are operative the pressure for inpatient services for young patients on the State hospitals may be eased.

B. THE ILLINOIS YOUTH COMMISSION—INSTITUTIONAL PROGRAM

The Illinois Youth Commission, a State agency created by the 68th Illinois General Assembly, was enacted into law in 1953. At that time, Illinois became one of the first states in the nation to unify its treatment program for juvenile offenders and its delinquency prevention programs. The Youth Commission Act placed delinquency prevention and correctional services under a single administrative unit. The purpose of this Act as stated in the statutes "is to conserve the human resources represented by the youth of the State and to protect society more effectively by providing a program looking towards the prevention of delinquency and crime and by providing methods of training and treatment directed toward the correction and rehabilitation of young persons found delinquent or guilty of crime and by coordinating these programs."

Underlying the Youth Commission Act is the philosophy of individualizing the treatment and rehabilitation of the youth. Treatment is viewed as a continuing process, beginning with diagnosis, through institutional treatment, parole (aftercare) and discharge. Since treatment of an individual varies and undergoes changes, several facilities and services are provided by the Youth Commission. Throughout the State, commitment of all wards (boys under age 17 and girls under age 18) is made to the Illinois Youth Commission by the Circuit Courts (Juvenile and Criminal Divisions) for an indeterminate period. However, wards convicted of a crime are sentenced under criminal proceedings and are given a maximum sentence to the Youth Commission. The Youth Commission receives its wards on petitions of delinquency or as misdemeanants or on felony charges from the courts. The Youth Commission may maintain jurisdiction until the age of 21 years. Offenses leading to commitment include running away, habitual truancy, incorrigibility, auto larceny, assault, rape, and murder. By having commitments to a central administrative agency, transfers between facilities and services are effected more easily and in keeping with the needs of the individual and the provisions of the Commission. This statutory provision centralizes responsibility and vests authority in the Commission to direct treatment programs.

Services of the Youth Commission operate under three divisions, each administered by a superintendent or supervisor who is responsible to the Chairman of the Commission: The Division of Community Services which conducts a statewide program of delinquency prevention through community organization and public education; The Division of Correctional Services; The Division of Administrative Services. Because this study is concerned with youth in the facilities of the Illinois Youth Commission, the program description is that of the Division of Correctional Services only.

The varied programs and services offer academic training, remedial reading, vocational training, work programs, recreational activities, and religious services. Individual counseling, group counseling and psychotherapy are a part of the treatment program and provided if staff case load permits. Emphasis is placed on providing a therapeutic environment in all of the facilities whereby all those who come in contact with the wards will have a positive impact in the team rehabilitation process. Cottage life and group living are important parts of the program.

The Division of Correctional Services is responsible for the administration of and provides services in four institutions, three special education schools, seven forestry camps, three school camps and Field Services (Parole or Aftercare).

The Reception and Diagnostic Center for Boys at Joliet admits directly all boys upon commitment. The average length of stay at the Center is approximately three to four weeks. Following the diagnostic process by the multi-discipline team, the clinic staff submit their findings and recommendations for a course of treatment to Commission members who review and act upon them. The ward may be transferred to an institution, a forestry camp, a special education school; to a State mental hospital for further study, observation, and treatment or committed to the Department of Mental Health on Court Order. He may be placed in a private facility or returned to the community under parole supervision. On occasion wards are retained here for a special treatment program offered by the professional clinical staff. The disposition is made on the basis of the youth's individual needs and the treatment program available. Medical, dental and psychiatric services are provided in the program.

Parole violators who are returned to the Reception and Diagnostic Centers are re-evaluated and a further disposition is made. Runaways from camps and special education schools may be returned to the Reception and Diagnostic Center also for re-evaluation and disposition.

The Illinois State Training School for Boys is a medium security facility. During 1964, the institution handled 1,614 different boys establishing an all-time record for the 60 years of its operation. It has a rated capacity for 550 yet the daily population averaged 687 in 1964. The medium age was approximately 15.5 years.

The educational program includes an academic curriculum, vocational training and remedial reading. Religious, recreational, individual counseling and group counseling and psychotherapy are part of the treatment program. The clinic team includes social workers, youth counselors, psychologists and a part-time consulting psychiatrist.

The Industrial School for Boys is a maximum security institution for older boys who require special controls. Emphasis is on treatment, education, and guidance. Transfers are made to a less secure unit or to an open facility, whenever indicated, for a gradual loosening of controls prior to returning the ward to the community. Clinical services are provided by social workers, counselors, a psychologist, and by a part-time consulting psychiatrist. Intensive counseling and psychotherapy is an important part of the treatment program. Seriously disturbed boys are housed in a separate building for specialized intensive treatment and counseling. Medical, dental, recreational, athletic, academic and vocational training, and religious services are a part of the program. Barbering, shoe repairing, auto mechanics, meat cutting, welding, and electrical work are included in the vocational training program.

The Illinois State Training School for Girls at Geneva is, at the present time, the only facility for girls. The Reception and Diagnostic Center for Girls is located at this facility with a diagnostic process similar to that for the boys. Academic and vocational education, remedial reading, and work programs are provided. Clerical training, industrial sewing, occupational crafts, beauty culture, and restaurant training are a few of the vocational training programs. Off campus work is a significant part of the rehabilitation program. Individual counseling, religious, medical and dental services are provided. This institution has a part-time consulting psychiatrist in addition to the clinic team of social workers, counselors, psychologists and chaplain.

Special Education Schools. Wilmington and DuPage State Boys' Schools have a program specifically geared to the needs of younger boys under 14 years of age. Valley View State Boys' School is for boys 14 and 15 years of age. Remedial instruction is emphasized and boys are grouped in classes according to their reading achievement. The curriculum includes grades one through eight. Classes are small and individual attention is of prime importance. Recreational activities include a variety of sports, hikes, hobbies, crafts, field trips and movies both at the schools and in the local theaters. These are open facilities and the boys partcipate in various local community activities which include religious services. During special occasions they are guests in the homes of local citizens.

The Forestry Camp Program for Boys. Work camps for boys 16 years of age and older provide work programs in seven open settings: Channahon State Boys' Camp (Morris); Giant City State Boys' Camp (Makanda); Illini State Boys' Camp (Mar-

seilles); Mississippi Palisades State Boys' Camp (Savanna); New Salem State Boys' Camp (Lincoln's New Salem); Shawnee State Boys' Camp (Brownfield); Union Forest State Boys' Camp (Jonesboro).

The primary objective of the camp program is to stimulate the development of wholesome work attitudes and good work habits, and to inspire the youths to develop meaningful goals. They are involved in a variety of public services through conservation work in State parks, city parks, helping churches and civic groups in charity drives and preparing Scout camps or helping in time of disaster. In addition to such activities these boys are assigned to other conservation projects and to work in State hospitals. The boys are paid a nominal sum for their services on a graduated pay scale depending on the type of work, quality of performance, etc. Money earned is placed in each boy's trust fund to be allocated during his parole. Limited amounts are disbursed while they are still in camp for commissary purposes.

In one of the camps, eligible boys attend high school in the local community. Some also work in the community. All of the boys participate in local community activities, attend religious services in the community and have a well planned recreation program in each camp.

School Camps provide for wards 14 years of age and older. In the three school work camp programs, Pere Marquette State Boys' Camp (Grafton); Fort Massac State Boys' Camp (Metropolis); Kankakee State Boys' Camp (Manteno), boys attend school on a half-time basis, but comply with State regulations and standards for full-time school attendance. Individual attention is given in small classes. They are also involved in recreational activities and community programs similar to those provided in the work camps.

Parole Service or Aftercare (Field Services) is an important aspect of the continuum of treatment and rehabilitation. It operates through eight District offices. The Juvenile Parole Agent serves as a link between the institutionalized ward and the community, establishing a relationship with the family at the time of commitment when he secures the social history information. He makes pre-parole studies of all wards to be released from the Commission facilities and arrangements for suitable placements.

Since 1964, the Youth Commission and the State Division of Vocational Rehabilitation have worked together in the placement of eligible parolees in the Decatur Job Training Center, a residential facility providing vocational training and social adjustment under supervision.

SECTION III

STUDY, DESIGN, SCHEDULES AND PROCEDURES

In order to evaluate the needs of the institutionalized emotionally disturbed child, it was decided to survey the population of State Mental Hospitals and the institutions of the Illinois Youth Commission. To this end cases were selected and schedules were designed.

A. CASE SELECTION

The total hospitalized population under 18 years of age in all Illinois State Mental Institutions was 720 cases on June 30, 1964. A sample of these patients was selected for intensive study. The Institute for Juvenile Research staff selected on a random basis 150 of the 720 patients. This process insured that the cases studied would be representative of the total population.

In addition to these 150 patients, the Illinois Youth Commission staff selected from their institutions those youth who in the judgment of their clinical staff, were in need of mental treatment. This agency originally selected 52 cases, but 17 were excluded who were judged to be primarily mentally retarded.

The total random sample used in this study was 185 cases.

B. METHOD

The method chosen by the Committee was a case record review of each of the 185 cases. Two members of the study team selected at random several state hospital case records and reviewed them from the standpoint of completeness and adequacy for the study. Independently, the two members indicated that the records would be adequate and the following material was deemed basic for the study:

Face Sheet

Admission Notes and Initial Examination

Social Study

Psychological Test Results

Psychiatric Examination

Diagnostic, Follow-up and Discharge Conference Proceedings

Progress Notes of all Clinical Staff

Correspondence and Reports by Institution Staff to Outside Agencies (i.e. clinics, social agencies, courts and schools, etc.)

Correspondence and Reports by Agency Staff to the Institutions

Non-routine Correspondence by and to the Parents

Legal Papers (i.e. commitment papers, delinquency petitions, etc.)

Each one of the 185 cases was then identified by a number. A listing of study cases by institution was sent to the Superintendents of the respective institutions. The Superintendent then made copies of the material available to the study committee.

C. SCHEDULES

Two schedules were designed for the collection of relevant information for each case. (See Appendices C and D.) The content of these schedules was developed by the Institute for Juvenile Research staff after discussions were held with the Interdepartmental Committee. Each schedule was designed for automatic data processing.

Schedule 1: "Identifying, Administrative, and Sociological Data" (Appendix C) was based primarily on the Institute for Juvenile Research case finding system. This schedule included demographic data and clinical findings on the children, parent-child relationship and family members.

Schedule 2: "Committee Schedule" (Appendix D) was especially designed for this study. It consisted of the following sections:

(1) Total needs of the child

(2) Kinds of services to meet these needs
- (a) needed by child, family, or child and family;
- (b) whether or not service would have shortened institutionalization;
- (c) availability and use of service.

(3) State and local agencies and services available to meet these needs
- (a) active or not;
- (b) appropriateness of agency action, or inaction;
- (c) timing of agency activity in relation to institutionalization.

(4) An overall evaluation of institutionalization
- (a) quality of coordination of resources;
- (b) quality of collaboration of participating agencies;
- (c) appropriateness of institutionalization;
- (d) appropriateness of length of institutionalization.

(5) Narrative Case Summary.

D. PROCEDURES

Three cases were chosen for a trial run which were not in the sample of 185 cases used in the full study. All members of the Interdepartmental Committee completed the Schedule for these cases. These evaluations were discussed and the Schedule revised.

The final schedules were rated in the following manner: The Schedule "Identifying, Administrative and Sociological Data" (Appendix C)—Part I—Demographic Data was compiled for 185 cases by a Social Worker and Child Psychiatrist and Part II—Psychiatric Evaluation—was completed for all cases by two Child Psychiatrists; the Schedule "Study on Emotionally Disturbed Children" (Appendix D) was completed for the 185 cases by two Child Psychiatrists and two Social Workers and in addition each of the remaining members was assigned 40 or 41 cases to be rated. The cases were assigned in such a way that:

(1) Each case was rated by two different Committee members plus the two Social Workers and two Child Psychiatrists. Thus, 5 of 6 raters[1] completed this Schedule on each of the 185 cases.

(2) Cases were assigned randomly with the restriction that every pair of Committee members rated the same number of cases in common—eliminating bias.

All cases were reviewed independently and the completed schedules were forwarded to the Institute for Juvenile Research—Research Program in Child Development—for coding and data processing.

E. INSTRUCTIONS USED BY COMMITTEE MEMBERS FOR REVIEWING CASES

(1) Review the cases with these questions in mind: What are the reasons for the child going to the hospital or institution? What are the chief complaints? When did the complaint start? What could have been done in the community in the 6 to 12 weeks prior to institutionalization which would have made institutionalization unnecessary or reduced the length of stay?

(2) The purpose of the Schedule is to provide Committee members with a means of noting

(a) total needs of the child of each case reviewed;

(b) kinds of services required to meet these needs;

(c) State and local services available to meet these needs; and

[1] One of the Committee members became ill and was unable to complete all his cases.

(d) whether or not the existence and effective utilization of such services could have prevented or shortened institutionalization of the child.

(3) PART ONE of this Schedule is concerned with the *child's needs* (as noted from case record material) in the period immediately prior to the first admission or commitment as noted in the hospital or Youth Commission record. In general, this concerns about a three-month period or less preceding the admission date. Data should be collected on all of the child's needs. Those needs which were of greatest importance to the child at the time of or immediately preceding institutionalization should be checked as "Primary" and all other needs should be checked as "Secondary." We shall *not* be concerned with whether or not the needs were met, in this Section.

(4) PART TWO is concerned with the *type of services* needed by the *child and/or his family on his behalf* for the period *before and during* hospitalization or commitment. The services needed by the child and/or family should be checked and then indication should be made whether the use of the service would have

  (a) shortened his stay in the facility;

  (b) the service was: (1) available and used; (2) available and not used and why not used; or (3) unavailable.

(5) PART THREE is concerned with *existing* services (State and local). This part provides opportunity to indicate whether *agencies* were *involved* or *not* and whether the agencies *should have been involved.*

(6) PART FOUR is concerned with

  (a) quality of coordination of the services of agencies (when more than one is involved);

  (b) collaboration of the institution with the community at admission and release and during the child's stay at the institution; and

  (c) the appropriateness of institutionalization.

(7) On page 8 of the Schedule, write a brief narrative summary of the case, giving the most salient and important features. Also use page 8 to spell out especially important or unusual aspects of the case and/or questions and/or problems you had in reviewing it.

F. DATA PROCESSING AND ANALYSIS

Completed Schedules were forwarded to the Institute for Juvenile Research where they were checked for accuracy and completeness and the data were punched on IBM cards.

Research staff obtained tabulated data from each of the Schedules. This information is reported and described in Sections IV and V of this Report. In addition the following should be noted:

(1) Administrative Schedule—for each item, the percentage of cases in each category was computed by adding the ratings and dividing by 370 (2 raters, 185 cases).

(2) Committee Schedules

(a) Section 1: primary and secondary needs were combined before analysis of percent of cases for each need;

(b) Section 2: all persons (child, family and child/family) needing services were combined. Percent of those needing service, percent of those needing but not getting service, and percent of those not using service or for whom service was not available, were computed;

(c) Section 3: percent, where agency was not active but should have been, was computed;

(d) Section 4: percent of cases in each category was computed;[1]

(e) Section 5: narrative summaries were used in making composite case summaries.

In general results are in terms of the percentage of cases in each category for each item or section. Because of the random selection of cases, if on the basis of this sample 18 cases (10%) needed a certain service, then it is reasonable to assume that 75 children in State institutions (10% of 755—720 State hospital plus 35 Illinois Youth Commission cases) needed that service.

[1] Special analyses were performed on cases selected on the basis of: appropriateness of institutionalization (judged "inappropriate" when so rated by one M.D. rater and one other rater); and length of institutionalization.

SECTION IV

THE CHILDREN

This section is divided into four parts. Part One consists of individual illustrative case summaries. These summaries include information (1) on the child and his problems which led to institutionalization; (2) on the family and past experiences which were important in the development of the child's problems; (3) on institutionalization and its effect on the child and his family; and (4) on the appropriateness of institutionalization and the length of stay, coordination of services, collaboration between institution and agency staff, and gaps in services. These illustrative cases were selected from the sample so as to give as representative a picture of the cases in each group as space permitted. Ten cases are included from the cases designated as "appropriately institutionalized" by the raters, six cases from those "inappropriately institutionalized" and three from those which had been rated as having a "prolonged stay."

Part Two consists of statistical data on the children, their families, their needs and the services required to meet these needs. Statistics (in the form of percentages) are reported on the total random sample (185 cases) from the Schedule with identifying, administrative and sociological data. Part One of this Schedule was completed by a child psychiatrist and social worker; Part Two of this Schedule was completed by two child psychiatrists. Statistics are also reported from the Schedule with information on the child's and family's needs, services, agencies, and coordination and collaboration between the institution and the community agencies. This Schedule was completed by two child psychiatrists, two social workers and one or two other members of the Committee.

Part Three consists of statistical data on the 33 cases judged to be "inappropriately institutionalized."

Part Four consists of statistical data on the 16 cases judged to be "appropriately institutionalized" but where institutionalization was unnecessarily long.

I. ILLUSTRATIVE CASE SUMMARIES

A. APPROPRIATELY INSTITUTIONALIZED

Case No. 4

This nine year-old boy was admitted to a central Illinois State Hospital on a voluntary basis in June, 1962 because he had not developed any speech, was destructive of material objects, and for long periods of time was withdrawn and would rock. He lived at home with his parents who belonged to a middle class economic group and six older, non-disturbed siblings in a small community in Northern Illinois.

His parents first sought help for him in 1956 when he was three years old. He was examined at a hospital for children in Chicago and pediatric staff indicated he was autistic and/or retarded. In January, 1959 the family sought help at a regional clinic of the Institute for Juvenile Research. Subsequently, the boy was hospitalized at a University Hospital for diagnostic study and the parents were told that he was psychotic and should be "institutionalized." The parents reapplied to the Institute for Juvenile Research and in December, 1960 Institute staff referred the boy to the central Illinois State Hospital for admission to the children's ward. There were no vacancies at that time and he was placed on a waiting list. After 18 months, the boy was admitted to the hospital.

Hospital staff, after completing a diagnostic study, made a diagnosis of schizophrenic reaction, childhood type. The patient was given medication, speech therapy and placed in the hospital's special education program. His parents maintained their contact with their son and also participated in a group therapy program for parents. Subsequently, the boy was given home visits and by June 30, 1964 he was being considered for a conditional discharge.

All six raters indicated that hospitalization was appropriate. Coordination of services between the Institute for Juvenile Research and the Hospital was quite effective. Collaboration between the two agencies and the parents was also very good with Institute staff taking the initiative both before and during hospitalization. The primary gap in services occurred in the school. This boy had not attended school prior to being hospitalized. The school lacked a special class for psychotic children and did not have a school social worker.

Case No. 7

This tiny, friendly, overly dependent eight year-old girl was admitted to a Chicago area State hospital for the first time in May, 1964. She lived at home in Chicago with her mother and seven half-brothers and sisters. She was hospitalized at her mother's request at the County Psychiatric Receiving Hospital. The mother reported that she was unmanageable, destructive, and was setting fires. She was reputed to be homicidal and was given a diagnosis of mental retardation with psychosis. She had previously been hospitalized at the County Receiving Hospital in June, 1962 (at the age of six) but was discharged then in the charge of her mother. The incident which led to hospitalization then occurred on a Sunday when the mother left the children alone at home in order to attend church. When she returned home she discovered that the patient had tried to lift her 14 month old sister and had dropped her down the stairs.

The social history revealed that the patient's mother had lived with four different men, primarily on a common-law basis, during the past 15 years. Since 1956, she was on Aid to Dependent Children and at the time the patient was hospitalized the mother and her eight children lived in an eight room house with another mother, her five children and two foster children. From June, 1954 to February, 1962 the family had 20 different residences. This little girl was placed in an adult ward at the State hospital. Since she was admitted less than five weeks prior to the date selected for this study, little clinical information was available in the case record.

All six raters indicated that hospitalization was appropriate. Coordination of services was rated as poor and there was no evidence of collaboration, either on the part of the hospital or the community. While this family lived in poverty and received welfare payments, only financial assistance was provided to the family. It was obvious that day care and protective services for the children were greatly needed and the mother should have had guidance or family planning and case-

work services. This child was out of school (expelled two times) but should have been given special education (no psychological report available to determine intellectual level of functioning).

Case No. 15

This nine year-old, foreign born, adopted boy was admitted to a Chicago area hospital in July, 1961 on a voluntary basis. He had been referred for hospitalization on the children's ward of the hospital by a Chicago Child and Family Service Agency on the recommendation of the Chief Child Psychiatrist of a large teaching hospital. Prior to hospitalization he was constantly active, he clung to and was protective of his mother, and was so impulsive and disruptive he was expelled from school.

This boy suffered marked affectional deprivation during infancy and early childhood. He was born in a children's institution, presumably illegitimately, and was adopted at age two by his current parents who proved to be extremely disturbed. His parents were in constant conflict with each other and in a seven year period there were numerous separations, reconciliations and moves. The father was emotionally distant and the mother used the boy to gratify her own neurotic needs in a symbiotic-type relationship. Shortly after the mother and boy arrived in this country, they conferred with the Child and Family Service Agency where it was evident that the boy's problems were severe and that drastic measures were needed. At the same time, the boy was hospitalized and a private child welfare agency assigned caseworkers to the boy and to the parents. These caseworkers worked with the family and hospital staff during the entire period of hospitalization.

This boy was placed on the children's ward in the State hospital. Here he received milieu therapy, attended school, and was in individual therapy with a caseworker from the child welfare agency. Over a three year period, he made steady progress and the spring of 1964 he was ready to leave the hospital.

All five raters agreed that hospitalization was indicated. All raters agreed that coordination of services and collaboration between hospital staff and agency staff in the community was outstanding.

Case No. 16

This 17 year-old Chicago girl attempted suicide by jumping out of a second story window after being rejected by her boy friend and was committed to a Chicago area State hospital. She was born and spent her early life in the South with adoptive parents. For the past eight years she lived with her mother and three sisters in a housing project in Chicago. Her mother had been married three times but lived alone recently and received public assistance funds for the family. The mother herself had been emotionally and culturally deprived and had little to give to her children from an emotional standpoint. At one point she was depressed and had psychiatric treatment.

The patient was a shy girl who had no friends and who did poorly in school. In 1960, she left home to live with her boyfriend and his mother but her mother interceded. Subsequently, she had several boyfriends but none of them really cared for her. Finally, after experiencing few positive life experiences, she decided to take her life and was hospitalized.

In the hospital she was placed on a ward with adult patients and was given a tranquilizer and antidepressant medication. She improved in a short period of time and in January, 1964 was sent home on a conditional discharge. She was treated on a follow-up basis at the Mental Health Center where it was learned that she was attending night school and had plans to obtain training as a Nurses Aide.

ERIC

All six raters indicated that hospitalization was appropriate. Coordination of services and collaboration were both effective and ineffective. The case record indicated that the patient had been in psychiatric out-patient treatment at a local teaching hospital but neither the mother nor the hospital staff made any efforts to contact her therapist for information or for therapy for the patient. There was an effective transfer of the patient from the in-patient service to an out-patient service for aftercare. Major gaps in services existed in connection with the financial assistance program and the schools. This family should have had casework services and encouragement and support in seeking fuller lives. The schools lack a school social work program as well as vocational counseling, training and placement. The patient and her sisters should have had an opportunity to participate in meaningful leisure time activities. Lastly, the patient should have been placed in a residence for adolescent girls rather than returning to the inadequate home after discharge from the hospital.

Case No. 21

This 16 year-old girl was admitted to a downstate State hospital in February, 1964. She had previously been hospitalized from September to December, 1961 and was hospitalized on the psychiatric ward of a general hospital of a nearby city just prior to her first admission to the State hospital and again in May, 1962 for a suicidal attempt. Prior to each admission she became suspicious, had ideas of reference and hallucinations, became anxious and in 1962 was depressed.

The patient was the younger of two daughters, both of whom had paralytic poliomyelitis in 1949 when the patient was two. The patient's lower extremities were involved and subsequently she had corrective surgery. A second major problem for the family was the fact that the patient's mother had repeated psychotic reactions. Her mother was first hospitalized in 1945, again in 1947, before and after the patient's birth, and again in 1951. The parents were divorced in 1952 and the father remarried in 1953. The patient apparently had no major emotional disturbance until 1961 when she had a psychotic reaction and was hospitalized.

In February, 1964, the patient again became disturbed and was readmitted to the hospital. There she was given medication, participated in patient government and group therapy, was given a work assignment and vocational testing and guidance. She gradually improved and as of June 30, 1964 was being considered for conditional discharge so that she might be seen on an out-patient basis in a state-aided community mental health clinic in a nearby city.

All six raters indicated that hospitalization and length of stay was appropriate. Coordination of services was adequate but collaboration between hospital staff and staff of community agencies at the time of her discharge in 1961 and readmission was lacking. This girl should have had psychiatric treatment on an out-patient basis after her discharge in 1961 but for reasons unknown, no arrangements for this were made. At school she should have been seen by a school social worker and been given special consideration in her class assignments. She should have had vocational counseling and training. Arrangements in the community and church should have been made for her to participate in constructive leisure time activities. There was no evidence in the case record that this was done. Hospital staff had only minimal contact with her parents. While this girl received satisfactory treatment at the hospital, neither hospital staff or agency staff in the community took steps which were essential to foster her mental health and prevent recurrences of her illness.

ERIC

Case No. 57

This patient was a 13 year-old girl, one of six children, who lived with her mother in a housing project in an eastern Illinois city. Over the past several years she did not work at her potential in school and became increasingly abusive, argumentative, and rebellious toward her mother. She and several other family members were seen at the local mental health clinic but she missed many appointments, was truanting from school, became aggressive and destructive. In January, 1964, she was expelled from school and in May, 1964, she was committed to a central Illinois State Hospital as being in need of mental treatment. In June, 1964, she was transferred to another central Illinois State Hospital so that she could be placed in the program for adolescent patients.

This girl's home environment was quite unsatisfactory. Her father, as a teenager, was in a reformatory two times for forging checks and in 1958 he deserted the family. The mother was a self centered individual who gave little to her children and was devoting much of her time to community activities. All six children had emotional and significant medical problems. The family was receiving financial assistance.

In both State hospitals the patient made a good adjustment. In the program for adolescents she attended special education classes, activities, and in general, was much more involved in her life situation than had been reported as her involvement at home and in the community. By June 30, 1964 there had been no serious problems developed in the hospital.

All five raters indicated that hospitalization and the length of stay were appropriate. Hospitalization took place through the Court and all ties to the community were disrupted. It was felt that she would need short term hospitalization and then placement in a small group home for adolescent girls. The reviewers agreed that she needed help in maturing, emotionally. The Division of Vocational Rehabilitation, the Department of Children and Family Services for casework and institutional placement should have been active but were not prior to hospitalization. Most of the reviewers indicated that she should have been in a special class at school and should have had religious counseling. Staff of the Department of Public Aid could have been more active in seeing that this multiproblem family had more assistance in resolving their problems.

Case No. 61

This 16 year-old girl was admitted to a central Illinois State hospital after having been hospitalized on the psychiatric service of a nearby general hospital for five weeks. Prior to hospitalization, she had become unmanageable, truanting from home and school, stealing money from her parents, associating with older youth who were in difficulty with the law, and going with an unstable man ten years her senior. For a year prior to hospitalization, she had been drinking with friends.

This girl grew up in a home with immature parents. Her mother was a prudish, highly restrictive woman while her father was emotionally unstable, having been a patient at the same State hospital on one occasion. The father reacted to the mother by seeking affection in extramarital affairs. There was an indication that he had had sexual experience with the patient on one occasion. The patient managed to make a satisfactory social adjustment until about the age of 12 when inner controls gave way and she began rebelling both at home and at school. At 14 she was "raped" near school by two students and was subsequently expelled because she was involved in sexual experiences.

ERIC

At the general hospital, medical staff made a diagnosis of psychomotor epilepsy with psychosis. Since family finances were limited she was transferred to the State hospital where she was placed in the Youth Center program. She made an excellent adjustment in the hospital, responding quite favorably to the program. Furthermore, her parents were seen in group psychotherapy by hospital staff and they, too, responded favorably to therapy. By June 30, 1964 hospital staff and the parents were making arrangements for the patient to be placed in a semiclosed group home for adolescent girls.

All six reviewers indicated that hospitalization was needed by this girl. One of the reviewers indicated that hospitalization was prolonged and could have been of a shorter duration had placement resources been available. The reviewers indicated that collaboration between the hospital staff and staff at agencies in the community was adequate and good. Hospital staff took the initiative in collaborating with the agencies. Practically all of the reviewers indicated that child welfare or child and family services should have been available for the family. Out-patient mental health services were also needed and not used in the four year period. This girl exhibited maladaptive behavior. The patient should have had special education services, religious counseling, vocational rehabilitative services, and medical services but these were either not available or not used.

Case No. 91

This 16 year-old was committed to a large State hospital south of Chicago in March, 1964 from the County Psychiatric Receiving Hospital. In October and December, 1963 the boy had set fires in the family homes in two different suburbs south of Chicago and each time the houses burned completely. Prior to hospitalization the boy was apprehended by the police and taken to the County Detention Home where a psychiatrist recommended hospitalization.

The patient is the oldest of three children and was born and raised in a southern State. He did poorly in school and frequently received severe physical punishment from the teachers. When the family moved to Illinois, he found school more interesting, but did not make more rapid progress and graduated from the eighth grade at the age of 16. The patient was never close to his parents or to peers. Since he stopped going to school he had been unoccupied except for sitting with his four year old sister while both parents worked. Little information was obtained on the nature of the fire setting except that an electroencephalogram had been given to him and there were no findings indicative of a convulsive disorder or organic brain disease. The family was intact but the parents apparently had little emotional support to give to the boy during childhood.

This adolescent was placed on an adult ward. There was a paucity of clinical information in the record. The diagnostic study, therapy and planning were unimaginative and apparently the boy had only custodial care in the hospital. This was not an improvement over the boring life he had had at home. There was little evidence of improvement at the time this study was made.

All five raters indicated that hospitalization and length of stay were appropriate. Coordination of services was lacking and the only efforts at collaboration were made by the hospital and these were minimal. This boy should have been placed on a unit for adolescents. There he should have had a thorough diagnostic study and participated in an intensive treatment program. The latter would include milieu therapy, special education, vocational counseling training and eventually placement, and meaningful leisure time services. All of these services, except milieu therapy, should have been available in the community but were unavailable. Casework services should have been available for the family as should school social work.

Case No. 116

This 14 year-old adopted girl was admitted to a Chicago area State hospital for the first time in August, 1963. Prior to admission she had become withdrawn and had hallucinations and was taken to a suburban community mental health clinic where she was found to be psychotic and hospitalization was recommended. Since there were no openings in the adolescent programs of the other State hospitals she was placed in a hospital nearest her home.

This girl first manifested social, emotional and learning problems when she entered the first grade. Her adjustment in school was unsatisfactory and she was unable to make progress in a regular classroom. Her adoptive father began molesting her when she was eight years old and while this led to numerous separations between the parents, the adoptive mother was not strong enough to protect her child and she repeatedly permitted the father to return to the home.

At the hospital, this adolescent girl made a satisfactory adjustment in spite of the fact that the services provided were custodial rather than therapeutic and services for adolescents were lacking.

All five reviewers indicated that hospitalization was necessary. They stressed that the patient should have been placed in a hospital having a program for adolescents. Mental health services in the community were available and used but only after the girl had become unmanageable. She actually had been disturbed for at least five years prior to hospitalization. Protective services should have been provided for this girl but none of the agencies who had contact with this family intervened or requested such services. A child and family service agency should have been active before and during hospitalization. Collaboration between agency and hospital staff should have been effected to locate a placement (group home) for this girl after she recovered from her illness. Special education services and a school social worker were not available in the local public school. Vocational services and church youth group activity would be needed in the future.

Case No. 167

This 16 year-old boy was admitted for the first time to a County Psychiatric Receiving Hospital in February, 1964 immediately after he became confused, euphoric and developed delusions of grandeur. After being hospitalized for seven days he was committed to a Chicago area State hospital where he was placed on an adult ward.

The boy is the oldest of five children who live with both parents in Chicago. The most relevant information on the family is that the mother has had recurrent psychotic reactions and had been hospitalized on six occasions at the same State hospital. There was no evidence in record of pathology in the family or in the marriage.

Hospital staff made a diagnosis of schizophrenic reaction, acute undifferentiated type and placed the boy on drug therapy. He made rapid improvement but had a relapse while on a home visit and subsequently needed more intensive treatment and supervision. He gradually improved and arrangements were being made to have him participate in the hospital's program for adolescent patients. Contacts with his mother were limited by the hospital staff when it seemed evident that his visits with her were disturbing to him.

All six raters agreed that hospitalization and the length of stay were appropriate. Coordination of services and collaboration was not applicable in this case since only one agency was active at any one time.

Postscript: Subsequent to June 30, 1964, the patient was transferred to the Children and Adolescent Unit of the hospital. He continued to improve and was placed on a 30 day home visit. About the same

time his mother was readmitted to the State hospital. He was placed on conditional discharge and arrangements were made for him to be seen on an out-patient basis at the Mental Health Center of the Department of Mental Health. He failed to keep his appointment and there was no evidence of arrangements which had been made to assure the transfer from the hospital to the out-patient clinic. This would be an essential transaction to assure maximum effectiveness of hospitalization and to prevent readmission.

B. INAPPROPRIATELY INSTITUTIONALIZED

Case No. 34

This ten year-old boy was admitted in August, 1963, for the first time, to a Chicago area State hospital from the Cook County Mental Health Clinic on a court commitment basis. His parents reported that he had become unmanageable at home—kicking, screaming and scratching his mother and siblings. He was born prematurely and in infancy and early childhood was examined and treated in several university and community general hospitals. Diagnoses of profound mental retardation, arrested hydrocephalus, congenital hypotonia and bilateral congenital cataracts were made. At the time of hospitalization, he was bed ridden—because of poor locomotion and coordination in his lower extremities, was unable to communicate except by babbling, was severely visually handicapped, was not toilet trained and was totally dependent. He had never attended school.

In 1955 and again in 1959, a child welfare agency offered counseling to his parents because of his blindness but the parents did not accept help. The parents were advised by medical authorities to place him in a State school but after visiting one of them refused to arrange for such a placement; instead, they sought placement at a State hospital. In the State hospital the boy was placed with adult infirm males; even so, the parents were pleased with the placement.

All six of the raters agreed that placement in a State hospital was inappropriate. Rather this boy should have been placed in a nursing home, private or public, where he could be given continuous physical care. This family should have had family or child welfare casework services or public health nursing services to help the parents understand the need for and to help locate an appropriate placement.

Placement could have been arranged through any one of the general hospitals or the child welfare agency but the parents did not accept help. Such services should have been available and used instead of the court to effect admission to a nursing home. There was no coordination of services achieved on this case and collaboration at the time of admission and during hospitalization was lacking. Linkage with the community except for the interest the parents maintained while the boy was in the hospital was non existent. Hospital staff was attempting to have the patient transferred to a State school.

Case No. 49

This 13 year-old girl was admitted for the first time to a downstate State hospital in May, 1960, being certified by two physicians as being in need of mental treatment. She was born and raised in a small rural community in central Illinois and was hospitalized because she was truanting from home, had frequent grand mal seizures and needed constant adult supervision because of infantile behavior (i.e., put all kinds of objects in mouth, was not toilet trained, etc.) and playing with fire on the gas stove. At the age of four she had measles and subsequently developed grand mal seizures. She did not seem to be retarded in her development according to the parents, but she barely passed the first grade of school, was unable to achieve in the second

grade and was out of school at the time of hospitalization. Her parents had sought placement for her in one of the State schools in 1959, but since there was little chance of her being admitted to the school and since she was unmanageable at home she was hospitalized one year later.

At the time of hospitalization she was untidy, had severe problems in communication and locomotion, and needed constant supervision. Hospital staff made a diagnosis of chronic brain syndrome associated with intracranial infection other than syphilis with convulsive disorder and severe mental retardation. She was placed on an adult ward and made a poor adjustment for many months. Gradually, however, with the help of tranquilizers, anticonvulsant medication, speech therapy, and industrial therapy, she showed marked improvement in all areas, even achieving some independence in the hospital. In June, 1964 she achieved a mental age of 4 years, 4 months and an Intelligence Quotient of 31 on the WISC. In the summer of 1964, hospital staff made a study of the family and home to see if she could return home as a result of her improved functioning.

The patient is the sixth of 11 children; six of them are in the home with their natural parents. The home was modest and was not in good condition. The community was tolerant of the patient; however, her mother insisted that she was not physically able to accept the patient back in the home. The siblings were said to function at an average or above average level in school.

Five of the six raters indicated that hospitalization was inappropriate. Placement in a State school was indicated. The patient benefited from hospitalization over a four year period but placement with patients her own age and developmental level and a medical, child care, and educational program in line with her needs and level of development would have been much more appropriate for her. With family counseling for the parents, the patient could eventually return home, but only if there was a Trainable Mentally Handicapped Class in the local schools. Coordination of services provided for the patient and her family was lacking, and collaboration between the institution and the community was initiated only by hospital staff after a long period of hospitalization.

Case No. 71

This is a 16 year-old boy who was admitted in April, 1964 to the Reception and Diagnostic Center of the Illinois Youth Commission as a delinquent for committing armed robbery. Just prior to his arrest for taking $72 from and molesting a waitress, he had been seeing his minister in pastoral counseling and had been seen at the Regional Clinic of the Institute for Juvenile Research on the minister's recommendation. The boy had been involved in shoplifting for eight or nine years, taking portable radios, cigarettes, food, magazines, phonograph records and women's underclothing. For two years, he had worn and used this clothing for sexual stimulation. Illinois Juvenile Research staff found him to be in need of hospitalization and recommended this to his parents and the court. However, his parents expressed preference for commitment to the Youth Commission and the court acted accordingly.

This boy is the oldest of five children and was born and raised in a moderate sized downstate community, except for several years when the family moved to another midwestern state. His parents described him as non-cooperative since kindergarten and indicated that he had considerable difficulty in learning in school. At age 13, he was still in fifth grade and when the family moved out-of-state he was placed in a vocational school. After two years, the family returned to the same Illinois community and he was arbitrarily placed in the eighth grade

since there was no vocational school in the community. After six weeks in school in 1962-1963, he was expelled and was out of school at the time of his commitment. He had no close friends, was not close to family members and had had three different non-skilled jobs between the time he dropped out of school and was committed. His family lived on a marginal economic existence for while his father was a skilled craftsman, employment was seasonal and he had no steady income. This youth's only community resource was the church and there he developed a meaningful relationship with the minister.

At the Reception and Diagnostic Center, clinical staff found that the boy had marked feelings of inadequacy and failure and was confused about sex. Initially, his adjustment was poor but when a staff member was assigned on an individual basis he improved. On the WAIS he achieved at an average intellectual level. Clinical staff concurred with the plan formulated by Illinois Juvenile Research staff and had initiated a request for transfer for the boy to a State hospital for psychiatric inpatient treatment.

Five of the six raters indicated that commitment to the Illinois Youth Commission was inappropriate. Hospitalization was indicated. Unfortunately, collaboration between Illinois Juvenile Research staff, the minister, the parents and the court did not take place soon enough or was not sufficient to result in effecting the treatment plan of choice. This was costly from numerous standpoints. In this case and in the community there were sufficient clinical services to meet this boy's needs. The church proved to be a most important resource. Otherwise, community resources were woefully inadequate. The school was inadequate both from an instructional standpoint and clinically. There was no opportunity for the boy to have vocational counseling, training and placement in the school. Nor was there a vocational rehabilitation agency in the community. There were no classes for the emotionally disturbed nor was there a school social work program. Recreational and character building services were also lacking. Such a paucity of community resources assures the above unfortunate outcome and provides little or no opportunity for prevention.

Case No. 110

This 14 year-old multiple handicapped boy was committed by a central Illinois County Court as being in need of mental treatment to a downstate State hospital. He was admitted for the first time to the hospital in October, 1962 when community placement resources were exhausted. The patient was the youngest of five children and was raised in a moderate sized central Illinois city. The family lived in squalor and poverty. The father had a chronic heart disorder and he provided poor supervision for the children while the mother worked and provided a meager income to supplement public aid funds. By 1958, however, both parents had died and the children were placed in a local children's home. The patient remained there four years until he was excluded from the home because of sexual behavior and truancy. He was then placed with an elder sister and her family (six children) but within two months this proved to be unsatisfactory and he was placed in the County Jail. He apparently was involved in sexual behavior there also and this led the court to "dump" him in the hospital.

Hospital staff found this youth to be a severely emotionally and socially deprived youth who functioned at a moderate level of mental retardation and who had lost nearly all vision in one eye. He initially made a good adjustment on an adult ward but later his behavior deteriorated and he sustained repeated injuries, was involved in sexual activity with other male patients and went on unauthorized absence several times. Within a month after admission hospital staff made efforts to transfer the boy to a State school but these had not borne fruit by June, 1964.

All six raters indicated that hospitalization was inappropriate. Furthermore coordination of services on behalf of the child was lacking and the "dumping" resulted in a disruption of linkage to the community. Hospital staff made repeated efforts to reinvolve the sister and county officials but were unsuccessful.

A lack of community resources and failure by the community to help this "hard core" family eventually contributed to the above outcome. The family had been known to social welfare agencies for years. Three of the five children were retarded and a fourth child was placed in the Illinois State Training School for Boys. The parents' deaths led to the patient's placement and when this deteriorated it was only a matter of time until he was hospitalized. From a positive standpoint the public schools provided special education for the boy from his entry into school and were most understanding and supportive of him. Initially in school he was sullen, suspicious and filthy but his teachers gave him recognition and worked with him at the appropriate level. They recognized symptoms of increasing maladjustment prior to hospitalization and it was unfortunate that a school social worker was not available to intervene and/or mental health consultation and services were sought by the children's home. Instead his situation deteriorated. In the school in 1955, 1958, and 1961 he functioned at an Educable Mentally Handicapped level; at the hospital he functioned at a Trainable Mentally Handicapped level.

This boy should be transferred to a State school in order to obtain more appropriate educational, vocational and leisure time services. Plans should also be made to re-establish his ties to the community so that he can live a meaningful life in semisheltered environment rather than be "put away" for the rest of his life.

Case No. 112

This 13 year-old Spanish speaking girl was admitted to a Chicago area State hospital for the first time in February, 1963 on two physicians certificates via the county psychiatric receiving hospital. Immediately prior to hospitalization, she had been placed in the juvenile detention home by the police and then certified by two psychiatrists as mentally ill. She had been apprehended by the police for truancy from home and while in the detention home reputedly had hallucinations. Later at the hospital, she indicated that she had reported these in order to get out of the detention home.

At the hospital, staff found her to be an aggressive, highly emotional adolescent who spoke little English. Because of the language barrier she was kept on an adult ward rather than placed on a ward for adolescents. Shortly after admission, it was evident to staff that she was not psychotic and was in need of placement in a closed group home for adolescent girls. For six - eight months hospital staff initiated contacts with the Juvenile Court and numerous social agencies in this and her native country but had not succeeded in involving any significant adult or agency in finding an appropriate placement for her as of June 30, 1964.

This girl was born in the West Indies and was brought to the United States at the age of three by an elderly paternal aunt. Her father was accidentally killed when she was an infant, and her mother deserted her just prior to her father's death. She lived with her elderly aunt in a Chicago neighborhood which had a very high rate of delinquency. The aunt was illiterate and spoke no English and was rejecting and punitive to the girl. The patient's language barrier and personal problems were a severe handicap in school and she was rejected by youth of her own National group and was a scapegoat for youth of the predominant cultural group in the neighborhood. She eventually became involved in prostitution and in smoking marijuana. Staff of a neighborhood community center made attempts to involve her in their youth program but she rejected their efforts.

Five of the six raters indicated that hospitalization was inappropriate. Coordination of services on behalf of the girl in the community was poor as was collaboration. Hospital staff found that their efforts to collaborate with agency staff in the community proved to be futile. Actually protective casework services for this girl were badly needed and she should have been placed in a closed small group home for adolescents. This family should have had financial assistance but apparently did not qualify for it. Appropriate special education services were not available. Eventually, the girl would need vocational counseling, training and placement.

Case No. 143

This 11 year-old boy was admitted for the first time to a Chicago area State hospital having been committed through the Cook County Mental Health Clinic. He had been taken there by his mother who indicated that she could no longer manage him. He was a non-verbal, non-toilet trained boy who had no interest in other human beings or in objects but who sat and rocked all day. At night he would become hyperactive and restless and since he was fascinated by fire there was real danger that he might set the house on fire. He was living at home with a brother, sister and mother who was the sole support of the family. A neighbor woman watched the boy while the mother was at work. The siblings were well adjusted children of average intellectual ability. The parents were divorced and after the father disappeared the mother decided to place the patient.

This boy was placed on the male infirmary ward at the State hospital. He was found to be profoundly retarded, functioning at less than the one year level and presented autistic behavior. He received minimal custodial care at the hospital.

Four of the six raters indicated that hospitalization was inappropriate. This boy should have been placed in a private or public nursing home where he could receive continuous nursing care. Instead he was "dumped" in a State hospital and as a result his ties with the community were disrupted. Hospital staff initiated contacts with community agencies but the agencies' responses were perfunctory.

C. PROLONGED STAY

Case No. 64

This ten year-old boy was committed to a central Illinois State hospital in April, 1963 by a county court on the recommendation of the clinical director of a state-aided community mental health clinic. He was taken to the clinic by his foster parents on the recommendation of child welfare staff because he was withdrawn, fearful, aggressive with other children, and destructive. The boy was the youngest of seven children—three of whom were half siblings—and was born and raised in western Illinois. His mother was psychotic at the time of his birth and was in and out of a State hospital intermittently since then. This father lived a marginal existence and was never able to provide a stable home environment. Finally after the children had had multiple placements, all were removed from the parents by the court and placed in foster homes. Eventually, two siblings were placed in State schools and the patient and a sister were admitted to State hospitals. The patient lived with his parents for two years and from then until hospitalization lived with foster parents. During his first two years of life, he experienced severe social and emotional deprivation and subsequently, even in a supportive foster home, was only able to make a marginal adjustment—emotionally, intellectually and socially.

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This boy was placed in the children's ward at the State hospital where he soon improved and made a good adjustment. Initially, he was given tranquilizers but in a short time he developed positive interpersonal relationships and made good academic progress in school. Hospital and child welfare staff made joint plans for his placement in the community but a lack of a suitable placement in a small child care institution resulted in a prolonged stay (by at least six months) at the hospital.

All raters indicated that hospitalization was appropriate but five of six of the raters indicated that hospitalization was prolonged.

Case No. 166

This 15 year-old boy and his older brother were committed to a Chicago area State hospital by a county court in November, 1963. Both boys had been quarreling and the patient managed to lock his brother in the basement and was alleged to have turned on the gas stove in the basement. The boys were apprehended by the police, put in jail and then committed to the hospital. They had only recently joined their father and stepmother after having grown up with their mother in another midwestern state. The mother had been married three or four times and had had numerous lovers. The boys were exposed to the love affairs and several of the men involved one and possibly both boys in a sadomasochistic relationship.

After the brothers came to live with their father and attended school, the father and school authorities learned that the boys had experienced the severe emotional and educational deprivation. The patient had only completed the equivalent of a third grade education. The superintendent of schools, with the assistance of the public health nurse, referred the boys to the County Mental Health Clinic. The boys had been tested by the area psychologist and they both achieved Intelligence Quotients in the fifties. At the clinic the patient achieved an Intelligence Quotient of 67 on the WISC. These psychologists, as well as the psychologist at the hospital, were convinced that the retardation was the result of deprivation. Before the clinic study was completed, however, the above incident took place and the boys were committed.

The boys were placed on an adult ward in the hospital where they received a meager diagnostic study. Hospital staff found no evidence of an acute emotional disturbance or a psychotic process. The hospital record, however, contained very little clinical information, either from work done by hospital staff or information from the several community agencies active prior to hospitalization. Hospital staff, however, devoted considerable effort to managing the boys and to returning them to the community. Commitment, as the type of hospitalization used by the communities, disrupted community ties and seven months after the decision to discharge the boys was made, staff were still attempting to locate a placement for them.

All of the six raters indicated that hospitalization was appropriate and four of them indicated that it was unnecessarily prolonged. Coordination of services was completely lacking and collaboration was a "one way street" with hospital staff alone being active. Actually these boys should have been served by a child and family agency. If possible, they should have remained in their father's home; if not, they should have been placed in a small group home and attended a class for emotionally disturbed youth. Furthermore, they should have had vocational counseling, training and placement. Outpatient psychiatric services or psychiatric services to the agencies involved with the boys would also be needed. As of June 30, 1964, hospital staff had been unsuccessful in obtaining any of the above.

Case No. 185

This ten year-old boy was admitted in February, 1963 to a Chicago area State hospital for the first time through the County Psychiatric Receiving Hospital. He had been taken there by his mother because he had had violent temper tantrums, had threatened to kill himself with a knife, frequently truanted from home and needed constant close supervision. The patient was one of four children born to parents who were incompetent as parents. The father was married three times, was a gambler, and often was unemployed. The mother was married four times, had numerous affairs and reputedly four other illegitimate children and drank heavily. The parents' marriage was stormy and resulted in numerous separations and eventually in a divorce. The patient began exhibiting emotional problems in early childhood. In 1958, he was taken to a child guidance clinic because he was a slow learner. In 1959, he was seen at an eye and ear clinic because of a severe speech impediment. In 1960, the children were taken to Family Court and placed in a Protestant Child Care Institution. By October, 1962, however, the patient had become unmanageable, was truant, destructive, and hyperactive and was placed in the County Detention Home. He was then sent to the County Psychiatric Receiving Hospital and was released to his mother at her request. Two months later, however, she returned him to the Receiving Hospital as indicated above.

This patient was admitted to the adult male receiving ward at the State hospital and was then placed on a ward with mentally retarded boys. Initially, his adjustment at the hospital was poor, but after he was given an EEG and placed on anticonvulsant medication he improved and eventually made a good adjustment. On psychological tests he tested in the dull normal level and he responded in a positive way to special education services at the hospital. He was also given speech therapy for a severe speech impediment and made a positive response to therapy. Hospital staff made a diagnosis of chronic brain syndrome associated with convulsive disorder and behavior reaction (passive aggressive personality—aggressive type). Hospital staff had begun to find a placement for him in the community.

All raters indicated that hospitalization for this boy was appropriate. Three of the five raters indicated that hospitalization was prolonged (by about five months). The type of admission-commitment had resulted in a disruption of the boy's ties to the community. Once this takes place it is extremely difficult to re-establish the ties. This boy should have been admitted to the hospital on a voluntary basis through the child welfare agency which gave up on him. The agency could have maintained its involvement with him during hospitalization and participated with hospital staff in planning and implementing an after care program. The boy should be placed in a foster home or small group (child care) home where he could attend school in the community, and continue with special education and speech services. Vocational counseling, training and placement would eventually be needed by the patient.

II. DESCRIPTION OF CHILDREN AS REFLECTED IN STATISTICAL DATA FROM SCHEDULES

A. PROFILE OF TOTAL SAMPLE (APPENDIX "C", "IDENTIFYING, ADMINISTRATIVE AND SOCIOLOGICAL DATA")

Identifying, sociological and clinical data on each of the 185 cases in the sample were collected and coded on IBM cards. Two raters, one a former Social Worker and the other a Child Psychiatrist recorded the

information in Part I of the Schedule and two Child Psychiatrists recorded the information in Part II of the Schedule (Appendix "C"). A composite picture of the cases as recorded by the two examiners is here presented.

1. DATA ON CHILDREN IN SAMPLE[1] (185 CASES)

(A) INSTITUTIONALIZATION

1. Referral Source

Source	%
Medical	27.3%
Court	25.1%
Self or parents	22.1%
Combination of referral sources	11.2%
Social Agency	5.2%
Relatives and friends	2.2%
Other (miscellaneous)	2.2%
Medical plus Social Agency	2.2%
Unknown	1.6%
School	0.8%

While school referrals generally constitute some 20% - 35% of all referrals for child guidance clinics, the 0.8% noted in this study is in great contrast. Likewise, social agency referrals account for some 20% or more of referrals for child guidance clinics in contrast to the 5.2% noted in this study.

2. Sex and Race (By Agency)

Total Sample

	Male	Female	Total
White	(88) 47.51%	(32) 17.29%	(120) 64.80%
Non-White	(38) 20.54%	(27) 14.59%	(65) 35.13%
Total	(126) 68.05%	(59) 31.88%	(185) 99.93%

Department of Mental Health

	Male	Female	Total
White	68	29	97
Non-White	30	23	53
Total	98	52	150

Illinois Youth Commission

	Male	Female	Total
White	20	3	23
Non-White	8	4	12
Total	28	7	35

	Male	Female	Total
White	(1,535,390) 44.57%	(1,475,786) 42.87%	(3,011,176) 87.44%
Non-White	(215,253) 6.24%	(218,284) 6.33%	(433,537) 12.57%
Total	(1,750,643) 50.81%	(1,694,070) 49.20%	(3,444,713) 100.01%

Child Population 17 Years and Under in Illinois Census[1]

White males comprise 44.57%[2] of the 17 years and under age population in the Illinois Census and White males comprise 47.51% of

[1] The term "children" includes all ages up to 18 years.
[2] United States Census Population - 1960 - Illinois—Detailed Characteristics - U.S. Department of Commerce - Bureau of the Census - p. 463.

the total sample in this study. White females comprise 42.87% of the 17 years and under age group in the Illinois Census and White females comprise 17.29% of the study group.

Non-White males comprise 6.24% of this age group in the population in the Illinois Census and non-White males of this age group comprise 20.54% of the total sample in this study. Non-White females of this age group in the population of Illinois comprise 6.33% and non-White females of this age group comprise 16.21% of the study group.

3. Sex and Age (By Agency)

Birth Year	1959	'58	'57	'56	'55	'54	'53	'52	'51	'50	'49	'48	'47	'46	Total
Department of Mental Health															
Male......	1	1	5	2	3	3	8	7	9	9	20	17	11	2	98
Female....	0	0	1	0	5	1	2	1	1	3	11	6	14	7	52
Total..	1	1	6	2	8	4	10	8	10	12	31	23	25	9	150
Illinois Youth Commission															
Male......	0	0	0	0	0	0	0	0	0	3	2	11	11	1	28
Female....	0	0	0	0	0	0	0	0	0	1	0	4	1	1	7
Total..	0	0	0	0	0	0	0	0	0	4	2	15	12	2	35
Grand Total..	1	1	6	2	8	4	10	8	10	16	33	38	37	11	185

The hospital population shows great preponderance of boys over girls who were born after 1950 (48:14) and a nearly 1:1 ration for the adolescents (50:38). The Youth Commission wards arę all adolescents (born prior to 1951).

4. Previous Admissions (By Agency)

	One	Two	Three	Total
Department of Mental Health..........	17	1	0	18
Illinois Youth Commission.............	13	5	3	21
Total..............................	30	6	3	39

18 of the 150 Department of Mental Health cases (12%) had 1 or more previous admissions to State hospitals while 21 of 35 (60%) of Illinois Youth Commission cases had 1 or more previous admissions to Illinois Youth Commission facilities. Furthermore, the Illinois Youth Commission cases had also been hospitalized previously—23 cases hospitalized one time, 4 cases hospitalized two times, and 1 case hospitalized three times.

5. Institution (By Agency)

Department of Mental Health

Anna State Hospital	1
Alton State Hospital	9
Chicago State Hospital	63
East Moline State Hospital	1
Elgin State Hospital	42
Galesburg State Research Hospital	11
Jacksonville State Hospital	6
Illinois Security Hospital	1
Kankakee State Hospital	3
Manteno State Hospital	3
Peoria State Hospital	10
Total	150

Illinois Youth Commission

Illinois Industrial School for Boys	6
Illinois State Training School for Boys	4
Illinois State Training School for Girls	7
Diagnostic and Reception Center	18
Total	35

6. Length of Stay (By Agency)

Below is a listing of children and youth by agency and by length of stay. (Date of admission to June 30, 1964)

	0-3 Mo.	4-12 Mo.	12-24 Mo.	24-36 Mo.	36-48 Mo.	48+ Mo.	Total
Department of Mental Health	31	56	32	22	5	4	150
Illinois Youth Commission	16	15	4	0	0	0	35
Total	47	71	36	22	5	4	185

The length of stay varied from 6 days to 4 years 9½ months.

7. Participation in the Program of the Institution

Recreational Activity	52.7%
Educational Program	48.1%
Drug Therapy	44.3%
Occupational Therapy	24.3%
Supportive Therapy	24.1%
Vocational Training and Guidance	21.1%
Relationship Psychotherapy	21.1%
Patient Government	15.1%
Somatic Therapy	1.6%
Religious Activity	1.1%

(B) CLINICAL FINDINGS

1. Presenting Symptoms of the Child

(a) Behavior

Symptom	Percent
Unmanageable	61.9%
Aggressive Behavior	61.9%
Destructive Behavior	55.4%
Impulsive Behavior	47.8%
Stealing	34.6%
Truancy from Home	33.5%
Bizarre Behavior	26.5%
Sexual Behavior	25.7%
Withdrawn Behavior	21.1%
Suicidal Behavior	16.8%
Homocidal Behavior	10.5%

(b) Thought

Symptom	Percent
Learning Disturbance	54.1%
Loss of Contact with Reality and Thought Disturbance	21.9%

(c) Disturbance of Bodily Functions

Symptom	Percent
Speech	23.0%
Bladder	14.6%
Bowel	12.2%
Locomotor	7.8%
Vision	5.4%
Hearing	4.9%
Feeding	3.8%

2. Primary Problem Area

Problem Area	Percent
Socially Unacceptable Behavior	45.9%
Psychotic Break	17.3%
Personality Problem	11.9%
Learning Defect	11.4%
Acute Emotional Disturbance	4.9%
Sex Problem	4.1%
Somatic Dysfunction	2.4%
Unknown	2.1%

3. Onset of Present Illness

Onset	Percent
Infancy	9.2%
Preschool Period	13.8%
Elementary School Period	33.5%
Junior High School Period	26.8%
High School Period	12.4%
Unknown	4.4%

4. Diagnosis (To Nearest 5%)

Diagnosis	Percent
Personality Disorder	40.0%
Psychotic Disorder	20.0%
Mental Deficiency	15.0%
Chronic Brain Syndrome	15.0%
Psychoneurotic Disorder	5.0%
Unknown or Undiagnosed	5.0%

5. Intensity of Disturbance

Intensity	Percent
None	.0%
Mild	0.5%
Moderate	18.1%
Marked	58.4%
Very Intense	22.2%
Unknown	0.8%

ERIC

6. Psychological Test Findings

Finding	Percent
Severe Mental Retardation (below 20)	2.7%
Moderate Mental Retardation (20-49)	5.4%
Mild Mental Retardation (50-69)	12.2%
Dull (70-89)	22.7%
Average (90-109)	28.6%
High Average (111-119)	3.2%
Superior (120-139)	2.2%
Very Superior (140 and above)	.0%
No Data, Undetermined	23.0%

7. Factors in Disturbance Which Led to Institutionalization

Medical

Factor	Percent
Central Nervous System Pathology	20.5%
Convulsions	14.9%
Pathology During Pregnancy and Labor	12.4%
Other Medical-Surgical Pathology	8.4%
Congenital Anomalies	4.3%
Physical Defects from Disease/Injury	3.5%
Allergy	1.1%

8. School Placement

(a) Grade Level

Grade Level	Percent
Kindergarten	1.9%
Elementary	42.6%
Secondary	20.5%
Ungraded	3.8%
Out of School; Insufficient Information	31.2%

(b) Type of School

Type of School	Percent
Public	57.4%
Private	2.5%
Parochial	4.1%
Child Not in School; Undetermined	36.1%

(c) Grade Placement

Grade Placement	Percent
In Grade Expected on Basis Chronological Age	36.3%
Accelerated Grade Placement	0.0%
Retarded in Grade Placement or Ungraded Room	27.0%
Child Not in School; Undetermined	36.6%

(d) Type of Class and/or School

Type of Class and/or School	Percent
Regular Classroom Placement	51.9%
Special Class or School for Physically Handicapped	0.3%
Special Class or School for Emotionally Disturbed	5.5%
Special Class or School for Mentally Retarded	6.6%
Child Not in School; Undetermined	35.8%

2. DATA ON FAMILIES OF CHILDREN IN SAMPLE

(A) COUNTY OF RESIDENCE (BY AGENCY)

	Dept. of Mental Health	IYC[1]	Total No.	%
City of Chicago	78	18	96	51.9
Cook (Outside Chicago)	18	2	20	10.8
St. Clair	6	0	6	3.2
Kane	4	2	6	3.2
Madison	4	1	5	2.6
Vermilion	4	0	4	2.1
Will	4	0	4	2.1
DuPage	3	1	4	2.1
Sangamon	3	1	4	2.1
Henry	3	0	3	1.6
Rock Island	3	0	3	1.6
Lake	1	1	2	1.0
Ogle	2	0	2	1.0
Peoria	1	1	2	1.0
Winnebago	2	0	2	1.0
Bureau	0	1	1	0.5
Champaign	0	1	1	0.5
DeWitt	1	0	1	0.5
Fayette	1	0	1	0.5
Franklin	0	1	1	0.5
Fulton	0	1	1	0.5
Greene	1	0	1	0.5
Hancock	1	0	1	0.5
Jackson	1	0	1	0.5
Logan	1	0	1	0.5
Marion	0	1	1	0.5
Massac	0	1	1	0.5
McHenry	1	0	1	0.5
McLean	1	0	1	0.5
Menard	1	0	1	0.5
Morgan	1	0	1	0.5
Perry	0	1	1	0.5
Randolph	1	0	1	0.5
Stephenson	1	0	1	0.5
Tazewell	1	0	1	0.5
Warren	1	0	1	0.5
White	0	1	1	0.5
Total	150	35	185	

(B) LIVING ARRANGEMENT AT TIME OF INSTITUTIONALIZATION

Child Living in Own Home with Both Natural Parents	34.7%
Child Living in Own Home with One Natural Parent	34.4%
Child Living in Jail or Detention Home	6.6%
Child Living with Relation	6.0%
Child Living in Foster Home	5.5%
Child Living in Child Care Institution or Boarding School	5.5%
Child Living in an Adoptive Home; No Natural Parent in Home	2.7%
Other Living Arrangement	2.2%
Unknown	2.5%

[1] Illinois Youth Commission.

(C) REASON FOR PARENTAL ABSENCE FROM HOME AT TIME OF CHILD'S INSTITUTIONALIZATION

	Father	Mother
Absent Because of Divorce	19.7%	4.1%
Dead	5.7%	4.9%
Absent Because of Separation	6.8%	0.0%
Absent Because Hospitalized for Mental Illness	1.9%	3.3%
Absent Because in Prison	0.8%	0.5%
Absent Because Hospitalized for Physical Illness	0.0%	0.0%
Absent Because in Military Service	0.0%	0.0%
Absent for Some Other Reason	9.3%	6.6%
Reason for Absence Unknown	14.0%	26.0%
Item Not Applicable; Parent in Child's Home	41.8%	54.6%

(D) FACTORS CONTRIBUTING TO DISTURBANCE WHICH LED TO INSTITUTIONALIZATION

Disturbance of the Mother-Child Relationship	70.5%
Disturbance of the Father-Child Relationship	63.5%
Disturbance of the Marital Relationship	57.3%
Loss of Parent(s) by Divorce or Separation	49.2%
Traumatic Separations	34.1%
Acquisition of Siblings	15.7%
Loss of Parent(s) by Death	10.0%
Loss of Siblings	3.8%

It is obvious that the above percentages are several times greater than exists for the general population pointing up that these children came from seriously disturbed and disrupted homes.

(E) OCCUPATION OF PRINCIPAL WAGE EARNER

Operatives and Kindred Workers	12.6%
Craftsmen, Foremen and Kindred Workers	9.8%
Service Workers Except Domestic	8.7%
Laborers Except Farm	7.9%
Clerical, Sales and Kindred Workers	5.5%
Managers, Officials and Proprietors Except Farm	4.6%
Professional, Technical and Kindred Workers	2.7%
Private Household Workers; Domestic Service Workers	1.6%
Farmers and Farm Managers	0.8%
Farm Laborers and Foremen	0.0%
Unknown	27.0%
Item Not Applicable; Neither Parent Employed	18.6%

(F) OUTSIDE SOURCE OF INCOME

Family Receiving ADC, Unemployment Compensation or Other Benefits	34.2%
Income Received from Other Source, i.e. Divorced Spouse, Relatives, Etc.	3.0%
Neither Parent Employed But Source of Income Unknown	2.5%
Item Not Applicable; Family Income Supplied by Principal Wage Earner	56.6%
Unknown	3.9%

(G) FAMILY CURRENTLY LIVING IN (TYPE OF RESIDENCE)

Rented Apartment	28.4%
Own Private Home	22.4%
Rented House	6.0%
Public Housing Project	4.9%
Rooms in Apartment or House of Relative	4.4%
Insufficient Information	33.9%

(H) QUALITY OF HOUSING

Meets Minimal Standards	39.1%
Substandard	6.3%
Insufficient Information	54.7%

3. DATA ON PARENTS OF CHILDREN IN SAMPLE

(A) RELIGION

	Father	Mother
Protestant	40.7%	59.6%
Catholic	15.0%	24.6%
Jewish	3.0%	3.0%
Other	0.3%	0.0%
None	1.6%	0.8%
Unknown	39.4%	12.0%

(B) EDUCATION

	Father	Mother
Elementary School	15.3%	19.7%
Some High School	7.4%	16.4%
High School Graduate	6.3%	7.9%
Some College	5.7%	4.6%
College Graduate	1.1%	0.8%
Graduate Studies	0.3%	1.1%
Unknown	64.0%	49.5%

(C) FACTORS CONTRIBUTING TO DISTURBANCE WHICH LED TO INSTITUTIONALIZATION

1. Parental Relationship

Marked Overt Conflict	42.2%
Unsatisfactory	14.3%
Unusual Absence of Conflict	3.5%
Reasonably Satisfactory	17.0%
Unknown	21.9%

2. Differences in Parental Backgrounds

Different Educational Attainment	5.1%
Different Cultural and/or Economic Background	3.8%
Different Cultural and/or Economic Background and Educational Attainment	0.5%
Item Not Applicable; Differences Not Present	42.7%
Unknown	47.8%

3. Age Difference Between Parents

Unusual Age Difference	17.0%
No Unusual Age Difference	49.7%
Unknown	33.0%

4. Socioeconomic

Marked Economic Problems	35.9%
Parents Working	23.2%
More Than One Placement	26.2%

(D) PARENT AREA OF DIFFICULTY

	Father	Mother
Mental Health	29.5%	40.5%
Alcoholism	23.2%	7.6%
Crime or Promiscuity	5.7%	11.6%
Vocational	11.9%	1.1%
Physical Health	3.2%	4.1%
Intellectual	0.8%	4.3%
Other	4.1%	3.8%
Insufficient Information	50.8%	44.9%

(E) PARENT-CHILD RELATIONSHIP

	Father	Mother
Negative—Rejecting—Punitive—Depreciating	30.0%	41.9%
Lack of Consistency—Conflicting Authorities	18.1%	24.6%
Uninvolved	24.1%	11.4%
Setting Example for Child's Pathology—Acting Out Through Child	13.0%	11.9%
Pathologically Positive (Infantilizing, Over Permissive, Over Protective, Seductive)	2.0%	22.4%
Pushing to Early Responsibility	1.9%	8.6%
Rivalrous; Competitive	1.9%	2.2%
Reasonably Wholesome	7.6%	7.8%
Insufficient Information	37.3%	28.6%

4. DATA ON SIBLINGS OF CHILDREN IN SAMPLE

(A) NUMBER

One	Two	Three	Four	Five	Six	Seven	Eight
19.1%	16.7%	14.2%	11.5%	8.5%	5.5%	7.9%	3.3%

Nine	Over Nine	None	Unknown
0.8%	1.6%	9.0%	1.9%

(B) SEX

Same	15.8%
Opposite	17.8%
Both	54.6%
No Siblings; Unknown	11.7%

(C) ORDINAL POSITION

Patient Is Oldest	30.9%
Patient Is Middle Child	34.7%
Patient Is Youngest	18.6%
Patient Is Twin	2.5%
Patient Has No Siblings	7.1%
Unknown	6.3%

B. CLASSIFICATION TABLES OF TOTAL SAMPLE (APPENDIX "D", "STUDY ON EMOTIONALLY DISTURBED CHILD")

Evaluation of needs of the children and their families, coordination and collaboration as well as appropriateness and length of stay of the child in the institution was made by two Child Psychiatrists, two Social Workers and two additional Committee members. These data were compiled for 185 cases and were coded on IBM cards. (Appendix "D")

TABLE I.

PERCENT OF CHILDREN AND THEIR FAMILIES HAVING NEEDS[1] (185 CASES)

Service	Percent
Medical Services	
Specialized medical care (excluding psychiatry)	20.6%
General medical care	19.1
Intensive and/or continuous physical care	9.5
Psychiatric and/or Social Work Services—Diagnostic	
Comprehensive and intensive diagnostic study of child	73.0
Diagnostic study and evaluation of family	59.9
Diagnostic study and evaluation of child	28.8
Psychiatric and/or Social Work Services—Treatment	
Furthering emotional maturation	67.0
Psychotherapeutic treatment of child	64.1
Counseling or guidance of family	62.3
Relief from disabling emotional symptoms	61.0
Close, continuous adult supervision	56.4
Total and intensive long-term treatment of child	49.1
Resolution of internal conflict	45.4
Permanent removal from stressful or inadequate home environment	44.3
Protective services (to protect child from self)	43.2
Elimination of social deprivation	38.7
Protective services (to protect family and/or community from child	36.7
Drug Therapy	35.0
Supervised living situation with authority figures whose role is less involved than that of parent-surrogate	33.8
Temporary removal from stressful or inadequate home environment	32.0
Development of conscience	31.7
Strengthening parent-child relationship	28.9
Provision of stable parental figures	27.6
Psychotherapeutic treatment of family	21.3
Total and intensive short-term treatment of child	20.2
Financial assistance	14.9
Emergency supportive care (24-hour supportive care for emotional crisis)	13.0
Restriction of activity for correctional purposes	12.9
Additional needs	7.7
Counseling or guidance of specific problem	6.7
Somatic therapy (excluding tranquilizers, sedatives or anti-depressants)	2.8
Educational Services	
Special educational service during regular school day	42.4
Special service for longer daily period than regular school day	11.4
Vocational Services	
Vocational counseling and/or guidance	28.3
Vocational training	25.6
Job placement	5.8
Leisure Time Services	
Leisure time and recreational services	60.6
Provision of emotionally healthy peer-group associations	55.8
Character building and ethical training	40.8
Religious Services	
Religious counseling	26.3

[1] Primary and secondary needs are combined. (See Part I of Appendix "D")

TABLE II.

PERCENT OF CHILDREN AND THEIR FAMILIES NEEDING A TYPE OF SERVICE AND PERCENT OF THOSE NEEDING BUT NOT RECEIVING IT[1]

	% of Total Sample of Cases Needing Service	% of Those Cases Needing Service But Not Receiving It
Medical and Psychiatric Services		
Psychiatric out-patient services—diagnostic	68.2	38.
Psychiatric out-patient services—therapeutic	57.2	61.
Psychiatric social work	26.4	63.
Specialized medical care (excluding psychiatry)	24.7	32.
General medical care	21.4	28.
Public health nursing	8.9	67.
Medical social work	5.5	67.
Psychiatric day school services	4.7	57.
Family and Child Welfare Services		
Casework	51.6	61.
Institutional placement	34.6	58.
Financial assistance	16.9	15.
Foster home placement	15.4	54.
Protective services	10.6	49.
Unmarried parent service	2.5	64.
Adoption	1.2	67.
Day care placement	1.1	73.
Boarding club placement	.9	67.
Correctional Services		
Probation	10.6	10.
Detention	8.9	02.
Institutional and/or forestry camps	7.0	09.
Parole (aftercare)	6.8	06.
Juvenile police supervision	2.6	42.
Community services	2.0	45.
Educational Services		
School social work	26.2	77.
Class for emotionally disturbed	24.3	64.
Educable Mentally Handicapped Class	13.4	42.
Class for socially maladjusted	13.2	51.
Class for learning disorder or perceptual handicapped or brain damaged	10.0	48.
Speech therapy	5.2	60.
Boarding school	5.0	72.
Class for trainable mentally handicapped	4.3	67.
Classes for the deaf	1.0	50.
Boarding school (non handicapped)	.9	67.
Homebound tutoring	.8	25.
Partially sighted	.7	43.
Boarding school—auditory	.5	100.
Multiple handicapped class	.4	75.
Hard of hearing class	.4	50.
Gifted class	.2	100.
Boarding school—visual	.1	100.
Classes for the blind	.1	100.
Physically handicapped class	.1	100.
Boarding school—physical	.0	....

[1] See Part II of Appendix "D".

	% of Total Sample of Cases Needing Service	% of Those Cases Needing Service But Not Receiving It
Vocational Services		
Vocational counseling	22.0	78.
Vocational training	20.8	75.
Emotional restoration	5.7	84.
Vocational placement—part-time	1.7	100.
Vocational placement—regular	1.6	100.
Physical restoration	.6	83.
Vocational placement—summer only	.3	67.
Leisure Time Services		
Community centers and settlement house clubs, neighborhood	32.2	53.
Character building and recreational services: youth center program	29.1	47.
Character building and recreational services: YMCA-YWCA	22.5	56.
Character building and recreational services: scouting	15.7	31.
Religious Services		
Pastoral counseling	26.5	64.
Church attendance	21.8	19.
Church youth group	19.4	45.
Sunday school or similar	18.9	52.

TABLE III.

PERCENT OF CHILDREN AND THEIR FAMILIES NEEDING BUT NOT RECEIVING SERVICE IN RELATION TO 10 STATE AGENCIES AND 8 LOCAL PUBLIC AND PRIVATE AGENCIES SET UP TO PROVIDE SUCH SERVICES

State Agencies[1]	
Department of Children and Family Services	31.7%
Department of Mental Health (IYC Cases only)	27.8
Division of Vocational Rehabilitation	20.8
Division of Services for Crippled Children	11.5
Department of Public Health	9.5
Illinois Youth Commission (on DMH Cases only)	9.3
Office of Superintendent of Public Instruction	7.1
Department of Public Aid	6.7
Department of Labor	4.3
Illinois Veterans Commission	4.3
Local Agencies[2]	
Special education program—local schools	38.0
Mental health clinic	37.3
Religious counseling	32 6
Child and family service	30.5
Family service	19.3
Child welfare service	15.6
Youth department of the city police	7.8
Probation service	7.6

[1] The term agency is used to include departments, commissions and divisions.
[2] The term local agency denotes type of agency rather than a specific agency's name.

TABLE IV.

PERCENT OF CASES AS RATED IN RESPECT TO COORDINATION OF SERVICES AND COLLABORATION BETWEEN AGENCIES

COORDINATION OF SERVICES BETWEEN AGENCIES	
Good	22.7%
Adequate	21.3
Some aspects good, some poor	27.5
Poor	28.5
COLLABORATION	
A. Between Institution and Community	
At Time of Child's Admission to Institution	
Good	29.2%
Adequate	37.4
Poor	33.4
During Child's Hospitalization	
Good	22.4%
Adequate	32.0
Poor	45.6
At Time of Child's Discharge	
Good	17.9%
Adequate	22.6
Poor	59.6
B. Initiative Regarding Collaboration	
Entirely by Institution	32.9%
Mostly by Institution Although Some Initiative Taken by Community	32.2
By Institution and Community in Nearly Equal Amounts	25.9
Mostly by Community, Though Some Initiative Taken by Institution	6.3
Entirely by Community	2.8
Insufficient Information to Evaluate	....
C. Collaboration or the Lack of It	
Facilitated Release or Discharge	16.1%
Impeded Release or Discharge	27.1
Played Little or No Role in Release or Discharge	56.8

TABLE V.

PERCENT OF CASES AS RATED IN RESPECT TO APPROPRIATENESS OF INSTITUTIONALIZATION AND LENGTH OF STAY IN INSTITUTION

Appropriateness of Institutionalization	
Appropriate	81.1%
Inappropriate	17.8
Insufficient information to evaluate	1.1
Length of Institutionalization	
Appropriate	65.6%
Excessive	13.6
Item not applicable (Because entire institutionalization was considered inappropriate)	20.9

C. PROFILE OF THOSE CHILDREN IDENTIFIED AS BEING INAPPROPRIATELY INSTITUTIONALIZED (APPENDIX "C" IDENTIFYING, ADMINISTRATIVE AND SOCIOLOGICAL DATA")

The following data are presented on those children defined as inappropriately institutionalized. Two or more of the raters indicated that institutionalization in a State hospital unit was inappropriate and that an alternative plan was needed. One of the raters who made this judgment was a Child Psychiatrist.

Of the total sample of 185 cases, 33 (17.8%) of them were judged to be inappropriately institutionalized. Of the 150 cases in the Department of Mental Health, 23 (15.33%) of those 150 cases were in the inappropriately institutionalized group. Of the 35 cases in the Illinois Youth Commission, 10 (28.57%) of those 35 cases were in the inappropriately institutionalized group.

Using the same outline as used for the total sample, a "profile" of the children who were found to be inappropriately institutionalized is here presented.

Information is included only on those items where there was a difference of at least 10% between the percentages for the total sample and the cases which were deemed inappropriately institutionalized.

None of the cases of Illinois State Training School for Boys and Illinois Industrial School for Boys was in the inappropriately institutionalized group.

Five of seven cases from the Illinois State Training School for Girls in the sample were in the inappropriately institutionalized group.

Five of 18 Diagnostic and Reception Center for Boys in the sample were in the inappropriately institutionalized group.

1. DATA ON CHILDREN IN THE INAPPROPRIATELY INSTITUTIONALIZED GROUP

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
Department of Mental Health	(127) 68.65%	(150) 81.08%	(23) 12.43%
Illinois Youth Commission	(25) 13.51%	(35) 18.92%	(10) 5.40%
Total	(152) 82.16%	(185) 100.00%	(33) 17.83%

(A) INSTITUTIONALIZATION

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
1. Referral Source			
Court	22.1%	25.1%	39.7%
2. Participation in the Program of the Institution			
Recreational Activity	56.6%	52.7%	35.9%
Educational Program	52.3%	48.1%	28.1%
Occupational Therapy	26.5%	24.3%	14.1%
Supportive Therapy	26.5%	24.1%	12.5%
Relationship Therapy	22.9%	21.1%	12.5%
Psychotherapy	22.9%	21.1%	12.5%

(B) CLINCAL FINDINGS

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
1. Presenting Symptoms of the Child			
(a) Behavior			
Aggressive Behavior	65.4%	61.9%	45.3%
Destructive Behavior	58.8%	55.4%	39.1%
Bizarre Behavior	29.7%	26.5%	10.9%
Withdrawn Behavior	23.9%	21.1%	27.8%
Suicidal Behavior	19.3%	16.8%	4.7%
(b) Thought			
Loss of Contact With Reality and Thought Disturbance	25.8%	21.9%	3.1%
(c) Disturbance of Bodily Function			
Speech	19.6%	23.0%	39.1%
Bladder	12.4%	14.6%	25.0%
Bowel	9.8%	12.2%	23.4%
Locomotor	5.6%	7.8%	18.8%
2. Primary Problem Area			
Socially Unacceptable Behavior	47.7%	45.9%	37.5%
Psychotic Break	20.9%	17.3%	0.0%
Learning Defect	5.9%	11.4%	37.5%
3. Onset of Present Illness			
Infancy	6.9%	9.2%	20.3%
Elementary School Period	35.6%	73.5%	23.4%
4. Diagnosis (To nearest 5%)			
Psychotic Disorder	......	20.0%	0.0%
Mental Deficiency	......	15.0%	30.0%
5. Intensity of Disturbance			
Marked	61.4%	58.4%	43.8%
6. Psychological Test Findings			
Moderate Mental Retardation (20-49)	2.0%	5.4%	21.9%
Average Intelligence	31.0%	28.6%	17.2%

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
7. Factors in Disturbance Which Led to Institutionalization			
Medical			
Convulsions	12.7%	14.9%	25.0%
8. School Placement			
(a) Grade Level			
Elementary	44.9%	42.6%	31.7%
Out of School; Insufficient Information	28.1%	31.2%	46.1%
(b) Type of School			
Public	......	......	......
Child Not in School; Undetermined	33.0%	36.1%	50.8%
(c) Grade Placement			
In Grade Expected on Basis of Chronological Age	38.6%	36.3%	25.4%
Child Not in School; Undetermined	33.7%	36.6%	50.8%
(d) Type of Class and/or School			
Regular Classroom Placement	53.8%	51.9%	42.9%
Child Not in School; Undetermined	33.4%	35.8%	47.6%

2. DATA ON FAMILIES OF CHILDREN IN THE INAPPROPRIATELY INSTITUTIONALIZED GROUP

(A) LIVING ARRANGEMENT AT TIME OF INSTITUTIONALIZATION

Child Living in Own Home With One Natural Parent	36.6%	34.4%	23.8%

(B) REASON FOR PARENTAL ABSENCE FROM HOME AT TIME OF CHILD'S INSTITUTIONALIZATION

Absent Because of Divorce (Father)	21.8%	19.7%	9.5%

(C) FACTORS CONTRIBUTING TO DISTURBANCE WHICH LED TO INSTITUTIONALIZATION

Disturbance of Mother-Child Relationship	73.5%	70.5%	56.3%
Disturbance of Father-Child Relationship	68.6%	63.5%	39.1%
Disturbance of Marital Relationship	62.1%	57.3%	34.4%
Loss of Parent(s) by Divorce or Separation	53.6%	49.2%	28.1%
Traumatic Separations	36.9%	34.1%	20.3%

(D) FAMILY CURRENTLY LIVING IN (TYPE OF RESIDENCE)

Own Private House	18.8%	22.4%	39.7%

3. DATA ON PARENTS OF CHILDREN IN THE INAPPROPRIATELY INSTITUTIONALIZED GROUP

(A) RELIGION

Protestant (mother)	57.4%	59.6%	69.8%

(B) FACTORS CONTRIBUTING TO DISTURBANCE WHICH LED TO INSTITUTIONALIZATION

1. Parental Relationship

Marked Overt Conflict	47.4%	42.2%	17.2%
Unknown	18.3%	21.9%	45.3%

(C) PARENT AREA OF DIFFICULTY—FATHER ONLY

Mental Health	32.7%	29.5%	14.1%
Alcoholism	25.8%	23.2%	10.9%
Insufficient Information	48.7%	50.8%	60.9%

(D) PARENT-CHILD RELATIONSHIP

Father			
Negative-Rejecting-Punitive Depreciating	33.0%	30.0%	15.6%
Lack of Consistency-Conflicting Authority	20.9%	18.1%	4.7%
Setting Example to Child's Pathology-Acting Out Through Child	15.0%	13.0%	3.1%
Insufficient Information	34.6%	37.3%	50.0%
Mother			
Negative-Rejecting-Punitive Depreciating	44.1%	41.9%	31.3%
Lack of Consistency-Conflicting Authority	27.5%	24.6%	10.9%
Setting Example to Child's Pathology-Acting Out Through Child	......	......	......
Insufficient Information	25.8%	28.6%	42.2%

4. DATA ON SIBLINGS OF CHILDREN IN THE INAPPROPRIATELY INSTITUTIONALIZED GROUP

(A) NUMBER

None	6.6%	9.0%	20.6%

(B) SEX

No Siblings; Unknown	8.9%	11.7%	25.4%

(C) ORDINAL POSITION

Patient Has No Siblings	5.0%	7.1%	17.5%

D. CLASSIFICATION TABLES OF CHILDREN IDENTIFIED AS INAPPROPRIATELY INSTITUTIONALIZED (APPENDIX "D", "STUDY ON EMOTIONALLY DISTURBED CHILD")

As for the total sample, evaluations were made and data were compiled for the 33 children identified as inappropriately institutionalized.

TABLE VI.

COMPARISON WITH TOTAL SAMPLE OF THE PERCENT OF INAPPROPRIATELY INSTITUTIONALIZED CHILDREN AND THEIR FAMILIES HAVING NEEDS

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
Medical Services			
Intensive and/or continuous physical care	6.9%	9.5%	21.7%
Psychiatric and/or Social Work Services—Diagnostic			
Comprehensive and intensive diagnostic study of child	76.5	73.0	56.7
Diagnostic study and evaluation of child	25.0	28.8	46.7
Psychiatric and/or Social Work Services—Treatment			
Furthering emotional maturation	69.6	67.0	55.0
Psychotherapeutic treatment of child	68.6	64.1	42.8
Relief from disabling emotional symptoms	65.8	61.0	38.9
Total and intensive long-term treatment of child	52.3	49.1	33.9
Resolution of internal conflict	49.2	45.4	27.8
Protective services (to protect family and/or community from child)	38.6	36.7	27.8
Temporary removal from stressful or inadequate home environment	34.2	32.0	21.7
Vocational Services			
Vocational counseling and/or guidance	30.2	28.3	19.4
Leisure Time Services			
Provision of emotionally healthy peer-group associations	58.9	55.8	41.7

TABLE VII.

COMPARISON WITH TOTAL SAMPLE OF THE PERCENT OF INAPPROPRIATELY INSTITUTIONALIZED CHILDREN AND THEIR FAMILIES NEEDING A TYPE OF SERVICE BUT NOT RECEIVING IT

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
Medical and Psychiatric Services			
Psychiatric social work	60.0%	63.0%	80.0%
Psychiatric out-patient services—therapeutic	58.0	61.0	75.0
Psychiatric out-patient services—diagnostic	35.0	38.0	54.0
General medical care	24.0	28.0	41.0
Family and Child Welfare Services			
Foster home placement	49.0	54.0	73.0
Unmarried parent service	44.0	64.0	89.0
Correctional Services			
Community	55.0	45.0	00.0
Juvenile police supervision	33.0	42.0	67.0
Educational Services			
Boarding school (non-handicapped)	67.0	67.0	77.0
Class for emotionally disturbed	61.0	64.0	86.0
Speech therapy	57.0	60.0	80.0
Homebound tutoring	25.0	25.0	00.0
Vocational Services			
Vocational counseling	76.0	78.0	93.0
Leisure Time Services			
Character building and recreational services—scouting	30.0	31.0	44.0
Religious Services			
Sunday school or similar	50.0	52.0	65.0

TABLE VIII.

COMPARISON WITH TOTAL SAMPLE OF THE PERCENT OF INAPPROPRIATELY INSTITUTIONALIZED CASES AS RATED IN RESPECT TO COORDINATION OF SERVICES AND COLLABORATION BETWEEN AGENCIES

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
COORDINATION OF SERVICES BETWEEN AGENCIES			
Good	24.6%	22.7%	13.2%
Poor	26.8%	28.5%	37.2%

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
COLLABORATION			
A. Between Institution and Community *At Time of Child's Admission to Institution* Poor	31.0%	33.4%	44.3%
B. Initiative Regarding Collaboration Entirely by Institution	29.8%	32.9%	47.7%
C. Collaboration or the Lack of It Played Little or No Role in Release or Discharge	9.4%	56.8%	45.3%

TABLE IX.

COMPARISON WITH TOTAL SAMPLE OF THE PERCENT OF INAPPROPRIATELY INSTITUTIONALIZED CASES AS RATED IN RESPECT TO LENGTH OF STAY IN INSTITUTION

	Total Sample Minus Inappropriately Institutionalized	Total Sample	Inappropriately Institutionalized
LENGTH OF INSTITUTIONALIZATION			
Appropriate	12.5%	65.6%	35.2%
Item not applicable	3.9%	20.9%	51.2%

E. PROFILE OF THOSE CHILDREN IDENTIFIED AS HAVING A PROLONGED STAY IN THE INSTITUTION (APPENDIX "C", "IDENTIFYING, ADMINISTRATIVE AND SOCIOLOGICAL DATA")

The following data are presented on those children defined as having a prolonged stay in the institution. Two or more of the raters indicated that prolonged stay in the institution was inappropriate and that the patient could have been discharged at an earlier date had services been available or used at the local level. One of the raters who made this judgment was a Child Psychiatrist. 16 (8.6%) of the 185 cases were judged to have a prolonged stay. Using the same outline as used for the total sample, a "profile" of the children who were found to have had a prolonged stay is here presented.

Information is included only on those items where there was a difference of at least 10% between the percentage for the total sample and the cases which were deemed to have a prolonged stay.

1. DATA ON CHILDREN IN THE PROLONGED STAY GROUP

(A) INSTITUTIONALIZATION

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
1. Sex (only)			
Male	67.1%	68.3%	81.3%
Female	32.9%	31.7%	18.8%
2. Race (only)			
White	63.8%	64.8%	75.0%
Non-White	35.0%	34.2%	25.0%

3. Institution (By Agency)

Department of Mental Health

	Percent of Total Sample	Percent of Prolonged Stay
Anna State Hospital	0.7%	0.0%
Alton State Hospital	6.0%	0.0%
Chicago State Hospital	42.0%	53.3%
East Moline State Hospital	0.7%	0.0%
Elgin State Hospital	28.0%	33.3%
Galesburg State Research Hospital	7.3%	6.6%
Jacksonville State Hospital	4.0%	0.0%
Illinois Security Hospital	0.7%	0.0%
Kankakee State Hospital	2.0%	0.0%
Manteno State Hospital	2.0%	0.0%
Peoria State Hospital	6.6%	6.6%

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
4. Participation in the Program of the Institution			
Recreational Activity	50.9%	52.7%	71.9%
Educational Program	45.9%	48.1%	71.9%
Supportive Therapy	23.1%	24.1%	34.4%
Vocational Training and Guidance	20.1%	21.1%	31.3%
Patient Government	13.9%	15.1%	28.1%

(B) CLINICAL FINDINGS

1. Presenting Symptoms of the child

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
(a) Behavior			
Aggressive Behavior	59.8%	61.9%	84.4%
Destructive Behavior	53.6%	55.4%	75.0%
Impulsive Behavior	46.2%	47.8%	65.6%
Truancy from Home	35.2%	33.5%	15.6%
Truancy from School	29.6%	30.5%	40.6%
Homocidal Behavior	9.2%	10.5%	25 0%
2. Primary Problem Area			
Socially Unacceptable Behavior	44.7%	45.9%	59.4%
Psychotic Break	18.3%	17.3%	6.3%

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
3. Onset of Present Illness			
Infancy	10.1%	9.2%	0.0%
Preschool Period	14.8%	13.8%	3.1%
Elementary School Period	32.0%	33.5%	50.0%
High School Period	11.5%	12.4%	21.9%
4. Diagnosis (To nearest 5%)			
Personality Disorder	......	40.0%	55.0%
Psychotic Disorder	......	20.0%	10.0%
5. Intensity of Disturbance			
Marked	56.8%	58.4%	75.0%
Very Intense	23.4%	22.2%	9.4%
6. Factors in Disturbance Which Led to Institutionalization — Medical			
Pathology During Pregnancy and Labor	13.6%	12.4%	0.0%

2. DATA ON FAMILIES OF CHILDREN IN PROLONGED STAY GROUP

(A) LIVING ARRANGEMENT AT TIME OF INSTITUTIONALIZATION

Child Living in Own Home With Both Natural Parents	37.1%	34.7%	9.4%
Child Living in Own Home With One Natural Parent	32.6%	34.4%	53.1%

(B) REASON FOR PARENTAL ABSENCE FROM HOME AT TIME OF CHILD'S INSTITUTIONALIZATION

Absent Because of Divorce (Father)	18.6%	19.7%	31.3%
Item Not Applicable: Parent in Child's Home (Father)	44.0%	41.8%	18.8%
Item Not Applicable: Parent in Child's Home (Mother)	55.7%	54.6%	43.8%

(C) FACTORS CONTRIBUTING TO DISTURBANCE WHICH LED TO INSTITUTIONALIZATION

Disturbance in Mother-Child Relationship	68.9%	70.5%	87.5%
Disturbance in Father-Child Relationship	62.4%	63.5%	75.0%
Loss of Parent(s) by Divorce or Separation	47.0%	49.2%	71.9%
Traumatic Separations	32.8%	34.1%	46.9%

(D) OCCUPATION OF PRINCIPAL WAGE EARNER

Unknown	26 1%	27.0%	37.5%
Item Not Applicable: Neither Parent Employed	17.7%	18.6%	28.1%

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(E) OUTSIDE SOURCE OF INCOME

Item Not Applicable: Family Income Supplied by Principal Wage Earner	57.8%	56.6%	43.8%

(F) QUALITY OF HOUSING

Meets Minimal Standards	40.4%	39.1%	25.0%

3. DATA ON PARENTS OF CHILDREN IN PROLONGED STAY GROUP

(A) RELIGION

Protestant (Father)	39.8%	40.7%	50.0%
Protestant (Mother)	58.4%	59.6%	71.9%
Catholic (Mother)	25.7%	24.6%	12.5%

(B) EDUCATION

Some High School (Mother)	17.4%	16.4%	6.3%
High School Graduate (Mother)	6.9%	7.9%	18.8%
Unknown (Father)	62.9%	64.0%	75.0%

(C) FACTORS CONTRIBUTING TO DISTURBANCE WHICH LED TO INSTITUTIONALIZATION

1. Parental Relationships			
Marked Overt Conflict	41.1%	42.2%	53.1%
Unknown	24.3%	21.9%	9.4%
2. Differences in Parental Background			
Different Cultural and/or Economic Background	2.7%	3.8%	15.6%
Item Not Applicable: Differences Not Present	43.8%	42.7%	31.3%
3. Age Difference Between Parents			
No Unusual Age Difference	50.9%	49.7%	37.5%
Unknown	31.4%	33.3%	53.1%
4. Socioeconomic			
More Than One Placement	24.6%	26.2%	43.8%

(D) PARENT AREA OF DIFFICULTY

Mental Health (Mother)	39.3%	40.5%	53.1%
Alcoholism (Mother)	6.5%	7.6%	18.8%
Crime or Promiscuity (Mother)	10.1%	11.6%	28.1%
Insufficient Information (Father)	52.1%	50.8%	37.5%
Insufficient Information (Mother)	47.0%	44.9%	21.9%

(E) PARENT-CHILD RELATIONSHIP

Negative-Rejecting-Punitive Depreciating (Father)	28.7%	30.0%	43.8%
Negative-Rejecting-Punitive Depreciating (Mother)	39.9%	41.9%	62.5%
Pathologically Positive (Mother)	21.0%	22.4%	37.5%
Insufficient Information (Mother)	30.8%	28.6%	6.3%

4. DATA ON SIBLINGS OF CHILDREN IN THE PROLONGED STAY GROUP

(A) NUMBER

One	17.7%	19.1%	34.4%
Two	18.3%	16.7%	0.0%

(B) ORDINAL POSITION

Patient Is Middle Child	36.2%	34.7%	18.8%
Patient Is Youngest Child	17.7%	18.6%	28.1%

F. CLASSIFICATION TABLES OF CHILDREN IDENTIFIED AS HAVING A PROLONGED STAY IN THE INSTITUTION (APPENDIX "D", "STUDY ON EMOTIONALLY DISTURBED CHILD")

As for the total sample, evaluations were made and data were compiled for the 16 children identified as having a prolonged stay in the institution.

TABLE X.

COMPARISON WITH TOTAL SAMPLE OF THE PERCENT OF PROLONGED STAY CHILDREN AND THEIR FAMILIES HAVING NEEDS

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
Psychiatric and/or Social Work Services—Treatment			
Furthering emotional maturation	66.0%	67.0%	76.9%
Psychotherapeutic treatment of child	62.9	64.1	75.8
Permanent removal from stressful or inadequate home environment	42.5	44.3	62.6
Elimination of social deprivation	37.6	38.7	49.5
Protective services (to protect family and/or community from child)	35.3	36.7	51.6
Temporary removal from stressful or inadequate home environment	33.1	32.0	20.9
Leisure Time Services			
Provision of emotionally healthy peer-group associations	54.6	55.8	68.1

TABLE XI.

COMPARISON WITH TOTAL SAMPLE OF PERCENT OF PROLONGED STAY CHILDREN AND THEIR FAMILIES NEEDING A TYPE OF SERVICE BUT NOT RECEIVING IT

Medical and Psychiatric Services			
Medical social work	68.0%	67.0%	100.0%
Psychiatric social work	66.0	63.0	42.0
Psychiatric out-patient services—therapeutic	62.0	61.0	51.0
Psychiatric out-patient services—diagnostic	39.0	38.0	24.0
Specialized medical care (excluding psychiatry)	31.0	32.0	44.0
General medical care	30.0	28.0	16.0

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
Family and Child Welfare Services			
Casework	63.0	61.0	43.0
Foster home placement	55.0	54.0	44.0
Correctional Services			
Community	50.0	45.0	33.0
Detention	01.0	02.0	14.0
Educational Services			
Class for trainable mentally handicapped	70.0	67.0	25.0
Class for emotionally disturbed	65.0	64.0	53.0
Speech therapy	58.0	60.0	75.0
Boarding school (non handicapped)	56.0	67.0	100.0
Class for socially maladjusted	52.0	51.0	40.0
Vocational Services			
Vocational counseling	79.0	78.0	67.0
Leisure Time Services			
Character building and recreational services: YMCA-YWCA	55.0	56.0	67.0

TABLE XII.

COMPARISON WITH TOTAL SAMPLE OF PERCENT OF PROLONGED STAY CASES IN RESPECT TO COORDINATION OF SERVICES AND COLLABORATION BETWEEN AGENCIES

	Total Sample Minus Prolonged Stay	Total Sample	Prolonged Stay
COORDINATION OF SERVICES BETWEEN AGENCIES			
Good	21.7%	22.7%	32.0%
COLLABORATION			
A. Between Institution and Community			
At Time of Child's Admission to Institution			
Good	28.1%	29.2%	40.4%
B. Collaboration or Lack of It			
Impeded Discharge	24.9%	27.1%	46.9%
Played Little or No Role in Release or Discharge	58.7	56.8	39.5

SECTION V

FINDINGS AND RECOMMENDATIONS

The primary purpose of this study was to ascertain which children and youths could have remained in the community or could have returned to the community at an earlier date. To carry out this purpose, data were compiled through the use of the Schedule found in Appendix D: types of services needed by the children and their parents—Part II; identification of needed services which ten State agencies and eight types of local tax supported and voluntary agencies are set up to provide—Part III; how communication, coordination or collaboration or lack of them affected the youth receiving needed services—Part IV; cases rated by the reviewers as being "inappropriately institutionalized" or institutionalization was found to be "prolonged"—Part IV, Item III.

Each of the 185 cases in the total sample was reviewed by five or six reviewers. A case was designated as inappropriate (for such institutionalization) or prolonged (in institutional stay) when two or more reviewers, one of whom was a child psychiatrist, so designated that case. A total of 33 cases or 17.8% were so designated as inappropriate; and 16 cases or 8.6% of the total sample were designated as prolonged.

These two groups present significant differences in characteristics.

The inappropriately institutionalized group, as seen in the profiles in Section IV, may be characterized as more often presenting problems in management and training. For example, they experienced much greater percentages of difficulties in bodily functions and in moderate to severe mental retardation; their problems appear more often in infancy and during the pre-school ages; they more often are afflicted with congenital anomalies, suffer from convulsions, physical defects from disease and injury and from central nervous system pathology; none of this group was diagnosed psychotic.

In contrast, the prolonged stay group is characterized by socially unacceptable behavior. Their behavior is aggressive, impulsive and destructive; they are more often truants from school and onset of their difficulty appears in the high school age period. Their primary problem area more often is due to psychotic break. They come more often from upset homes, and homes without fathers present yet have greater percentage of difficulty in both father-child and mother-child disturbances.

The findings and recommendations of this study fall into four areas:

I. Those relating to the institutions (the hospitals of the Department of Mental Health and the institutions of the Illinois Youth Commission);

II. Those relating to the community, with parents included as part of the community;

III. Those relating both to the institutions and the community;

IV. General considerations.

I. THE INSTITUTIONS

A. The Institutions' Programs

FINDINGS

There was consensus among the reviewers that the services provided individual children and youth were too often limited to custody and correction instead of treatment, both in the State hospitals and in the institutions of the Illinois Youth Commission.

In the State mental hospitals, there were youngsters whose aggressive behavior was disruptive to the hospital program. These youth needed containment along with treatment but the hospital facilities lacked adequate security provisions to enable the staff to be therapeutic with these youth.

A number of case records revealed that youth in institutions of the Illinois Youth Commission acting out their emotional problems in disruptive behavior often were transferred to a State mental hospital for treatment. The hospital diagnosed many of them as "not psychotic" and not properly institutionalized in a State mental hospital. Such youth were transferred back and forth between the State hospital and Illinois Youth Commission facility. These transfers were too often not therapeutic. Hospital facilities lacked adequate security provisions to enable the staff to give the necessary treatment; the staffing of Illinois Youth Commission facilities was insufficient and inadequate to provide treatment which was needed. Thus, these acting out youth, who presented serious problems of management, were frequently "passed on" to another facility for want of a proper security facility with treatment services.

RECOMMENDATIONS

(1) The programs of the institutional services of the Department of Mental Health and the Illinois Youth Commission must be treatment focused. Anything less than treatment programs in these State agencies results in human misery and in waste of human and economic resources. These programs should be strengthened and expanded to enable staff to provide treatment which is appropriate for the individual children and youth.

(2) The Department of Mental Health is the State agency which must assume responsibility for providing a com-

plete and comprehensive program (facilities and staff) for the containment, the handling and the treatment of the seriously emotionally disturbed children and youth who present management problems.

(3) The Illinois Youth Commission's institutional program should be further strengthened to provide its wards treatment so that more appropriate intensive treatment is available for wards who can profit from such services.

B. Comprehensive Treatment Plan for Each Child

FINDINGS

In very few instances in the case records was there evidence of the formulation of an overall treatment plan for the child. Furthermore, there was lack of evidence of assigning responsibility for implementing the plan.

RECOMMENDATIONS

(4) The hospitals and institutions should develop a treatment plan for each child.

This could include, as indicated, milieu, individual and/or group therapy, necessary medical treatment, special education and activity, and/or speech and hearing therapies. This should also include measures to maintain the child's ties to the community and involve the adults who have significance in the child's life so that they may cooperate with the hospital in carrying out the treatment plan. Unless specifically contraindicated the parents should maintain and improve their relationship with their child in the hospital through visiting, frequent correspondence and better communication.

(5) Parents or substitute parents of every child in the institution should be involved at time of child's admission in a treatment program which should be provided by the institution staff unless a community agency is already providing this. In the latter case, periodic communication and coordination of therapy between the institution and agency is required. Basic responsibility for this coordination should rest with institution staff.

(6) Each institution should foster the development of parents' organizations, the purposes of which would be to provide to parents further orientation to institution policies and procedures and to the plans for their children and to enable parents to participate in social action projects which would benefit their children.

C. Release Planning and Aftercare

FINDINGS

Release and after care planning were often put off until shortly before the child's release from the institution. Collaboration between the institution and community at the time of release was rated as poor in 59.6% of the cases in the study, and good in only 17.9%.

RECOMMENDATIONS

(7) Release and placement planning should be initiated at the time of admission and be revised as the child's problems are resolved and finalized at the dispositional planning conference.

(8) Arrangements for aftercare should be an integral part of the release or discharge planning conference. Prescribed steps should be designated as to what should be done in preparation for the child's release from the institution and what should be done in the community and by whom. The institution should develop contacts in the community to assure implementation of the prescribed plans. The institutions should accept their responsibility for providing "back-up services," should readmission be required. Agreement must be worked out so that community representatives will know that the institution will expedite readmission and transfers of youth released from State mental and correctional institutions when adjustment in the community breaks down.

D. The Roles of Various Professional Disciplines and the Team Approach

FINDINGS

The roles of various professional disciplines in the hospitals and to a lesser extent in the Illinois Youth Commission institutions, are not clearly defined. This has led to confusion in roles, overlapping and gaps in functions, inappropriate use of staff time, and, thereby, inadequate provision of needed services to children.

Clear-cut administrative direction is needed to assure coordination.

For example, there was marked difference in the use and function of the social service staff in different institutions. Too often social service staff was used in a type of secretarial function—i.e., to get off to a parent or agency, letters which someone else had decided was needed.

Evidence was lacking in the records of casework activity and the professional contribution of social work in the overall

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treatment plan for the child and/or his family. Information was lacking as to what a social worker was trying to accomplish, what he was doing or how his activity or lack of it was related to the treatment plan and the progress of the patient. At times it appeared that the social worker was missing from the team. Or, too often the social worker was brought into active participation just prior to release or discharge.

Only rarely did the records indicate use was made of the social worker as either one-to-one or group therapist using casework skills and techniques within his competency and as a recognized team member. Likewise, psychologists were infrequently used in such roles. Such coordinated professional services can be important in providing the needed therapy and support to patients whether or not they are on drug medication and under supervision of the psychiatrist.

Better and more appropriate use of social work skills with patient, family and community could result in better adjustment of the discharged child and provide for better continuity and follow-up between institution and community.

All aspects of the child's life must be considered while he is in the institution, namely, his basic emotional needs as well as his physical, social, spiritual and intellectual requirements. Psychiatric problems and different levels of development demand a prescribed treatment plan for each child. Unless such an individually focused program is developed and interdisciplinary services rendered, the child is sacrificed to gaps or conflicts in treatment.

RECOMMENDATIONS

(9) The Illinois Youth Commission and the Department of Mental Health should each define, within the scope of its program responsibilities, the role and functions of each professional discipline. One set of defined roles and functions should apply to all institutions and hospitals within the same department. These disciplines would include psychiatrists, psychologists, social workers, educators, nurses, etc.

(10) There should be a plan for orientation of staff members to each other's functions and responsibilities in relation to the agency's goals.

E. CASE RECORD

FINDINGS

Community agency reports on diagnostic studies and treatment of the child are not reaching the hospitals or the Youth Commission institutions in time to be of effective use. As

a result breakdowns in service occur, all of which are damaging to the child. For instance, the institution makes plans for the child or releases the child on the basis of insufficient information. This might have been avoided had the data from the local agency(s) been available and used preceding or immediately after the child's admission. Too often the institutions have set up machinery to secure data which is already well documented in local agency records. Perfunctory requests to community agencies often produce perfunctory answers.

Hospital records are too often repetitious; clinicians re-record material of social history and reports obtained from outside agencies.

Records have few notations of a treatment program. Recordings failed to reveal what was planned or accomplished. Similarly, records lacked information on a clear-cut treatment plan for aftercare and placement of responsibility for follow-up.

RECOMMENDATIONS

(11) The Department of Mental Health and the Illinois Youth Commission should inform community agencies and referral sources on the most important data which are needed.

(12) Referral and active agencies should adopt a policy and practice of sending such information to the hospital and or Illinois Youth Commission preceding the child's admission if possible; if not, immediately following admission.

(13) The Department of Mental Health and the Illinois Youth Commission should make an analysis of their records system to update and modernize them and eliminate duplications, inconsistencies and unnecessary information. In conjunction with this, an in-service program in record keeping for staff should be initiated.

(14) There should be a recording of the plan for treatment and for aftercare. Minimum progress notes at specific intervals and periodic summaries should be recorded. The records should include summary recording of staff conferences. Agreements with outside agencies and contacts and agreements with parents should be included in the record.

F. Communication Between Agencies Particularly With Regard to Each Agency's Function

FINDINGS

Although, in many instances, two or more disciplines within the same department, or two or more agencies were involved

in planning for a child, there was little evidence that each was conversant with the services, responsibilities and functions of the other. Good communication is a most vital factor in collaboration.

Lack of communication of agency function played a significant part in many of the study cases. 56% were found to be poor in some aspect of coordination. A large percentage of study cases were marked poor in collaboration as follows:

Poor at time of child's admission	33.4%
Poor at time of child's institutionalization	45.6%
Poor at time of release or discharge	59.6%

Staff of institutions and community agencies were not adequately informed about functions of various agencies; each agency appeared to expect more of the other than was realistically possible. Unrealistic assumptions were that the hospitals and institutions were equipped to provide individual, group, and milieu therapy based on adequate diagnosis and prescription for each child; that public and private child welfare agencies were able to guarantee the appropriate post-institution placement when return home was contra-indicated; that public assistance agencies were providing skilled counseling services to parents; that court personnel were maintaining close and effective relationships with parents or relatives.

RECOMMENDATIONS

(15) The Department of Mental Health and the Illinois Youth Commission should provide more extensive in-service training for their staffs on the functions, responsibilities and programs of their own agencies. This instruction should also include an orientation to other children's institutional and community programs (public and private) and the interdependence of them all.

(16) Periodic joint regional meetings of all major agencies serving children should be held for exchange of information on policies and services. These regional conferences could well be an important part of the Zone Center program of the Department of Mental Health.

II. THE COMMUNITY

Table XIII is an abridged table which itemizes types of services needed by the children and/or their parents. (See Appendix D, Part II, Items 14 - 71.) The first column gives the percentage of cases of the total sample in which the type of service was needed and the second column gives the percentage of those cases in which the type of service was needed but was not received. Only those types of services are listed where the percentage in column one exceeded 15%. There are 21 different types of services listed in Table XIII.

Table XIV shows the percentage of the total sample of cases needing or not needing the type of service which the agency is set up to provide and the percentage of the total sample of these cases which received or did not receive that type of service.

A. Lack of Community Resources

FINDINGS

A variety of public and private agencies are set up to provide specialized services to the children of Illinois.

Although the services of these combined agencies theoretically cover the State, it is disturbing that from 4.3% to 37.3% of the total sample of cases did not get the services which were needed. Whether this is due to resistance and lack of motivation on the part of the child and his family or failures and/or limitation of the agency's program in its service to children, the results are serious in loss and waste of human resources.

While there were many factors, both in the institution and in the community, which contributed to inappropriate institutionalization and prolonged stay, a major factor was the lack of community resources to provide alternatives to institutionalization and to facilitate the young person's return to the community.

Services were needed by at least one member of the family in 15.4%—68.2% of the cases. Based on the original 755 cases from which the random sample was taken, this would represent a need for a service in 116 to 515 of those cases; 19 of the cases needing financial assistance and not receiving it; 263 of the cases needing outpatient psychiatric treatment and not receiving it at the time of admission to the institution. The need for other services listed in Table XIII falls between 19 and 263 cases. Certainly these figures strongly emphasize the fact that the children, whose cases were studied, and their families needed many different services and that too often these services were not provided.

TABLE XIII.

AN ABRIDGED TABLE OF TYPES OF SERVICES NEEDED

Type of Service Needed	Percentage of Total Sample of Cases Needing the Type of Service	Percentage of Cases Needing the Type of Service But Not Getting It
Medical and Psychiatric Services		
Psychiatric Outpatient Diagnosis	68.2%	38%
Psychiatric Outpatient Therapy	57.2%	61%
Psychiatric Social Work	26.4%	63%
Specialized Medical Care	24.7%	32%
Generalized Medical Care	21.4%	28%

Social Work Services		
Casework Services	51.6%	61%
Institutional Placement	34.6%	58%
Financial Assistance	16.9%	15%
Foster Home Placement	15.4%	54%
Educational Services		
School Social Work	26.2%	77%
Class for the Emotionally Disturbed	24.3%	64%
Vocational Services		
Vocational Counseling	22.0%	78%
Vocational Training	20.8%	75%
Leisure Time Services		
Social Group Work: Community Centers, etc.	32.2%	53%
Youth Center Program	29.1%	47%
YMCA-YWCA Type Programs	22.5%	56%
Scouting	15.4%	31%
Religious Services		
Pastoral Counseling	26.5%	64%
Church Attendance	21.8%	19%
Church Youth Group	19.4%	45%
Sunday School Attendance	18.9%	52%

TABLE XIV.

AGENCY ACTIVITY OR LACK OF IT IN RELATIONSHIP TO THE INSTITUTIONALIZATION

	Percentage of Total Cases Needing Activity	**Percentage of Total Cases Not Needing Activity**	**Percentage of Total Cases Needing Activity and Receiving It**	**Percentage of Total Cases Needing Activity But Not Receiving It**
Dept. of Children and Family Services	45.3%	53.6%	13.6%	31.7%
Dept. of Labor	4.3%	94.0%	0.0%	4.3%
Dept. of Mental Health (on IYC cases only)	52.7%	30.6%	24.9%	27.8%
Dept. of Public Aid	30.7%	67.8%	24.0%	6.7%
Dept. of Public Health	16.1%	82.6%	6.6%	9.5%
Division of Services for Crippled Children	15.9%	82.5%	4.4%	11.5%
Division of Vocational Rehabilitation	22.2%	76.3%	1.4%	20.8%
Office of Supt. of Public Instruction	10.5%	88.1%	3.4%	7.1%
Veterans Commission	6.4%	91.9%	2.1%	4.3%
Illinois Youth Commission DMH Cases Only	19.3%	73.0%	10.0%	9.3%
Mental Health Clinic	88.1%	10.9%	50.8%	37.3%
Family Service	25.5%	73.0%	6.2%	19.3%
Child Welfare Service	26.0%	72.0%	10.4%	15.6%
Special Education Program	56.8%	41.7%	18.8%	38.0%
Child and Family Service	36.0%	61.3%	6.5%	30.5%
Youth Dept. of City Police	28.2%	70.0%	20.4%	7.8%
Probation Services	25.3%	72.9%	17.7%	7.6%
Religious Counseling	36.3%	61.5%	3.7%	32.6%

Medical and Psychiatric Services

FINDINGS

The inadequacy of outpatient psychiatric services—both diagnostic and treatment—in the communities is serious. Of the 68.2% of the total cases which needed outpatient diagnostic service, 38% did not receive it; of the 57.2% of the total cases which needed outpatient psychiatric therapy, 61% of those needing such treatment did not receive it.

There are psychotic and disturbed children for whom a day school in their community would be a real benefit. Such schools combine both education and treatment and would replace hospitalization for certain children.

The large proportion of brain damaged children in the total sample indicates the need of proper diagnostic and treatment services and/or proper referrals for such children in the community. In the total sample there were found to be 13.5% which were brain damaged; in the inappropriately institutionalized group 20.3%; and in the prolonged stay group 12.5% were found to have been brain damaged and to have needed community services prior to institutionalization. Had such services been more available, many of these cases could have been better and more appropriately served in the community.

Although over a quarter of the cases (26.4%) needed psychiatric social work services, 63% of those cases needing this service did not receive it—again reflecting serious lack in community mental health services.

Since the presence of health problems and physical defects is a contributing factor to the individual's state of emotional health, it is disturbing to find that prior to institutionalization over a fifth of the cases were in need of generalized medical care and that 28% of those needing this care did not receive it. In addition, nearly a quarter of the cases were found to have needed specialized medical care, excluding psychiatry, but almost one third of those cases needing specialized medical care had not received it. Since the Division of Services for Crippled Children has a specialty program, a considerable number of these children may have been eligible for their care. The services of a local public health nurse might have facilitated obtaining care for both general and specialized services. In 15.9% of the total sample needing Division of Services for Crippled Children service, 11.5% did not receive it. In 16.1% of total sample needing public health service, 9.5% did not receive this service.

It would seem that the statistics of 82.6% of cases not needing public health activities may not be a true reflection of these service needs, but instead it may reflect the lack of

information that the State and local service agencies have regarding the role that Division of Services for Crippled Children and Public Health could and should perform.

RECOMMENDATIONS

(17) Because of the magnitude of the need for outpatient psychiatric service—both diagnostic and treatment—

(a) the services of the Department of Mental Health should be expanded to provide more adequately the needed mental health services to children and adolescents in such a way that families are served in their areas of residence;

(b) the services of the State aided, local mental health clinics, both public and private, should be greatly expanded and the number and distribution of such clinics be increased.

(18) Programing for disturbed children with organic brain damage who have behavior and/or learning problems should be expanded so that inpatient, day treatment, outpatient and emergency services are available. This should be the responsibility of the Zone Centers of the Department of Mental Health when these services are not available in the community.

(19) Within the gamut of mental health services required to meet the needs of seriously emotionally disturbed and/or psychotic children who cannot remain in classes in local school programs, there should be established day treatment and educational centers. These centers should be an integral part, wherever possible, of a comprehensive community service and should involve the parents. The Department of Mental Health, by providing consultation and grant in aid programs, should assure the development of such centers for emotionally disturbed children under public and private auspices. The Department of Mental Health should collaborate with the Office of Superintendent of Public Instruction which has and should exercise the responsibility for standard setting for the educational program.

(20) In order to meet the needs of children with physical handicaps which may initiate or aggravate their mental health problems, the case finding activities of public health agencies, which includes Division of Services for Crippled Children, should be intensified and avenues of referral for diagnosis and treatment to both public and private medical resources be established. The Division of Services for Crippled Children should expand its scope so that more categories of physical

handicapping conditions will be covered and it is recommended that this expansion occur as rapidly as possible.

(21) The Department of Public Health should make every effort to improve the level of mutual understanding of all agencies' roles concerned with health, both physical and emotional, by:

(a) exploring all possible points of contact among the health agencies;

(b) pursuing a program to overcome the lack of understanding by other State and local agencies of the public health role and available services;

(c) incorporating and understanding of the roles of other disciplines at the level of continuing health education;

(d) assisting in the design of training programs for professional as well as auxiliary groups regarding physical and emotional health needs.

(22) The Department of Public Health, where there are no local public health programs, should initiate contacts to develop needed health services at the local level or should provide these services to the families in the communities through its own staff.

(23) Medical services should be expanded to follow through on children identified as needing medical care. Medical resources, both public and private, should be supplemented by mental health and social work counseling and consultation services. Community services should be expanded to provide nurses and social workers who can assist parents of children suffering mental, physical and emotional difficulties. These professional workers, by supplementing and cooperating with the medical resources in the community, could aid in directing parents and child to the facility best able to meet the child's needs. Where private resources do not meet the needs adequately the State service should be expanded.

The Department of Public Health should initiate a program which would provide vital nursing services appropriate to the respective communities.

(24) The Department of Mental Health should develop a strong preventive program which will include in-service mental health education for teachers and nurses in the local communities as well as for training for these professionals in the use of mental health consultation and the case conference. Such a program would require that social workers, nurses and mental health personnel cooperate in supplying leadership for workshops for teachers and for other significant "helping" groups.

Social Work Services

FINDINGS

That social work services are needed by many families is emphasized by the findings that 51.6% of the total cases were found to have needed family and child welfare casework services but that 61% of those needing this service did not receive it. Of the total sample of cases, 15.4% were found to have needed foster home placement but 54% of those needing it did not receive it, and 34.6% of the total sample were found to need institutional placement but 58% of those needing it did not receive it.

RECOMMENDATIONS

(25) Casework services for children and families should be expanded. Where these services are not otherwise available they should be provided by the Department of Children and Family Services. The staff and services of this department should be expanded as necessary.

Likewise, the staff and services of the Department of Public Aid should be expanded to meet the casework needs of the emotionally disturbed children and youth as well as the families in their current, former and potential caseloads.

(26) The Department of Children and Family Services should have the primary responsibility for developing placement resources within the community.

We recognize that subsidized foster homes are preferable and that present plans should be expanded but if such foster homes cannot be provided, or are not appropriate for certain children, the Department of Children and Family Services should develop throughout the State small group homes with maximum number of 5 - 8 children and youth.

(27) The Illinois Youth Commission and the Department of Mental Health should be responsible for program planning and implementation for developing half-way houses or transitional community residences for youth ready to leave the institutions, who are in need of a transitional facility before moving into their homes or other placement. These should be developed in collaboration with the Department of Children and Family Services and should meet child welfare licensing standards.

(28) The Court should seek and use consultation from the Department of Children and Family Services, Illinois Youth Commission and Department of Mental Health so that Court referrals will be to the service best equipped to meet the specific needs of the child.

Educational Services

FINDINGS

Many cases of maladjustment and emotional disturbance manifested their early difficulties in the school. Yet often school personnel failed to recognize the seriousness of the situation, did not know how best to meet the situation, how to accomplish the proper referral, etc. Problems were carried along from teacher to teacher or school to school only to exacerbate with time.

That special educational services in communities are needed is re-enforced by the findings of this study. It was found that from 42% to 67% of the children needing such services had not received them.

Over a quarter of the total sample needed school social work services but over three quarters of those needing this service did not receive it.

The Committee recognized the tremendous impact which the mandatory special education program established by H.B. #1407 in the 1965 Session of the Legislature will have in opening up educational opportunities for these children.

RECOMMENDATIONS

(29) The Office of Superintendent of Public Instruction should be commended for its efforts to secure early implementation of this mandatory special education program. The Committee recognizes that Illinois does not have the experience to build on in developing classes for emotionally disturbed children and the Office of Superintendent of Public Instruction should give leadership to developing pilot projects during this interim period before the mandatory provisions take effect.

(30) The Office of Superintendent of Public Instruction should assume leadership in promoting under the mandatory special education provisions, the school social work program so that the social and/or emotional problems which impede the child's taking full advantage of his educational opportunities can be dealt with in the school set-up or by referral of the child and/or his parents to other services.

(31) Plans should be expanded for personnel training in special education and guidance to enable schools to obtain the services of special education teachers, school social workers and guidance personnel.

Vocational Rehabilitation Services

FINDINGS

While many of the children in the study were too young to qualify for the services of the Division of Vocational Rehabilitation, the case reviewers found that in at least 15% of the cases these services were needed. However, three-fourths of those youths who needed these services did not receive them.

RECOMMENDATIONS

(32) The Division of Vocational Rehabilitation should expand its program and develop an educational and informational service better to inform individuals in the community about resources and use of this agency's services.

(33) The Division of Vocational Rehabilitation should expand its services, both counseling and placement for the emotionally disturbed youth.[1] The Division also should expand its activities in fostering the development of training facilities through its purchase of service or grant-in-aids programs.

Religious, Character Building and Leisure Time Services

FINDINGS

In other a quarter of the cases pastoral counseling and related services were needed but nearly two-thirds of those needing this service did not receive it.

Leisure time and the several types of community group and character building activities were found to have been needed by from 15.7% to 32.2% of the children studied but from a third to over a half of those needing a particular activity did not receive it.

RECOMMENDATIONS

(34) Units within the various religious faiths which arrange for pastors within State institutional programs also should devise a plan to work with local ministers to provide religious counseling and experiences for such families and children.

[1] A separate set of recommendations on joint programs for handicapped youth was developed by another Committee of the Commission on Children. These recommendations are in the Report "A Guideline for Cooperative Vocational Services for Handicapped Youth at the H.S. Level."

B. Early Problem Identification and Prevention

FINDINGS

There was evidence in the case record material of long term maladjustment in the children. In a majority of the cases, had significant adults in the child's life recognized the problem and initiated and/or secured appropriate action and had comprehensive mental health and social service resources for early diagnosis and planning been more widely available, the extent of emotional disturbance might have been modified and institutionalization might not have been needed. Professionals who are in key positions to recognize and provide early identification and referral are physician—particularly pediatricians—nurses, school personnel, social agency staff and clergymen.

The potential of public health services and the public health nurse for fostering mental health has not been recognized. In particular, the public health nurse has not been used in the past and may not be in the future because of a lack of such nurses and because of a lack of local or regional public health agencies or inadequate staffing of those which do exist.

RECOMMENDATIONS

(35) In order that parents and professionals may be capable of meeting their responsibilities for early identification and treatment, the Department of Mental Health and other agencies should expand their educational programs.

(36) The Department of Public Health and other public health services should pursue more vigorously their role of early identification of infants and children with handicapping conditions and behavior problems. They should then follow through via referral and collaboration with other appropriate agencies to assure that necessary services are obtained.

(37) The Department of Public Health and Division of Services for Crippled Children should pursue a program to improve the level of understanding by other State and local agencies of their roles and available services.

(38) Teachers should be trained to recognize early the symptoms of emotional upset, to feel comfortable in their teaching roles with all children and to know how and when to initiate referrals of those children needing special services.

(39) Every school district should provide services for early detection of children with potential emotional disturbances and make prompt referrals to appropriate services.

(40) Educators must be helped to realize the full potential of the school and the teachers in the development of healthy personalities and the prevention of illness.

(41) All professional disciplines should give particular attention to motivating parents who are resistant to using mental health services.

C. Modification of Environment in Which the Child Lives

FINDINGS

In most cases there was no evidence of action taken during the child's institutionalization to improve the environment—i.e., home, neighborhood, school—from which the child came.

In only 34.7% of cases (see Appendix C, Part I, Item 25, Sub-Item 1) were both natural parents living in the home at the time of hospitalization or commitment. The reviewers noted problems having to do with individual parent, with the marital relationship and with parent-child relationships.

In cases where there was sufficient information for making a clinical judgment, it was found that there were multiple problems in these families.

Serious mental problems in father	29.5%
Serious mental problems in mother	40.5%
Pathological drinking in father	23.2%
Pathological drinking in mother	7.6%
Crime or promiscuity in father	5.7%
Crime or promiscuity in mother	11.6%
Vocational problems in father	11.9%
Punitive and rejecting (and depreciative of their child) fathers in	30.0%
Punitive and rejecting (and depreciative of their child) mothers in	41.9%
Over protective, overly permissive mothers in	22.4%
Marked parental conflict regarding authority and lack of consistency (in handling child) by fathers in	18.1%
Marked parental conflict regarding authority and lack of consistency (in handling child) by mothers in	24.6%
Uninvolved (toward child's problems) fathers in	24.1%
Uninvolved (toward child's problems) mothers in	11.4%
Example set for child's pathology on acting out by fathers	13.0%
Example set for child's pathology on acting out by mothers	11.9%

Parental absence from the home was due to:

Death of father in	5.7%
Death of mother in	4.9%
Separation from father	6.8%
Separation from mother	0.0%
Divorce from father	19.7%
Divorce from mother	4.1%

In 18.6% of the cases (see Appendix C, Part I, Item 28, Sub-Item Y) neither father nor mother was employed and in 34.2% of the cases (see Appendix C, Part I, Item 29, Sub-Item 1) the family was receiving ADC, unemployment compensation or other benefits.

RECOMMENDATIONS

(42) Since the community or neighborhood contributes to the development of emotional disturbance, institution and community agency staff as professionals and as citizens should be responsible for contributing to and fostering community action to remedy such conditions. These would include such social problems as poverty, discrimination and social injustice.

(43) Where the home and family situation require improvement, remedial services must be provided, such as mental health, family and child welfare (casework, financial assistance and homemaker) educational (adult education), vocational, leisure time and character building and recreation, and religious services. These services should be aimed at improving the home situation so that the child may be returned to a healthier environment. They should enable the family members to develop additional strengths to foster mental health and prevent further breakdown.

(44) When an appropriate community agency is already active at the time of admission of the child to an institution, responsibility for continuing a relationship with the child and with the family rest with that agency. This should not preclude institution staff from working with the parents.

(45) When no appropriate community agency is active it should be the responsibility of the institution staff to refer the family to the appropriate community service. (Department of Children and Family Services, local public and private family and/or child casework agencies.)

(46) When upon careful evaluation it is determined that the family cannot become healthy enough to resume responsibility for the child, plans for placement must be

formulated before the child's release. Planning and implementation of the plan will involve collaboration between the institution, a child welfare agency and possibly the court. Careful consideration should be given to prior evaluations by community agencies including mental health services and child welfare agencies.

D. Programs to Handle the Acting Out Child in the Community

The acting out child as defined in this study is one whose emotional disturbance is expressed in aggressive, disruptive behavior involving other people or property. This disturbance may stem from intra-psychic conflict, from problems in parent-child relationship or be a reaction to an unfavorable environment or community conditions.

The problem of acting out youth is being handled by the community in a variety of ways; for example, the youth is not declared delinquent but is handled by the school and/or the community; the youth is referred to or is committed to mental health services or to a family or children's agency; the youth is taken into Juvenile Court and placed on probation; the youth is taken into Juvenile Court and is committed to Illinois Youth Commission.

FINDINGS

Such acting out youngsters presented serious problems of management in the schools, home and community for want of a proper program or facility to meet their needs.

RECOMMENDATIONS

(47) Closed or semi-closed group facilities for acting out children and adolescent boys and girls providing a therapeutic milieu and casework services should be established in local communities. These homes should be under the auspices of the Department of Children and Family Services either directly or through use of other public and private facilities.

(48) Comprehensive community mental health program should provide for serving through outpatient services as many as possible of these acting out youth in the local community.

E. Guardianship

FINDINGS

In the study of these cases the problem of guardianship emerged as an important issue.

In several cases in which guardianship continued while the child was in the hospital this fact was ignored, the guardian was by-passed, and staff, with resulting conflicts, dealt directly with parents whose legal rights had been terminated.

In a number of cases young children under the custody of child welfare agencies were committed to hospitals and institutions for care and treatment. Subsequently, the agencies petitioned the court to be relieved of guardianship and this was granted. As a result the child had no ties with the community and had no significant adult outside of the institution who was interested in his welfare; he also had no place to which he could return when he no longer needed institutionalization. This situation prompted the Interdepartmental Committee on Children and Youth of the Commission on Children to make an extensive review in this area and led to the development of a Position Paper on Guardianship. This full Position Statement on Guardianship has been published as a separate document. A number of the findings and recommendations of this Position Statement are so significant to this study that they are repeated here.

Many children grow up with no legal guardian because their parents are dead or incompetent and no one else is designated legal guardian of their person.

The courts generally permit personal guardianship to be terminated at the guardian's request. In Illinois, when a child is committed to a State facility, i.e., Department of Mental Health or the Illinois Youth Commission, both public and private agencies usually petition the court to be relieved of guardianship.

Children admitted to State facilities for the mentally ill or mentally retarded need to have someone planning for their return from the moment of departure from the community.

The institutions of the Department of Mental Health are currently making financial demands of guardians of children. Since guardianship of the person carries with it no financial responsibility, the institutions by their financial requirements on these guardians are forcing agencies to withdraw from cases in spite of the fact that their legal guardianship responsibilities are urgently needed.

RECOMMENDATIONS

(49) It is important that institutional staff understand the implications and requirements of guardianship. The Juvenile Court Act defines and distinguishes clearly responsibilities in custody, guardianship and residual parental rights. Chief and supervisory social service staff should see that staff have knowledge of and respect these legal responsibilities.

(50) When a child is admitted to State facilities of Department of Mental Health or the Illinois Youth Commission and when an agency has guardianship of the person of such a child, such guardianship should be continued and joint planning of both the guardian and the State facility should be maintained during the institutionalization. If such a child has no available parent or guardian, steps should be taken by the State facility to ask the court to name a guardian.

(51) The Department of Mental Health should assume the financial responsibility for clothing and commissary expenses where the child has no responsible relative or financial resources.

(52) Where long term care in a hospital or institution is required, and the review of the child's family situation points up the need for a guardian, such guardianship may be placed in the hospitals for the mentally ill or the schools for mentally retarded, or, in the case of a delinquent, in the Illinois Youth Commission.

III. INSTITUTION — COMMUNITY RELATIONSHIP

A. Communication, Coordination and Collaboration

Communication, coordination and collaboration must be a two way street between the institution and the community. Otherwise, services and resources, both material and financial, are wasted and in many cases, already damaged individuals are more traumatized and needlessly hurt.

FINDINGS

In too many instances little respect or recognition seemed to be given to specific recommendations for use of community resources, the home or living arrangements for the child when he left or might have left the institution. Frequently, such failure to follow through with needed action seemed to contribute to early breakdown or inability to make satisfactory adjustment in the community. In many cases the patients and wards were returned to the very situation which had been declared unsuitable, detrimental and dangerous.

Breakdown in communication and cooperation on behalf of the child is indicated in over half of the cases.

Coordination between active agencies was rated poor in 28.5% of the total sample of cases; in an additional 27.5% of the cases, coordination was poor in some respects and good in some. Collaboration between institution and community was rated poor in 33.4% of the total sample at the time of the child's admission to the institution, in 45.6% of the total sample during the child's institutionalization and in 59.6% of the sample at the time of the child's release.

Collaboration was rated as facilitating release from the institution in only 16.1% of the cases and a lack of collaboration was rated as impeding release of youth in 27.1% of the cases.

Review of the profiles of the inappropriately institutionalized and the prolonged stay groups re-enforces the necessity for immediate improvement in coordination and collaboration. One cause of institutionalization being prolonged was lack of collaboration between the institution staff and significant adults in the community.

RECOMMENDATIONS

(53) Liaison between the institution and the community must be improved. The institution has the responsibility for developing effective communication, coordination and collaboration between institution and the community. Social Service staff in the institution should be the designated staff for carrying out this function. In order to accomplish this assignment, institution social work staff not only must be involved early in the child's institutionalization but must use aggressive social work techniques to establish appropriate community contacts and collaboration. Special educators in the institutions should develop and maintain an effective relationship with local schools in behalf of planning for individual children.

(54) Ways and means must be devised to improve methods of communication and collaboration between both public and private agencies. Consideration should be given to the development of a guide to be used as a reference by agencies and individual professionals in establishing a plan to assure effective coordination of services.

(55) An "Implied Contract" between the facilities of the Department of Mental Health and the hospital or Illinois Youth Commission and the community must be agreed upon at the time of admission of the child to the hospital. This "Contract" should involve the parents or guardian and if there are no parents or guardian, a guardian in the community should be obtained through court action. This "Contract" should also involve appropriate community agencies—those agencies which will provide services during and/or after hospitalization or commitment.

(56) Administrative policy and procedures and, if necessary, legislation should be developed which will facilitate the transfer of youth needing such services between the Department of Mental Health and the Illinois Youth Commission with support of the Court of Jurisdiction.

(57) It is recommended that the type of admission of children to State mental hospitals should be voluntary with the parents or guardian being responsible for the decision. Where parents are incompetent or uncooperative, court commitment should be sought. The Mental Health Code should be revised to this effect.

(58) Hospital and Illinois Youth Commission institution staff should have diagnostic, progress and pre-release case staffings; community professionals and agency staff should participate in them. In many instances, psychiatric evaluations included specific suggestions and recommendations which were never followed through. Methods must be evolved to implement such recommendations, especially between institution staff and community representatives.

(59) Procedures must be developed for smooth functioning on cases among all State agencies but particularly between the Department of Children and Family Services, the Illinois Youth Commission and the Department of Mental Health.[1]

(60) Agreements between institution and community should be developed so that staff know that the community will facilitate the child's return to the community and so that the community representatives know that readmission to the institution will be possible if needed.

(61) Institutional staff at the time of a child's admission should identify agencies and professionals who have served or could serve the child and obtain from them and provide to them information which will further diagnostic and treatment efforts on behalf of the child.

(62) Programs should be expanded by the Division of Vocational Rehabilitation to provide a continuum of vocational counseling and training for the youth who moves from institution to the community or vice versa. Such vocational programs should be developed in collaboration with the local education programs and facilities.

(63) The hospital should initiate activity and programs to encourage parents to organize citizen groups or associations to support the hospital programs and services for their children. These groups could vary from small neighborhood or community based groups to larger associations comprising a larger area such as a county or several counties. Their function would be to educate and to interpret needs and policies; to raise funds

[1] This recommendation has been dealt with in greater detail by the Inter-agency Committee on Collaboration on High Risk Children whose recommendation was . . . "at the regional or zone level should be established an inter-agency committee for collaboration and planning for children's services, . . ."

for special projects or equipment; to study needs; to help develop and to support legislation in behalf of the hospital and also for comprehensive mental health programs and services.

These groups should be autonomous but closely allied with the hospital and centers developed by the State comprehensive mental health program.

Such groups should be associated with the State association for mental health and its local units.

IV. GENERAL CONSIDERATIONS

FINDINGS

The study of these 185 cases revealed shocking inadequacies and gaps in services to these children and to their families. Although in some areas of the State services were non-existent, more of the "lacks" existed in areas where there were many services. Much responsibility for such failure to serve those in need must rest on the local community, its community planning or lack of it, and the administration of the various programs in the community.

Shortages of staff and creative ways of meeting staff problems may be linked to budgetary problems but also reflect the level of interest and knowledge of citizens and aggressiveness of the agency.

Direct treatment services in the community to emotionally disturbed children (and their families) are less costly to provide and are the preferred treatment, where appropriate, to institutionalization and are the best treatment in many, probably most, instances.

One of the serious inadequacies which this study emphasized was the lack of sufficient psychiatric services in the local communities. In many instances Outpatient Clinics were unable to meet the demands for diagnosis and treatment prior to institutionalization. Too often when such clinics were involved, they failed to maintain contacts with the child and institution upon release or maintained only perfunctory contact. Often this seemed to be related to the child's failure to adjust in the community and the resulting re-institutionalization.

In all human societies the family is the social unit in which the child is nurtured. Under our present socio-economic system the family is the unit upon which the structure of our society rests. From a mental health standpoint, a relationship with a responsible and mature adult who cares for and loves the child is essential to the child's well being as well as for his physical, emotional, social and intellectual growth and development.

ERIC

The most important service to all children is prevention. Certain direct services are preventive but public and private agencies must work together to develop, especially in the local community, the network of cooperating and integrated services and programs which will foster and strengthen the development of better homes, better parents and healthier children. Many programs and services which are preventive if they are available early enough could eventually decrease the demand for the more costly direct treatment and institutional services. Only by a program of prevention can the pressure of ever increasing needs be decreased. A program of prevention must involve the entire community and reach into homes, schools, offices and churches; it must give insight and understanding as well as teach technique and skills to parents, to adults, to children and to youth.

This study revealed serious gaps and the failure of many well recognized social welfare services to reach or adequately serve these children and their families. The findings of this study have confirmed the opinion of knowledgeable people in the social welfare and mental health fields that much more intensive work should be done to strengthen family life, to better family living conditions and to improve parent-child relationships.

Perhaps the most significant finding is the obvious need for more intensive study and research and making use of the great amount of research material which these institutions contain.

Throughout the Committee's discussion there has been an ever present concern over the increase in funds that implementation of these recommendations would require. Although a number of the recommendations should not require new funds for they deal with better utilization of existing staff and realignment of services, even the maintenance of the present level of service will require increased financing. Illinois is in danger of losing ground in its children's services unless some additional sources of financing are found.

In looking at the needs of these families and children, the shortage of qualified personnel is a glaring problem in all the services. The costly results of the lack of professional personnel, particularly in the preventive and followup programs in the community, came through clearly. The State, in the long run, had to bear and will continue to bear for years to come, far greater costs in expensive institutionalization, avoidable re-admissions, and in the misery and irreparable damage to its most important resource—its children.

RECOMMENDATIONS

(64) Strong community organization structures should be developed for both large and small communities. These organizations should initiate and improve the quality and quantity of community services and help secure adequate support for them.

(65) Research programs should be set up in all State Programs for children (strengthened where they exist) and implemented with funds and staff.

(66) Additional financing of basic services to families and children must be found. Every effort should be made by all groups in the State who are concerned with children to secure an amendment to the revenue article of the State Constitution so as to provide additional financial resources. The Legislature is urged to give greater consideration to the financing of the preventive community services which are admittedly harder to see and understand than an institutional program. Also, increased funds for extending the treatment staff in the institutions should be granted so that treatment and prevention of further deterioration may become as effective and rapid as possible.

This Committee believes the implementation of the foregoing recommendations would bring us much nearer to achieving the goal enunciated by the Midcentury White House Conference on Children and Youth.

"A FAIR CHANCE FOR
EVERY CHILD TO ACHIEVE A HEALTHY PERSONALITY."

APPENDIX A

Acknowledgments

Although the Study pointed up the need for better coordination and collaboration in services for children, the coordination, collaboration and special efforts of the people who participated in the Study were of the highest quality. The Commission on Children acknowledges, with appreciation, the special effort and heavy burden placed on the members of the Interdepartmental Committee on Children and Youth in the review and rating of cases. To Dr. Raymond Robertson, the Chairman of the Committee, Mrs. Edwin Eisendrath, Co-Chairman, and to Dr. Gloria Berkwits, who reviewed all 185 cases and marked several schedules, a special word of gratitude is given.

We are most grateful for the excellent cooperation of the Superintendents of the Institutions in the Illinois Youth Commission and the Department of Mental Health in making available to the Committee, the case records on which the Study was based and to the Directors of other State Departments and Voluntary Agencies which contributed information.

The development of the Schedules used in the Study, the preparation of the Random Sample, and the data processing were significant contributions to the Study and we are indebted to Dr. Kenneth I. Howard, Chief of the Division of Measurements and Statistics in Research, and to Dr. Elise Lessing of the Research Program in Child Development, both in the Institute for Juvenile Research, for their contributions.

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APPENDIX B

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Mrs. Frank Stewart, Dolton
Mr. Harold O. Swank, Springfield
Sen. Arthur R. Swanson, Chicago
Mr. John A. Troike, Springfield
Harold M. Visotsky, M.D., Springfield
Mr. Cyril H. Winking, Springfield
Franklin D. Yoder, M.D., Springfield
Mr. James Zacharias, Winnetka

APPENDIX C

INTERDEPARTMENTAL COMMITTEE SCHEDULE

IDENTIFYING, ADMINISTRATIVE AND SOCIOLOGICAL DATA

Name of Child __________ (1-5) Case No. ______
(6) Card No. 1
(7-12) Birthdate ____ (13-16) Date of admission, Mo. & Yr. ______
(17) No. of previous admissions ______
(18) Institution ______ (19) County of residence ______
(20) Sex: 1 Male 2 Female
(21) Race

1 White
2 Negro
3 Other nonwhite (e.g. Oriental, Indian, etc.)
4 Mixed (parents differ in race)
5 Unknown

Religion

Father (22)	Mother (23)	
1	1	Protestant
2	2	Catholic
3	3	Jewish
4	4	Other
5	5	None
6	6	Unknown

(24) Person or agency responsible for initiating referral

1 Self or parents
2 Relatives, friends
3 Social agency
4 School
5 Court
6 Medical
7 Other
8 Medical plus social agency
9 Medical plus school
X School plus social agency
Y Other combination of referral sources
0 Unknown

(25) Living arrangement at time of hospitalization or commitment

1 Child living in own home with both natural parents
2 Child living in own home with at least 1 natural parent
3 Child living in a foster home
4 Child living in an adoptive home; no natural parent in home
5 Child living with relatives
6 Child living in child care institution or boarding school
7 Jail or detention home
8 Other living arrangement
9 Unknown

Reasons for parental absence from home at time of child's hospitalization or commitment. (Code only *one* alternative for each parent.)

Father (26)	Mother (27)	
1	1	Dead
2	2	Absent from child's home because separated from spouse
3	3	Absent from child's home because divorced from spouse
4	4	Absent because hospitalized for physical illness
5	5	Absent because hospitalized for mental illness
6	6	Absent because in military service
7	7	Absent because in prison
8	8	Absent for some other reason
9	9	Reason for absence unknown
0	0	Item not applicable; parent in child's home

(28) Occupation of principal wage earner

1 Professional, technical, and kindred workers
2 Farmers and farm managers
3 Managers, officials, and proprietors except farm
4 Clerical, sales, and kindred workers
5 Craftsmen, foremen, and kindred workers
6 Operatives and kindred workers
7 Private household workers, domestic service workers
8 Service workers except domestic
9 Farm laborers and foremen
X Laborers except farm
Y Item not applicable because neither father nor mother employed
0 Unknown

(29) Outside sources of income

1 Family receiving ADC, unemployment compensation, or other benefits
2 Income received from some other source such as divorced spouse, relatives, etc.
3 Item not applicable; family income supplied by principal wage earner
4 Neither father nor mother employed, but source of income unknown

(30) Family currently living in

1 Own private house
2 Rented house
3 Rented apartment
4 Rooms in apartment or house of relatives
5 Public housing project
6 Insufficient information

(31) Quality of housing accommodations

1 Meets minimal standards
2 Substandard (e.g., slum housing)
3 Insufficient information

(32) Number of siblings excluding patient ______ (Record number up to 9; if patient has over 9 sibs, code as X. Include adoptive, half, and step-sibs)

(33) Sex of siblings

1 Same
2 Opposite
3 Both

(34) Ordinal position (circle only one)

1 Patient is oldest
2 Patient is middle child
3 Patient is youngest
4 Patient is twin
5 Item not applicable; patient has no siblings
6 Unknown

Education of parent

Father (35)	Mother (36)	
1	1	Elementary school
2	2	Some high School
3	3	High school graduate
4	4	Some college
5	5	College graduate
6	6	Graduate studies
7	7	Unknown

(37) School placement of child in community; grade level

1 Kindergarten
2 Elementary
3 Secondary
4 Ungraded
5 Out of school
6 Insufficient information

(38) School placement of child in community—type of school

1 Public
2 Private
3 Parochial
4 Item not applicable; child not in school
5 Undetermined

(39) School placement—grade placement

1 In grade expected on basis of chronological age
2 Accelerated in grade placement
3 Retarded in grade placement or in ungraded room
4 Item not applicable (e.g., child not in school)
5 Undetermined

(40) School placement—type of class and/or school

1 Regular classroom placement
2 Special class or school for physically handicapped
3 Special class or school for emotionally disturbed
4 Special class or school for mentally retarded
5 Item not applicable (e.g., child not in school)
6 Undetermined

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INTERDEPARTMENTAL COMMITTEE SCHEDULE PART II

PSYCHIATRIC EVALUATION

Name of child ______________________ (1-5) Case No. ______

(6) Card No. 2 (7-12) Birthdate ______________

Presenting symptoms of child (circle all that apply)

Behavior

(13) Aggressive behavior
(14) Impulsive behavior
(15) Bizarre behavior
(16) Sexual behavior
(17) Destructive behavior (e.g. persons, property, arson)
(18) Withdrawn behavior
(19) Homicidal behavior
(20) Suicidal behavior
(21) Truancy from school
(22) Truancy from home
(23) Stealing
(24) Unmanageable

Thought

(25) Loss of contact with reality and thought disturbance
(26) Learning disturbance

Disturbance of Bodily Function

(27) Bowel
(28) Bladder
(29) Feeding
(30) Locomotor
(31) Speech
(32) Hearing
(33) Vision

(34) Primary problem area (circle only *one*)

1 Socially unacceptable behavior, acting out
2 Sex problem
3 Learning defect
4 Personality problem
5 Somatic dysfunction including habit disorders involving disturbance of bodily function
6 Acute emotional disturbance
7 Psychotic break
8 Unknown

(35) Onset of present illness

1 Infancy
2 Preschool period
3 Elementary school period
4 Junior high school period
5 High school period

Diagnosis

(36-39) Hospital ____________________
(40-43) Reviewer ____________________

(44) Intensity of disturbance

1 None
2 Mild
3 Moderate
4 Marked
5 Very intense

Factors contributing to disturbance which led to hospitalization or commitment

Medical

(45) Pathology during pregnancy or labor
(46) Congenital anomalies
(47) Allergy
(48) Convulsions
(49) Other medical—surgical pathology
(50) Physical defects—from disease, injury
(51) Central nervous system pathology

Socioeconomic

(52) Marked economic problems
(53) Parents working
(54) More than one placement

Familial

(55) Traumatic separations
(56) Disturbance of marital relationship
(57) Disturbance of father-child relationship
(58) Disturbance of mother-child relationship
(59) Loss of parent(s) by death
(60) Loss of parent(s) by divorce or separation
(61) Loss of sibling(s)
(62) Acquisition of sibling(s)

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(63) Parental relationship (code only *one*)

1 Reasonably satisfactory
2 Unsatisfactory
3 Marked overt conflict
4 Unusual absence of conflict
5 Unknown

(64) Differences in parental backgrounds (code only *one*)

1 Different cultural and/or economic background
2 Different educational attainment
3 Different cultural and/or economic background and difference in educational attainment
4 Item not applicable; these differences not present
5 Unknown

(65) Age difference between parents

1 Unusual age difference between parents
2 No unusual age difference
3 Unknown

Card 2 of Psychiatric Evaluation
(1-5) Repeat child's case no. __________ (6) Card No. 3
(7-12) Repeat child's birthdate ______________

Parent areas of difficulty (circle all that apply)

Father	Mother	
(13)	(14)	Mental health
(15)	(16)	Physical health
(17)	(18)	Alcoholism
(19)	(20)	Vocational
(21)	(22)	Crime or promiscuity
(23)	(24)	Intellectual
(25)	(26)	Other
(27)	(28)	Insufficient information to code "parent areas of difficulty" (Lack of coding on preceding items means "no data" rather than that item does not apply)

Parent-child relationship (circle all that apply)

Father	Mother	
(29)	(30)	Reasonably wholesome
(31)	(32)	Negative—rejecting (e.g. punitive, depreciative, neglectful)

Father	Mother	
(33)	(34)	Pushing (e.g. pushing to early responsibility, overly ambitious, etc.)
(35)	(36)	Rivalrous, competitive
(37)	(38)	Pathologically positive (e.g. infantilizing, overprotective, overly permissive, seductive)
(39)	(40)	Lack of consistency and/or conflicting authorities
(41)	(42)	Uninvolved
(43)	(44)	Setting example for child's pathology or acting out through child
(45)	(46)	Insufficient information to code parent-child relationship (Lack of coding on preceding items means "no data" rather than that item does not apply)

(47) Psychological test findings—intelligence
1 Severe mental retardation (below 20)
2 Moderate mental retardation (20 through 49)
3 Mild mental retardation (50 through 69)
4 Dull (70 through 89)
5 Average (90 through 109)
6 High average (111 through 119)
7 Superior (120 through 139)
8 Very superior (140 and above)
9 No data, undetermined

(48) Validity of test findings
1 Unquestioned
2 Somewhat questioned
3 Seriously questioned; not representative of actual potential

(49) Source of IQ data
1 Individual test (e.g. Binet, WISC)
2 Group test
3 Unknown

(50) Evaluation of degree of disturbance on basis of psychological examination
1 None (no disturbance)
2 Mild
3 Moderate
4 Marked
5 Very intense
6 Undetermined (e.g. no personality testing)

(51) Source of psychological data regarding personality

1 Projective testing including Rorschach
2 Projective testing not including Rorschach
3 Objective tests only (e.g. MMPI)
4 Projective and objective testing
5 Undetermined or no personality testing

Participation in hospital program (circle all that apply)

Psychotherapy
(52) Individual
(53) Group

Type of psychotherapy

(54) Psychoanalysis
(55) Relationship
(56) Supportive
(57) Drug therapy
(58) Somatic therapy
(59) Patient government
(60) Occupational therapy
(61) Recreational activity
(62) Vocational training and guidance
(63) Religious activity
(64) Educational program

APPENDIX D

SCHEDULE ON NEEDS OF CHILD AND AGENCY SERVICES

STUDY ON EMOTIONALLY DISTURBED CHILDREN

INTERDEPARTMENTAL COMMITTEE ON CHILDREN AND YOUTH

Name of child ______________________ (1-5) Case No. ________
(6) Card No. 4
(7-12) Child's birthdate ____________ (13) Agency completing schedule ________________

Part One

The following is a list of *needs* which an "emotionally disturbed or delinquent child" might have. You are to consider the needs of the child in the period (i.e., 6-12 weeks) immediately preceding hospitalization or commitment. Place a check in the first column (headed "Primary") before a need, if you feel that need was applicable to this case and centrally important. Place a check in the second column (headed "Secondary") before a need, if you feel that the need was applicable but not centrally important. Check as many as apply for this child. Remember to base your opinions on the status of the child immediately before the present hospitalization or commitment. (Please check the appropriate needs regardless of whether or not they were met.)

Primary	*Secondary*	
______	______	14. Diagnostic study and evaluation of child
______	______	15. Comprehensive and intensive diagnostic study of child
______	______	16. Diagnostic study and evaluation of family
______	______	17. Psychotherapeutic treatment of child
______	______	18. Counseling or guidance in handling specific immediate problem (e.g., arranging for adoption of illegitimate child)
______	______	19. Psychotherapeutic treatment of family
______	______	20. Counseling or guidance of family
______	______	21. Total and intensive short-term treatment of child
______	______	22. Total and intensive long-term treatment of child
______	______	23. Somatic therapy (excluding tranquilizers, sedatives or anti-depressants)

Primary	*Secondary*	
______	______	24. Drug therapy (e.g., tranquilizers, sedatives, etc.)
______	______	25. Protective services (to protect child from self)
______	______	26. Emergency supportive care (24-hour supportive care for emotional crisis)
______	______	27. Protective services (to protect family and/or community from child)
______	______	28. Temporary removal from stressful or inadequate home environment
______	______	29. Permanent removal from stressful or inadequate home environment
______	______	30. Strengthening parent-child relationship
______	______	31. Provision of stable parental figures
______	______	32. Supervised living situation with authority figures whose role is less involved than that of parent-surrogate
______	______	33. Close, continuous adult supervision
______	______	34. Restriction of activity for correctional purposes
______	______	35. General medical care
______	______	36. Specialized medical care (excluding psychiatry)
______	______	37. Intensive and/or continuous physical care
______	______	38. Special educational service during regular school day
______	______	39. Special service for longer daily period than regular school day
______	______	40. Vocational training
______	______	41. Vocational counseling and/or guidance
______	______	42. Job placement
______	______	43. Leisure time and recreational services
______	______	44. Provision of emotionally healthy peer-group associations
______	______	45. Character building and ethical training
______	______	46. Religious counseling
______	______	47. Financial assistance
______	______	48. Additional needs (please specify) ________ ________________________________ ________________________________ ________________________________
______	______	49. Resolution of internal conflict

______ ______ 50. Development of conscience
______ ______ 51. Furthering emotional maturation
______ ______ 52. Relief from disabling emotional symptoms
______ ______ 53. Elimination of social deprivation

Part Two

Repeat child's case no. (1-5) ______ (6) Card No. 5 Repeat birth-date (7-12) ________ (13) Agency completing schedule ________
Following is a list of *services* presently provided for children and their families. Before each service is a "C" (Child), "F" (Family), "CF" (Child and Family). If you feel that the service should have been provided for the Child you should circle "C"; if it should have been provided for the Family (excluding the Child) you should circle "F"; if the service should have been provided for both the Child and the Family, you should circle "CF".

C F CF 14. General medical care ______ ______
C F CF 15. Specialized medical care (excluding psychiatry) ______ ______
C F CF 16. Psychiatric services: Out-patient services-diagnostic ______ ______
C F CF 17. Psychiatric services: Out-patient services-therapeutic ______ ______
C F CF 18. Psychiatric services: Day school services ______ ______
C F CF 19. Public health nursing
C F CF 20. Family & child welfare services: casework ______ ______
C F CF 21. Family & child welfare serv.: foster home placement ______ ______
C F CF 22. Family & child welfare serv.: institutional placement ______ ______
C F CF 23. Family & child welfare serv.: adoption ______ ______
C F CF 24. Family & child welfare serv.: day care placement ______ ______
C F CF 25. Family & child welfare serv.: boarding club placement ______ ______
C F CF 26. Family & child welfare serv.: unmarried patient service ______ ______
C F CF 27. Family & child welfare serv.: financial assistance ______ ______
C F CF 28. Family & child welfare serv.: protective services ______ ______
C F CF 29. Correctional services: probation ______ ______
C F CF 30. Correctional services: detention ______ ______
C F CF 31. Correctional services: parole (aftercare) ______ ______
C F CF 32. Correctional services: institutional and/or forestry camps ______ ______
C F CF 33. Correctional services: juvenile police supervision ______ ______
C F CF 34. Correctional services: community services ______ ______
C F CF 35. Educational services: homebound tutoring ______ ______
C F CF 36. Educational services: class for emotionally disturbed ______ ______
C F CF 37. Educational services: class for socially maladjusted ______ ______
C F CF 38. Educational services: class for learning disorder or perceptual handicapped or brain damaged ______ ______
C F CF 39. Educational services: EMH class ______ ______
C F CF 40. Educational services: TMH class ______ ______
C F CF 41. Educational services: physically handicapped class ______ ______
C F CF 42. Educational services: speech therapy ______ ______
C F CF 43. Educational services: hard of hearing class ______ ______
C F CF 44. Educational services: classes for the deaf ______ ______
C F CF 45. Educational services: partially sighted ______ ______
C F CF 46. Educational services: classes for the blind ______ ______
C F CF 47. Educational services: multiple handicapped class ______ ______
C F CF 48. Educational services: gifted class ______ ______
C F CF 49. Educational services: boarding school (non handicapped) ______ ______

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C F CF 50. Educational services: boarding school—visual ______ ______
C F CF 51. Educational services: boarding school—auditory ______ ______
C F CF 52. Educational services: boarding school—physical ______ ______
C F CF 53. Educational services: boarding school ______ ______
C F CF 54. School social work ______ ______
C F CF 55. Medical social work ______ ______
C F CF 56. Psychiatric social work ______ ______
C F CF 57. Vocational services: vocational counseling ______ ______
C F CF 58. Vocational services: physical restoration ______ ______
C F CF 59. Vocational services: emotional restoration ______ ______
C F CF 60. Vocational services: vocational training ______ ______
C F CF 61. Vocational services: vocational placement—regular ______ ______
C F CF 62. Vocational services: vocational placement—part-time ______ ______
C F CF 63. Vocational serv.: vocational placement—summer only ______ ______
C F CF 64. Leisure time, character building and recreational services: scouting ______ ______
C F CF 65. Leisure time, character building and recreational services: YMCA - YWCA ______ ______
C F CF 66. Social group work: community centers and settlement house clubs, neighborhood ______ ______
C F CF 67. Leisure time, character building and recreational services: youth center program ______ ______
C F CF 68. Religion: church attendance ______ ______
C F CF 69. Religion: Sunday school or similar ______ ______
C F CF 70. Religion: pastoral counseling ______ ______
C F CF 71. Religion: church youth group ______ ______

Please review the items above which you circled. Place an "S" in the first blank (column one) after the circled item if you believe that provision of the service would have shortened the period of the child's hospitalization or commitment. If you believe that the provision of the service would not have shortened hospitalization or commitment, place an "N" in the blank.

Again review the above items which you circled. Below is a listing which indicates whether or not the service was available or unavailable. In the second blank place the number of the item below which is appropriate for each of the items you circled above.

Available and Used

1. Service used and helpful
2. Service used and not helpful

Available and Not Used

3. Service not offered
4. Service not used because of long waiting list
5. Service not used because of parents' resistance
6. Service not used because of child's resistance
7. Child was ineligible for service
8. Service not requested by agency or family

Unavailable

9. Service unavailable

Reason Unknown

0 Insufficient information

Example: If the child could have used general medical care and it was not offered you circle "C" for the item number one. If you feel that provision of general medical care, however, would not have shortened the period of hospitalization required by the child you would have placed an "N" in the first blank following item one. If general medical care was not offered because the parents would not allow it, you would place a "5" in the second blank following the item.

The completed item would now appear as follows:

C F CF 14. General medical care N 5

Part Three

Repeat child's case no. (1-5) ____ (6) Card No. 5 Repeat birthdate (7-12) ________ (13) Agency completing schedule ____________

Under Part One you evaluated the needs of the child and under Part Two you indicated services which would have helped the child. The services listed under Part Two are provided by a variety of State and local agencies, many of which are listed below. On the first line in front of each agency, please write the number of one of the following codes:

1. Agency active on case, but not in connection with hospitalization or commitment
2. Agency active on case prior to and in connection with hospitalization or commitment
3. Agency active on case during hospitalization or commitment
4. Agency not active and lack of activity appropriate
5. Agency not active but should have been involved

List of State Agencies

______ ______ 14. Department of Children and Family Services
______ ______ 15. Department of Labor
______ ______ 16. Department of Mental Health (on IYC cases only)
______ ______ 17. Department of Public Aid

______ ______ 18. Department of Public Health
______ ______ 19. Division of Services for Crippled Children
______ ______ 20. Division of Vocational Rehabilitation
______ ______ 21. Office of Superintendent of Public Instruction
______ ______ 22. Veterans Commission
______ ______ 23. Youth Commission (on DMH cases only)

List of Local Agencies

______ ______ 24. Mental health clinic
______ ______ 25. Family service
______ ______ 26. Child welfare service
______ ______ 27. Special education program—local schools
______ ______ 28. Child and family service
______ ______ 29. Youth department of the city police
______ ______ 30. Probation service
______ ______ 31. Religious counseling

Now consider *only* those agencies which you have coded as 5 "Agency not active but should have been involved." On the second line, place the number of *one* of the following codes.

1. Agency should have been active before hospitalization or commitment
2. Agency should have been active during hospitalization or commitment
3. Agency should have been active after hospitalization or commitment
4. Agency should have been active before and after hospitalization or commitment
5. Agency should have been active before, during, and after hospitalization or commitment
6. Agency should have been active during and after hospitalization or commitment
7. Agency should have been active at some periods not covered by alternatives 1-6. (Please specify the periods ______________)

An example of a completed item would be as follows:

5   4   Division of Vocational Rehabilitation

These codes indicate that the Division of Vocational Rehabilitation was not active on this case, but you think it should have been active ("5" code) and that the desired period of activity was before and after hospitalization ("4" code).

Part Four

Below are some statements concerning your overall evaluation of this case. Please answer each item.

I. Coordination of Services

32. Coordination of services between agencies active on the case was: (circle the appropriate number)

    1. Good 2. Adequate 3. Some aspects good, some poor 4. poor 5. Item not applicable; only one agency active

II. Collaboration between Institution and Community

For the purposes of this section, the term "Institution" refers to the hospital or correctional facility where the child now resides, while the term "Community" includes all persons and facilities outside of the child's current institutional placement.

Collaboration between Institution and Community was: (circle appropriate number for each item)

33. 1. Good 2. Adequate 3. Poor at the time of child's admission to institution
34. 1. Good 2. Adequate 3. Poor during the child's hospitalization
35. 1. Good 2. Adequate 3. Poor at the time of the child's discharge
36. Initiative regarding collaboration was taken: (circle appropriate number below)
    1. Entirely by Institution
    2. Mostly by Institution though some initiative taken by Community
    3. By Institution and Community in nearly equal amounts
    4. Mostly by Community, though some initiative taken by Institution
    5. Entirely by Community
    6. Insufficient information to evaluate
37. Collaboration or the lack of it was a factor which: (circle appropriate number below)
    1. Facilitated discharge
    2. Impeded discharge
    3. Played little or no role in discharge

III. Appropriateness of Hospitalization or Commitment

38. Hospitalization or Commitment was: (circle appropriate number below)

    1. Appropriate
    2. Inappropriate
    3. Insufficient information to evaluate

39. Length of Hospitalization or Commitment: (circle appropriate number below)

    1. Appropriate
    2. Excessive by amount of time recorded on line following this item (please specify *months* or *years* in addition to recording a number)

       ____

    3. Item not applicable because entire confinement considered inappropriate

CASE SUMMARY

Please write a brief narrati⸝ summary of the primary features and problems presented by this case. Include any outstanding or unusual features.

APPENDIX E

Changes Made in Department of Mental Health Program Since Study Began

A look at trends in the admissions and on-books statistics is indicated prior to reviewing program changes.

Admissions

Year	Admissions
1938-39	52
1946-47	63
1954-55	164
1959-60	384
1960-61	423
1961-62	548
1962-63	535
1966-67	767

In 1963-64 none of the Zone Center facilities had been completed. A breakdown of the admissions for the fiscal year 1966-67 reveals a change in Department resources.

Facility	Admissions
Alton State Hospital	72
Anna State Hospital	13
Chicago State Hospital	93
East Moline State Hospital	52
Elgin State Hospital	123
Galesburg State Research Hospital	47
Illinois Security Hospital	8
Jacksonville State Hospital	23
Kankakee State Hospital	68
Manteno State Hospital	69
Peoria State Hospital	47

In addition the following mental health resources became available:

Facility	Admissions
Tinley Park State Hospital	28
Read Zone Center	110
McFarland Zone Center	10
Singer Zone Center	3
Meyer Zone Center	1

On-Books Population

On-Books Population

State Hospital	1955	1960	1961	1964	1965	1967
Alton	5	8	16	37	39	27
Anna	3	7	7	9	8	9
Chicago	23	125	120	263	288	186
East Moline	5	5	5	11	14	15
Elgin	40	42	62	201	180	139
Galesburg	0	78	113	66	59	52
Illinois Security	0	0	0	5	7	12
Jacksonville	8	15	12	19	15	14
Kankakee	6	4	10	17	46	66
Manteno	14	12	11	10	10	28
Peoria	50	69	65	82	70	48
Read Zone Center	0	0	0	0	0	24
Tinley Park	0	0	0	0	0	14
Total	154	364	421	720	736	634

In 1964 the only public inpatient resources available for child and adolescent patients were the eleven (11) state hospitals and only Chicago, Elgin, Galesburg and Peoria had special programs and facilities for them. Alton and East Moline had developed special programs but the young patients were housed with adult patients.

In the three year period that elapsed while the study was made the Department developed additional resources and began to develop more effective relationships with other agencies and families so that existing Department resources would be utilized in a most effective way. This largely accounts for the decrease in the on-books population from 720 to 634 from 1964 to 1967 and for the change in distribution of patients in the hospitals. Another significant development has been the development of additional resources for mentally retarded children and youth. 71 (10%) of the 720 patients in the hospitals on June 30, 1964 were transferred to state schools in the interim.

Below is a summary of the changes made in the Department's program by Zone:

Rockford Zone

This zone had no inpatient services in 1964. By June, 1967, the Singer Zone Center staff were just beginning to provide inpatient services for children and adolescents. Three young patients were admitted.

Chicago—North Zone (Read)

In June, 1964, the inpatient services of this Zone consisted of the children and adolescents units of Chicago and Elgin State Hospitals. There were 263 young patients at *Chicago State Hospital* but only 133 of them were in special programs. The remaining 130 pa-

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tients were housed with adult patients and were receiving minimal custodial care. In the interim period the hospital was reorganized and the children and adolescent unit of the hospital was merged with the new developing children and adolescent unit of the Zone Center, to form a comprehensive community mental health program. All young patients were placed in special programs and the facilities of the unit and the bed capacity were increased from 133 to 225. In spite of this, the need for staff and shortage of mental health services in the Chicago area resulted in the service providing for only a small fraction of the need. The General Assembly approved the Department's request for new facilities for the unit and as a result it will be possible to provide services in an area away from the other units of the hospital.

In June, 1964 there were 201 patients at *Elgin State Hospital* but only 48 young patients were placed in separate programs and facilities. Subsequently, additional facilities and staff from the hospital were made available so that 100 of the 139 young patients are now being served in separate programs and facilities. The General Assembly also approved the Department's request for new facilities for this unit.

Chicago South Zone (Madden)

In June, 1964, there were no inpatient services for children and adolescents in this Zone. There were 10 adolescents at Manteno State Hospital but they were housed with adult patients and received custodial care.

Since then *Manteno and Tinley Park State Hospitals* have been developing separate programs, and separate facilities are being allocated for children and adolescents at Tinley Park. Inpatient services at the Madden Zone Center are being developed.

Peoria Zone (Zeller)

In June, 1964, the inpatient services of this Zone consisted of children and adolescent units at Galesburg and Peoria State Hospitals. In addition, young patients were housed with adult patients at East Moline State Hospital.

There were 66 young patients at *Galesburg State Research Hospital* in 1964 and 52 in 1967. All of these patients were served in special programs and facilities.

In 1964, there were 82 patients at *Peoria State Hospital* and this had decreased to 48 in 1967. All of them were served in special programs and facilities.

In 1964, there were 11 patients at *East Moline State Hospital* and 15 patients in 1967. Funds have been allocated to provide separate facilities for a small unit for adolescents at this hospital.

There has been a decrease in the On-Books Population of the young patients in hospitals in this Zone from 159 to 115. Two of these hospitals formerly served a number of patients from the Chicago area. Under the new Zone plan, patients are admitted to the hospital nearest the child's home. This largely accounts for the above.

The Zeller Zone Center inpatient services are being developed but by June 30, 1967 were not operative.

Champaign-Decatur Zone (Adler and Meyer)

In June, 1964, there were no separate inpatient services in this Zone for children and adolescents. Young patients were housed at Kankakee State Hospital.

There were 17 young patients housed at *Kankakee State Hospital* on June 30, 1964 and this increased to 66 by June 30, 1967. This hospital accepted a number of Chicago area patients in addition to serving the Zone. By June, 1967, separate programs and facilities were available for the majority of the patients in the hospital. By the same date inpatient services were beginning to be available for adolescent patients at the Meyer Zone Center.

Springfield Zone (McFarland)

In June, 1964, there were no inpatient services for children and adolescents in this Zone. 19 young patients were housed with adult patients at *Jacksonville State Hospital* on June 30, 1964 and this decreased to 14 by June 30, 1967. By June 30, 1967, the inpatient unit of the Zone Center was operative and 10 young patients had been admitted.

East St. Louis Zone

In June, 1964, the inpatient services of this Zone consisted of the children and adolescent unit at Alton State Hospital.

On June 30, 1964, there were 37 young patients housed on adult wards at *Alton State Hospital.* A separate program was available. Three years later the number in the hospital was 27.

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Carbondale Zone

In June, 1964 and 1967, there were no inpatient services available for young patients in this Zone. Adolescents were housed with adult patients at both *Anna State Hospital* (9) and at *Illinois Security Hospital* (5). Custodial care was provided, particularly at the latter hospital. Three years later, there were 9 young patients at Anna and 12 at Illinois Security. The latter is used by all state hospitals for patients requiring maximum security.

Only Department of Mental Health

Division of Mental Retardation

On June 30, 1964, the Department's inpatient resources for young retarded patients needing a residential service, consisted of the Dixon and Lincoln State Schools. In the subsequent three years, the Bowen, Fox and Murray Centers were opened and 71 young patients were transferred from state hospitals to state schools.

Comment

This report focuses only on inpatient services for children and adolescents needing treatment in an inpatient service. While outpatient and day care services for the emotionally disturbed child are significantly related to the inpatient services, the scope of the study precludes a review of the developments in this area.

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APPENDIX F

Follow-up of the 720 Department of Mental Health Cases in the Study

Since the study extended over a long period of time a follow-up of the status of each of the 720 children and youth who were in the hospitals as of June 30, 1964, was made. The Data Analysis Section of the Division of Planning and Evaluation of the Department, provide information on patient movement from June 30, 1964 to June 30, 1967. Below is a summary of the findings for each young patient by hospital:

	Alton	Anna	Chicago	East Moline	Elgin	Galesburg	Illinois Security	Jacksonville	Kankakee	Manteno	Peoria	Total
Number of Patients	37	9	263	11	201	66	5	19	17	10	82	720
Length of Stay by Mo.	24	27	37	21	25	31	69	28	30	35	44	33
Discharged	25 (68%)	6 (66%)	139 (53%)	5 (46%)	147 (73%)	45 (68%)	4 (80%)	8 (42%)	9 (53%)	3 (30%)	34 (41%)	425 (59%)
Length of Stay by Mo.	16	16	24	9	17	17	71	12	17	7	25	20
In Same Hospital	0 (0%)	0 (0%)	76 (29%)	1 (9%)	38 (19%)	14 (21%)	0 (0%)	5 (25%)	4 (23%)	5 (50%)	18 (22%)	161 (22%)
Length of Stay by Mo.	0	0	54	11	48	61	0	32	53	41	57	52
Transfer Total	11 (29%)	3 (33%)	40 (15%)	3 (30%)	16 (8%)	7 (10%)	1 (20%)	6 (31%)	3 (18%)	2 (20%)	29 (37%)	121 (17%)
To State School	11 (29%)	2 (22%)	25 (9%)	1 (10%)	7 (3%)	1 (1%)	0 (0%)	6 (31%)	1 (6%)	2 (20%)	15 (19%)	71 (10%)
Length of Stay by Mo.	44	54	53	46	45	76	0	47	55	59	60	52
To Other Hospital	0 (0%)	1 (11%)	15 (6%)	2 (20%)	9 (5%)	6 (9%)	1 (20%)	0 (0%)	2 (12%)	0 (0%)	14 (18%)	50 (7%)
Length of Stay by Mo.	0	67	39	33	53	62	63	0	38	0	61	51
Deaths	1	0	6	1	0	0	0	0	1	0	0	9
Readmissions												
Before June 30, 1964	8	0	24	5	18	11	1	3	4	4	14	92
After June 30, 1964	11	0	48	4	32	32	1	2	6	4	13	163
Average at Discharge or on June 30, 1967	9 (25%)	4 (33%)	49 (18%)	2 (18%)	48 (23%)	22 (33%)	5 (100%)	7 (41%)	4 (23%)	8 (80%)	18 (22%)	176 (24%)