THE BRONX COURT RELATED UNIT: EVALUATION AND RECOMMENDATIONS *

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RECOMMENDATIONS

1. THE BRONX CRU PROJECT SHOULD BE CONTINUED FOR A PERIOD OF ONE ADDITIONAL YEAR. (p. 5)

2. A MEMBER OF THE CRU, EITHER AS THEIR SOLE RESPONSIBILITY OR AT LEAST AS THEIR PRIMARY RESPONSIBILITY, SHOULD BE ASSIGNED TO THE TASK OF INTERACTING ON A CONTINUOUS BASIS WITH ALL REFERRAL SOURCES. (p. 8)

3. EFFORTS SHOULD BE MADE BY ALL INVOLVED TO REDUCE THE AVERAGE AMOUNT OF TIME TAKEN TO PROCESS YOUTHS REFERRED TO THE CRU. FURTHERMORE, SOMEONE ASSOCIATED WITH THE CRU SHOULD TAKE RESPONSIBILITY FOR MONITORING THE STATUS AND PROGRESS OF REFERRED YOUTH THROUGH THE VARIOUS STAGES OF PROCESSING. (p. 12)

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I. INTRODUCTION

This report presents findings and recommendations stemming from the data collected on the Bronx Court Related Unit (CRU) during its first ten months of operation by members of the Special Projects Research Unit of the Department of Mental Hygiene. The timing of this report is dictated by its potential utility. For while both additional collection and additional analyses of data remain, decisions regarding the future of the CRU are currently being discussed. As such, we have chosen to examine the data currently available and to report our recommendations based on these data now rather than waiting until the entire first year period is complete. The main aim of this report, then, is to supply information and suggestions relevant to the questions of how well the CRU has functioned during these ten months and how the CRU might be improved in the future.

The evaluative research upon which this report is based has been conducted continuously over the entire life of the CRU. A variety of instruments and techniques have been utilized in obtaining data including the following: social and medical history forms developed in conjunction with CRU staff; staff questionnaires; interviews with youths in the program; psychological testing; youth behavior rating forms completed by staff; records of fines and bonuses associated with the socialization program; interviews conducted with staff members who have resigned or been terminated; observations made on the processes leading to admission; and finally, systematic monitoring of the structure and development of the Bronx CRU.

Clearly not all of these data will be presented in this report nor do the findings presented represent a final statement of our research effort. There are several reasons for this. First, in order to maximize the readability and utility of this report we have decided to analyze and present only the more important findings and recommendations from the data collected thus far. Second, given the time needed to develop, pre-test, revise and implement various aspects of our research design, adequate information in some areas will not be available until the end of the entire year of the planned research. Lastly, and perhaps most importantly, many of the questions which need to be answered regarding the value of the CRU cannot be answered until more time has passed -- time to allow the program to function over an extended period, to treat larger numbers of youths, and to return some youths to the community.

Although in this sense, the report is not final, the data collected to date and the recommendations flowing from the findings are nonetheless useful and important. In fact, some of the data has been and continues to be fed back to the CRU project in an attempt to make our efforts result in benefits not only to

our research interests but to the program and the youths in the program as well. Indeed, since the inception of the research project, a spirit of cooperation and mutual belief in the value of research has characterized the relationship between the CRU staff and the members of the research team. As a result of this relationship, our main concern in collecting data has not been simply to conduct research on an interesting project but rather to collect data which would be of value to the CRU in its attempt to improve itself and the treatment offered those under its care. It is with this latter aim that the following report is offered.

II. THE BRONX COURT RELATED UNIT: GOALS AND STRUCTURE

Recently, the New York Times Sunday Magazine published an article describing the current state of the juvenile justice system (The New York Times Magazine, July 19, 1975). The article began by describing the mugging, kidnapping, beating, brutal torture and sodomizing of two juveniles by two other juveniles. During the same year a New York State senator and his staff conducted a study of the juvenile system and reported their findings with similar shocking case histories in an article entitled, "The New and Dangerous Juvenile Delinquent" (Marino and McKenna, New York Affairs, Spring, 1975). Again in 1975 the Governor of New York, in response to the increase in violent acts by juveniles and perhaps more so in response to expressed public, mass media and political concern, established a special panel of experts on juvenile violence to develop a report with recommendations for appropriate executive and legislative action (N.Y.S. Governor's Panel on Juvenile Violence, 1976).

Despite the difference in aims, perspectives and backgrounds of the authors of these three pieces, all three are remarkably similar in their perception of what constitutes a major part of both the problem and the solution of juvenile violence. All three emphasize the importance of improving and expanding mental health services for violent juveniles. Thus, the New York Times article described how "time after time" the Family Court Judges "get probation reports that recommend therapy in a structured environment". The article by the state senator details how "a significant percentage of the juveniles arrested had at some point in their criminal careers been diagnosed as mentally ill and in need of therapy in a mental hospital". Both articles also criticize the mental health system for it's refusal and inability to deal with these juveniles and the lack of secure mental hygiene facilities for their treatment. The Governor's Panel also noted these same needs and problems. In fact, half of their eight major recommended steps for immediate action by the state were directed toward increasing services and facilities offered by the mental health system.

Thus, the need for providing psychiatric services to violent juveniles was seen as particularly acute within N.Y.S. The problem was typically ascribed to the inability of both the Division for Youth (DFY) and the Department of Mental Hygiene (DMH) in New York to care for these youth. DFY training schools and other facilities were seen as unequipped to deal with the psychiatric problems being displayed by many of the violent youth while the DMH children's psychiatric centers were seen as lacking the security necessary to maintain these juveniles in order to treat them. Resulting from the perceived need for specialized mental health services for violent juveniles, a pilot program was established exclusively for the care and treatment of male adjudicated juvenile delinquents who were determined to be both violent and in need of psychiatric care.

The program, to be jointly run by DFY and DMH, officially opened in February, 1976. The project design of this Court Related Unit called for two components. The principal function of the Department of Mental Hygiene component, a ten bed secure In-Patient Diagnostic Unit (IPDU), is to determine the presence, nature and degree of mental illness by observing and assessing youths over a period of time. Based on this evaluation, the staff on the IPDU are to design a treatment plan for each youth assessed which also includes a statement of disposition and recommendations of appropriate placement to the DFY component or to other DFY or DMH facilities.

Youths diagnosed as episodically mentally ill are transferred to the Division for Youth component, a twenty bed secure Long Term Treatment Unit (LTTU). The objective of this unit is to provide long term treatment based on the IPDU treatment plan recommendations. Youths in the unit are to participate in a highly structured goal oriented socialization program. As part of this token economy program youths are to be intensively supervised by trained staff. The unit strives to help its residents to: develop coping skills; improve self esteem; express hostility in constructive ways; and accept responsibility for their actions.

Referral to the program can come from any of several sources including the Family Court, the Probation Department, and the Division for Youth. Following referral, the youth must then pass through clinical screening and legal hearing procedures which together establish the appropriateness of placement in the IPDU unit. The criteria for admission are that the juvenile has displayed violent behavior and that there is some indication that the juvenile is so mentally disordered as to require psychiatric treatment. These are in addition to the basic criteria that the youth be male and be placed with DFY in the Title III category prior to his 17th birthday. If placement within the program is deemed inappropriate, the youth may be referred to another Department of Mental Hygiene facility or remain with the Division for Youth and be placed in one of its facilities. If the decision is made to accept the juvenile he is admitted to the DMH diagnostic and stabilization unit for up to 90 days. After completing this phase of the program the youth can be transferred either to the long-term unit for up to 18 months or to one of the other facilities operated by the Department of Mental Hygiene or the Division for Youth.

III. EVALUATION AND RECOMMENDATIONS

A. Continuation of the CRU

Before proceeding to a description of some of the specific issues relating to the success of the CRU during its first ten months, we feel it important to address the primary question of whether or not this pilot program should continue. On the basis of our examination of the CRU, we recommend the following:

> RECOMMENDATION 1: THE BRONX CRU PROJECT SHOULD BE CONTINUED FOR A PERIOD OF ONE ADDITIONAL YEAR.

There are three primary reasons for this recommendation.

1. The Innovative Nature of the Program

When the CRU was established, a frequently raised issue revolved around the question of what was sufficiently new about the program to justify the development and funding of this project. The two aspects of the program which we find innovative are the fact that it was established specifically for youth who were both serious offenders and in need of mental health services and the fact that the project involved both the DMH and the DFY.

The importance of the first is emphasized by a summary statement from a 1976 study on "Intervening with Convicted Serious Juvenile Offenders" conducted under a grant from the National Institute for Juvenile Justice and Delinquency Prevention (D. Mann, Rand Publishing Corporation, 1976).

> Our persistent question, "Who is doing a good job with serious juvenile offenders?" regularly brought the same negative or puzzled response. While some programs for juvenile offenders include serious offenders and are doing useful work there are no programs of concentrated assistance specifically for this group.

Thus, the CRU may be the only program and certainly one of a very few in the country which deals exclusively with serious juvenile offenders who are in need of psychiatric attention.

In addition, the CRU is programmatically structured as a joint DMH and DFY program. Given the frequently criticized handling of youths as being disjointed and disorganized, this feature is also important. It provides for

the potential of a continuity of care, consistency in treatment and interagency interaction much needed in the provision of care to such youth.

2. The Need for Additional Time

Because the CRU is innovative in these ways does not by itself justify its continuation. At this point, there is no firm empirical data demonstrating the relative advantages of such a program. For example, we do not know that programs which concentrate exclusively on violent juveniles are any more effective than programs which intersperse violent with non-violent offenders. What is clear is that the ideas upon which the CRU was developed show some potential and that an adequate amount of time to effectively evaluate its potential has not yet passed.

Although the funding for the program began in November, the first youth was not admitted into the IPDU until the 25th of February and the first youth did not enter the LTTU until May 26th. Furthermore, both units have been operating at far below maximum capacity. Only very recently have they attained a size and a stage of development where it becomes reasonable to view them as an actual operating program and to evaluate their ability to fulfill their potential.

3. Indications of Improvement

Were the program functioning now, as it was during its first few months, and were there no indications of improvement, a recommendation for continuation would not be justified despite the prior two points. In many ways the early months of the CRU can and perhaps should be seen as a pilot or start up period. Given the absence of similar programs in the state or country upon which to draw from, the CRU has struggled on its own with several major problems. Some of these problems are admission criteria for the program, relations with Family Court, the level of cooperation between DFY and DMH, the use of medication as a part of therapy, security on the units and insufficient referrals. However, on the basis of our observations and data to be presented in this report it appears that the CRU has been able to successfully resolve most of these problems and that they no longer present the serious threat to program effectiveness they once did. Thus, there has been a gradual improvement and clarification in the organization, structure, purpose and programs of the project.

The resolution of these issues while important in its own right is more significant in that it allows the CRU to attend to its primary mandate - to provide services to the youths in the program. In a later section, the effectiveness of the program in dealing with the violence and mental illness displayed by the youth will be discussed. The important point is that there is some indication in recent months of limited success in treating the youths in the program. While this finding is stated cautiously because of the small sample size, the late development of the program and the need for further study, it is still significant.

For these reasons, then, the recommendation, we offer, is that the CRU be continued. It has not proven that it cannot work and its potential for actually treating this particularly difficult group is important enough to such youth and to the society to warrant an additional trial year.

B. Admission Process

One of the major problems confronting the CRU over its first ten months has been the lack of referrals and admissions to the program. During this period neither the IPDU nor the LTTU were ever functioning at maximum capacity. If one examines the number of youths housed in the units for the majority of each month, it is found that for the first six months no more than half of the beds on the IPDU were utilized and that for the first nine months no more than a fourth of the beds on the LTTU were utilized. Another way of examining this issue is by calculating a utilization index for each of the two units (the sum of the number of days each youth was actually on the unit divided by the total number of days for the maximum number of youths). This utilization index is found to equal .45[1] for the IPDU and .15 for the LTTU. Thus, both units were utilized far below their capacity.

The relatively poorer utilization of the LTTU can be accounted for primarily by the fact that admission to this unit is possible only through the IPDU. As a result, the LTTU had not a single youth in its care during the first three months of operation[2] resulting in a situation where large amounts of money were being spent for care where none was being provided and where many staff members were idle or funnelled into other activities. Clearly, with the advantage of hindsight, a staggered beginning date for the two units would have produced a more effective use of funds.

The criticisms stemming from this underutilization have focused not only on the vast amounts of money being wasted because of unfilled beds but also on the discrepancy between the expected number of youths appropriate for the CRU and the actual number referred and admitted. Indeed one of the common concerns expressed prior to the actual establishment of the CRU was that a total of 30 beds would be insufficient to meet the needs which existed. Estimates made by DFY, DMH and those based on the number of violent crimes committed by juveniles in N.Y. suggested that the CRU would be rapidly filled and constantly maintained at full capacity. In the following three sections, the data presented on the process by which youths are referred and admitted to the CRU help to explain some of the reasons for this problem.

1. Referrals

Over the ten month period under study, 59 youths were referred to the CRU for possible admission. The sources of these referrals by two month periods are given in Table 1 (since the first youth was admitted on February 25, this month is included with March and April in all Tables). There are two major

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1. As we will discuss later, there are three youths who have remained on the IPDU far beyond the 90 day period due to the unavailability of appropriate alternate DMH facilities. If the excess days accounted for by these youths are removed from the equation the resulting figure is .37.

2. Excluding these three months, the utilization index score for the LTTU equals .21.

points of interest in this table. First, by looking at the totals it can be seen that the largest number of referrals occurred during the first two months.

(TABLE 1 about here)

These 27 referrals account for over 45% of all those referred during the first ten months. Second, two of the sources, DFY facilities and Family Court, show very different trends. Over 70% of the referrals made by DFY facilities were in the first two month period during which they accounted for almost half of all the referrals made. Subsequently, their referrals dropped drastically from this high of 12 during the first two months to a total of five for the following eight months. Family Court referrals on the other hand, have sharply increased during the last two months under study as compared to the prior six months. Eighty percent of the referrals over the most recent two months were made through Family Court.

Some potential reasons for these trends can be offered. The dropoff in referrals, particularly in DFY facility referrals, is at least partially due to the high rejection rate encountered in the early months. During the first two months, final decisions were made on 13 of the 27 referrals. In only four of these cases was the decision in favor of admission. Ultimately only 8 of the total 27 were admitted. This early high rejection rate may have much to do with the lack of subsequent referrals. Since the first group referred probably represented those perceived as the most appropriate for treatment in the CRU, the high rejection rate may well have led to a resistance and hesitation on the part of DFY facilities to refer other juveniles.

To some extent, the increase in referrals by Family Court can be attributed to the efforts of members of the Division of Criminal Justice Services (DCJS), the primary funding source for the project, and of the CRU in informing judges as to the availability and purpose of the CRU. Responding to the lack of referrals and the criticisms of underutilization, members of DCJS visited with judges in the four New York City boroughs with the aim of increasing referrals. This occured in late September. Approximately two weeks later the director of the IPDU met with a Family Court Judge with the same goal. The result of these efforts appears to be evident in Table 1.

On the basis of the last two months, the problems of referrals and of underutilization appear to be diminishing. As of December, both the IPDU and LTTU were at their highest level of utilization and referrals had increased. We feel it important that this positive trend be continued. However, the use of DCJS personnel on a continued basis is inappropriate and the occasional effort by a CRU staff member is insufficient. Because of the newness of the CRU and because, even now, relevant aspects of the program are being modified, it is crucial that an individual associated with the CRU be given responsibility for communicating with all of the referral sources. We, therefore, recommend the following:

RECOMMENDATION 2: A MEMBER OF THE CRU, EITHER AS THEIR SOLE RESPONSIBILITY OR AT LEAST AS THEIR PRIMARY RESPONSIBILITY, SHOULD BE ASSIGNED TO THE TASK OF INTERACTING ON A CONTINUOUS BASIS WITH ALL REFERRAL SOURCES.

We perceive the tasks of this person to be that of: describing the structure and purposes of the CRU; explaining the specific services provided; clarifying intake procedures and criteria; and supplying feedback to the referral sources on the reasons for the decisions made regarding the referred youth. Given the nature of these tasks, this role would be best filled by a member of the CRU Screening Committee who by virtue of that position would have first hand knowledge of the information necessary to effectively perform the role.

2. Action on Referrals

The number of youth served by the CRU is a function not only of the quantity of referrals but also of the proportion of referrals accepted. During the first ten months there were 59 referrals, enough to fill the CRU twice. Why did less than a fourth of all referrals result in admission?

Table 2 summarizes the action taken on referrals. In one case, the information available does not allow for an accurate determination of status and is therefore eliminated from the following discussions. Of the remaining 58 cases referred to the program, 14 were accepted, 28 were rejected, 6 were

(TABLE 2 about here)

withdrawn, and 10 are still pending. Each of these groups will be discussed separately.

a. Youths Admitted

Excluding those cases withdrawn or pending, it is found that the percentage of youths accepted appears to have increased over the study period. As can be seen in Table 2, 30% of the 30 youths referred during the first four months were accepted, while 50% of the 10 youths referred during the following four months entered the program. Since most of the cases referred in the November/December period are still pending it is not possible to draw any firm conclusions regarding the continuation of this pattern over the last two month period.

Of the 14 youths who have entered the program through the IPDU, eight have been transferred to the LTTU. While the IPDU was seen as caring for those admitted up to 90 days almost all have remained for the entire three month period. One youth was transferred after 31 days as a result of his request for discharge. The other seven were maintained in the IPDU from 87 to 100 days before transfer. It is difficult at this point to determine whether this pattern of maintaining youths on the IPDU for the maximum amount of time is necessary or whether, given the differential needs of the entering youth, some could reasonably be transferred after shorter stays. What is clear is that three of the six youths on the IPDU at the end of December were there inappropriately. These are the youths for whom a DMH placement was deemed appropriate upon completion of their 90 days in the IPDU. However, due to the unavailability of an adequate alternate DMH facility, these youths remain on the IPDU. Their total length of stays as of December are 108, 198, and 211 days.

The length of stay on the LTTU, of the eight youths transferred, has ranged from 32 days to 219 days with an average of 118.5 days. Only one of these eight is no longer in the LTTU. This one youth was transferred to a DFY Training School following a series of incidents and elopements from the LTTU.

b. Youths Rejected

Excluding those cases still pending or withdrawn, the CRU during this ten month period rejected two youths for every one accepted. The usual process used in reaching these decisions involved three main stages: a preliminary screening; a subsequent review by the Screening Committee composed of members of the IPDU and LTTU; and a 517 hearing presided over by the Hearing Officer.

Of the 28 rejections, 13 were made at the preliminary screening on the basis that the youths did not meet the basic established criteria for admission. The Screening Committee accounted for the majority of the remaining rejections. Twelve youths were denied admission on the basis of the Screening Committee's recommendations. The Screening Committee also recommended that two other youths be rejected. The two youths, however, requested and were granted 517 hearings. One of these was subsequently rejected at the 517 hearing. The other was accepted at the hearing but later rejected by the CRU co-directors. In addition, one other youth was rejected at the hearing. The final decisions reached at each step are shown in Figure 1. Perhaps the most interesting point to be

(FIGURE 1 about here)

emphasized regarding this figure is the low rate of rejection once the youths reach the 517 hearing stage. Only 2 of the 17 youths who reached this stage were rejected and one of these two was eventually admitted when the criteria for admission were waived.

Some data were available with which to compare the characteristics of those youths accepted with those rejected.[1] This information is summarized in Table 3. There appears to be little difference between the two groups in age,

(TABLE 3 about here)

residence and referral source. However, there is some variation on the other two characteristics reported. Non-blacks and those youths with prior mental hospitalizations are more likely to be admitted to the CRU according to these data. Forty-seven percent of the white and Hispanic youths referred to the program were accepted as compared to 29% of the black youths and 50% of those with prior mental hospitalization were accepted as compared to 22% of those who were not previously hospitalized. Further analysis of these variables suggests that the difference in acceptance rate by race can be explained, for the most part, by differential rates of prior mental hospitalizations among the racial groups. That is, a higher percentage of the blacks had no prior hospita-

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1. The total rejections were broken down into those occuring at the initial screening stage and those resulting from the Screening Committee's decision. No major differences were found.

lizations as compared to the non-black youths referred to the CRU and it is this fact and not their race that seems to be related to admission decisions. Thus, when only those youths with prior mental hospitalizations are examined, it is found that the acceptance rate is identical for black and non-black youths.

c. Youths Withdrawn

Of the 59 youth referred, six were withdrawn by the referral source from consideration for the CRU. In three cases which occurred during the first four months, the withdrawal took place prior to review by the Screening Committee. The two other cases were processed through the Screening Committee which recommended admission for both. However, because of the apparent success these two youths were experiencing in the existing locations, the request for admission was withdrawn.

d. Youths Pending and Processing Time

The last group to be discussed are those for whom a final decision had not been made as of December 31st. There are several steps involved in the intake processing of youths. Following the referral of a youth, a formal file containing information on the youth is established. When it is decided that the youth meets the basic criteria for admission, a memorandum is circulated indicating that a screening can be set for the youth. Subsequently, the Screening Committee interviews the youth. The last usual step in the processing is the 517 hearings. While there are further divisions in the processing which can be made, these are the four major steps and the ones for which some systematic and reliable data were available. Of the ten cases still pending, two are at the first step, six have been cleared for a screening but not screened and two have been seen by the Screening Committee.

The fact that there were ten cases still pending, some of them for several months, raises the important issue of the length of time taken to process all youths once referred to the CRU. In order to examine the time taken to process youths, the mean number of days both for those youths rejected and those accepted through these four major stages were calculated. These data, presented in Table 4,

(TABLE 4 about here)

suggest that there is little difference in the time taken to process those rejected at different stages as compared to those accepted into the program. These data also show that the average amount of total time taken to process those youths who are ultimately accepted into the CRU is 51.3 days.

The data as presented in this table actually underestimate and overestimate the processing time. The figures underestimate the total time taken to process a youth by not including periods such as the time that elapses between the actual referral and the establishment of the file or that between rejection by the Screening Committee and formal notification of rejection. On the other hand, a good part of the time shown in Table 4 reflects what we have termed external periods of delay. These are delays in processing resulting from events extern to the CRU and the systems directly related to the intake procedures. Some of these cases were clearly beyond the control of those involved with the processing such as a youth's elopment from the facility housing him, a youth's

hospitalization because of illness or the need to wait for a Title III placement by the court.

Excluding all cases for which external delays were involved reduces the average total number of days in processing those admitted from 51.3 to 31.3 days. This is shown in Table 5 which details the mean number of days taken at each stage for only those admitted. Despite the smaller numbers upon which this

(TABLE 5 about here)

table is based because of the elimination of cases having external delays, the data raise several issues. The table suggests that there is significant variation from one time period to another in the amount of time taken to process the youths through the stages. The data also indicate that rather than the total amount of time taken decreasing over time, it actually appears to be increasing, especially in the screening to hearing stage. Youths referred in the September/October months experienced a 50% longer waiting period than those referred the first two months, 46 days as compared to 29 days.

As a result of the data presented in this section we would recommend the following:

RECOMMENDATION 3: EFFORTS SHOULD BE MADE BY ALL INVOLVED TO REDUCE THE AVERAGE AMOUNT OF TIME TAKEN TO PROCESS YOUTHS REFERRED TO THE CRU. FURTHERMORE, SOMEONE ASSOCIATED WITH THE CRU SHOULD TAKE RESPONSIBILITY FOR MONITORING THE STATUS AND PROGRESS OF REFERRED YOUTH THROUGH THE VARIOUS STAGES OF PROCESSING.

It is unfair to youths and referral sources to be placed in a state of uncertainty about future placement for long periods of time when it appears possible to significantly shorten the time necessary to reach a final decision. Certainly, as the recommendation suggests, the responsibility for improvement does not rest exclusively with CRU staff since they cannot proceed until information is forwarded to them. What the CRU can and should do, however, as stated in the second half of the above recommendation is to develop a simple but much needed monitoring system. With such a system, backlogs of pending cases and unnecessary delays in various stages could be identified and evaluated systematically and frequently. Many of the tasks associated with intake processing such as the establishment of files and the setting of screening dates were performed by the full time Hearing Officer initially assigned to the CRU. Since this position was altered, the tasks have fallen to several people resulting in an uncoordinated system. A new system under the responsibility of someone associated with the CRU would help to rectify many of the problems raised by the findings in this section.

3. Criteria for Admission

The decision to accept or reject referred youths depends on the criteria and interpretation of the criteria established for entrance into the CRU. Thus, this section which deals with the criteria for entry relates importantly to the preceding section on actions on referrals.

In terms of actual operation of the program, the two criteria which together accounted for over 70% of the rejections were violence and mental illness. Specifically, eleven youths were rejected because they were seen as not meeting the mental illness criterion, eight for not meeting the violence criterion and two others were seen as meeting neither. The remaining seven were rejected for not being Title III placements (4), for not being male (1), for failing to complete the interview with the Screening Committee (1), and the most recent rejection for the lack of need for a diagnostic workup. The data also reveal that most of the rejections for violence (7 of 8) were made by the Hearing Officer while most of the rejections over mental status (7 of 11) were made by the Screening Committee.

While other admission criteria exist, the two of major concern, as evidenced by their use in determining admissions as well as by the large amount of time spent by CRU staff and others in meeting discussions, are violence and mental illness. As a result of the problems discussed earlier there has been almost constant pressure for less stringent criteria in order to allow more youth into the program. In fact, the criteria have already been expanded. The list of crimes meeting the violence criterion has been expanded to include violent crimes of the second degree as well as those of the first degree, and juveniles adjudicated for a lesser offense can now be admitted if "there exists a history which suggests a pattern of increasing violence against persons as a method of adaptation". Similarly, the criterion for mental illness has also been modified to "behavior aberrant enough to warrant further examination in order to diagnose the existence, degree or lack of mental illness". Despite the concerted effort to clarify these criteria, confusion still exists. What precisely constitutes a "pattern of increasing violence" has never been defined. Nor is it clear whether the definition of the mental illness criterion refers to the behavior necessary to be considered by the Screening Committee or to be admitted into the program.

Because of the apparent confusion which continues to exist and because of the continuous pressure to expand the criteria we feel it important to recommend the following:

RECOMMENDATION 4: THE CRITERIA FOR ADMISSION TO THE CRU, PARTICULARLY THOSE RELATED TO VIOLENCE AND MENTAL ILLNESS, SHOULD BE FURTHER CLARIFIED AND SPECIFIED BUT NOT EXPANDED IN ANY SIGNIFICANT WAY.

As this recommendation states, we believe that the criteria should not be lessened simply to allow more youth into the program. It appears more sensible to concentrate efforts on increasing the number of appropriate referrals. As suggested earlier, there is some indication that this is beginning to occur. We see this as much preferable to changing the criteria in order to increase admissions. Our position is based on an understanding of the original goals of the CRU. The program was established to deal with a particular type of youth, those who are clearly in need of psychiatric services and who have clearly committed a violent act. This was a group defined as in need of specialized care and as one for whom appropriate facilities were lacking. To expand the criteria to any great extent would result in a redefining of the purpose and goals of the program and frustrate the possibility of establishing a model for effective treatment with this particular type of youth. It is clear, from the first ten

months of the CRU, that the number of youths who can be shown to be both violent and in need of psychiatric care, when these two criteria are defined strictly, is less than what many expected. Nonetheless, the more developed state of the program at this point and additional attention to referrals should increase the admissions, rendering the expansion of the criteria unnecessary.

More specifically, we would like to see the following occur: 1) the list of adjudicated crimes not be extended with the exception of adding the crimes of assault and kidnapping which do involve violence; 2) that serious consideration be given to the possibility of removing certain crimes committed in the second degree from the criteria in conformity with the crimes defined as violent by the N.Y.S. Governor's Panel on Juvenile Violence (1976) or those defined as "designated felony acts" in the new N.Y.S. Juvenile Justice Reform Act of 1977; 3) that unless the phrase "a pattern of increasing violence" is more clearly specified, it should be removed as a justification; and 4) that for actual admission the criterion of mental illness or need for psychiatric services be interpreted strictly as indicating a high degree of probability that the youth is suffering from a serious mental disorder.

C. Treatment Effectiveness

This section deals with the effectiveness of the treatment provided by the CRU. As such, it addresses the single most important question for the CRU - whether or not the treatment program is succeeding in improving the youth admitted to the unit. This is also probably the most difficult question to answer at this time. The many problems mentioned in this report such as the slow development, the small number of youths admitted and staff turnover, in addition to the problems associated with the research process such as the need for instrument development and testing render any attempt to draw firm conclusions premature. In addition, perhaps the most crucial test of CRU's effectiveness cannot be made until the youth return to the community and recidivism rates can be examined. Nonetheless, data has been collected over the ten month period on various indicators of treatment effectiveness which at least provide some idea as to the success of the treatment. These data will be presented separately for the IPDU and LTTU.

1. IPDU Indicators of Youth Improvement

The first set of data to be presented are based on youth Behavior Rating Forms (BRF). This instrument was developed in an attempt to systematically monitor the program participation and behavior of the youth being treated. Each week these forms were completed for each youth by the seven staff members primarily responsible for their care. The instrument was composed of 31 check-list type items, five related to program involvement, ranging from a score of one to six, and 26 related to behavioral manifestations, with scores ranging from one to four. The higher the score the poorer the program participation and the greater the frequency of the behavior and problems.

The overall results of the BRF data are displayed in the bar graph in Figure 2. The graph reveals little variation in the five program participation

(FIGURE 2 about here)

items. The items dealing with the behavior and problems presented by the youth

indicate, on the other hand, some interesting patterns. The two sets of behaviors which are displayed most frequently by the youth are those related to anti-social behavior (threat of physical violence, verbally abusive and anti-social attitudes) and those related to depression (depression, worry or nervousness, and social withdrawal, isolation). A correlation analysis on these variables has indicated a high relationship between the variables in each of these two sets.

In addition to suggesting the most frequently displayed problems and symptoms of the youths, these data have also been utilized as a mechanism for examining improvement over time. This information for all five program items and all 26 behavioral items is displayed in the two graphs shown in Figure 3.

(FIGURE 3 about here)

The graph based on the weekly mean scores for all youth indicates an improvement in the program area over the 90 day period of stay on the IPDU, particularly during their last six weeks. With the exception of the first few weeks and the 7th and 8th weeks, the means for the behavior items have been very consistent suggesting little variation in either direction.

When the data are examined further, however, the consistency in the behavior items is found to mask three very different patterns. In Figure 4,

(FIGURE 4 about here)

these items are grouped into three indices: those related to anti-social behavior (items 1-5, 26); those related to depression (items 9, 10, 20); and all the remaining ones. The means as reflected in the three graphs suggest an increase in the behavior measured by the depression index, a decrease in anti-social behavior and a lack of consistent variation in the other symptom index. Thus, the total set of data obtained from the BRF suggest an overall improvement which is accounted for primarily by positive changes in level of program participation and anti-social behavior of the youths over their three month stay in the unit.

The trend suggesting improvement in the youths as a result of their treatment on the IPDU is further substantiated by two other indicators. These two are the number of times PRN medication and control precautions are used. Both PRN medication and control precautions are used in a variety of situations to stabilize acting out behavior and serious psychiatric disturbances. Information on these two indicators is presented in Table 6. As can be seen,

(TABLE 6 about here)

the use of both decreases substantially over the three months that the youth are on the unit suggesting a decreasing need for the use of these measures.

The last set of data relating to the treatment success of the IPDU is based on the perceptions of the youth themselves. Nine of the fourteen admitted youths were interviewed by a member of the research team. The majority of their responses were favorable. Six of the nine felt that the staff could help them with their problems and disagreed with the statement that most of the staff don't really care what happens to them. The CRU staff, particularly the teachers and

therapy aides, were seen as helpful by the youths as were the various programs offered, especially the educational one. Finally, only two of the nine stated that the program had not been of benefit to them. While this information is little more than suggestive, it does correspond to and corroborate from a different perspective the trend toward improvement indicated by the other data presented.

2. LTTU Indicators of Youth Improvement

Unfortunately, much of the data presented above for the IPDU is not available for the LTTU. The Behavior Rating Form has been instituted on the LTTU. However, the length of time for which data on a large enough number of youths has been collected is insufficient for analysis. The indicators of youth improvement for which some information is available present a less clear pattern than that found on the IPDU.

Table 7 presents information obtained from the socialization program of

(TABLE 7 about here)

the LTTU. Included are three measures: the mean number of total points earned, the average number of bonuses given and the average number of fines. The first of these measures suggests an improvement while the other two present an irregular pattern. Since these data are based on no more than six and as little as two youths, it is difficult to interpret these figures with any confidence. Perhaps of more significance is the fact that of the five youth on the LTTU at the end of December who had been there for longer than a month, three had progressed enough to be placed into the second level of the three tier program.

The other indicators available to us were the frequency with which PRN medication was used and the number of incident reports filed for those five youths who had been on the unit for a full four months. The trend in these data, presented in Table 8, is less consistent than that found in the IPDU, although

(TABLE 8 about here)

there is some indication of improvement in the later months.

3. Need for Further Research

Although this section deals with treatment effectiveness, we feel that the discussion of the data on this issue points out most strongly the need for additional research. Continued evaluation is needed on all the various aspects of the CRU but most importantly on the success of the treatment offered. Thus, we recommend the following:

RECOMMENDATION 5: RESEARCH EFFORTS BEGUN DURING THE FIRST YEAR OF THE CRU SHOULD BE CONTINUED WITH THE MAJOR EMPHASIS DURING THE SECOND YEAR BEING PLACED ON EVALUATING THE EFFECTIVENESS OF TREATMENT.

Given the large amounts of money required to operate this program and given the potential significance to the youth for whom this program is designed and to society, we feel it imperative that as much relevant data as possible be collected. Whether this pilot program continues in the future or not should be based on factual information evaluating its successes and failures and not on subjective feelings or external pressures.

D. Staffing Patterns

1. Staff Vacancies and Turnover

Since the beginning of the project, 109 individuals have been hired by the CRU, 42 to work on the IPDU and 67 on the LTTU. Some of the characteristics of these staff members are given in Table 9 which is based on information obtained

(TABLE 9 about here)

from questionnaires administered to staff during their first few weeks in the CRU.

Details on vacancies and the turnover rate experienced by staff can be found in Table 10. The 109 staff members have been hired for 86 positions. Four

(TABLE 10 about here)

positions have never been filled. Overall, the CRU has experienced a 32% turnover during its first ten months. The LTTU rate, in particular, has been extremely high. Perhaps, as serious is the fact that almost half of these vacated positions remain unfilled and that most have been unfilled for more than two months.

Clearly, these vacancies and turnover in staff are detrimental to the functioning of the CRU. A few examples should suffice: neither unit had hired a psychiatrist by the time the treatment of youth began, necessitating a reliance on outside consultants; except for a short period of time, the IPDU has functioned without an occupational therapist, thus negating a potentially important aspect of the program; the LTTU presently has none of its three nursing items filled forcing them to depend on the IPDU nurses. Such situations deprive the youths of services which have been programatically defined as important to successful care and treatment.

2. Staff Terminated

The last set of data to be presented regarding staff deals with those who have left. Interviews were conducted with 20 of the 35 staff members who departed to determine their reasons for leaving and their attitudes at this point toward the CRU and the youth. Of the twenty interviewed, four were IPDU staff and sixteen LTTU were staff, thus, the data reflect mainly the feelings of LTTU staff.

The main reason reported by individuals for voluntarily departing (15 said they were leaving voluntarily) were job conditions (39%) followed by problems in dealing with the youths (31%) and problems with other staff members (19%). The other 11% gave personal reasons for leaving. When asked for the

greatest difficulty they faced in their job, most (90%) said either staff difficulties (e.g. no supervision, lack of trained line staff, poor communications and working relationships between upper and lower level staff) or poor job conditions (e.g. too much work, depressing work conditions).

Also, in these interviews a set of questions were included which were identical to those asked in the initial staff questionnaire discussed above. When responses were compared some interesting differences were found. Staff leaving the program were similar to the staff tested upon initial employment in their views of how violent the youth were, but tended to view them more as mentally ill, to see the program as less effective and to feel that the violence displayed by the youths greatly interfered with the treatment program, as shown in Table 11. For example, in the original staff questionnaire, 45% responded

(TABLE 11 about here)

that the CRU would be very effective in treating youth and 7% felt that the treatment would be only slightly or not at all effective. Of those staff leaving their positions, only 11% felt the program was very effective and 50% viewed it as only slightly or not at all helpful. A comparison of the responses given by those leaving the IPDU and the LTTU suggested that these trends were evident for both groups with the exception of the responses to the issue of effectiveness. Staff departing the IPDU tended to still view the treatment as effective while the majority of staff departing the LTTU saw it as much less effective.

It is difficult to determine whether these important attitude changes are confined to those staff leaving the program or whether they represent a general trend for all staff. Since a second wave of administering questionnaires to all staff is planned for March, it will be possible at that point to address this question more fully.

3. Need for Improvement in Staffing Patterns

The data presented in this section suggest that there is reason for much concern in the pattern of staffing thus far experienced by the CRU and particularly by the LTTU. Important positions have never been filled; turnover in high positions once vacated are being refilled slowly; and there are indications that initially positive attitudes of the staff toward the program and its potential effectiveness are decreasing. Furthermore, confusion has often resulted from the lack of a precise delineation of duties and responsibilities associated with various positions and from the existence of an unclear authority structure. As a result we strongly urge the following:

RECOMMENDATION 6: STAFFING PATTERNS ON THE CRU MUST BE IMPROVED - VACANT POSITIONS SHOULD BE FILLED, THE LENGTH OF TIME TAKEN TO REFILL POSITIONS SHOULD BE SHORTENED AND INCREASED ATTENTION SHOULD BE GIVEN TO THE CONDITIONS LEADING TO THE HIGH TURNOVER RATE EXPERIENCED BY THE PROGRAM.

E. Interagency and Intra-agency Cooperation

There are two other areas which require discussion because of their

importance to the success of the CRU. These two issues relate to the level of interagency cooperation between DMH and DFY and between the IPDU and DMH.

1. DMH - DFY Relations and Level of Cooperation

One of the more important aspects of this pilot project was its emphasis on continuity of care. All too often the media, politicians and other concerned individuals have noted examples of youths similar to those entering the CRU who have been shuffled back and forth between agencies without any of the relevant information on the youth, his needs, or his response to therapeutic intervention being forwarded with the youth. The CRU was structured in such a way as to avoid this discontinuity. The IPDU, operated by DMH, and the LTTU, operated by DFY, were physically located with no more than a hallway separating them in order to increase the probability that the youth would in fact experience a continuity of care. Furthermore, it was expected that there would be constant interaction, communication and cooperation between the two levels.

Unfortunately, at most levels this important relationship has failed to develop. This is probably due to a number of factors such as differing conceptions of the youth entering the program (for example, it was found that DFY staff were more likely to view the youth as similar to juvenile delinquents while DMH staff were more likely to view them as both delinquent and mentally ill) and different philosophies of treatment. On some levels though, such as in the Screening Committee meetings, where interaction has been encouraged through certain structural arrangements, cooperation has frequently resulted. This is significant, not only because of the positive interagency relations which develop but more so because of the positive consequences for the treatment of the youth.

Recently, discussion has taken place on the possibility of moving the LTTU component to another location. This we feel would only decrease the level of interaction between the two units. Rather, what is needed is the development of and experimentation with various arrangements for encouraging interaction and coopertaion between the staff of the two units and an increased emphasis on the use of such structures which already exist. Thus, we offer the following recommendation:

RECOMMENDATION 7: FOR THE BENEFIT OF THE TWO AGENCIES, THE CRU STAFF AND, MOST IMPORTANTLY, THE YOUTH BEING TREATED, STRUCTURES MUST BE DEVELOPED AND UTILIZED WITHIN THE PROGRAM TO FOSTER INTERACTION AND COOPERATION BETWEEN THE IPDU AND LTTU.

Examples of such structures have been discussed in the past. As early as last March the topic of establishing joint IPDU and LTTU staff meetings was raised. Such meetings would provide the opportunity for staff to exchange perceptions of the youth, discuss treatment strategies and update each other on the progress of the youth. Such modifications in the program are necessary if the CRU is to meet its objective of providing the youth under its care with a continuity of treatment.

2. IPDU-DMH Relations

Although the DMH has provided support to the IPDU in many ways, it has failed the IPDU and therefore the CRU in a very significant way. The primary function of the IPDU is to provide diagnostic and stabilization services and not long term treatment. Yet it has been forced to function in this way as a result of the lack of adequate alternate DMH facilities for the care of these youths. As discussed earlier, there are currently three youths on the IPDU who have remained there well beyond the prescribed 90 day period. Because of their need for intensive psychiatric care, they have been determined to be inappropriate for referral to the LTTU or other DFY facilities yet no appropriate DMH facility is available which is willing and capable to provide the secure treatment necessary.

Because of the low level of admissions thus far, the presence of these youths has not detracted from the primary mandate of the IPDU. However, given the trends discussed in this report it is expected that the unit will soon be full. At this point the continued presence of such youth would interfere with the IPDU's ability to accept those youth in need of diagnosis and stabilization. Thus, it is important that the following occur:

RECOMMENDATION 8: THE DEPARTMENT OF MENTAL HYGIENE MUST ESTABLISH A SECURE UNIT OR A NUMBER OF SUCH UNITS WHICH CAN PROVIDE INTENSIVE PSYCHIATRIC TREATMENT FOR THOSE YOUTHS FOR WHOM SUCH CARE IS RECOMMENDED BY THE IPDU.

The need for secure treatment units was discussed over a year ago in the report of the Sub-Committee on Violent Mentally Disabled Youth (N.Y.S. Department of Mental Hygiene Task Force Report, September, 1975). The difficulties experienced by the IPDU in placing these three seriously disturbed youths only serve to reinforce the necessity for such units.

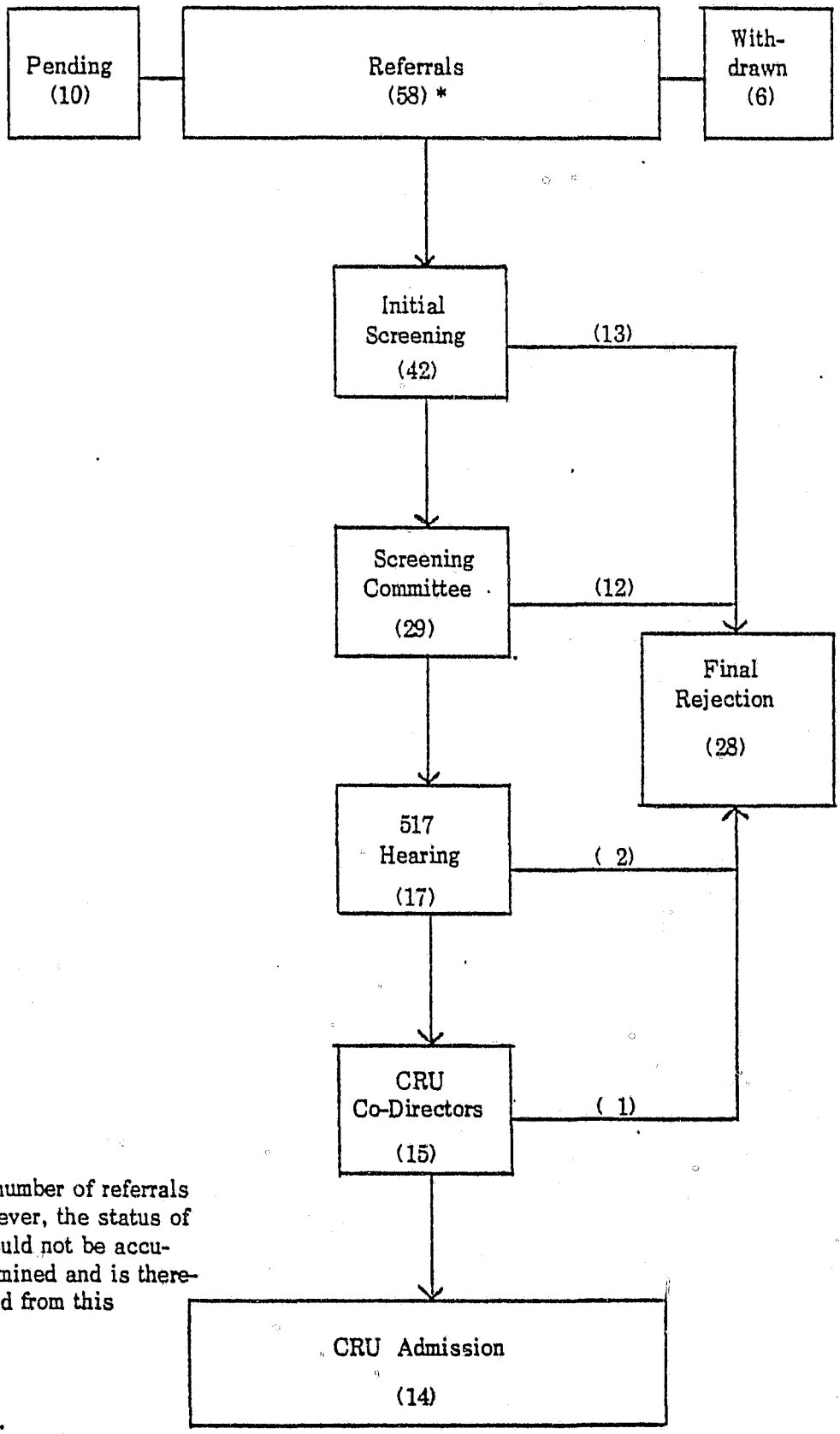
IV. CONCLUSION

In this report, we have presented the major findings and recommendations flowing from the data collected over the first ten months of the CRU. While we felt it important to stop and summarize the data at this point, the development of this report does not signify the end of our research effort. Rather, our collection of data is continuing and will be expanded in several important ways. For example, we hope in the near future to begin collecting similar data on relevant comparison groups with which to compare the experiences and progress of the youths treated in the CRU.

Also in this report, we have attempted to examine the data in a manner that maximizes its use in program development. Other more technical reports on specific issues are planned for the future. However, we felt it important at this point in the evolution of the CRU to present the main findings to date, particularly since the available data do address many of the most pressing issues surrounding the CRU.

FIGURE 1

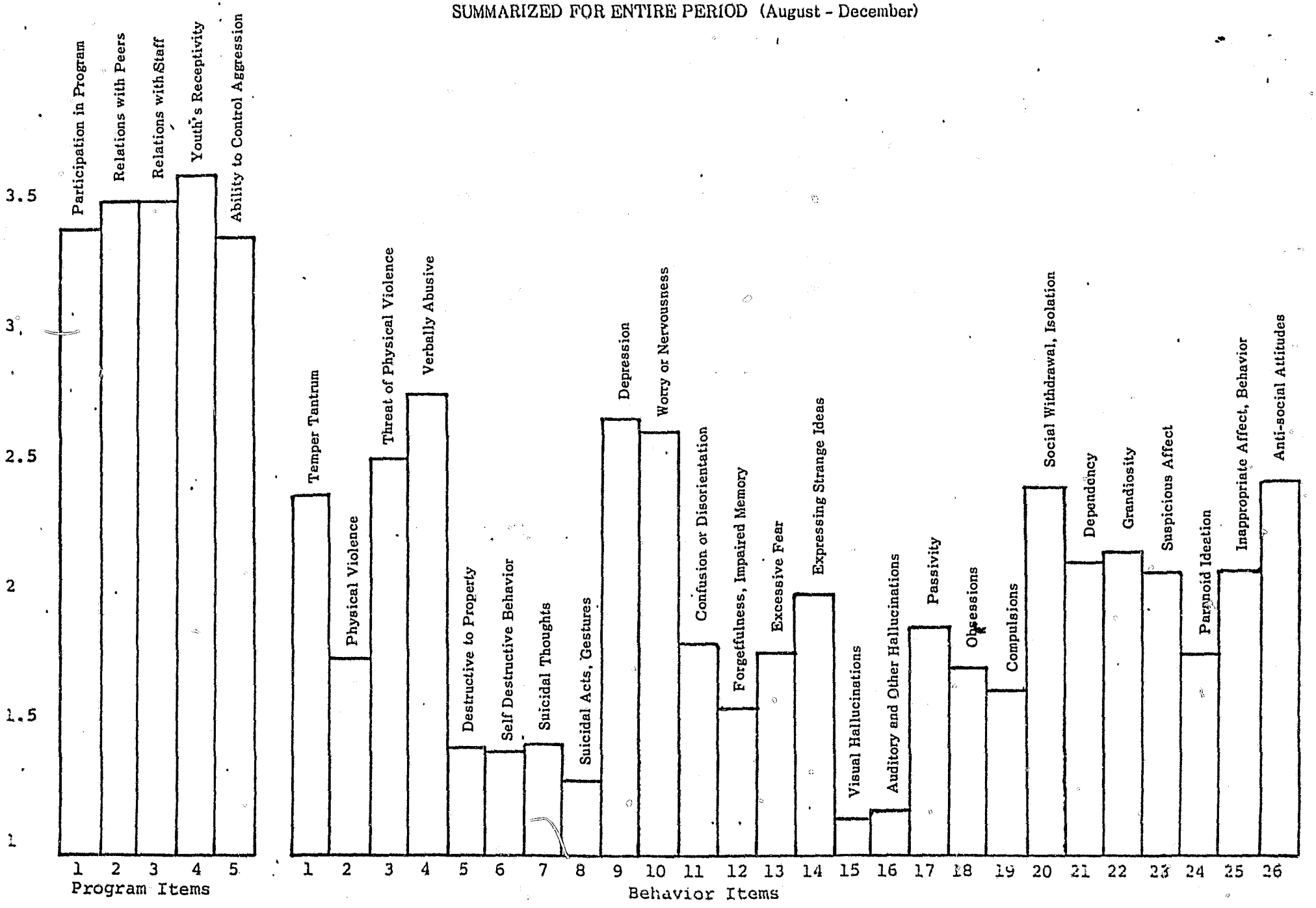
FLOW DIAGRAM OF DECISION POINTS IN ADMISSION PROCESSING



* The actual number of referrals is 59. However, the status of one case could not be accurately determined and is therefore excluded from this figure.

FIGURE 2: MEAN ITEM SCORES FROM THE BEHAVIOR RATING FORM

SUMMARIZED FOR ENTIRE PERIOD (August - December)



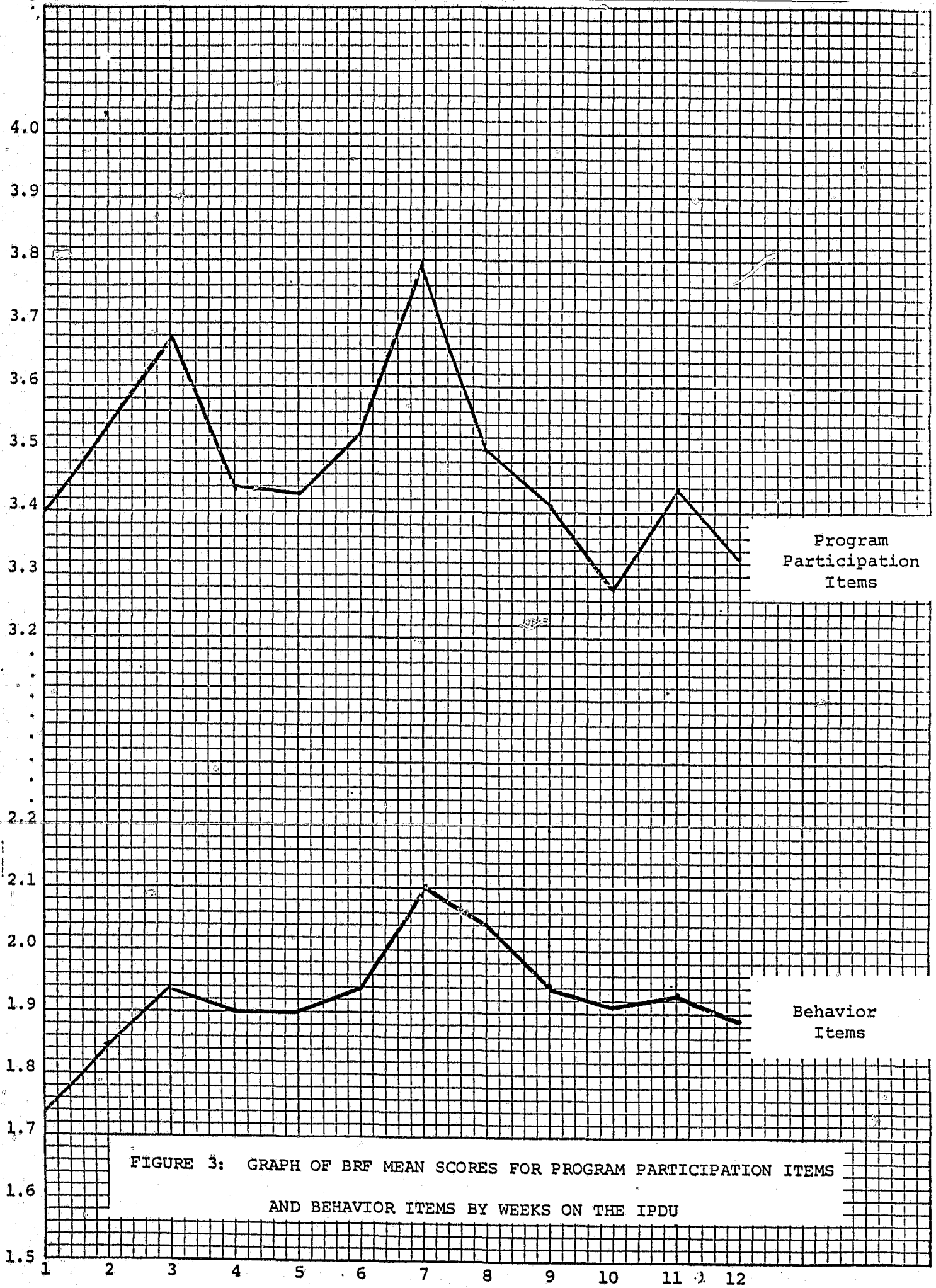


FIGURE 3: GRAPH OF BRF MEAN SCORES FOR PROGRAM PARTICIPATION ITEMS AND BEHAVIOR ITEMS BY WEEKS ON THE IPDU

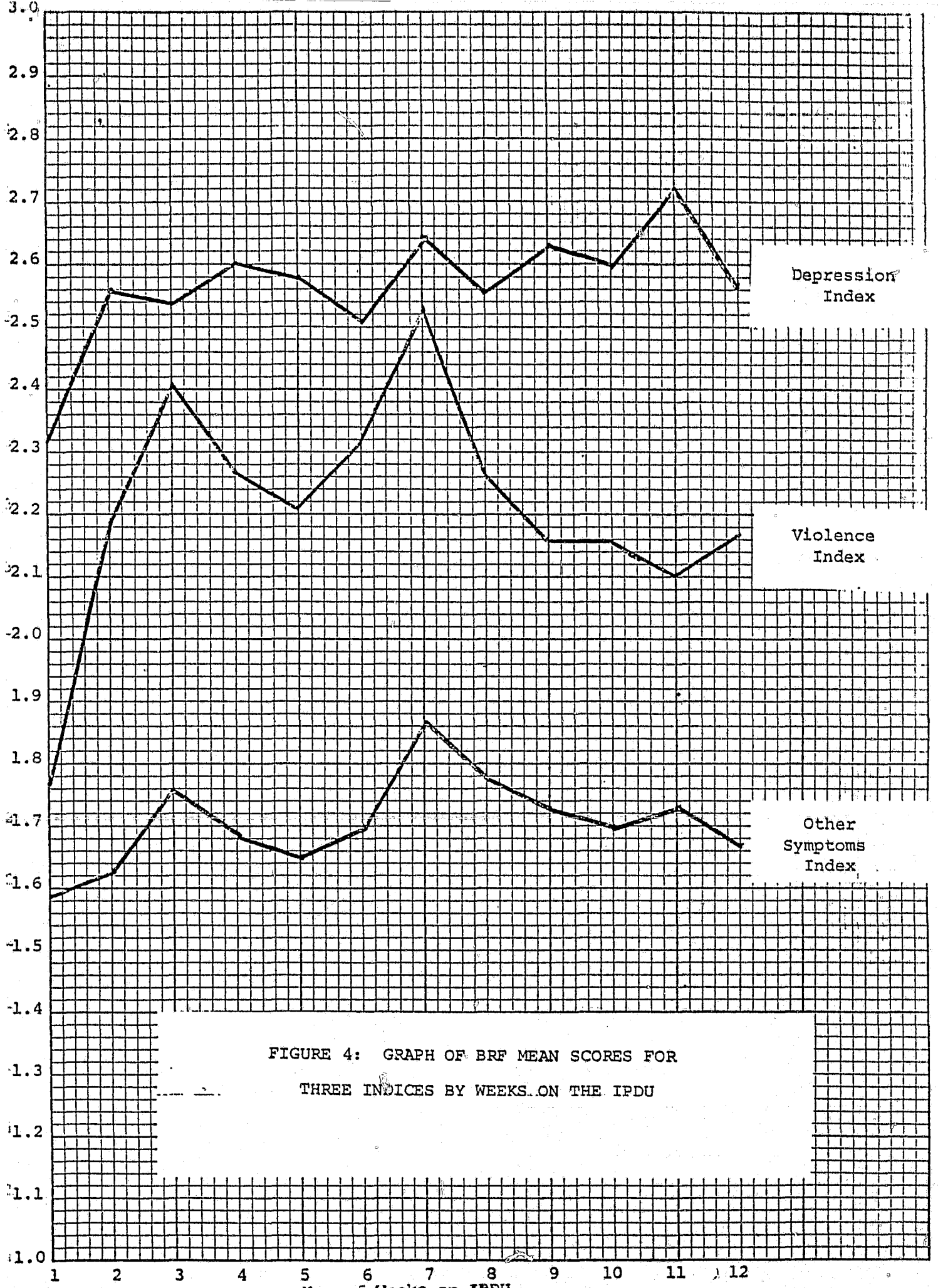


FIGURE 4: GRAPH OF BRF MEAN SCORES FOR THREE INDICES BY WEEKS ON THE IPDU

TABLE 1

SOURCES OF REFERRAL DURING TEN MONTH PERIOD OF STUDY

Referral Source	Month Referred: Feb., March/ April %	(N)	May/ June %	(N)	July/ August %	(N)	Sept./ Oct. %	(N)	Nov./ Dec. %	(N)	All Months %	(N)
DFY Facility	44.5	(12)	14.2	(1)	42.9	(3)	12.5	(1)	0.0	(0)	28.8	(17)
DFY Placement [1]	22.2	(6)	28.6	(2)	42.9	(3)	62.5	(5)	10.0	(1)	28.8	(17)
Family Court [2]	29.6	(8)	28.6	(2)	14.2	(1)	25.0	(2)	80.0	(8)	35.6	(21)
Other [3]	3.7	(1)	28.6	(2)	0.0	(0)	0.0	(0)	10.0	(1)	6.8	(4)
TOTAL	100.0	(27)	100.0	(7)	100.0	(7)	100.0	(8)	100.0	(10)	100.0	(59)

1. Includes DFY Placement Service and the referral agent at Spofford Detention Center.

2. Includes all those referred at the Family Court hearing stage whether the referral was made by the judge, probation officer, legal aide attorney or CRU court liasons.

3. Includes those cases for which precise information was unavailable or which were referred by other sources.

TABLE 2

ACTION ON REFERRALS DURING TEN MONTH PERIOD

	Month Referred											
	Feb., March/ April		May/ June		July/ August		Sept./ Oct.		Nov./ Dec.		All Months	
Action on Referrals	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)
Admitted	29.6	(8)	16.7	(1)	42.9	(3)	25.0	(2)	0.0	(0)	24.1	(14)
Rejected	59.3	(16)	83.3	(5)	57.1	(4)	12.5	(1)	20.0	(2)	48.3	(28)
Withdrawn	11.1	(3)	0.0	(0)	0.0	(0)	25.0	(2)	10.0	(1)	10.3	(6)
Pending	0.0	(0)	0.0	(0)	0.0	(0)	37.5	(3)	70.0	(7)	17.3	(10)
TOTAL	100.0	(27)	100.0	(6)	100.0	(7)	100.0	(8)	100.0	(10)	100.0	(58)

TABLE 3

COMPARISON OF CHARACTERISTICS OF YOUTHS

REJECTED AND ACCEPTED BY THE CRU

Characteristics	Youths Admitted (N=14)	Youths Rejected (N=28)
Average Age	15	15
Race/Ethnicity:		
Black	50%	68%
Hispanic	21%	16%
White	29%	16%
Residence:		
from Bronx	28%	28%
from Other N.Y.C. Areas	36%	44%
from Outside N.Y.C.	36%	28%
Past Institutionalization:		
DFY Facility Only	14%	38%
Mental Hospital Only	36%	16%
Both DFY and MH	36%	25%
Neither DFY or MH	14%	21%
Referral Source:		
DFY Facility	42%	35%
DFY Placement	25%	38%
Family Court	33%	27%

TABLE 4

MEAN NUMBER OF DAYS TAKEN TO PROCESS YOUTHS REJECTED AND ACCEPTED THROUGH FOUR MAJOR INTAKE STEPS (N = 42)

	Intake Steps				
	Opening of File	Notification for Screening	Screening	Hearing	Admission
Final Action on Referrals	Mean No. of Days	Mean No. of Days	Mean No. of Days	Mean No. of Days	
Rejected at Initial Screening	15.1				
Rejected by Screening Committee	12.2	18.3			
Rejected at Hearing or by Co-directors	8.3	13.3	55.7		
Admitted	11.3	19.2	17.6	3.2	

TABLE 5

MEAN NUMBER OF DAYS TAKEN TO PROCESS YOUTHS ACCEPTED INTO THE CRU THROUGH FOUR MAJOR INTAKE STEPS, EXCLUDING EXTERNAL DELAYS

	Month Referred									
	Feb., March/ April		May/ June		July/ August		Sept./ Oct.		All Months	
Intake Steps	Mean Days	(N)	Mean Days	(N)	Mean Days	(N)	Mean Days	(N)	Mean Days	(N)
Opening of File to Screening Notification	4.8	(5)	3.0	(1)	6.5	(2)	2.5	(2)	4.5	(10)
Screening Notification to Screening	12.8	(5)	4.0	(4)	8.0	(1)	8.0	(1)	7.6	(11)
Screening to Hearing	8.7	(6)	0.0	(0)	19.3	(3)	33.0	(2)	16.0	(11)
Hearing to Admission	2.9	(8)	0.0	(0)	4.3	(3)	2.5	(2)	3.2	(13)
TOTAL	29.2		—		38.1		46.0		31.3	

TABLE 6

FREQUENCY OF PRN MEDICATION AND CONTROL PRECAUTION

BY LENGTH OF STAY ON THE IPDU (N = 10)

	Months On Unit							
	1		2		3		All Months	
	%	(N)	%	(N)	%	(N)	%	(N)
PRN Medication	47.8	(76)	30.8	(49)	21.4	(34)	100.0	(159)
Control Precautions	40.0	(26)	32.3	(21)	27.7	(18)	100.0	(65)

TABLE 7

MEAN NUMBER OF POINTS EARNED AND FREQUENCY OF BONUSES AND FINES GIVEN BY LENGTH OF STAY ON THE LTTU

	Months On Unit					
	1	2	3	4	5	6
Earned Points	391	392	482	444	490	480
Number of Bonuses	8.0	4.1	6.1	4.3	7.0	3.4
Number of Fines	2.1	5.4	5.0	4.5	6.0	8.6

TABLE 8

FREQUENCY OF PRN MEDICATION AND INCIDENT REPORTS

BY LENGTH OF STAY ON THE LTTU (N = 5)

	Months On Unit								All Months	
	1		2		3		4			
	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)
PRN Medication	14.0	(6)	23.2	(10)	41.9	(18)	20.9	(9)	100.0	(43)
Incident Reports	21.2	(7)	42.4	(14)	18.2	(6)	18.2	(6)	100.0	(33)

TABLE 9

CHARACTERISTICS OF CRU STAFF BASED ON

INITIAL STAFF QUESTIONNAIRE

Characteristics	CRU (N=70)	IPDU (N=20)	LTTU (N=36)
Average Age	28	27	29
Sex:			
% Males	70	63	86
% Females	30	37	14
Race:			
% White	38	37	41
% Black	49	42	50
% Hispanic	13	21	9
Education:			
% College Graduate or Better	53	50	52
Marital Status:			
% Never Married	53	63	50
% Married	38	21	44
% Divorced or Widowed	9	16	6
Prior Employment Experience:			
% Direct Service Experience with Youth	62	43	73
% Other Social Service Experience	21	36	17
% Other	17	21	10

TABLE 10

STATUS OF CRU STAFFING PATTERNS

	CRU	IPDU	LTTU
Number of Allocated Positions	90	34	56
Number of Staff Hired	109	42	67
Number of Positions Never Filled	4	1	3
Number of Staff Leaving	35	10	25
Number of Positions Presently Not Filled	16	2	14

TABLE 11

COMPARISON OF INITIAL CRU STAFF RESPONSES WITH RESPONSE OF STAFF NO LONGER EMPLOYED AT THE CRU TO ATTITUDE ITEMS

Attitude Items	Initial Staff (N=70) %	Staff No Longer Employed (N=20) %
Effectiveness of CRU Treatment:		
Very Effective	45	11
Somewhat Effective	48	39
Only Slightly Effective	7	39
Not Effective At All	0	11
CRU Youth Similar to:		
Juvenile Delinquents	64	44
Mentally Ill	20	28
Both	16	28
Expected Violence of CRU Youth:		
Very Violent	12	20
Somewhat Violent	76	65
Not Violent	12	15
Interference of Violence with Treatment:		
Greatly Interfere	11	58
Somewhat Interfere	71	16
Not Interfere	18	26

The New York State Court Related Unit, located at the Bronx Childr... Psychiatric Center, is a jointly operated program of the Department of Mental Hygiene and the Division for Youth. This innovative project, funded by DCJS for its first 2-1/2 years, was established to identify and provide services for the most violent and emotionally disturbed adjudicated male juvenile delinquents.

The Department of Mental Hygiene administers the In-Patient Diagnostic Unit (IPDU) which consists of a secure 10-bed hospital ward serving two primary purposes: 1) to determine the presence, nature and degree of mental illness by observing and assessing youth within a 90-day time period; and 2) to design a treatment plan for each youth, based on the diagnostic assessment.

The Division for Youth administers the Long Term Unit (LTTU), an 18-bed secure treatment facility providing long-term clinical and rehabilitative treatment to those violent, aggressive youngsters who have been found to need this kind of intensive treatment by the IPDU. This unit implements the treatment plan developed by the IPDU and further seeks to foster behavioral change through a highly structured goal-oriented re-socialization program.

A relatively large and highly qualified clinical staff offers a full range of psychiatric and rehabilitative services such as individual psychotherapy, group therapy and family therapy. Residents are provided whatever combination of these services best meets their individual needs. A full scale in-house educational program is offered through which the LTTU further equips residents with skills necessary fora successful transition to community life. In addition, recreational, vocational and arts therapy programs are provided.

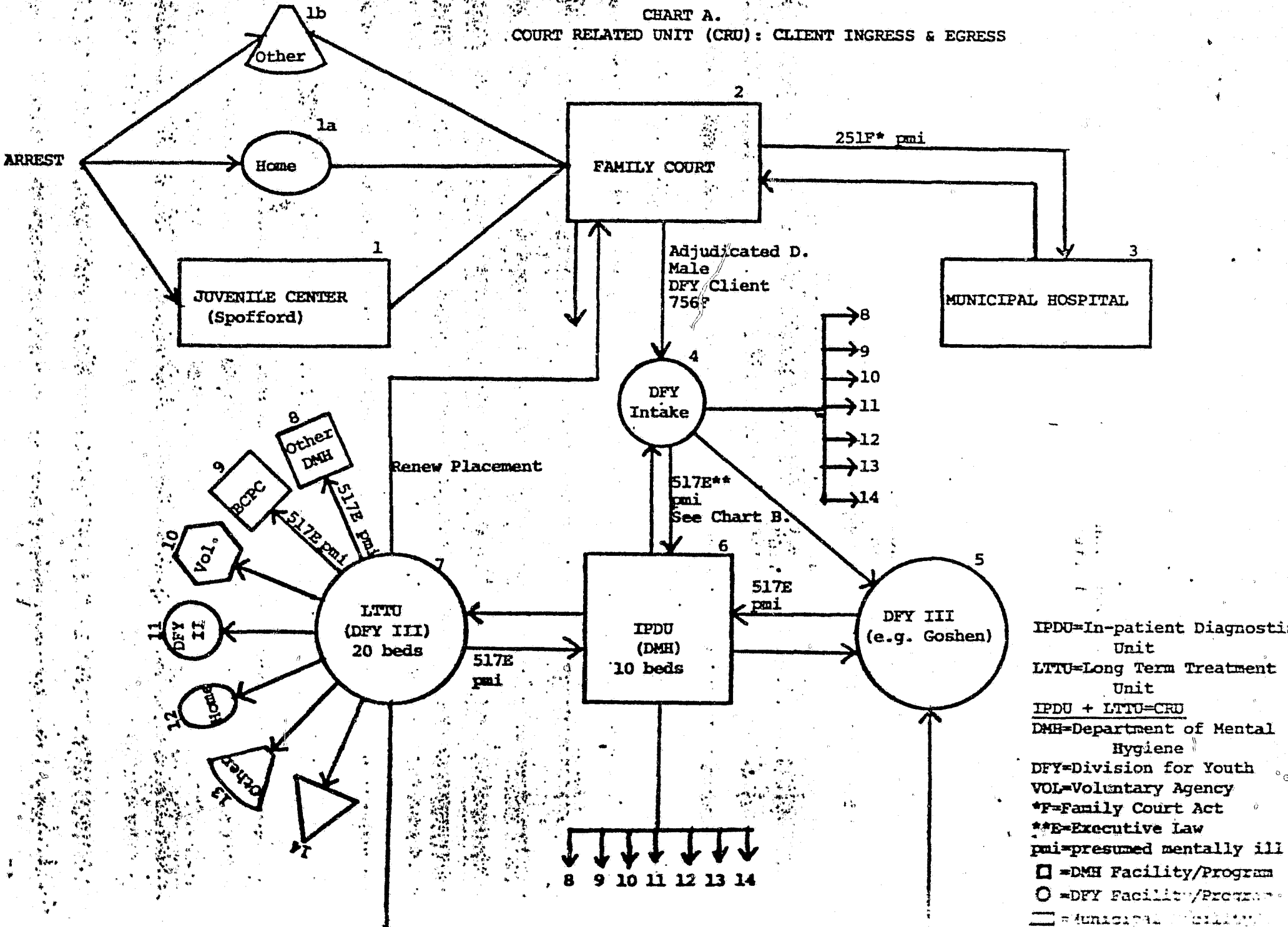
Youths in this program come from all parts of New York State and are either referred directly from Family Court or come to the program from another DFY facility. All have been adjudicated juvenile delinquents and have been placed with DFY Title III. In order to be elligible, the youth must have committed one of the following acts: Murder 1' or 2'; Kidnapping 1' or 2' (but where the abduction involved the use of threat or use of deadly physical force); Arson 1' or 2'; Manslaughter 1'; Rape 1'; Sodomy 1'; Robbery 1'; Attempt to commit Murder 1' or 2'; and Attempt to commit Kidnapping 1'; or, if adjudicated for a lesser offense there must be evidence that his history suggests a pattern of increasing violence against persons. A request that a youth be screened by the project may be made by the Legal Aid Society prior to the dispositional hearing.

When broad eligibility requirements have been met and the child has been screened by project staff for possibility of mental illness, a hearing is scheduled under Section 517 of the Executive Law for transfer to the Department of Mental Hygiene. If the hearing officer decides in favor of such a transfer, the youth enters the IPDU for a period of up to 90 days for diagnosis and stabilization (all youths enter the project through the IPDU). At the end of his stay on the IPDU, another hearing is held if the youth is considered appropriate for transfer to the LTTU or to another DFY facility. Youths who are felt to need further long-term intensive mental hospital care are referred to other facilities within the Department of Mental Hygiene. Youths who are transferred to the LTTU spend at least nine months there. Youths adjudicated prior to February 1, 1977, cannot be kept beyond their 18th birday without their consent. Those adjudicated and given a restrictive placement after February 1, 1977, cannot be kept beyond their 21st birthday.

Chart A shows the flow of clients from the Family Court through the project. Chart B is a flow chart covering the period from admission of the first resident through the end of DCJS funding, at which point the project was institutionalized in the state budget.

Because of its significance as a model of treatment for New York and the rest of the country, this pilot project for the provision of services to violent, dangerous juveniles has been extensively researched and evaluated with funds provided by DCJS. Preliminary findings have indicated an improvement in youths in this program with regard to violent behavior.

CHART A.
COURT RELATED UNIT (CRU): CLIENT INGRESS & EGRESS



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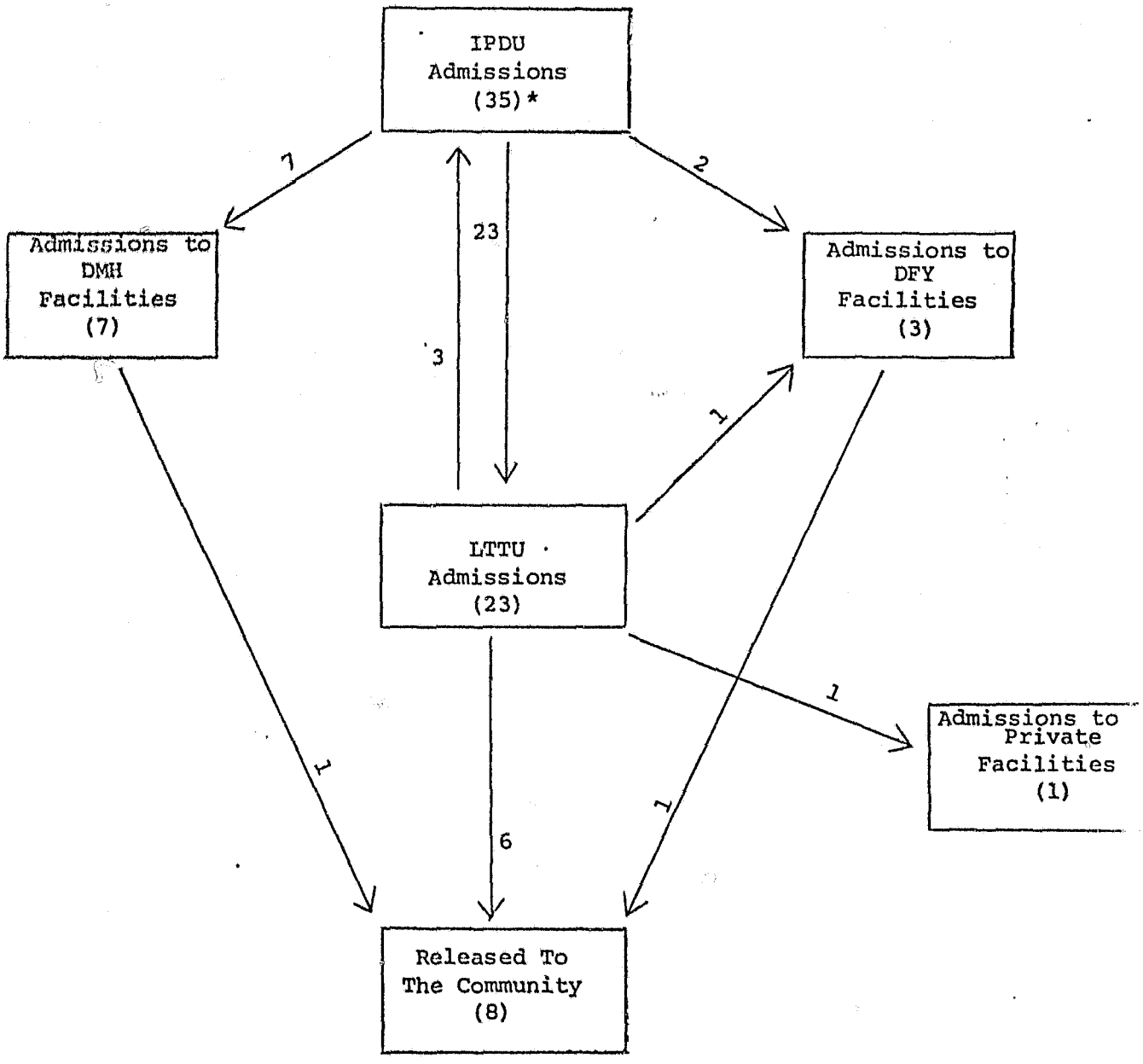
BRONX COURT RELATED UNIT

RESIDENT FLOW CHART

2/25/76 - 3/31/78



CRU Resident Population as of 3/31/78
IPDU - 6
LTTU - 12

*In addition to the 35 admissions, there have been 3 readmissions from the LTTU. Two of these 3 readmissions have been transferred to DMH facilities and are included in the total of 7 transfers to these facilities; the third is still on the IPDU.

END