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caring for youth

Essays on Alternative Services

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the runaway center as community mental health center

INTRODUCTION

Community mental health centers were hailed in 1963 by President John F. Kennedy as a "bold new approach." Designed as an alternative to "large, impersonal, remote, primarily custodial institutions," the community mental health center was to provide a "flexible array of services that disrupt as little as possible the patient's social relations in his community."[1] In addition to the concerns of professionalization, training and manpower, two early shapers[2] of the community mental health center movement emphasized "community involvement and control . . . range of service . . . serving those who most need help . . . innovation . . . planning for problem groups that nobody wants . . . [and] variety, flexibility, and realism." Community mental health centers were to meet people's mental health needs in a respectful and responsive way, to help them live better in a better community.

Several years after the passage of the Community Mental Health Centers Act, and in the same climate of social activism, the first runaway house was founded by a minister in the Haight-Ashbury district of San Francisco.[3] It was named Huckleberry House after America's most famous runaway and was designed to provide—without stigma, labeling or constraint—temporary food, shelter, and counseling to some of the thousands of young people who flocked to the Haight during the 1967 "summer of love." Since 1967 approximately 200 additional runaway centers[4] have been opened. This year they will serve 50,000[5] young people and their families, in suburbs, small towns,

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Note: Many of the ideas expressed in this paper and the impetus to write it were the result of discussions with my colleague, Ms. Joan Houghton.

[1] Feldman and Goldstein 1971.

[2] Smith and Hobbs 1966.

[3] See Beggs 1969.

[4] See Gordon and Houghton 1977.

[5] See Aggregate Client Data 1976.

and ghettos as well as in the hip neighborhoods of large cities. These runaway centers regard themselves—and are regarded by their communities—as more or less permanent resources for the one-half to three-quarters of a million young people[6] who each year leave their homes without permission.

During the course of their evolution and proliferation, staff at runaway houses discovered that the young people who came to them had a variety of social and emotional problems[7] which they could not or would not bring to private mental health professionals or existing mental health facilities.[8] The majority were preoccupied with parents who in many cases were themselves disturbed, but many were also troubled by their relations with their schools and their friends and by their own use and misuse of drugs, alcohol, and sex. Though they refused to label these young people as mentally ill, the staff found some of them to be more self-destructive than rebellious; others seemed "weird," even to counselors steeped in nonconformity; and still others seemed hopelessly depressed and/or confused.[9]

To meet the needs of these young people and their families, runaway centers have gradually enlarged the scope and sophistication of their services and administration. They have made use of increasing numbers of mental health professionals; trained their workers in techniques of individual, group, and family therapy; provided long-term residential care; inaugurated "preventive" services; improved the quality of their administration; and created solidly based community boards of directors. During the last several years they have begun to conceptualize themselves as "youth and family crisis centers" and "mental health facilities." Indeed, without having planned it, they have created a system of community mental health centers for troubled young people and their families that is at once a complement and challenge to the principles and practice of federally funded community mental health centers.

COMMUNITY MENTAL HEALTH CENTER CRITERIA APPLIED TO RUNAWAY CENTERS

In describing and conceptualizing runaway centers as spontaneously emerging community mental health centers I will try to show how they embody the early spirit of the community mental health center movement and how they provide the services mandated by its legislation and its amendments. In the framework for this discussion, I will use categories borrowed from the legislation as well as those which Feldman and Goldstein[10] employed "to distinguish community mental health centers from other mental health services." In each section I will present an evolutionary perspective as

[6]See National Statistical Survey 1976.

[7]See Beyer, Jenkins, Leventhal, and Stierlin for a psychopathological perspective on runaways.

[8]See Gordon 1975*a* and 1975*b*.

[9]Ibid.

[10]Op. Cit.

well as information about the current status of runaway centers. The portrait that will emerge is both a composite of many runaway centers and a fair replica of a number of them.[11]

Specific Geographic Responsibility

The first runaway houses—in New York's East Village, Washington, D.C.'s Dupont Circle, and the Haight-Ashbury—tended to work with young people who had come, sometimes from great distances, to be part of the burgeoning counterculture. As the counterculture has disappeared and the number of services for troubled and disaffected young people has increased, this pattern has changed. Increasingly, runaway centers tend to serve young people who come from their immediate geographic area. In 1971, 85 percent of those who came to Runaway House in Washington, D.C., were from outside the city; in 1976, over 50 percent came from the District of Columbia.[12] Nationwide, more than 60 percent of the young people staying in the 130 runaway centers funded by DHEW's Office of Youth Development have travelled less than 10 miles from their homes.[13]

Comprehensiveness

Almost every runaway center provides its 10- to 17-year-old population with all five of the basic services which were originally mandated for community mental health centers. Many offer their clients several of the additional seven services which have more recently been prescribed.

EMERGENCY SERVICES 24 HOURS A DAY

Every runaway center offers its clients and their families a facility that is staffed 24 hours a day, 7 days a week. Young people or their parents are free to call, and young people can walk in off the street, obtain counseling, or stay as a resident any time, day or night.

INPATIENT SERVICES

When runaway centers were first created, one of their primary aims was to provide young people with an alternative, both to exploitation on the street and to the constraints of living in an institution. Though they currently focus on offering young people a place to "cool out" and gain perspective on family conflicts, they continue to view themselves, and are viewed by courts, as a short-term alternative to institutionalization and a crisis-intervention service that may obviate the need for it. Runaway centers work with a number of young people who have been diagnosed "schizophrenic" or "border-

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[11] See Gordon and Houghton, op. cit.
[12] See SAJA—Annual Reports and Statistics 1971-1976.
[13] See Aggregate Client Data 1976.

line psychotic" as well as many others who have been described as "acting out," "delinquent," "drug or alcohol dependent." Many of the young people previously have been institutionalized and many more have been threatened with it. A sample of runaways during one quarter in 1974 at the D.C. Runaway House revealed that approximately 10 percent had spent time in mental hospitals and 20 percent in juvenile detention facilities. An additional 25 percent had had institutionalization recommended by a mental health professional or probation officer just prior to running away.[14]

While they are in residence at a runaway center, young people are involved in an extremely active and varied program. They function as members of a therapeutic community and must obey rules—no drugs, alcohol, sex, or violence; an evening curfew, daily cleanup, etc.—while they devote themselves to "working on their situation." Usually this means trying to understand why they have run; what their problems are; what they want to do about them; and then, with their counselors' help, doing it.

Virtually every young person (98.4 percent) receives individual counseling from a "primary" counselor who may be either a mental health professional or a trained nonprofessional; 44.5 percent are involved in family counseling with their own counselor and, usually, a mental health professional who works with the center; 40.5 percent take part in a group counseling experience, which in many programs involves daily discussion of the young people's "situations" and the way they are getting along with one another in the house.[15] In addition, counselors help young people to obtain specialized legal, educational, and vocational services. Those who cannot live at home are assisted in finding alternative living arrangements outside of an institutional setting.

Virtually all of these centers have one or more Master's level social workers on their regular staffs as well as a consulting psychiatrist or psychologist with whom the staff discusses, at least once weekly, each young person and his or her progress in individual, group, and family counseling. In addition, runaway center staffs usually work closely with several other mental health professionals who are available to see, on a consultative or long-term basis, young people who seem particularly baffling or troubled.

OUTPATIENT SERVICES

Though most of those who use runaway centers come for shelter and food as well as counseling, a large number of young people, perhaps as many as 25 percent,[16] simply make use of counseling facilities. They live nearby—at home, in their own apartment, or on the street—and come for help with family and school problems, when they're anxious or depressed, acutely suicidal, intoxicated, or simply in need of someone to talk to. Runaway cen-

[14]See Gordon 1975*a*, op. cit., and SAJA op. cit.
[15]See Aggregate Client Data, op. cit.
[16]Ibid.

ters provide these services to young people without delay and with minimal or no formal intake procedure.

PARTIAL HOSPITALIZATION

Though few runaway centers have explicit "day hospital" programs, many function in that capacity for young people who have returned home, gone to live in foster placement, or are on their own. The center is a place where the ex-runaway can come to talk—daily if need be—with counselors and be part of group therapy and recreational activities.

In the last few years, a number of centers have instituted peer counseling programs in which ex-runaways are paid to help with house maintenance and administration as well as with counseling. These programs, which include a substantial psychologically oriented training component, provide young people with the ongoing opportunity to be part of a community of helpers, to learn more about themselves and their problems, and to earn some money.

CONSULTATION AND EDUCATION

Runaway centers are not generally funded for any activities beyond direct services and therefore tend to allocate the vast majority of staff time to responding to the sometimes overwhelming direct service needs of young people and their families. Nevertheless, many centers have tried to maintain some kind of "outreach" program. In most cases, this has meant providing lectures on youth and family problems to high school and college classes, PTAs, churches, fraternal organizations, etc.; organizing seminars with local probation officers and mental health professionals who are concerned with reaching young people; and offering technical assistance to community groups which are interested in starting new programs for young people.

As runaway centers have become more financially secure, they have begun to devote more staff time to consultation and education. Among the projects currently undertaken are semester-long courses—on adolescence, alternative services, or youth rights—for high school, college, or graduate students; regular consultation with street gangs and street workers; organization of peer counseling groups in local high schools and of parent and family groups at local churches, community centers, etc.

SCREENING SERVICES

In the course of their work, runaway centers have routinely provided or arranged for mental health screening services for the young people who come to them. Their emphasis has always been on finding not only the least restrictive setting possible, but the one that the particular young person chooses.

FOLLOWUP CARE

Though they have not specifically addressed themselves to teenagers leaving State mental hospitals or penal institutions (either as discharged inmates or escapees), runaway centers have always been available to these young people and have regarded it as their responsibility to provide the full range of their services to them. In many cases, runaway centers are chosen as alternatives to institutionalization not only by the young people themselves, but also by parents and mental health professionals.

TRANSITIONAL SERVICES

As runaway centers have evolved, many have set up programs specifically designed to meet the long-term supportive needs of young people and their families. Among their innovations are specialized and flexible group foster homes for young people who would otherwise be institutionalized; foster placement programs where individual young people and prospective foster families are carefully matched and supervised; and long-term family counseling programs where runaway house counselors and mental health professionals tailor their therapy to each family's particular social, economic, and emotional situation.[17] Runaway centers also provide continued individual and group counseling for young people as well as ongoing vocational, educational, and legal advice and advocacy.

ALCOHOLISM AND DRUG ADDICTION; ALCOHOL AND DRUG ABUSE SERVICES

Many of the young people who come to runaway centers have problems with alcohol and drug abuse and some are, indeed, addicted. Runaway centers work with all of these young people on a short-term basis and with some on a long-term basis. If a more specialized addiction services program is needed, they generally refer the young person elsewhere for these supplementary services while continuing to be available for counseling, advocacy, and crisis intervention.

SERVICES FOR CHILDREN AND THE ELDERLY

Runaway centers work with young children and the elderly only when they are part of the family of the person who has run from home.

Accessibility

Runaway centers have always prided themselves on their immediate accessibility to their clients. The first ones were founded by indigenous helpers in areas in which large numbers of young people congregated. Later ones

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[17] See Gordon 1975*b*, 1976*a*, 1976*b*, 1977, and Gordon and Houghton, op. cit.

were deliberately established in similar neighborhoods or near major means of transportation. Young people who noticed the building simply walked in off the street; others heard about the runaway centers from hotlines, school counselors, and, most often, from friends and street acquaintances.

Though they wanted to be available to all the young people who needed them, the first runaway houses didn't want to be accused of "encouraging kids to run away from home," nor did they wish to draw unnecessary police attention to themselves: Running away was a crime in the majority of States in 1967 and still is a crime in almost half of them.[18] As runaway centers have put down roots in their communities and as they have shifted somewhat from a posture of youth advocacy to one of youth-and-family-crisis-work, they have felt increasingly free to publicize themselves and their services; to reach out to troubled youth who are thinking about running but have not yet left home. The young people seem to be responding to this preventive approach: During the last quarter of 1976, over 20 percent of those who used the services of runaway centers continued to live at home.[19]

The accessibility of runaway centers is facilitated by three other well-publicized factors: (1) Neither young people nor their families pays for services rendered; (2) Counseling is immediately available 24 hours a day; and (3) Unless the house is filled to—and usually beyond—capacity, no one who is under 18 and in need is turned away.

Continuity of Care

Runaway centers have been particularly concerned with preserving a feeling of intimacy and communality. They have kept their programs small enough so that each counselor works with every other counselor and all know the young people who live in the house. Though runaway house counselors may be in sporadic contact with other young people, the entire staff of 6 or 8 works actively with no more than 10-15 current residents and 20-30 ex-residents. This full-time paid staff is augmented by 5 to 20 volunteers who provide help with counseling, house maintenance, and ancillary services. The house itself, usually a large private dwelling, tends to promote a feeling of intimacy and cohesiveness for the 200 to 300 young people who stay in it each year.

Those projects which have started foster care or group home programs maintain the sense of intimacy and continuity among their projects by having regular meetings among the members of the different staffs. When more specialized services—long-term housing, legal aid, etc.—are necessary, it is the counselor's responsibility to work with each young person in obtaining what he or she needs.

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[18] See Beaser 1975.

[19] Aggregate Client Data, op. cit.

Responsiveness to Community Needs

The first runaway centers began as a direct response to the needs of troubled and disaffected young people who filled the streets of their surrounding neighborhoods. They and their descendants have considered this responsiveness to be a hallmark of their services. Runaway centers have, as a matter of principle, included young people—present and ex-residents—in virtually every aspect of their decision and policy making. In daily or weekly meetings, young residents have the opportunity to criticize and, with the counselors, change house rules and policies; as peer counselors and as members of the runaway center's board of directors, they are in a position to shape overall organizational policy. In fact, virtually all the new programs that runaway centers have opened—family and vocational counseling, foster care, group homes, peer counseling, street work projects, etc.—have been catalyzed by the expressed and demonstrated needs of their clients.

When runaway centers opened, they were often an alien presence in a residential neighborhood, advocates for children's rights in a community of not always sympathetic adults. At first, many runaway centers reacted defensively to their suspicious or hostile neighbors, ignored or mocked their concerns. In recent years, as their focus has broadened and their existence has become slightly less precarious, runaway centers have made substantial efforts to meet with and explain themselves to neighbors. In addition to working with individual families and schools, runaway centers have joined, and sometimes formed, block and civic associations to keep the neighborhood clean and quiet. They have brought onto their boards of directors supportive and skeptical neighbors, city and county legislators, local business and professional people.

At the same time, runaway centers have also begun to conceive of themselves as part of a larger community. They have organized locally, with other social and mental health services, to lobby for youth rights and services for young people. As part of a National Network of Runaway and Youth Crisis Centers they have tried to change delinquency laws which continue to make running away a crime; to amend social service and juvenile justice requirements which restrict the services available to young people; and to urge the Congress to pass laws that are designed to help meet the needs of young people and their families before, as well as after, the child leaves home.

Funding

The founders of Huckleberry House would never have believed that the House would be there 10 years later: It was created to deal with the casualties of a cultural phenomenon that, they assumed, would soon subside. Huckleberry House, like its early sister projects, survived from day to day on church support, scrounged supplies, local foundation grants, and benefit dances. The discovery in 1973 in Houston of the bodies of two dozen boys—

presumed to be runaways—changed all that: Major Federal funding and legislation on behalf of runaways were initiated.

Recognizing that runaway centers were "natural experiments in c m-munity mental health," NIMH provided the first monies: $1.6 million for service, training, and research contracts to 32 projects across the country.[20] With the passage of the Juvenile Justice and Delinquency Prevention Act of 1974 (Public Law 93-415), 66 projects were awarded a total of $4.1 million by the administering agency, DHEW's Office of Youth Development. At the same time, other runaway centers were obtaining grants from the Law Enforcement Assistance Administration, the United Way, and the National Institutes of Drug and Alcohol Abuse, under Title XX of the Social Security Legislation, and from local social service agencies. By 1976 some $7.9 million was being allotted through OYD to 130 runaway houses.

In spite of this increase in funding, most runaway centers continue to operate at little more than a subsistence level: On budgets of between $70,000 and $150,000 a year, an average salary for each of a staff of seven is $7,000 to $9,000 a year for a 50- to 55-hour work week. Partly because of this low salary level, runaway centers are able to provide comprehensive services at a fraction of the cost of mental health—or indeed—correctional facilities: A 1975 survey[21] of some 20 runaway houses revealed that the cost per day for residential care ranged from $32 to $50, approximately one-fifth of that in a mental hospital and one-third of that in local detention centers. The cost per hour of "outpatient" counseling ranged from $5 to $12, about one-third of that in local community mental health facilities.

Discussion

In recent years, a number of critics[22] have pointed out that community mental health centers are often far less innovative and flexible than their creators had hoped, that they are more often responsive to professional imperatives than the needs of those whom they serve. According to these critics, many centers have abandoned the public health for the clinical model and have neglected their consultation and education functions. Though some have created satellite centers to offer more innovative and responsive services, others have remained stagnant; community control has often been subverted, and, according to these critics, the activist spirit of the community mental health movement has often been betrayed.

Runaway centers, begun without any professional ideology, present an interesting contrast. Though they serve a specific population and though they have not been consistently conceptualized as mental health services, they have maintained the kind of responsiveness to people's problems which the founders of the community mental health movement had envisioned. Runa-

[20] See Gordon & Houghton, op. cit.
[21] Gordon 1975*c*.
[22] See Musto; and Snow and Newton, for example.

way centers provide the five basic services to their clients in ways that are at once carefully individualized and highly economical. They have incorporated mental health professionals in their programs and have often used a "therapeutic" model without adopting an "illness" model of diagnosis, treatment, and cure and without stigmatizing those who come to them for help as mentally ill. They have continued to serve "a group that nobody wants" and to expand and change their services to meet the changing needs of this group and their families. And they are deeply committed to the preventive work which the community mental health center legislation and its later amendments have mandated.

My description of runaway centers in this paper has been suggestive rather than exhaustive or critical—questions can and should be asked about the centers' focus on crisis work, their ability to deal with seriously disturbed young people, and indeed their overall level of expertise—but it does raise the possibility of conceptualizing and studying these centers as community mental health centers. I hope that it will also begin a dialog about offering such centers funding—either under the Community Mental Health Center Act, through State mental health funds, national health insurance, or some combination of these.

I think that these runaway centers may also offer a model for a variety of other, actual or potential, community mental health services—drop-in centers for individuals and mediation centers for families in crisis; shelters for battered women and community residences for people in the midst of an acute psychotic break. I hope, at any rate, that their existence can be instructive to those who are concerned with making mental health services more relevant and accessible. Without having intended it—and without being funded to do it—runaway centers are, in fact, participants in and heirs to the tasks and aspirations of the community mental health movement.

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