RESIDENTIAL TREATMENT OF MALADJUSTED CHILDREN

A SURVEY AND RECOMMENDATIONS FOR HAWAII

ROBERT HORWITZ

REPORT NO. 1
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LEGISLATIVE REFERENCE BUREAU
UNIVERSITY OF HAWAII
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FOREWORD

Joint Resolution 34 of the 1955 territorial Legislature, which directed this report, placed an unusual responsibility upon the Legislative Reference Bureau. In addition to requiring a factual study, a routine function of this agency, it directed that recommendations be made for the establishment and operation of such residential treatment center facilities as were shown to be required. While the survey of need was to be territory-wide, recommendations with respect to facilities were to be limited to Oahu.

The initial aspect of the study--formulating the nature and program of a residential treatment center--was the most difficult, for the institution is still new in Hawaii, as in most American communities. For such insight as this presentation may have we are indebted to many people, professionally concerned with helping children in trouble, who gave generously of their knowledge and advice during the preparation of the report. Special thanks are due to Dr. E. W. Haertig, Mrs. Shirley Hayashi, Judge Gerald R. Corbett, Dr. Ferris F. Laune, Mrs. Rade Awana, Mr. William G. Among, Mr. Walter H. Ehlers, Rev. Eugene L. McClure, Mr. H. B. Simpson and Mrs. Clorinda Lucas--all of Honolulu. We are also deeply indebted to Dr. Henry C. Schumacher, medical director of the ninth regional office of the Public Health Service, and to Dr. Manuel M. Escudero and Dr. N. I. Rieger, the respective directors of the Kansas Children's Treatment Center and the Children's Unit of the Camarillo State Hospital, in California. A complete listing of all those persons, both with public agencies and in private practice, who cooperated in the survey on which this report is based would be surprisingly lengthy. A general expression of our appreciation must suffice.

Dr. Horwitz, author of the report, immersed himself in the study with characteristic zest. His devotion to the project and the enthusiasm which he transmitted to his associates engendered a fruitful cooperation between our staff and the many persons in the community who participated in the research.

Robert M. Kamins, Director
Legislative Reference Bureau

August 1, 1956

JOINT RESOLUTION 34

JOINT RESOLUTION REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO MAKE A STUDY OF THE NEED FOR THE ESTABLISHMENT OF A RESIDENTIAL STUDY AND TREATMENT CENTER TO AID CHILDREN MANIFESTING SYMPTOMS OF MALADJUSTMENT AND ANTI-SOCIAL BEHAVIOR.

WHEREAS, the children and youths of today are our most valuable resources in determining the future of the Territory of Hawaii; and

WHEREAS, many of our children manifest symptoms of maladjustment and anti-social behavior and are highly vulnerable of becoming juvenile delinquents and adult criminals; and

WHEREAS, there are no diagnostic facilities or institutions to aid in or care for these maladjusted and anti-social children, other than the training schools for delinquent children; and

WHEREAS, many of these children and youths can be helped in their maladjustment and anti-social behavior pattern through proper diagnosis and institutional care; now, therefore,

BE IT ENACTED BY THE LEGISLATURE OF THE TERRITORY OF HAWAII:

SECTION 1. The Legislative Reference Bureau of the Territory shall make a territory wide study on the need for an institution on Oahu, other than the training schools, to care for maladjusted and anti-social children of the Territory of Hawaii who can be aided through such an institution. If there is a finding for the need of such an institution, the Legislative Reference Bureau shall make recommendations for its establishment and operation. The Legislative Reference Bureau may seek the assistance and cooperation of any territorial government agency or agencies.

SECTION 2. The Legislative Reference Bureau shall submit its findings and recommendations to the Twenty-Ninth Legislature of the Territory of Hawaii on or before the third day of said legislative session.

SECTION 3. This Joint Resolution shall take effect upon its approval.

APPROVED this 13th day of May, A.D. 1955.

(s) SAMUEL WILDER KING

Governor of the Territory of Hawaii

SUMMARY OF FINDINGS

A territory-wide survey was conducted in cooperation with the departments of Health, Institutions, Public Instruction and Public Welfare, the juvenile courts, community social agencies and private psychiatrists to determine the number of emotionally disturbed, maladjusted children requiring rehabilitation through a residential study and treatment center. Confidential questionnaires on 287 children indicated a need, in varying degrees, for such facilities: 92 being in definite need of residential treatment, 124 being in marginal need, 71 requiring further diagnosis before a conclusive judgment can be made about them.

It would be possible to establish one large treatment center to accommodate at least those children classified as definitely requiring residential treatment. Construction of the necessary plant would approximate $750,000, judging from recent mainland experience, while, by the same standards, the biennial operating budget would exceed $1,000,000. This approach is not recommended, but rather the gradual development of a decentralized treatment program, which would have a number of advantages, among them: greater flexibility in operation, location near neighborhoods where the children come from and to which they would return, proximity to cooperating social agencies, economy through the use of existing and presently unused facilities.

Three possible means of implementing a decentralized program are described and evaluated. The first considered is the expansion, under territorial subsidy, of the new residential treatment program at the Susannah Wesley Home. The second is the conversion of unused facilities of the Kawailoa Girls School into a treatment center under the administration of the Department of Institutions. The third is the creation of a center at Palama Settlement under the administration of the Department of Health. Operating budgets of these three programs would range from about $240,000 to $300,000 per biennium, exclusive of construction costs.

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Part I. SURVEYING THE NEED

Chapter 1

DEFINITION OF THE PROBLEM

LEGISLATIVE DIRECTION

The purpose of this study is most clearly established by brief reference to Joint Resolution 34, a directive of the 28th Territorial Legislature. The resolution affirms that the "most valuable resource in determining the future of the Territory of Hawaii" is its children and youth. It asserts that the full and proper development of this human resource is threatened, since "many of our children manifest symptoms of maladjustment and anti-social behavior and are highly vulnerable of becoming juvenile delinquents and adult criminals." The resolution posits that "many of these children and youths can be helped" through the operation of a residential study and treatment center program, and, accordingly, requests the Legislative Reference Bureau to study the need for the establishment of such a program.

INCIDENCE OF ANTISOCIAL BEHAVIOR

The Legislature's concern with the rehabilitation of maladjusted children may, in part, reflect a realization of the social consequences of the behavior of these emotionally disturbed and antisocial youngsters. Hundreds of cases of juvenile larceny, burglary, sex offenses and automobile thefts are now referred annually to the courts, while public attention has been especially drawn to instances of attacks by juvenile gangs against servicemen, and to cases of arson, murder and rape. It is virtually impossible to calculate the total damage wrought by the antisocial behavior of such juvenile offenders, but indisputably it is great and is increasing at a rate which can be roughly forecast. Describing the situation anticipated by the end of the present biennium, the judge of the Juvenile Court in Honolulu notes that we are

> confronted with scientifically sound predictions that, before we reach the end of that biennium, the total number of children within the 12-17 year age group will have increased from 31,700, the 1954 figure, to 40,100 as of April 1, 1957, and, further, that the number of children in this age group referred to us for delinquency and traffic violations will have increased from 1,500 in 1954 to 1,700 in 1955, 1,800 in 1956 and 2,000 in 1957. . . . In addition, experience indicates that we can expect the referral

for delinquent conduct of about 200 children under 12 during each of these years.[1]

The financial cost of this antisocial behavior cannot be calculated merely in terms of the immediate damage generally associated with criminal activity; to these direct social losses must be added the far greater costs of maintaining a substantial portion of this group in custodial institutions throughout the greater part of their lives.[2] It is evident that the effective rehabilitation of maladjusted and antisocial children would prevent both suffering and monetary losses.

THE GOAL OF REHABILITATION

Stating the argument for rehabilitation more positively, it may be noted that our society takes a constructive interest in its members, devoting a sizable portion of its resources to free public education, public health and other measures designed to achieve and maintain the full development of the citizenry. It is within this context that the purposes of a residential treatment center may begin to be understood, for such a program is designed to rehabilitate the maladjusted child in the following manner: (1) to remedy as thoroughly and as quickly as possible his educational and character deficiencies, and (2) to foster a healthy environmental situation in which he can then develop normally.

CONTRAST WITH CUSTODIAL CARE

As the residential treatment process is new to Hawaii and not likely to be well understood within the community at large, it may be helpful to begin by indicating the major aspects of this process as it has come to be understood in the course of this study. Its meaning may be somewhat clarified by contrasting it briefly with the approach which is still prevalent in those communities where maladjusted children are committed to custodial reform schools. The residential treatment center attempts to apply simultaneously the disciplines of education, psychology, psychiatry and social work to the overall rehabilitation of the emotionally disturbed, maladjusted child. This approach is based on the premise that maladjustment stems from causes which can be sufficiently ascertained through systematic diagnosis, and, to a large extent, eliminated through therapy. Dealing with *causes* rather than *symptoms* is basically different from the approach of the custodial institution. The underlying premise of the custodial approach is the notion that delinquency can best be overcome through the creation of certain habits, such as regularity, neatness, courtesy and obedience. It proceeds on the assumption that surface conformity to the institution's regulations reflects a genuine acceptance of these qualities by the inmates. Emotionally disturbed children generally find it difficult to conform

even outwardly with the rules of the institution, hence, it is customary to maintain an extremely strict regime, one frequently characterized by unrelenting harshness, reinforced by resort to physical punishment.

This approach has been strongly condemned by the superintendent of the territorial training schools for delinquent children, who writes that:

> The average citizen still believes that keeping a delinquent child out of circulation by incarceration will make him a better child. Little does he realize that what happens during the period of incarceration determines, to a large degree, the success or failure of that particular child when he is returned to the community. He forgets that incarcerating the child merely for the sake of keeping him out of circulation will most likely engender in him bitterness and hate as he waits for the day he is released for an opportunity to get even with society.
>
> In recent years, training school superintendents have been faced with a very important decision concerning the philosophy of a training school. They have had one of two choices to make: either to restrict themselves to the supervision of a close custodial institution and thus conform with a too well known archaic system, or to establish a true treatment center designed to ASSIST the child gain new feelings, new values and attitudes. Past experience has shown that the first choice has been disastrous to society morally and economically and that the second, though it contains many challenges, also contains those conditions and circumstances which harmonize with the ideals of democracy.[3]

As this statement clearly implies, the conformist behavior which the custodial institutions attempt to stamp upon their wards is frequently only skin deep. Emotionally disturbed children who have been inmates of such institutions are seldom adequately adjusted adults, but rather "pseudo-social" types who, while appearing for a time to conform to the social demands made upon them, are in fact only awaiting opportunities to give vent to their true emotions. Through the acquisition of "institutionalized personalities" they are prepared, in effect, for further residence in other institutions rather than for normal life in the community.

General recognition of the failure of the custodial institution characterized by harshness has led, in some quarters, to a reaction which might be described as the "enlightened reform school" approach. Such a reaction may be based on the conviction that if a regime of general harshness and strict discipline has failed to secure rehabilitation of emotionally disturbed children, then what is needed must be the diametrically opposed approach, namely, a regime characterized by extreme gentleness and permissiveness. This approach has succeeded little better than the one it replaced.

It has, in fact, enabled greater numbers of maladjusted and antisocial children to escape from these institutions, an outcome which is beneficial neither to them nor to the community at large.

It is suggested that the custodial-institution approaches characterized either by indiscriminate discipline or by indiscriminate permissiveness share the same failing. Neither approach deals with the root causes of the maladjustment underlying antisocial behavior. In contrast, the residential study and treatment center process is based on the recognition that the unacceptable behavior of every maladjusted child is related to unique problems with which treatment must deal. Diagnosis and treatment must therefore consider individual need rather than apply some standardized technique. The successful rehabilitation of a given child may require considerable firmness during one portion of his treatment; then again he may need to be handled quite permissively for a time. But questions of "discipline" or "gentleness" are not the dominant considerations, rather they are simply aspects of an overall treatment plan tailored to the needs of each child.

TREATMENT IN BREADTH

The ultimate goal of residential treatment is sought through a process which might be characterized as "treatment in breadth," a shorthand term, further developed in Chapter 3, which emphasizes the fact that chief reliance is placed on a process rather than on institutional care. While it is true that intensive, though preferably brief, treatment in the residential center constitutes an essential portion of this process, the period of actual residence is only one of the important factors involved in a program of rehabilitation. No less essential is the mutual cooperation of the treatment center and those community agencies which would be working directly to rehabilitate the child's family during the time he is receiving residential treatment. The objective is to keep periods of actual residence in the treatment center to the minimum while utilizing every resource in achieving the basic objective of assisting the child to make an adequate adjustment to a normal environment. In achieving this goal, inter-agency cooperation is essential both in the preparation of the family environment into which the child is to be placed after leaving the center and in the development of plans for his continued treatment until rehabilitation has been completed. In order for the outpatient portion of the treatment to be effective it would have to be related to all other community services that may be received by the child during this period. "Treatment in breadth" is here visualized as a cooperative effort of the treatment center, schools, social agencies, recreational agencies, ministers, employers and other persons who have extended contact with the child. Such cooperation is necessary for achievement of the objective of the residential study and treatment process.

FAMILY ENVIRONMENT

It is a well established fact, further confirmed by this study, that a substantial portion of emotionally disturbed, maladjusted and delinquent children are the products of defective family settings and generally poor environmental conditions. It is hardly surprising that families rent by marital discord, infidelity or violence do not give children the security, strength of character or education necessary for an adequate adjustment to adult life.

Background information gathered on the children reported in this survey indicates that approximately half come from homes which have been broken by divorce, legal separation or frequent absence of one parent--a circumstance oftentimes accompanied by the entry of the other parent into clandestine relationships. *Less than a third of the children reported in this survey are living with both natural parents.*[4] Even where both parents are living together, frequently one or both of them are afflicted with emotional difficulties which contribute to the maladjustment of the child. It is evident that effective treatment of maladjusted children is dependent on simultaneous rehabilitation of the parents.

FOSTER HOMES

When a child's family cannot be sufficiently rehabilitated to provide a healthy environment, then consideration must be given to the selection of a foster home. Unfortunately, the discovery and development of adequate foster homes is a difficult matter; hence those persons responsible for the development of a thoroughgoing program of residential study and treatment would have to give considerable attention to this problem. The facilities of the Department of Public Welfare might prove to be especially useful in the development of foster home resources in general, although in any particular case the chief responsibility for foster home placement would remain with the agency referring a child for residential study and treatment. It follows, then, that there would have to be the closest contact between the staffs of the referring agencies and the staff of the residential treatment center.

TURNOVER OF POPULATION

The treatment center's task of rehabilitating the emotionally disturbed, maladjusted child to the point where he may be returned to a healthy environment for continued therapy will be hampered if residential treatment is too protracted. The tendency for centers to become congested with long-term cases is so pronounced that the legislative enactment establishing the new Kansas Children's Treatment Center specifically provides that no child shall be given more than twelve consecutive months of residential treatment.[5] While questions may well be raised as to the wisdom of this particular device for preventing congestion, the fact remains that some

existing centers have found their capacity for accepting new cases severely curtailed because they lacked adequate cooperative arrangements with other community agencies which could take over responsibility for the aftercare of children discharged from the treatment center. If, to avoid becoming clogged with long-term cases, the treatment center releases incompletely rehabilitated children into the community without adequate provision for follow-up care, there is the greater risk of total failure of the entire therapy program.[6]

Development of an adequate program in breadth makes possible not only more complete and effective treatment, but, no less importantly, facilitates the full utilization of costly professional skills which are heavily concentrated within the treatment center itself. Such utilization of staff can markedly reduce the cost of treatment per child while making possible the implementation of a relatively large program, even though the treatment center may be of rather modest proportions.

COOPERATIVE TREATMENT PROGRAM

The achievement of an adequate program in breadth can provide the solution to another difficulty generally associated with the type of children in need of residential study and treatment. Within any community these children may be characterized as "the kids nobody wants."[7] Their behavior and symptoms are such that they cannot be tolerated very easily or for very long in their homes, foster homes or institutions. Oftentimes aggressive, cruel, rude, even dangerous and sometimes so withdrawn as to be virtually unapproachable, these children are shuffled around the community--quickly wearing out their welcome wherever they go. Almost everyone into whose hands they fall becomes anxious to "pass them along"; hence they are circulated around until, typically, they end up as long-term inmates of a custodial institution. A program of residential treatment and study that is integrated with those of other community agencies would make it possible for these "kids that nobody wants" to be successfully handled. The therapy given to them while residential patients would be designed to facilitate continuation of their treatment outside the center, though instances might arise in which further periods of residential treatment would be required.

To reiterate: achieving the objective of "treatment in breadth" requires that the treatment center plan, establish, develop and maintain a program of cooperative relationships with other community agencies. The value of a program of residential study and treatment would be questionable unless adequate plans were made on this score. The more thorough the arrangements for general acceptance of the disturbed child, the greater the chances of ultimate achievement of the goal of therapy--the total health of the

child within a good family and community setting. The scope of this task may best be appreciated by reference to some actual cases of children in the Territory who are in need of residential study and treatment.

FOOTNOTE

1. *Annual Report, The Juvenile Court of Honolulu, Calendar Year 1954*, p. 3.
2. A survey conducted by the Division of Paroles and Pardons indicates that as of July 1, 1956, approximately 30 per cent of the inmates of the Hawaii prison system were former inmates of the Koolau Boys Home, of the former Waialee Training School for Boys, or of the Kawailoa Girls Home. Other maladjusted children become inmates of the Territorial (mental) Hospital or the Waimano Home for feebleminded persons.
3. *Annual Report, Department of Institutions, 1953*, p. 15.
4. See Figure 2.
5. See *Session Laws of Kansas, 1953.* Chapter 411 provides for the "Establishment, Construction, Equipment, Maintenance and Operation of a Treatment Center for Children." Section 2 provides, in part, that "The parent, parents or guardian of any child admitted by application, or the state department of social welfare, when referring a child, shall execute an agreement of surrender entrusting the personal control of the child to said treatment center for an initial period of not to exceed three (3) months, subject to discharge before the expiration of such period in the discretion of the director of said treatment center. Upon the expiration of such agreement, additional agreements may be entered into, but in no event shall a child remain in said treatment center for more than twelve (12) consecutive months . . . "
6. See Fritz Redl and David Wineman, *Controls From Within* (Glencoe, Illinois: The Free Press, 1952). In the "Epilogue," pp. 314-15, the authors describe the aftermath of premature termination of treatment accompanied by return to inadequate environments. "Moving back to their own homes re-exposed them to traumatic life situations ranging all the way from the amazing to the unbelievable. . . . Thus our 'children who hate' went back into the limbo of 'the children that nobody wants.' The spectacle of their retraumatization, of strengths that had been so painfully, if incompletely, implanted in their personalities being literally wasted in a battle with a hostile environment, is one that fades slowly, if at all, from our minds."
7. *Ibid.*

Chapter 2

ILLUSTRATIVE CASES

The following illustrations are based essentially on the case records of some children reported in this survey, though proper names have been changed and sufficient alterations made in the circumstances of each case to prevent identification of the children.

THE CASE OF "JOHNNY" Johnny is an eight-year-old. His mother was estranged from his father while still pregnant with Johnny, who has never known his natural father or brothers. Shortly after birth he was given over to the care of his maternal grandparents, but at the age of three was taken back by his mother, who had remarried. His early childhood at the grandparents' home was not a constructive one. He was very destructive and responded to the severe punishment which he frequently received by breaking up the furniture, by tearing up sheets and clothing, and by striking his grandparents. He became an inveterate liar and has been stealing from his grandparents and others even before he began school.

Johnny's unhappiness and maladjustment were increased through his being moved, when he was three, from his grandparents' home to the home of his mother and stepfather. His stepfamily, especially his stepbrothers and sisters, resented his presence and he felt unwanted in the family. This made him hostile and his conduct became so destructive that the family could not handle him.

Johnny persistently plays with matches, thus finding opportunities to show his hostility. One time he set fire to his stepbrother's bed; he has burned a stepsister severely. Even the harshest punishment does not succeed in changing his conduct. Scolding provokes Johnny to violence, after which he becomes sulky and refuses to talk. On one occasion his response to punishment was an attempt to set fire to the house.

Unwanted and feared, within his own home, Johnny does not get along better outside. Other children are terrified by his strange and cruel behavior so that he has no playmates. He destroys his toys and those of other children; among the few toys he appears to enjoy are wooden daggers and spears with which he threatens other children.

Johnny's teachers report that at school he is a source of constant trouble. He picks fights, bullies other children and puts thumbtacks on his teachers' chairs. He seems unable to concentrate on any of his school activities and is so destructive that he unsettles the whole classroom. Correction and threat of serious punishment by the school authorities have not improved Johnny's conduct, but have provoked the same type of hostile reactions that he shows at home. He continues to play with matches in school and his teachers fear that Johnny will be responsible for a disastrous fire. Johnny will probably be permanently expelled from school, and, since his family is unable to afford private schooling, he will then remain at home to threaten and injure his stepbrothers and sisters, or else will be let loose in the neighborhood to wander unrestricted and unobserved.

Johnny is now receiving limited outpatient treatment. Comprehensive examinations have shown that he is suffering from no organic brain damage or other physical deficiencies that might be responsible for his antisocial behavior, and he has the intelligence to meet school standards. Rather, his behavior appears to be related to the fact that he has never been emotionally accepted by his parents or relatives and thus has been denied the security of normal relationships. Those who have been treating Johnny feel that an adequate program of rehabilitation, which would include a period of residence in a treatment center, followed by outpatient treatment under supervision of a social service agency, can secure his rehabilitation. Otherwise it is felt that his condition will worsen and that his destructive behavior ultimately will necessitate his removal from society altogether.

Johnny cannot be given adequate help at present because outpatient treatment provides neither sufficient time nor an adequate setting for the professional staff to win his confidence and develop a long-range treatment program for him. Furthermore, the home environment is a major source of his illness. Johnny's rehabilitation clearly requires intensive residential treatment and preparation of an adequate home--ideally his own. If his own home cannot be made adequate, then it would be necessary to place him in a foster home or institution. Only then would Johnny be in a position to profit fully from the outpatient phase of his treatment.

Johnny's maladjustment has expressed itself in violently aggressive, "acting-out" behavior and activities of this type are bringing him more and more to the attention of outsiders. He is prone to vent immediately and without restraint the hostile feelings generated by his totally unsatisfactory life situation, and the resulting damage will make him increasingly intolerable to society. It should not be assumed, however, that Johnny's pattern of behavior is the only--or even the typical--reaction expressed by children in such unsatisfactory situations as his. The effects of maladjustment may be turned *inward* by the child, with deep and irreparable damage being inflicted upon himself. Such is the situation presented by the next illustrative case.

THE CASE OF "RUTH"

Ruth is a ten-year-old, the only child of a middle-aged couple which has had a stormy marital history. The mother is herself maladjusted and emotionally unstable. She cannot cope with the difficulties presented by everyday life and is seldom far from a total breakdown. The father, too, is overwhelmed with personal problems from which he attempts to escape by heavy drinking. He has withdrawn almost all interest and involvement from his family; hence, rather than being of assistance to his overburdened wife, he is an additional source of concern to her.

Ruth has been almost totally deprived of satisfactory emotional experiences throughout her life, for her disrupted family has neither friends nor relatives with whom satisfactory contacts are maintained. As a consequence, Ruth has

increasingly withdrawn from human relationships. She has no playmates and has rejected even dolls, playing exclusively with her pets. She is extremely fearful of any contact with other people. On being approached she either becomes tense and pale, holding herself rigid, eyes downcast, or else she is seized by panic and tries to hide in a corner of the room. When questioned, even by the physician who has been treating her, she remains completely silent, or may whimper like a hurt animal. If the questioner persists, her breathing becomes rapid, her pallor increases, and no answers can be elicited beyond a whimpered "yes" or "no".

It would be expected that Ruth's adjustment at school has been precarious. Her teachers have tended to leave her quite alone, rather than risk upsetting her. The students regard her as "queer," and ignore her completely. Despite this virtual isolation, she has succeeded in making limited academic progress, one indication that she is not mentally defective. This judgment has been borne out by an extended program of psychological testing. Ruth's educational development has, however, been seriously retarded. In one instance she was placed in a special adjustment class, and, for the first time, she began to secure a relationship with other children. In the adjustment class she was among children some three years younger than she, and apparently did not fear them as she does her peers or adults. Through patient individual attention the teacher was able to establish the beginnings of a satisfactory contact with her, but the size of the class precluded the continued devotion of so much time to one student.

Ruth is being given limited psychiatric assistance, but this is ineffective, since she continues to reside in her unsatisfactory home. She cannot be placed in a foster home or an ordinary child-caring institution because her pronounced withdrawal would make her unacceptable to foster parents or to other children.

Her physician believes that unless Ruth is given effective treatment, she will, when faced by the additional strains of adolescence during the next few years, probably have to be committed to the Territorial (mental) Hospital, an institution which has no special facilities for treating children.

Those charged with the responsibility for developing a program of treatment for Ruth would be faced with the task of habituating her to satisfactorily experiencing the most elementary and basic human feelings. Her emotional development has progressed hardly beyond that of an infant. These lost years of social and intellectual development must be remedied within a relatively short period; hence Ruth requires intensive residential treatment followed by a carefully designed program of outpatient treatment.

Strikingly different is the situation presented by a final illustrative case--a child also definitely in need of the type of rehabilitation afforded by a residential study and treatment center program. This is the case of an adolescent girl who will very shortly be called upon to carry the responsibilities of an adult. Her needs illustrate additional facets of the functioning of a residential treat-

THE CASE OF "MARY"

Mary is a fifteen-year-old girl born out of wedlock. Her mother, as a girl, had been confined to an institution because of delinquent conduct. Mary's natural father subsequently married another woman, and he brought Mary to live with his wife and their several children. The stepmother has been married three times and engages in

clandestine relationships. The father is a heavy drinker and also continues to be sexually promiscuous. He leaves the family for extended periods, returning for only short intervals.

A disrupted family background and unstable home environment have had a profoundly deleterious effect on Mary's character. She does not feel wanted by her stepmother and tries to attach herself to her natural mother, whose children by other marriages and clandestine relationships Mary claims as brothers and sisters. Mary is naturally troubled and confused as to which household, if any, she really belongs. Her relationship with her stepmother is a most unhappy one; she occasionally bursts into fits of temper and threatens her. She steals from her and from others and habitually lies to conceal her misdeeds. Mary is sexually promiscuous and has illicit relationships with older men and with boys her own age.

At school Mary is unable to secure an adequate adjustment, though she has the capabilities for adequate work. She bullies her classmates, steals from them and habitually lies to her teachers. Her school behavior is so disruptive that she has been forced by the school authorities to change from one school to another. on an average of once a year.

Continued difficulties at school and at home led to Mary's placement in a foster home several years ago. The capable and understanding foster parents were fond of her, and she appeared to be making some improvement. However, she was alternately depressed and overstimulated without apparent provocation, and at times would try to play the role of a small baby around her foster parents. The foster brothers and sisters were unable to understand this bizarre behavior and a satisfactory family relationship was not formed. This placement accordingly lasted only a few months, after which Mary ran away and was found to have become sexually delinquent again. Returned to the foster home, she ran away a second time, and was then confined in a detention home. There she soon became aggressive in homosexual activities and active in engineering escape attempts. On occasion she became the ringleader and "boss" of the other children in the home, but alternatively she would lose confidence in herself and display suicidal impulses.

Following her confinement in another institution, Mary has been returned to the unsatisfactory environment of her stepmother's home. The facilities needed for her rehabilitation are lacking in the Territory and she is being given only outpatient psychiatric therapy. While she benefits temporarily from this therapy, her lack of self-control makes it unlikely that she will receive permanent benefit from this infrequent treatment which is followed by her return to an uncontrolled and inadequate environment.

Mary has shown, from time to time, an awareness of her need for firm but intelligent guidance and competent supervision. She is, however, so little in control of her impulses that she will run away from the ordinary institutional or foster home setting.

Chapter 3

PERSONNEL AND TECHNIQUES OF THE RESIDENTIAL TREATMENT CENTER

What combination of professional services are necessary for the rehabilitation of "Johnny," "Ruth" and "Mary" and their counterparts in Hawaii's juvenile population? The answer to this question may be summarized as "treatment in depth"--an objective whose meaning has been well expressed as the achievement of "a real character change [in the child] . . . the retrieving of that part of his development which is necessary for a proper adjustment to society."[1] As is evidenced from the illustrative cases, the most basic behavior patterns would have to be modified in these maladjusted children. Through contact with staff members of the treatment team, there would have to be created among them the feelings of security associated with acceptance and a sureness of "belonging"--feelings which they have never known. Because of their maladjustment and unhappiness, "Johnny," "Ruth" and "Mary" have never had the satisfaction of normal children's games; they have never enjoyed the play and fun naturally associated with childhood. They must, in effect, be taught how to play, how to participate in satisfactory activities with other children, rather than using such situations as a vent for destructive urges.

This objective of "treatment in depth" is contrasted to superficial treatment by August Aichhorn through comparing residential therapy with the treatment of mere symptoms. He notes that

> fever, inflammation, and pain are *symptoms* of disease. If the physician limits himself to clearing up symptoms, he does not necessarily cure the disease. . . . new symptoms may replace the old. In the re-education of the delinquent, we have an analogous situation. Our task is to remove the *cause* rather than to eliminate the overt behaviour. . . .[2]

The way in which such fundamental character change is achieved may be indicated by brief consideration of the position, function and something of the qualifications of each of the members of the treatment center staff. A treatment team combines a variety of professional skills, all of which must be integrated into a coordinated treatment team. Such integration is indispensable, since it is not possible to predict with which of the team members the maladjusted

child will form the most significant and constructive relationships. Each staff member, whether psychiatrist, psychologist, social worker, remedial educator, houseparent or whosoever, must be closely acquainted with every case and in a position to participate actively in therapy. Selection of the members of the treatment team thus poses a special consideration, one which has been given strong expression by Aichhorn, who stresses that the "personality of the workers" is of decisive importance, since

> a character change in the delinquent [child] means a change in his ego-ideal. This occurs when new traits are taken over by the individual. The source of these traits is the worker himself. He is the important object with whom the *antisocial* child or youth can retrieve the defective or non-existent identification and with whom he can experience all the things in which his father failed him. With the worker's help, the youth acquires the necessary feeling relation to his companions which enables him to overcome the *antisocial* traits. The words "father-substitute," so often used in connection with remedial education, receives its rightful connotation in this conception of the task.[3]

It is in the light of these and other qualifications that the function of each of the staff members of the treatment team will be described.

PSYCHIATRIST The chief psychiatrist would have initial responsibility for establishing an individual program of therapy for each child. He would participate on a continuous basis in the treatment of the child during his period of residence in the center, following which he would play a directing role in the outpatient phase of the rehabilitation program. In addition, he would carry the chief responsibility for developing and directing training programs for personnel of the center. Assisting or visiting psychiatrists[4] would be primarily concerned with individual case treatment and would participate actively in those treatment conferences which concerned their cases.

PSYCHOLOGIST An experienced clinical psychologist would play a key role as a member of the diagnostic and treatment team, administering various tests to determine whether potential patients were suffering from congenital deficiencies, brain damage or other organic limitations which would preclude them from being benefited by the services of a treatment center. Such a testing program would help determine the nature of a patient's personality disturbance and secure necessary data about the child's development and basic aptitudes. The duties of the psychologist would not be limited to diagnosis but would include varying degrees of direct participation in the treatment of those children for whom his skills were particularly needed.

PSYCHIATRIC SOCIAL WORKERS

A substantial portion of the day-by-day responsibility for patients during their period of residence within a treatment center would be carried by psychiatric social workers. They would be most immediately concerned with carrying out the program of therapy prescribed for each child by the psychiatrist and other staff members during diagnosis. Their work with the children would also routinely include consultation with social workers on the staff of the referring agency.

Through working with the child daily the psychiatric social worker would acquire the most intimate knowledge of his development; this special awareness could become a source of guidance to the others working with the child. It follows that considerable responsibility for providing overall guidance to the treatment team would be in the hands of the psychiatric social workers.

SOCIAL GROUP WORKERS

Within the treatment center the endeavors of the psychiatric social workers would be integrated with those of the social group workers, among whom might be trained recreational workers. They would play an extensive role in planning and carrying out the daily treatment program. Patients would typically be involved in a variety of group projects and recreational activities, and this portion of the center's program would require these professional skills for its design and execution. The social group workers would provide step-by-step guidance in developing social relationships and responsibility among the children. Under the suggested arrangements made in Chapters 7 and 8 for sharing staff with child-caring agencies which might house a treatment center, these social workers would also help integrate the efforts of outside instructors in such activities as arts and crafts, homemaking, sewing and sports.

REMEDIAL EDUCATORS

Remedial academic education is one of the fundamental tasks of a total program of rehabilitation. The educational deficiency of maladjusted children has been found generally to increase in proportion to their age, as is indicated in Figure 6. Therefore, the services of a remedial educator should be brought into play as quickly as possible for each child. Depending on such factors as the findings of the diagnostic testing program, the degree of educational retardation and the ability of the child to attend any conveniently located public school, the work of the remedial educator would vary. In some instances the educator might be called upon to spend several hours each day with a child in the early stages of treatment before attendance at an outside school could even be considered; in other cases the educator might primarily assist the

child in overcoming a particular educational deficiency. The obvious requirements of skill and flexibility in designing individual programs suggest that the remedial educator required for residential treatment center work must be of high caliber, for such a person would have to have broad experience not only in the field of education but also in working with emotionally disturbed, maladjusted children.

HOUSEPARENTS It could be anticipated that many of the children receiving treatment would form their closest personal relationships with the houseparents within the center. While it is generally agreed that the use of couples for service as houseparents is ideal, it has been found in practice that the recruitment of couples in which both husband and wife are qualified is virtually impossible; in part because inadequate salaries are generally offered. Hence, the general practice is to recruit individuals who, through in-service training, can become part of the treatment team. For a center treating adolescent girls the recruitment of mature women as housemothers would be indicated, though provision might also be made for a housefather. The housemothers would help the girls master some of the homemaking skills in which they would generally be found to be surprisingly deficient. The daily tasks of caring for their quarters, helping with the preparation and serving of food, decorating the cottage and such activities would all provide opportunities to guide the energies of the disturbed child in a beneficial direction.

The work of the housefathers would be especially rigorous, since emotionally disturbed adolescent boys may break into destructive temper tantrums, display overt aggression against other boys or staff members, and manifest other symptoms which require temporary physical suppression.

The houseparents on the staff would be invaluable for working with the children during periods when formal activities were not scheduled or when a child was emotionally unable to participate. The houseparent would see that the child was prepared as thoroughly as possible for each of his activities and would help him understand and accept his treatment program.

The men and women serving as houseparents would constitute an integral part of the treatment team; hence their selection and in-service training would be extremely important--indeed, one of the major, continuing responsibilities of the professional staff.[5]

DOMESTIC HELPERS Inasmuch as there might well be considerable contact between the children receiving treatment and the cooks and other domestic helpers in the center, especially in the case of adolescent girls whose re-

habilitation should include the acquisition of homemaking skills, the selection of these staff members must also be undertaken with considerable care. Experience in established treatment centers indicates that many children find it less difficult initially to form sound and healthy relationships with the domestic helpers and maintenance personnel than with members of the professional staff. This reinforces the contention that everyone connected with the treatment center must be chosen as part of a treatment *team.*

OTHER STAFF MEMBERS

The size and character of other staff requirements for operation of a publicly operated treatment center would depend, in large part, on the type of cooperative arrangements which could be made with the agency at which the center were to be established. Medical, dental, nursing, nurses' aid and maintenance staff, for example, might be provided on a cooperative basis by an existing agency with which a treatment center were affiliated. Such arrangements are discussed in some detail in connection with the specific program suggestions of Part II.

STAFF OF COOPERATING AGENCIES

While a child was receiving residential treatment, a social worker would have to prepare the environment to which he would later return. Usually this social worker would be on the staff of the agency which initially referred the child for treatment, but he would have to carry out his task in the closest cooperation with the staff of the treatment center. In some cases the child could best be returned to his home, which would involve extensive work within the home by the social worker. In other cases, it might not be desirable to return the child to the environment which produced his maladjustment. The task of the social worker would then be the discovery and preparation of another environment--perhaps that of a foster home or institution--or to make temporary arrangements until the child's family or relatives were in a position to provide a satisfactory environment. During the extended period following residential treatment, the child would therefore continue to have contact with the social worker, who, in cooperation with the treatment center, would be responsible for the supervision of the outpatient treatment required for complete rehabilitation.

The cooperative endeavors of the staff of the residential treatment center, a multi-disciplinary team which combines the skills of a number of professions, make possible "treatment in depth." Such an intensive, though brief, period of rehabilitation is combined with "treatment in breadth" in endeavoring to secure thoroughgoing and lasting rehabilitation of the emotionally disturbed, maladjusted child. These two portions of the treatment program may vary in

duration from a number of months to several years. During this period, the continuity which is essential to successful rehabilitation would be secured by the social workers on the staffs of both the treatment center and the agencies with which it cooperates.

FOOTNOTES

1. August Aichhorn, *Wayward Youth* (New York: The Viking Press, 1935), p. 236; originally published as *Verwahrloste Jugend*, (Vienna: The Internationaler Psychoanalytischer Verlag, 1925). August Aichhorn is described by a present-day authority in residential treatment work as one of the pioneers in the rehabilitation of maladjusted, antisocial children. Shortly after World War I, Aichhorn became director of a school for delinquent children near Vienna and there "obtained remarkable results by applying Freud's psychoanalytic theories to the rehabilitation of these children." [From an unpublished paper by Dr. N. I. Rieger, superintendent and medical director of the Children's Unit of the Camarillo State Hospital, California, entitled "The Residential Treatment of Emotionally Disturbed Children," on file at the Legislative Reference Bureau along with copies of a number of his other unpublished papers.]

2. Aichhorn, *op. cit.*, pp. 38-39.

3. *Ibid.*, pp. 234-35, italics supplied, indicating that the word "antisocial" has been substituted for the original translation "dissocial," which, although its meaning is more precise, is not encountered frequently in ordinary usage.

4. See *Plans for an Institution for the Treatment of Emotionally Disturbed Children*, published by the Illinois Children's Home and Aid Society, Chicago, 1946, pp. 9-10, and 25 for specific suggestions regarding such visiting personnel. It is suggested that "private patients of psychiatrists and pediatricians may be admitted, and it is hoped that a visiting staff of such referring physicians may be appointed. Regulations governing the relationship of the visiting staff to the institution in such matters as jurisdiction over patients, collaboration on research, etc., should be drawn up by the resident staff."

5. For a helpful discussion see *Some Considerations in the Selection of Cottage Parents for Children's Residential Treatment Centers*, 1955; Michigan Department of Mental Health, Research Report No. 18. See also *Who Does What In a Children's Institution* (New York: Child Welfare League of America, Inc., 1955), p. 8. While topics such as this are given only brief treatment in this study, bibliographical references are furnished to selected portions of the literature in this developing field in order to facilitate follow-up by those interested in particular aspects of this subject.

Chapter 4

SURVEY RESULTS

A territory-wide survey was conducted between October, 1955 and January, 1956 to carry out the directive of Joint Resolution 34 in ascertaining the need for residential treatment center facilities.[1] This survey was designed to include every promising source from which pertinent information might be secured. Both public and private agencies dealing with children were contacted, as well as other organizations which had shown an interest in this problem. Among the public agencies from which data was secured were the juvenile courts of the various circuits; Division of Parole and Home Placement, Territorial (mental) Hospital, Kawailoa Girls Home and Koolau Boys Home of the Department of Institutions; Department of Public Welfare; Division of Mental Health and Division of Public Health Nursing of the Department of Health; and the Department of Public Instruction. In those cases where the agencies had county offices, data were secured directly from each island. A number of private social service agencies participated in the survey: among them were the Catholic Social Service, Child and Family Service, Honolulu Council of Social Agencies, Liliuokalani Trust, Palama Settlement, Salvation Army and the Susannah Wesley Home. Information was also sought from private psychiatrists and other individuals whose work might have brought them into contact with disturbed children. Each of these sources was asked to complete a confidential questionnaire[2] on every child between the ages of 4 and 20 in the Territory who was personally known to be in need of residential treatment. Reports were limited to currently active cases and no questionnaires were to report past cases or to be based on hearsay.

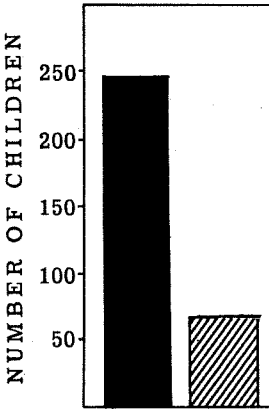
Two hundred and eighty-seven unduplicated individual returns were received during the course of the survey. Of these, 223 were from Oahu, 43 from Hawaii, 13 from Maui and 8 from Kauai. The distribution of this survey population by age and sex is indicated in Figure 2.[3] In order to extract from these questionnaires the information required by Joint Resolution 34, it was necessary to divide the returns into several groups; however pertinent background information which provides an insight into the overall problem of these emotionally disturbed, maladjusted children can be ascertained by considering them initially as an undifferentiated group.

UNSTABLE ENVIRONMENT

A glance at Figure 3 indicates that approximately half of the 287 children on whom questionnaires were returned were residing in either public or private institutions, while the other half were living with their parents, relatives or in other non-institutional settings. As has been noted, it is especially significant that less than a third of all children reported in the survey were living with both natural parents; the others, since birth, had resided in broken homes or had been completely separated from their parents. Some of these children had as many as a dozen placements in about that number of years. While it was not always possible to secure complete data on such placements, the evidence of pronounced environmental instability for many of these children was reinforced by the finding that the average duration of each reported placement was only 21 months. In other words, on the average, the home or other residence of these children had been changed more frequently than once every two years.

The behavior symptoms produced by environmental instability and the other factors contributing to maladjustment are incorporated in Appendix D. Inasmuch as it is the *interpretation* of these symptoms which yields information on the need for residential study and treatment center facilities, this general material was classified into the following categories, which serve as the basis for the subsequent discussion.

Fig. 1. Children in Need of Residential Treatment Facilities as Reported by Counties and Survey Categories



Category	Oahu	Hawaii	Maui	Kauai	Total
Definite	72	9	7	4	92
Further Diag. A	35	9	2	1	47
Further Diag. B	20	2	2	0	24
Marginal A	68	16	2	1	87
Marginal B	28	7	0	2	37
Total	223	43	13	8	287

Fig. 2. Age and Sex of All Children in Survey

AGE	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	TOTAL
BOYS	0	4	3	6	11	6	17	12	19	13	18	26	14	14	6	0	169
GIRLS	2	1	0	1	2	1	5	9	1	11	15	23	17	21	7	2	118
TOTAL	2	5	3	7	13	7	22	21	20	24	33	49	31	35	13	2	287

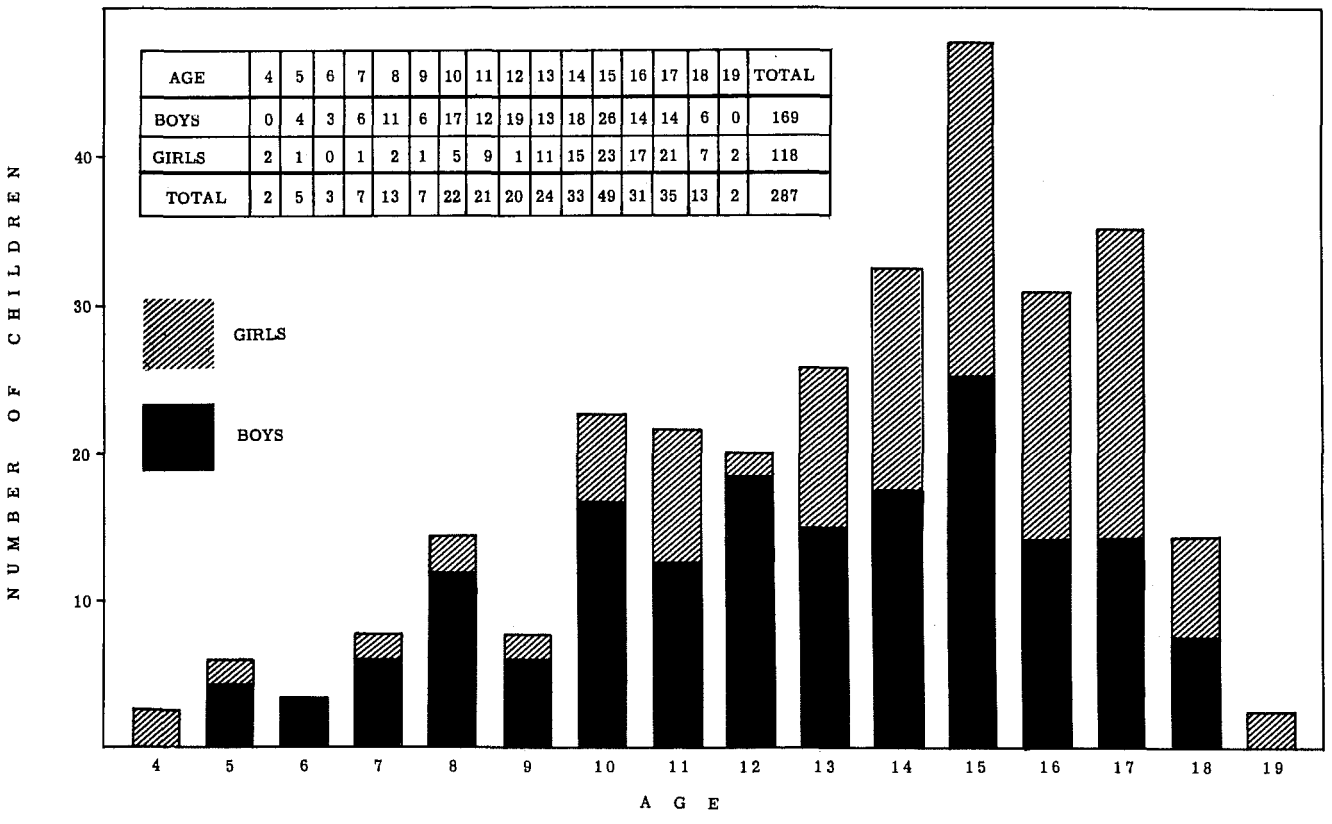
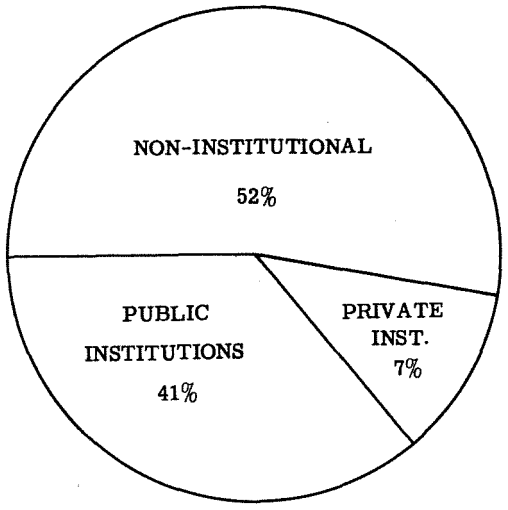


Fig. 3. Abode of All Children Reported in Survey



Abode	*No. of Children*
Public Institutions	
Agency foster home	20
Detention Home	6
Kawailoa Girls Home	51
Koolau Boys Home	41
Territorial (mental) Hospital	2
Subtotal	120
Private Institutions	
Boarding school	1
Non-agency foster home	1
St. Anthony's Boys Home	4
Salvation Army Boys Home	4
Salvation Army Girls Home	4
Susannah Wesley Home	1
Other	4
Subtotal	19
Non-Institutional	
Hanai home*	5
Relatives	14
Mother	29
Father	8
Mother and father	92
Subtotal	148
TOTAL	287

*The Hawaiian term *hanai* refers to adoption without recourse to legal procedures.

CLASSIFICATION CATEGORIES

Three major classifications were adopted for the analysis of data gathered by the questionnaires. On the basis of this information, 92 children were classified as being in *definite* need of residential study and treatment. Another 71 children were found to be in need of extensive *further diagnosis* if a sufficiently well informed judgment were to be made regarding their needs, while the remaining 124 children were classified as being in *marginal* need of treatment center facilities. Each of these classification categories will be considered in turn.

DEFINITE CATEGORY

The illustrative cases of "Johnny," "Ruth" and "Mary" presented in Chapter 2 are typical of the children classified within the "definite" category. Included in this category were only those children whose indicated program of rehabilitation should definitely include a period of residence within a treatment center. By way of providing a generalized symptomatology of the children in this category, there were extracted from Appendix D those symptoms which were reported for 20 per cent or more of the children so classified.

Table I

Symptom Data: Definite Category
(Total size of group--92)

Emotional retardation or incipient character disorder	56
Habitual runaway	40
Stealing	39
Psycho-physical symptoms*	36
Avoidance of close relationships with others	35
Inability to express directly feelings of hostility	33
Incorrigibility	31
Repeated truancy	28
Habitual lying	27
Excessive shyness or withdrawal	25
Severe aggression or destructiveness	23
Psychoneurosis (some degree reported)	21
Extremely severe temper tantrums	20

[Symptoms of 20% or more of group]

*Throughout the following tables, the tabulation of "psycho-physical symptoms" includes all entries made under question 16 in the questionnaire; see Appendix C.

Table II

Symptom Data: Further Diagnosis Category--Group A (Total size of group--47)

Emotional retardation or incipient character disorder	24
Psycho-physical symptoms	16
Stealing	16
Avoidance of close relationship with others	16
Excessive shyness or withdrawal	13
Inability to express directly feelings of hostility	13
Extremely severe temper tantrums	12
Repeated truancy	12
Habitual runaway	12

[Symptoms of 20% or more of group]

The most rigorous standards were applied in the assignment of cases to the "definite" category; only when a case conformed in every respect to those criteria was it so classified. Accordingly, slightly less than one-third of the total number of returned questionnaires were classified in this category.

FURTHER DIAGNOSIS CATEGORY--GROUP A

The 71 children classified as being in need of further diagnosis were differentiated within two sub-groups. Group A consisted of 47 children for whom further diagnosis was required because their questionnaires reported insufficient data on the type and degree of psychological symptoms manifested by them, as is evidenced by Table II.

While there was a strong possibility that many, even most, of the children so classified were in need of a period of residence in a treatment center, it was not possible to make a confident judgment on the basis of the data received. Diagnosis of the treatment needs of such children might have been made through the clinical facilities of the Division of Mental Health, but the very fact that such diagnoses had not been made for most of these children points to the present insufficiency of such facilities. Unless the services of the Division of Mental Health or a comparable agency were sufficiently increased to provide diagnostic and outpatient services for any proposed residential study and treatment center program, such services should be incorporated into the treatment center itself. Following a complete "diagnostic workup," the treatment of a portion of these children might continue on an outpatient basis, while others in this group would probably be found to be in imme-

diate need of some type of residential therapy.

Inasmuch as the children within this portion of the "further diagnosis" category were similar in most important respects to those classified as being in definite need of treatment, it was not felt necessary to illustrate this category by describing particular cases.

FURTHER DIAGNOSIS CATEGORY--GROUP B

The 24 children placed in Group B of this category were those for whom further diagnosis was indicated because certain aspects of their emotional disturbance and antisocial behavior were possibly associated with neurological disorder, feeblemindedness or such causes. In such cases it is generally a difficult matter to determine whether residential treatment might be useful. Conditions such as cerebral palsy, in which before, during or after birth some brain injury occurred, may lead to social problems. As one authority has put it:

> there are *antisocial* types with inborn defects, who lack the inherited capacity for object cathexis and identification. Whether this is a quantitative or a qualitative lack . . . is a problem for investigation. . . . In these cases of constitutionality determined *antisocial* behavior, we can accomplish nothing because educational means do not help us. We must classify these cases as incapable of social adaptation and thereby excluded from the possibilities of social retraining.[4]

Among the children so classified in this study were those whose questionnaires indicated that they were suffering from some form of epilepsy, organic brain damage (whether congenital or associated with head injuries), convulsions, and diagnosed feeble-mindedness, as established by comprehensive testing. Reported in a number of cases was a finding of "generalized abnormal" or "borderline" electroencephalogram (brain waves).[5] A large number of children in this category were reported as handicapped by poor sensory-motor coordination, various degrees of speech impairment or hearing loss.

The difficulty of evaluating these symptoms was increased by the fact that a variety of diagnoses, usually incomplete, had been made on these children by such diverse agencies as Queen's Hospital, Tripler General Hospital, the Territorial (mental) Hospital, the Division of Mental Health, the former Psychological Clinic and private psychiatrists. On the basis of the fragmentary information supplied by the survey questionnaires it was necessary to assign such cases to this category, but it should again be emphasized that there is no direct or implied judgment that these children could not be helped by residential treatment. This point is stressed because the children in this group frequently present acute behavior problems, as is evidenced by the following symptom data.

Table III

Symptom Data: Further Diagnosis Category--Group B
(Total size of group--24)

Emotional retardation or incipient character disorder	19
Severe aggression or destructiveness	11
Incorrigibility	10
Stealing	9
Excessive shyness or withdrawal	9
Avoidance of close relationships with others	9
Habitual runaway	8
Unmanageable hyperactivity	8
Inability to express directly feelings of hostility	8
Repeated truancy	5

[Symptoms of 20% or more of group]

MARGINAL CATEGORY--GROUP A

Approximately one-third of the questionnaires received were classified into "marginal" categories on one of two grounds. Group A within this category consists of those children on whom few or no symptoms of psychological difficulties were reported. While the children within this category clearly manifested antisocial behavior which might, *ipso facto*, have been taken as evidence of some type or degree of emotional maladjustment, the questionnaires did not provide a sufficient basis for determining whether these children were in need of treatment center therapy. A number of such questionnaires were returned to the agencies which had submitted them in order to secure further information. While in some cases this made possible more adequate classification, more often adequate data was not available; hence the "marginal" category remained large. The cases so classified vary in behavior patterns--from those children who would be loosely termed "bad boys" or "bad girls," to children who have already embarked upon careers of crime, as may be noted from the generalized symptomatology presented in Table IV.

Speaking of the problem presented by such children, Aichhorn points out that

> The extreme cases in these groups are often incorrectly designated as "born" criminals. One speaks of families of criminals, or even generations of criminals, and means thereby that the criminal constitution, about which we have only vague ideas, is inherited. This may be true, but the [rehabilitation] worker who

Table IV

Symptom Data: Marginal Category--Group A
(Total size of group--87)

Stealing	52
Habitual runaway	43
Emotional retardation or incipient character disorder	41
Repeated truancy	39
Incorrigibility	33
Habitual lying	30
Promiscuity	30
Habitual curfew violation	28
Severe aggression or destructiveness	20

[Symptoms of 20% or more of group]

> is concerned with *antisocial* types . . . recognizes . . . the driving power of traits taken over from the parents into the ego-ideal, which forces the individual to do what, as a child, he saw his father do. Thus, a generation of criminals can arise without any constitutional criminal inheritance.[6]

Some of these children may be partially or completely rehabilitated through residential treatment center therapy. The attitudes and behavior of others may, on the other hand, have become so strongly established that little can be done beyond the provision of strict custodial care. While the ultimate development of techniques of rehabilitation may some day make possible the successful treatment of all types and degrees of antisocial behavior, the children's treatment center must exercise great caution in its selection of cases. Otherwise the center runs the risk of becoming clogged with untreatable cases and will not be able to work effectively with those emotionally disturbed children who *can* be helped through presently available techniques. Only extended experience can determine which of the "marginal" category children might be successfully rehabilitated; for the others there must be provided some kind of custodial or other care since their behavior presents a serious social problem.

MARGINAL CATEGORY--GROUP B

The cases included in this final category were those on which so little data were reported that the questionnaires were considered of borderline importance for this study. This is evidenced by the scant symptom data, presented in Table V.

Table V

Symptom Data: Marginal Category--Group B
(Total size of group--37)

Excessive shyness or withdrawal	19
Emotional retardation or incipient character disorder	15
Inability to express directly feelings of hostility	9
Avoidance of close relationships with others	8

[Symptoms of 20% or more of group]

The significance of this type of marginal return may be briefly indicated, however. While the survey staff attempted, within the limitations of time, staff and budget, to make the survey exhaustive, a sizable portion of the maladjusted and antisocial children of the community were probably not detected. Indeed, incompleteness of coverage may be anticipated when the need for a new program of mental rehabilitation is being considered. There are a number of reasons for this. Generally undetected would be those children who have not come to the attention of private or public child-caring agencies, a situation generally prevailing with respect to pre-school children at one extreme, and older children who have completed their schooling or abandoned it, at the other extreme. Many young children, even infants, suffer from emotional maladjustment which can become serious enough to adversely affect their entire later development. The illustrations of "Johnny" and "Ruth" set forth in Chapter 2 are cases in point. Because the parents of such children are themselves oftentimes maladjusted, they are not in a position to secure necessary assistance for their children during the early years when it would have been most efficacious. It was to be expected, therefore, that a survey such as this would reveal relatively few of these younger children, though there is every probability that their numbers in the community are fairly large.

The maladjusted children who have finished school or abandoned their education somewhere along the way are most likely to come to public attention, since their antisocial behavior oftentimes brings them to public attention. However, unless they were receiving assistance from one of the agencies or individual therapists associated with this survey, they would not have been reported. Again, it is a safe assumption that the number of children in need of therapy is considerably larger than survey figures indicated. One significance, then, of Group B of the "marginal" category is that of pointing to the existence of an additional need for therapeutic services, though the extent and type of this need can be ascertained only through a much more extended survey.

FOOTNOTES

1. It may be noted that while a "territory-wide study" of the need was requested, under terms of Joint Resolution 34 recommendations for an institution were specifically limited to Oahu.

2. Set forth as Appendix C.

3. Following the *United States Census of Population: 1950, Detailed Characteristics Hawaii*, p. VIII, "The age classification is based on the age of the person at his last birthday as of the date of his enumeration, that is, the age of the person in completed years."

4. Aichhorn, *op. cit.*, p. 225, italics supplied.

5. Speaking of some of the difficulties associated with making these diagnoses, Dr. N I. Rieger said, "While the psychological tests are important in the consideration of a diagnostic formulation, they are only of ancillary value, like the electroencephalographic tracing, and other tests. They have only the importance which laboratory tests and x-rays have in arriving at a clinical diagnosis in internal medicine. We base our diagnosis on the observation of the clinical behavior of a child and take into consideration . . . other factors. . . ." "A Contribution to a Discussion of Childhood Schizophrenia," (unpublished typescript on file at the Legislative Reference Bureau), p. 5.

6. Aichhorn, *op. cit.*, p. 224, italics supplied.

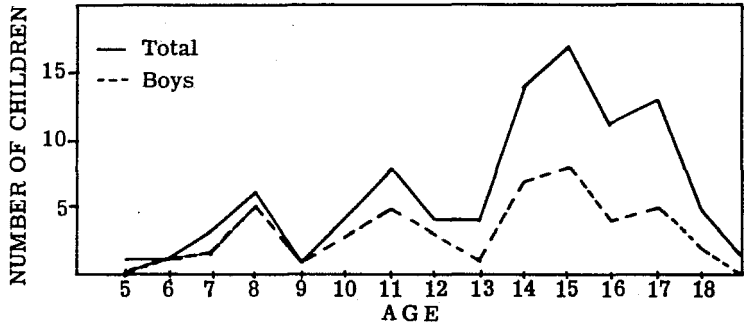
Part II. RECOMMENDATIONS

Chapter 5

RATIONALE

The survey described in Part I of this study was designed to ascertain the need for residential study and treatment center facilities within the Territory. The need for such facilities was found to be most acute for 92 children classified in the "definite" category, and the program suggestions of the following three chapters have been formulated primarily in the light of their requirements for rehabilitation. A treatment center, along with its associated diagnostic facilities, would, however, also benefit a sizable portion of the children classified as being in need of further diagnosis and some of the children in the marginal group.

Fig. 4. Distribution by Age and Sex of All Children Classified in the Definite Category



Age	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Total
Boys	0	1	2	5	1	3	5	3	1	7	8	4	5	2	0	47
Girls	1	0	1	1	0	1	3	1	3	6	9	7	8	3	1	45
Total	1	1	3	6	1	4	8	4	4	13	17	11	13	5	1	92

AGE-SEX GROUPS Inasmuch as the bulk of subsequent references will be to the children classified as in definite need of residence in a treatment center, it may prove helpful if additional information is furnished about them. Figure 4 indicates their distribution by age and sex. For treatment purposes, these

children may be considered as consisting of three basic groups: 24 boys and girls between the ages of 5 through 11, 28 boys between the ages of 12 through 17, and 34 girls between the ages of 12 through 17. Recommendations are not made for the treatment of children younger than 5 or older than 17, since their numbers were so small that it was not feasible within the limitations of this survey to investigate the special problems of staffing and program associated with this group.

PRESENT ABODE OF CHILDREN

The living arrangements, as of the time of the survey, of the children classified as being in definite need of residential treatment are indicated in Table VI. Fifty per cent were found to be in public institutions, another 5 per cent in private institutions; of the remainder, only 25 per cent were living with both parents. Further evidence that these children come from unstable environments is presented by Figure 5, which indicates the number from broken homes.[1]

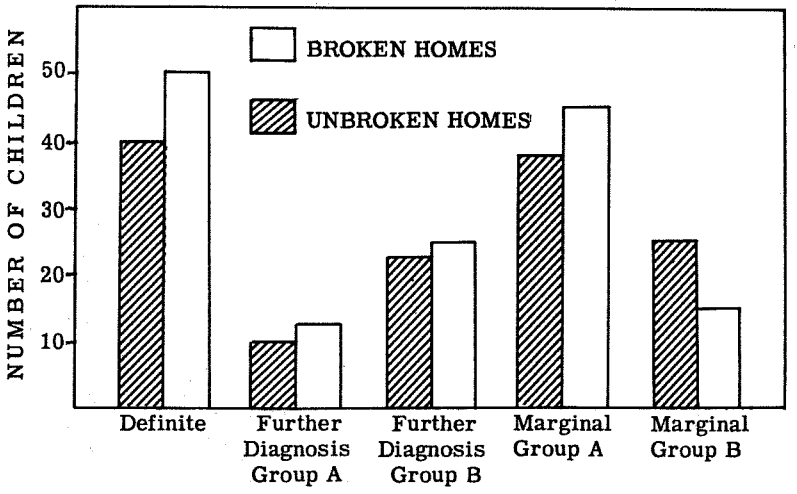
It is reasonable to infer that the disrupted living experience of these children has been one of the important factors contributing to their special need for residential treatment. Furthermore, ref-

Table VI

Abode of Children Classified in Definite Category

	No. of Children
Public Institutions	
Agency foster home	8
Detention home	5
Kawailoa Girls Home	18
Koolau Boys Home	14
Territorial (mental) Hospital	1
Total	46
Private Institutions	
St. Anthony's Home	2
Salvation Army Girls Home	3
Total	5
Non-Institutional	
Mother	8
Father	4
Mother and father	24
Relatives	5
Total	41

Fig. 5. Children Reported from Broken Homes, Classified by Survey Categories



erence to the generalized symptom list of Chapter 4, Table I, indicates that they display many symptoms which endanger society or themselves. Especially indicative of their need for residential study and treatment are the various symptoms of abnormal shyness and withdrawal from others, functional retardation, psycho-physical symptoms and the frequent evidence of psychoneurosis.

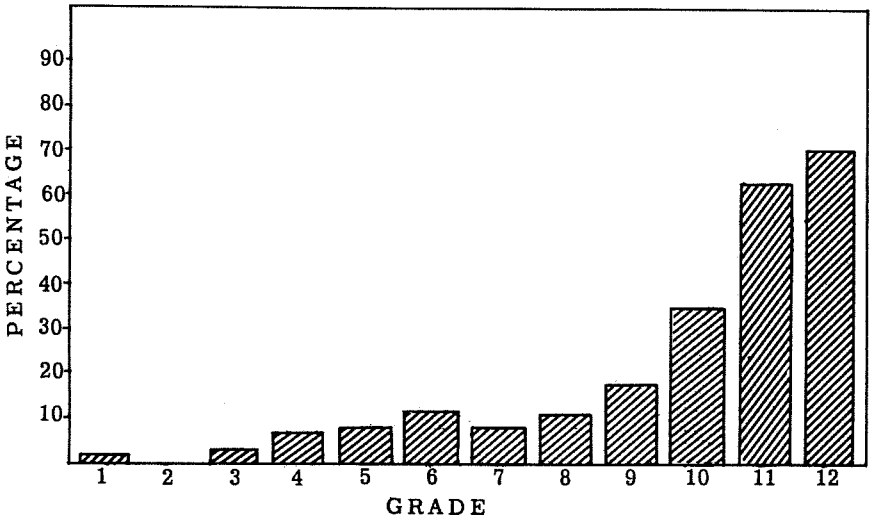
EDUCATIONAL RETARDATION

Emotional maladjustment is a contributing factor to the pronounced degree of educational retardation which characterizes this group, a phenomenon indicated by Figure 6.

The cumulative effects of unsatisfactory school work manifest themselves clearly at the high school level, where from 20 per cent to 70 per cent are behind in schooling. There is the clear implication that few of these children complete their high school education.

It is for such children as these that existing social services are obviously inadequate. The type and degree of their disturbance precludes satisfactory placement in existing institutions or foster homes, so that the prognosis for members of this group is very poor. What type of programs might be established for their rehabilitation?

Fig. 6. Percentage of Definite Category Children Who Have Not Reached Normal Grade Level for Age



CENTRALIZED PROGRAM

The most obvious approach to providing care for this group of children is to build a residential treatment center of sufficient size to serve the entire need, staff it and commence operations. While it is difficult to estimate what the cost of such an approach would be if applied in the Territory, some guides may be discovered by reference to current experience within some mainland jurisdictions. The state of Kansas is currently implementing an overall plan for construction of a treatment center with an ultimate capacity of 90 patients--almost exactly the size of the "definite" group described in this survey. Within the Kansas center, children are being housed in cottages with a maximum capacity of 15, with $90,000 authorized for the construction of each cottage. The sum of $175,000 has been budgeted for an "adjunctive therapy unit," containing offices, kitchen and dining rooms, schoolrooms, occupational therapy and music therapy facilities. "The cost of the completed center will probably be about $750,000."[2]

An operating budget of $200,000 a year was established by the state legislature in 1953 for the care of a maximum of 30 patients a year during the center's initial phase of operation. The cost per child per year of treatment would then approximate $6,600, a figure which is appreciably less than the fees charged by the somewhat comparable Southard School of the Menninger Foundation in Topeka. It is unlikely that any basic economies are realized through increasing the number of patients within a treatment center; it is

more likely that administrative and capital costs become proportionally larger. One may then reasonably assume that within a treatment center with a capacity of 90 children the annual cost per child would not be less than the initial $6,600; a minimum operating budget of approximately $600,000 would therefore be required annually.

If it is assumed that cost figures for construction and operation of a treatment center in the Territory would be approximately the same as those established for the operation of the Kansas center, the cost per biennium of providing residential treatment of this type for the 92 children classified as being in definite need of it would be approximately $1,200,000, with an initial capital outlay of some $750,000.

The cost of establishing and maintaining such a program is obviously great, but, costs aside, the desirability of attempting to establish one treatment center sufficiently large to accommodate all the children within the "definite" category alone may be questioned. Even though financial resources might be available for such a program, it can be predicted with considerable confidence that it would not fulfill its purpose. There are a number of reasons which may be presented in support of this view. Each will be developed subsequently after having been noted first in summary fashion.

STAFFING PROBLEM — The initial and continuing problem encountered in the implementation of a new residential treatment program is that of securing an adequate staff. Recruitment of a director poses the greatest difficulty, since the number of competent and experienced people available for such a post at any given time is extremely limited. The director, in turn, has the task of recruiting staff in other personnel categories for which vacancies have long remained unfilled in various existing territorial agencies. Still other types of personnel must be developed gradually through trainee and in-service training arrangements within a functioning treatment center, so that considerable time would be required to establish even a small scale program and achieve its optimal operation. No feasible mode of mass recruitment or speedy training of staff in this field has yet been discovered.

OTHER PROBLEMS — Still other important factors point to the desirability of establishing any program of residential study and treatment on a modest basis. As has been indicated, the development of close working relationships with a substantial portion of the other child-caring agencies in the community is indispensable for successful operation of a treatment center program. The permanent rehabilitation made possible by "treatment in breadth" is dependent for its success on the closest cooperative arrangements with other agencies. The development of these inter-

agency relationships requires considerable time and patience, for the staffs of each of the cooperating agencies must come to understand the purposes and operation of the treatment center. Any attempt to force this development or to overburden the associated agencies might jeopardize the entire program.

Finally, the experimental, the trial-and-error, aspect of treatment center therapy should be emphasized in this context. The precise approach to treatment which might prove most effective in the rehabilitation of the predominant types of maladjusted and emotionally disturbed children in the Territory will be discovered only during the course of extensive experience. A relatively modest initial program would be best designed to facilitate necessary research and experimentation and to minimize the effects of errors which, in a prematurely large scale program, could prove very costly.

DECENTRALIZED PROGRAM

It is with a view to these and other factors that a recommendation is herewith made for the establishment of what may be termed a "decentralized program," rather than for the construction of a single large center. The type of decentralization which is suggested is not so much that of decentralized administration, though this is not precluded, but rather operational, geographical and functional decentralization. In brief, it contemplates the possibility of establishing a number of small treatment centers at various strategic locations within Honolulu and elsewhere in the Territory as they are needed. Each of these units should be designed to provide specialized services of the precise type needed by a particular group of emotionally disturbed children. They would be differentiated initially by age group and sex, and to any feasible extent by symptoms and behavior patterns. The treatment units should be developed so as to take advantage of all community resources of a type that could make a contribution to the therapy programs. This might include the putting to use of unused portions of existing child-welfare facilities, an approach which could extend the sphere of cooperative activities of the treatment center while reducing costs materially. When it is feasible, the treatment center units should be placed close to areas of high delinquency.

It was with these criteria in mind that suggestions were solicited regarding possible means of establishing publicly supported residential treatment services which might be developed in conjunction with existing community resources, public or private. Three likely suggestions were thoroughly investigated and are presented for consideration.

FOOTNOTES

1. Data were collated in 230 cases of the 287 children reported in the survey as to the payments which their families could make toward their support in a treatment center. About 5 per cent were reported as able to contribute between $50 and $200 per month; 15 per cent less than $50 per month; the remaining number, approximately 80 per cent, were reported to be unable to contribute anything.

2. See *The Topeka Daily Capital*, Sunday, July 25, 1954, "Children's Center called 'Insurance,'" by Anna Mary Murphy.

Chapter 6

ALTERNATIVE I: SUSANNAH WESLEY HOME PROGRAM

Public residential treatment needs for boys and girls in the age group five through eleven could be partially met by subsidizing the Susannah Wesley Home, perhaps through a contractual arrangement between the Territory and the Home. The possibility of this course of action was suggested by the president of the Board of Health, who replied in the following manner to a request for suggestions for the best method of providing needed treatment center services:

> In my judgment, the most economical and efficient way to provide such a service would be through public subsidy of one or more private agencies or institutions. This is a formula which has worked with notable success in the treatment of tuberculosis through the years of high incidence. It appears likely that the incidence of children requiring residential treatment will increase as case finding measures improve.
>
> Upon inquiry, the Board of Managers of the Susannah Wesley Home has indicated its willingness to consider expansion of its program under subsidy. You will recall that this Home was recently converted to a residential treatment center for children from ages six through eleven.
>
> We have queried other institutions on this matter, but they have requested that their names be withheld from this letter. [1]

The Susannah Wesley Home[2] initiated a small treatment center program in 1956. Prior to that time, it had maintained a girls' home with a maximum capacity of 60 children. Continued subcapacity operation led to the recommendation by the Honolulu Council of Social Agencies that its facilities be converted to use for the residential treatment of emotionally disturbed children. The program is presently restricted to children between the ages of six through eleven, since it is felt that the Home's construction is not of a type which would safely permit treatment of older and potentially more destructive children. The present minimum charge for the treatment of a child is $200 per month but this amount meets only half the operational costs. Additional support for the program is currently being received from other sources, including the Honolulu Community Chest, the Woman's Division of Christian Service

of the Methodist Church, the G. W. Wilcox Trust and other foundations and trusts. The monthly charge of $200 per patient would have to be substantially increased if a large additional number of patients were accepted. Furthermore, the financing of the requisite construction program would require separate consideration.

ESTIMATED COSTS

It has been informally estimated that if the 24 boys and girls in the age group five through eleven, who have been classified in this survey as being in definite need of residential treatment care were accepted by the Susannah Wesley Home under a contractual arrangement, their treatment would cost the Territory between $5,000 and $6,000 annually each. If 24 children were treated under such a contract program, the annual cost to the Territory would, then, range between $120,000 to $144,000. This estimate of subsidy payments to defray operating costs of the Susannah Wesley Home program does not, however, take into account the assistance that might be required for the construction of a new plant.

It is anticipated that through staff expansion and the purchase or construction of a more adequate building, the Susannah Wesley Home program could, within a period of one year after completion of subsidy arrangements, provide treatment center care for a group of children of the size and age group indicated.

ADVANTAGES OF SUBSIDY ARRANGEMENTS

It can be said in favor of a subsidy arrangement that it would take advantage of such work as has already gone into the development of the only functioning residential program in Honolulu. Furthermore, in a relatively new and experimental field, such as this, there is a need for flexibility in staffing and programming, and necessary experimentation is perhaps more easily undertaken under private auspices than by a governmental agency. Finally, private organizations may be in a somewhat better position with regard to staffing than a public agency in this field. The policies and regulations developed throughout the years to safeguard public employees, especially by way of civil service procedures, might prove to be an initial handicap in the organization and operation of a treatment center program. There are a number of reasons for this. Salary scales, especially for the professional personnel on the treatment team, might have to exceed established civil service rates in order to recruit qualified persons, and considerable flexibility on this score would be an advantage.[3] Nor should flexibility extend only to hiring. The difficulties of staff selection are so great that any treatment center, especially a new one, is going to make some poor choices. Many otherwise competent--even outstanding--psychiatrists, psychologists and social workers do not succeed in treatment center work through lack of

ability for working with disturbed children. There should be ample latitude for dropping such people from the staff. Privately operated programs would have the considerable advantage of greater freedom of operation in both hiring and firing.[4]

DISADVANTAGES OF CONTRACT-SUBSIDY ARRANGEMENTS

Among the disadvantages of subsidy arrangements is the incompleteness of the controls which can be exercised over the public funds appropriated to private programs. The surveillance exercised by the territorial budget bureau over territorial departments would for the most part be lacking. Thus, there would be the possibility that the subsidized program would be allowed to develop without governmental check as to efficiency of its operation.

More basically, still, if the advantages of a decentralized program were to be sought through subsidizing several different private programs, the net effect would be to create a number of diverse and potentially unrelated programs throughout the Territory. This plurality could give rise to innumerable difficulties, especially in the development and maintenance of the complex inter-agency relationships described as "treatment in breadth." Finally, subsidy of private programs would not necessarily create the nucleus of trained staff and other resources required for a long-range program of sufficient size to care for the entire treatment center need.

Should it be decided to test the operation of a subsidy program arrangement in this field, it is suggested that the Susannah Wesley Home program would provide an appropriate vehicle for the purpose. The fact that the program is currently in operation would facilitate the early treatment of a portion of the younger children in need of rehabilitation. Beginning with children in this age group may be advantageous since their rehabilitation is oftentimes more easily accomplished than is the case with older children, and the children are reached before their maladjustment leads to antisocial behavior of serious proportions. Alternative modes of meeting somewhat different portions of the need for residential treatment center facilities will be considered in the subsequent chapters.

FOOTNOTES

1. Letter dated May 21, 1956, on file at the Legislative Reference Bureau. Dr. Richard K. C. Lee adds that "As an alternative to subsidy of private endeavors, it would be my recommendation that the responsibility and funds for a residential study and treatment center be delegated to the Department of Health, to be operated by its Division of Mental Health. The Division and its staff have had many years of experience in treating disturbed children. The augmented staff which a treatment center would require could be readily trained in the Division for this specialized work. While the Department does not now have the staff to

man such a center, it has the types of staff which are necessary for in-patient and out-patient treatment, for administration, and for follow-up. These include psychiatrists, psychologists, psychiatric social workers, public health nurses, health educators, and others.

"I would recommend further that such a center be as near as possible to neighborhoods of high incidence in order to increase the success and rapidity of treatment and rehabilitation. Should this be done, residential and out-patient treatment could be combined, thus making more efficient use of physical plant and staff. Such an arrangement could be best administered, I believe, through this Department."

2. The Susannah Wesley Home is under the auspices of the Woman's Division of Christian Service of the Board of Missions of the Methodist Church. Local control of the agency is vested in a board of thirty members who reside on the island of Oahu. The Home is a Community Chest agency and a member of the Honolulu Council of Social Agencies. Rev. Eugene L. McClure is its superintendent.

3. The law establishing the Kansas treatment center attempts to deal with this difficulty by providing that "The state director of institutions, subject to the approval of the state board of social welfare, shall appoint and fix the compensation of a director of said Kansas treatment center for children."

4. Dr. N. I. Rieger, in a talk given before members of the Medical Staff of the Camarillo State Hospital, comments on the qualifications of treatment center personnel. He notes that the "attitude" which workers in this field possess is of basic importance. "Some people have it as a natural talent; others have to cultivate such an attitude or acquire it by experience and training. And then there is a third group of people who just don't have a natural talent and are unable to cultivate such an attitude. If you assign people belonging to the latter group to work with emotionally disturbed children you can predict the outcome. If he is a very conscientious worker and tries hard he will sooner or later develop a stomach ulcer or high blood pressure or some other psychosomatic manifestation. And you will have to remove him . . . Or if he isn't a conscientious worker and you force him upon the children, the children will become unmanageable, and after an emotional explosion has occurred . . . , expressing itself in destructiveness, you will have to remove that worker too. That is one of the reasons why the physician in charge of the Children's Unit should always be in complete control of the personnel assigned to work with the children, and I include also the recreational therapist, the social worker and the psychologist. The social worker or the recreational therapist who may be very competent and excellent workers in dealing with adult patients, may be a complete flop when it comes to working with emotionally disturbed children." "The Residential Treatment of Emotionally Disturbed Children," (unpublished typescript on file at the Legislative Reference Bureau), pp. 9-10.

Chapter 7

ALTERNATIVE II: KAWAILOA PROGRAM

During the course of this survey specific inquiry was made of all appropriate public agencies as to the existence of unused facilities which might be adapted to the purposes of a residential study and treatment center. A number of responses were received, among them a letter from the assistant director of the Department of Institutions,[1] directing attention to certain vacant cottages at the Kawailoa Girls Training School, near Waimanalo, Oahu. Accordingly, arrangements were made to inspect these premises and to discuss with the director of the training schools, Mr. William Among, the feasibility of utilizing these facilities for a residential treatment program for adolescent girls between the ages of 12 and 17.

NEED FOR PROGRAM

The need for a program of residential treatment for this group of girls may be noted by reference to Figure 4. Somewhat more than 75 per cent of the girls classified within the "definite" category are between the ages of 12 and 17. Another 15 per cent of the girls found to be definitely in need of such services are below the age of 12 and therefore eligible for acceptance by the Susannah Wesley Home treatment center program described in the preceding chapter. The establishment of a public center of the type outlined below, coupled with full-scale operation of the private center, would then make possible the coverage of over 90 per cent of the total need of all girls classified in the "definite" category.

HILLTOP COTTAGE

The possibility of initiating a treatment center program at Kawailoa stems in part from the facilities made available through a sharp decrease in the number of girls committed by the Juvenile Court to the training school there. The number of inmates has declined from approximately 150 in 1946 to around 75 at present. This has meant that there is a considerable amount of dormitory space presently unused. Of the unused cottages it has been suggested that the one which might be most appropriately considered for use in a treatment center program is Hilltop Cottage. This relatively modern building is

located at one extremity of the Kawailoa grounds at a somewhat higher elevation than the other units on the campus. It is accessible to the recreational, vocational and other facilities of the training schools, but the fact that it is slightly set apart would enhance its use for a somewhat autonomous, though cooperative, program.

Some indication of the advantages and disadvantages of conducting a program of residential treatment in conjunction with the present training school program will be made throughout this chapter. However, it should be noted immediately that the initial costs of a center would be minimal at Kawailoa, since Hilltop Cottage could provide living quarters for all adolescent girls classified in this survey as definitely in need of residential treatment. Consideration of the potentialities of Hilltop Cottage may be facilitated by examination of Figure 7.

Hilltop Cottage was built in 1925 as one of the permanent units of the training schools. It was obviously well constructed; even though at the time of inspection it had not been in use for some three years, it showed hardly any evidence of the type of decay which renders poorly constructed buildings virtually unusable. Nor were there signs of termite damage, of leaking roofs, of dry rot or of any deterioration of plumbing, appliances or basic furnishings. The building presents a generally ship-shape appearance, suggesting that it could be restored to full and normal use quickly and at minimal expense.

CONSTRUCTION FEATURES

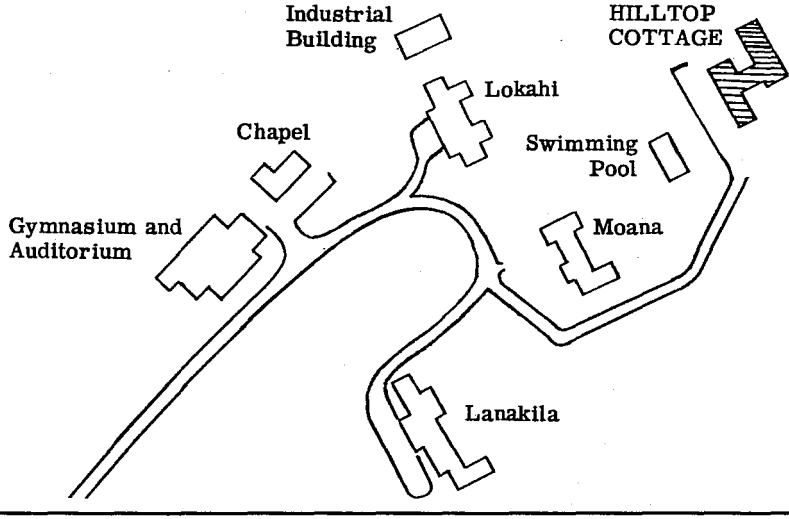
Hilltop Cottage consists of two units joined by a connecting structure. The *makai* section, which contains approximately 2,500 square feet of floor space, provides a well-planned kitchen, pantry, dining room, food storage and laundry facilities, all of which are adequate and in need of only minor repairs. With the replacement of a few appliances that have been removed, this portion of the center could be put into immediate operation.

In the *makai* unit there are also four smaller rooms which in the past have been used as a "day room," "teacher's room," "sewing room" and an office. With some refurbishing, these rooms would lend themselves to residential treatment center use, though they are neither sufficient in number nor of optimal size for this purpose. Considerably more space for staff activities would be preferable if Hilltop Cottage were to serve as a virtually self-contained center.

Inadequate space for indoor recreation, for arts and crafts and similar activities and for classrooms, and lack of additional small rooms needed for use in psychiatric treatment and for administration are basic limitations of Hilltop Cottage. To some extent, however, these deficiencies might be overcome by cooperative use of other facilities on the Kawailoa campus or the assignment of fur-

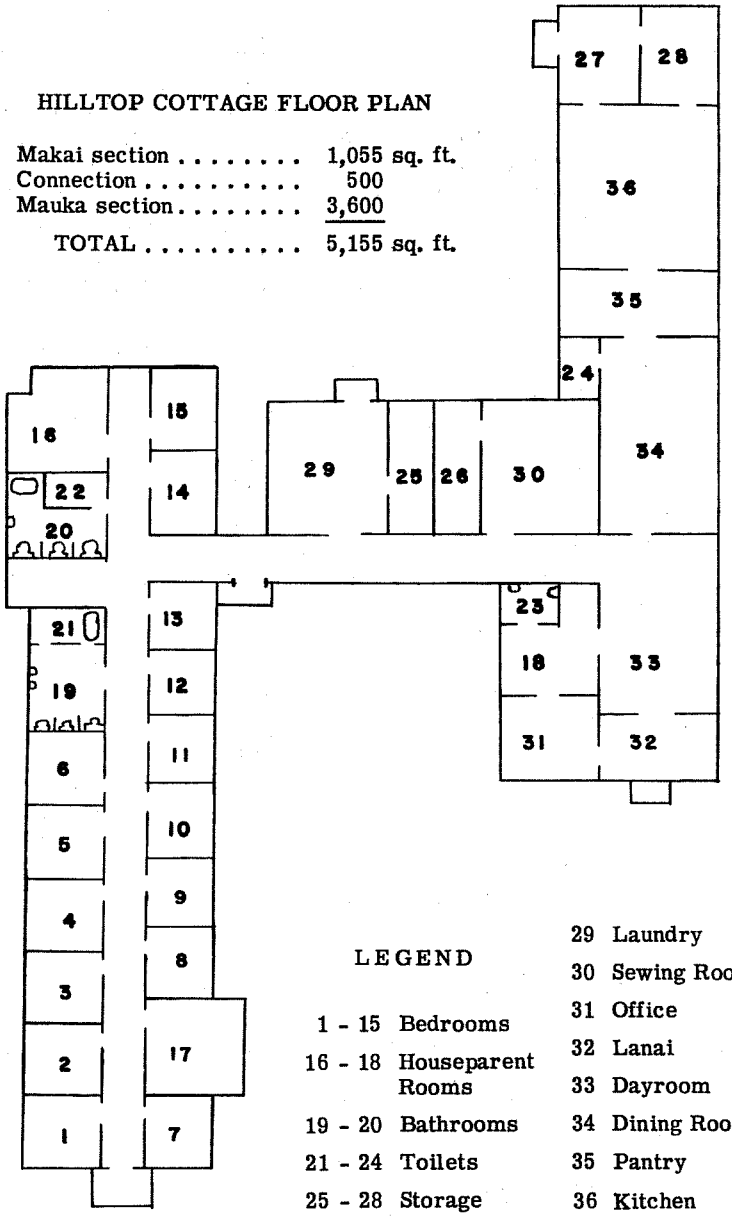
Fig. 7. Treatment Center Facilities: Kawailoa Girls Home

Construction: cement block, brick, stucco with steel reinforcements. Foundation: concrete block with wood piers. Roof: hip shingle. Inside: plaster. Floor: oak, cement and linoleum. Security screening.



HILLTOP COTTAGE FLOOR PLAN

Makai section	1,055 sq. ft.
Connection	500
Mauka section	3,600
TOTAL	5,155 sq. ft.



LEGEND

1 - 15	Bedrooms
16 - 18	Houseparent Rooms
19 - 20	Bathrooms
21 - 24	Toilets
25 - 28	Storage
29	Laundry
30	Sewing Room
31	Office
32	Lanai
33	Dayroom
34	Dining Room
35	Pantry
36	Kitchen

ther unused space, if there be any, for use in the residential treatment center program.

The *mauka* unit of Hilltop Cottage is designed to provide sleeping and lavatory facilities for approximately 40 residents. Like the *makai* unit it seems to be structurally sound and in generally good condition throughout. The first floor of this unit contains 15 rather small bedrooms, each generally suitable for one occupant, although several rooms could accommodate two or even three girls. Each bedroom contains a small closet and built-in dresser and has an outside window. There are, in addition, two "teachers' rooms" of somewhat more generous dimensions located at opposite ends of the building. These could serve for staff use, particularly for housemothers, and are reasonably well situated with respect to security considerations.

Lavatory facilities meet the standards established by the Department of Public Welfare for child-caring institutions in the Territory. The two lavatories each contain four showers with adjoining dressing rooms, two bathtubs, four basins and three water closets.

Through utilization of the second floor of the *mauka* unit, a total of some 40 adolescent girls could be comfortably housed in the Hilltop installation. The *mauka* unit would need somewhat more refurbishing than the *makai* unit, for it has suffered some deterioration, and requires repairs to woodwork and glass as well as complete repainting.

Structurally, there is a more serious problem. The two floors of the *mauka* unit are connected by rather steep and narrow stairwells which, in the event of fire, might quickly become impassable and would probably be destroyed. While there seems to be little tendency toward arson among adolescent girls,[2] it would not be prudent to rule out the possibility of such symptoms among any emotionally disturbed and maladjusted children. In any event, the standards of fire protection and control at Hilltop Cottage are obviously inadequate and the building could not in good conscience be recommended for residential use unless fire control devices were installed.

One general observation is pertinent to the adaptation of this building for use as a treatment center. The present design, furnishing and decoration of Hilltop Cottage reflect an earlier and somewhat different conception of rehabilitation. There is an "institutional" rather than a homelike appearance--especially with the interior decoration somewhat worn, a rather depressing atmosphere is created. This could detract seriously from its usefulness as a residential treatment center, for authorities in this field stress the importance of an adequate physical setting for "milieu therapy." In the view of Redl and Wineman, "it is amazing how sensitive even otherwise defensive children are to the 'atmosphere' which the very location, the architectural design, the space distribution of the house,

the arrangement and type of furnishings, the equipment, the style of housekeeping suggest."[3] They recommend that architects, interior decorators, psychiatrists, psychologists and others cooperate in the design of treatment centers with a view to helping the children feel at home rather than in confinement.

With regard to the physical limitations of Hilltop Cottage, it is possible that an effective scheme of redecoration could be carried out, but all such work, as well as any basic modifications of space utilization, should take place under the immediate supervision of the director of any treatment center program which may be established there.

PROGRAM AND ADMINISTRATION

The program suggested for a Kawailoa treatment center is, in general terms, based on the conception of "treatment in breadth and depth" discussed in Part I of this report. Such a program could hardly be developed if the treatment center were created as a completely autonomous agency, since it would have to develop resources unjustified for the limited number of patients it might serve--some 40 girls in residence and several times that number of outpatients. It is recommended that if a residential treatment center were to be established at Kawailoa it be incorporated into the program of the Department of Institutions, which now admiministers the following related services: the Division of Training Schools, the Territorial (mental) Hospital and the Division of Parole and Home Placement. Integration of a residential treatment center program with the community services of the Department of Institutions should facilitate placement and the follow-up aspects of treatment.

To achieve "treatment in depth," it would be necessary for the Department of Institutions to assign to a Kawailoa program a sufficient staff of experienced psychiatrists, psychologists, social workers and adjunctive therapists to carry out the intensive and personalized type of treatment which is required.

REMEDIAL EDUCATION

A special problem is indicated by the finding of the survey that adolescent children in need of residential treatment are, on the average, about two years behind in their school work, as is indicated in Figure 6. They would therefore require remedial school work, much of it on an individual basis. Although the territorial Department of Public Instruction maintains the Olomana School on the adjacent campus of the Koolau Boys Home, it would not appear to be sound policy to mix students from two such diverse programs as the one suggested for the treatment center and that currently operated by the training schools. Furthermore, the Olomana School is neither designed nor staffed to offer intensive remedial work, since its physical

plant is a makeshift arrangement set up in an unused dormitory of the Koolau Boys Home, and the staff is insufficiently trained in the techniques of remedial education required for residential treatment center work. The teacher-pupil ratio is basically the same as prevails in the other public schools throughout the Territory, and the special equipment and services required for a remedial program are lacking.[4] Should a residential treatment center be established at Hilltop Cottage, it is recommended that facilities be provided within the program for remedial education of those girls whose rehabilitation had not reached the point which would make possible their regular attendance at public schools. Transportation facilities would be required to enable the other girls to attend primary or secondary schools in the vicinity.

JOINT STAFFS AND SERVICES

While it is felt that common use of the Olomana School by the training schools and a treatment center would not be feasible, there are other areas where mutual benefit might be derived from sharing staff and services. Quite apart from the regular academic program, the training schools could provide instructors in arts and crafts, sewing, lauhala weaving and other skills. The part-time assignment of these instructors to the treatment center program would foster the rehabilitation of the girls in residence. Conversely, the superintendent of training schools has long expressed the need for greatly increased psychiatric and psychological testing services within the framework of the present program, since the training schools now receive only limited assistance of this type from the staff of the Territorial (mental) Hospital.[5] The part-time assignment of a resident psychiatrist and psychologist from a treatment center staff at Kawailoa to provide diagnostic and outpatient treatment for the wards of the training schools would be invaluable.

ESTIMATES OF COSTS

While it is difficult to make exact cost estimates in view of the foregoing suggestions for the sharing of certain staff and facilities, the attempt should be made to furnish a general figure.

Renovation of Hilltop Cottage should not cost more than $10,000, including the repair or replacement of some items of furniture and certain appliances. Final conversion costs would be contingent on many factors: the type and amount of redecoration which the director of the treatment center might think requisite, the proportion of needed equipment made available by the Division of Training Schools or other agencies, and how much of the renovation were to be accomplished by personnel of the training schools.

STAFFING COSTS

The categories of staff required for the operation of a treatment center have been described in Chapter 3; the number of positions to be filled in each category would depend upon the number of patients in a particular program. If both the residential and outpatient services of a Kawailoa treatment center were operating at maximum capacity, it is estimated that the annual expenditure for the type of staff described in Chapter 3 would approximate $100,000.[6]

PER CAPITA COSTS

The expenses of operation of a treatment center at Kawailoa, in addition to costs of renovating Hilltop Cottage and staff salaries, would vary with the number of children in residence at any given time. Assuming considerable integration of the treatment center program with the other operations of the training schools, it is probably most feasible to calculate the monthly per capita cost for each residential treatment center patient at the same rate for the children presently residing at the training schools.

Published data for the fiscal year which ended June 30, 1955 indicate that the annual cost per capita for meals was $344.12 while "other current expenses" were $825.88 per child per year, or a total of about $1,170 per year for all expenses except the provision of staff services.[7]

OVERALL COSTS: FIRST BIENNIUM

Account should be taken of the problems inherent in staffing any residential study and treatment center program in preparing its initial budget. This consideration would be especially pertinent if a program were to be established at Kawailoa, for the recruitment of a director, conversion of Hilltop Cottage and the administrative structuring of a new program there would probably require at least six months. Full responsibility for planning and overseeing the conversion of Hilltop Cottage should be vested in the director, who, with secretarial assistance and a limited appropriation for administrative expenses, would be responsible for carrying out this initial phase of the program. It is contemplated that during the second half of the first year he would have secured sufficient staff to commence limited operation of the outpatient program and to have begun training of the residential treatment team. An estimate of expenses for the first year of the program would, then, be approximately as follows:

(1) Salary of director	$10,000 to $15,000
(2) Salary of clerk-stenographer	2,700
(3) Six-months salary of remainder of staff	43,000
(4) Conversion of Hilltop Cottage	10,000
(5) Limited operation of outpatient clinic during second half of year, and all other expenses	14,300
Total Expenses for First Year	$80,000 to $85,000

Partial operation of the outpatient phase of the treatment center's operation would facilitate the "intake process" of the residential program, which could begin full-scale operation during the second year of the biennium. Assuming that the center might provide residential treatment for some 40 to 60 girls, with the average patient in residence for nine months, operating expenses during the second year of the biennium might be approximately as follows:

(1) Staff	$100,000
(2) Cost of residence for 60 patients for an average of 9 months each	53,000
Total Expenses for Second Year	$153,000

Once the program is well established, it is estimated that the basic operating costs of providing residential study and treatment facilities for a group of girls of the size revealed by this survey as being in need of treatment would approximate $300,000 per biennium.

FOOTNOTES

1. See letter dated March 14, 1956, on file at the Legislative Reference Bureau. In response to the request for information on unused facilities which might be considered for residential treatment center use, Mr. John H. Bergen, then assistant director of Institutions, replied, in part: "The Department of Institutions is not in a position to offer any assistance in the way of staff or equipment, but it is possible that we might be able to make a building available. At the Kawailoa Girls Home we have two vacant cottages; one of which could be made available for this purpose. . . ."

2. Arson was totally absent from the symptoms reported for girls in the survey, but was reported for seven of the boys.

3. Fritz Redl and David Wineman, *Controls From Within*, p. 42. For other helpful discussions of the plant design of treatment centers, see Bruno Bettelheim, *Love Is Not Enough* (Glencoe: Illinois, The Free Press, 1950); Eva Burmeister, *In The Family* (New York: Columbia University Press, 1949); and Mary Fran Beuhler, "Abbott Center in Illinois," (24 *State Government*, February, 1952), pp. 35-38.

4. See *Annual Reports of the Department of Institutions*, 1954 and 1955, as well as the annual reports of the principal of Olomana School. Further information on the operation of the school is on file at the Legislative Reference Bureau.

5. *Ibid.*, 1952 to present. The superintendent of training schools has made a number of requests for increased staff in these areas. His 1953 report stated, pp. 26-27, that "with due recognition of the part played by all other services in a training school, a thorough going classification of our children cannot be accomplished without the contribution of the professional individualizing services represented by psychiatry, psychology and social work. The functioning of the first two of these services on a liberal part-time basis has provided a sound understanding of each child's needs and has made possible better training and treatment in the light of these needs. . . ."

6. This estimate is intended to take account of staff needs for a maximum of some 35 to 40 girls in residence, diagnostic work and the provision of outpatient services. The positions which could reasonably be provided for this figure would be approximately as follows: chief psychiatrist; assistant psychiatrist; psychologist; psychiatric social workers (3); social group workers (2); remedial educators (2); houseparents (7); cooks (3); medical secretary; clerk stenographer.

In addition, provision would have to be made for medical and other services, a portion of which might be secured on a part-time arrangement with the Division of Training Schools, which presently retains a full-time dentist and part-time physician. Maintenance of buildings and grounds presents another area where cooperative arrangements might make possible more satisfactory services while effectuating personnel economies. It is suggested that maximum flexibility be given the director of the treatment center in working out such cooperative arrangements.

7. *Annual Report and Financial Statement, Division of Training Schools*, for the fiscal year 1954-1955, pp. 17-19 especially.

Chapter 8

ALTERNATIVE III: PALAMA PROGRAM

The program outlined in the preceding chapter would meet approximately 75 per cent of the reported need for residential treatment center facilities required for the care of emotionally disturbed and maladjusted girls between the ages of 12 and 17, inclusive, through the utilization of presently unused facilities at the Kawailoa Training School. In keeping with the objectives of a decentralized treatment center program discussed in Chapter 5, a complementary suggestion is presented here.

When information was requested regarding facilities potentially available for residential treatment center operations, the director of Palama Settlement, Mr. Walter Ehlers, replied concerning the possible use of certain facilities there. A number of discussions were held, and a thorough inspection was made of Palama facilities.[1] The following program was subsequently outlined whereby facilities at the Settlement, existent or potential, might care for almost all of the boys between the ages of 12 and 17 classified as being in "definite" need of residential treatment center services.

BACKGROUND INFORMATION

Inasmuch as this suggestion projects a cooperative arrangement with Palama Settlement, a brief indication of the Settlement's history and purposes should be helpful. The work of the Settlement and its predecessor organization dates back almost 60 years; the present grounds on Vineyard Street in central Honolulu have been in use since about 1925.

The Settlement views itself as a "semi-public health and welfare institution owned and operated for the people of Honolulu,"[2] and it has pioneered locally in such fields as child welfare, kindergarten work and a variety of other social services, as well as developing programs of public health nursing and district dispensaries. It has taken an initiative in the public health field, especially in combating tuberculosis and venereal diseases. As the community overcame each of these problems or other agencies were formed to deal with them, Palama Settlement resources have been transferred to new fields. Thus, during recent years there has been an almost complete elimination of the Settlement's medical program. Except

for a dental clinic, which is operated by an independent foundation, Palama's large medical building is now used for other purposes.

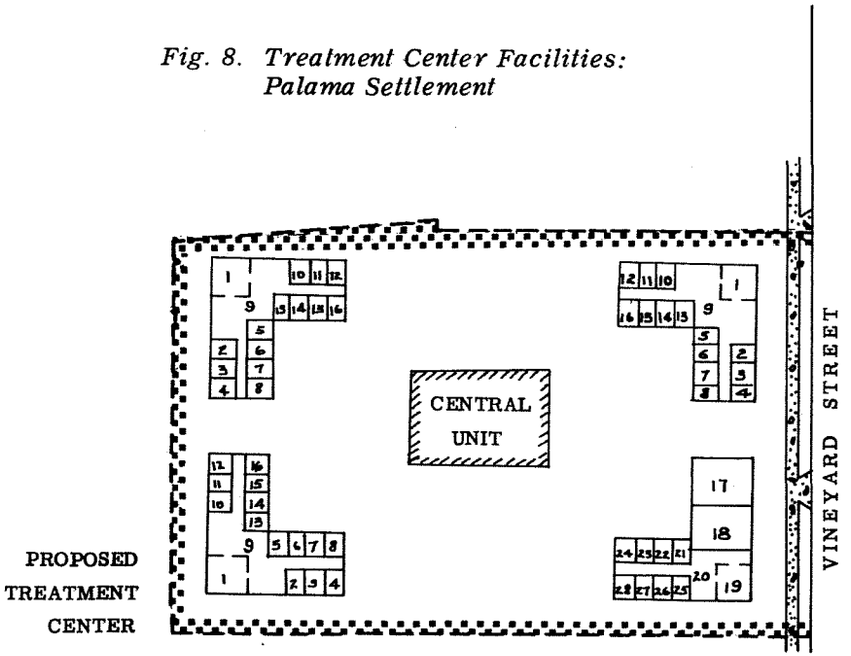
PROGRAM The rationale behind the suggestion of developing a cooperative program of residential study and treatment at Palama Settlement is similar to that of the Kawailoa proposal; both present the possibility of initiating needed programs with as much dispatch as appears prudent and at a minimum cost. These advantages are perhaps most evident at Palama, for the Settlement presently has in operation a well organized recreation-rehabilitation program for the underprivileged children of the Palama-Kalihi area. Reference to Figure 8 indicates that Settlement facilities include a gymnasium, swimming pool, athletic fields, a music building, craft shops and an auditorium. A staff of recreational and social group workers administers an extensive program, including scouting, weekend camping trips, social dancing and other group activities. Instruction is furnished in individual and team sports; a large music department provides voice, instrumental and other instruction. The basic purpose of such activities and the spirit in which they are undertaken is especially important to any contemplated residential treatment center program. In the words of the director of the Settlement:

> These activities are not intended as ends in themselves. We use activities merely as a peg on which to hang our work or to use another illustration, as a tool to get at people in a face to face friendly relationship. We try to help them meet their problems with all the techniques we have available.[3]

Of the techniques which are not presently available in the Palama-Kalihi area for assisting emotionally disturbed and maladjusted children, perhaps the most needed are those associated with the operation of a residential study and treatment center. Hence it is suggested that a staff of the type described in Chapter 3 would be required to provide diagnostic and outpatient services in addition to residential treatment. As with the Kawailoa proposal, the assignment of such a staff would facilitate the sharing of services and cooperative rehabilitation of the treatment center patients.

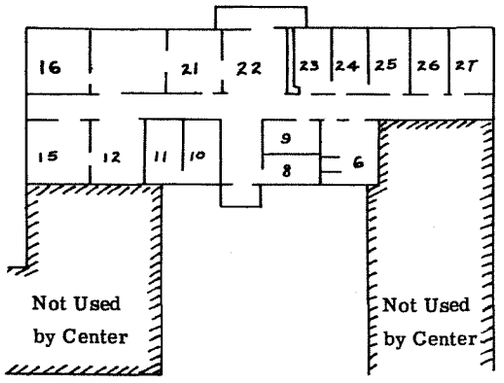
AVAILABLE FACILITIES AND LAND The possibilities of developing a residential study and treatment center program in conjunction with Palama Settlement are enhanced by the fact that not only would portions of the Settlement's medical building be available for such use, but, more importantly, a large tract of land on the *makai* side of Vineyard Street, opposite the main plant, might be used by a new program, as indicated in Figure 8. Of this two-acre area owned by the Settlement, perhaps half could be cleared

Fig. 8. Treatment Center Facilities: Palama Settlement



LEGEND

1, 19 Houseparent Rooms
5, 13, 21 Bathrooms
17 Dining Room
18 Kitchen
9, 20 Playrooms



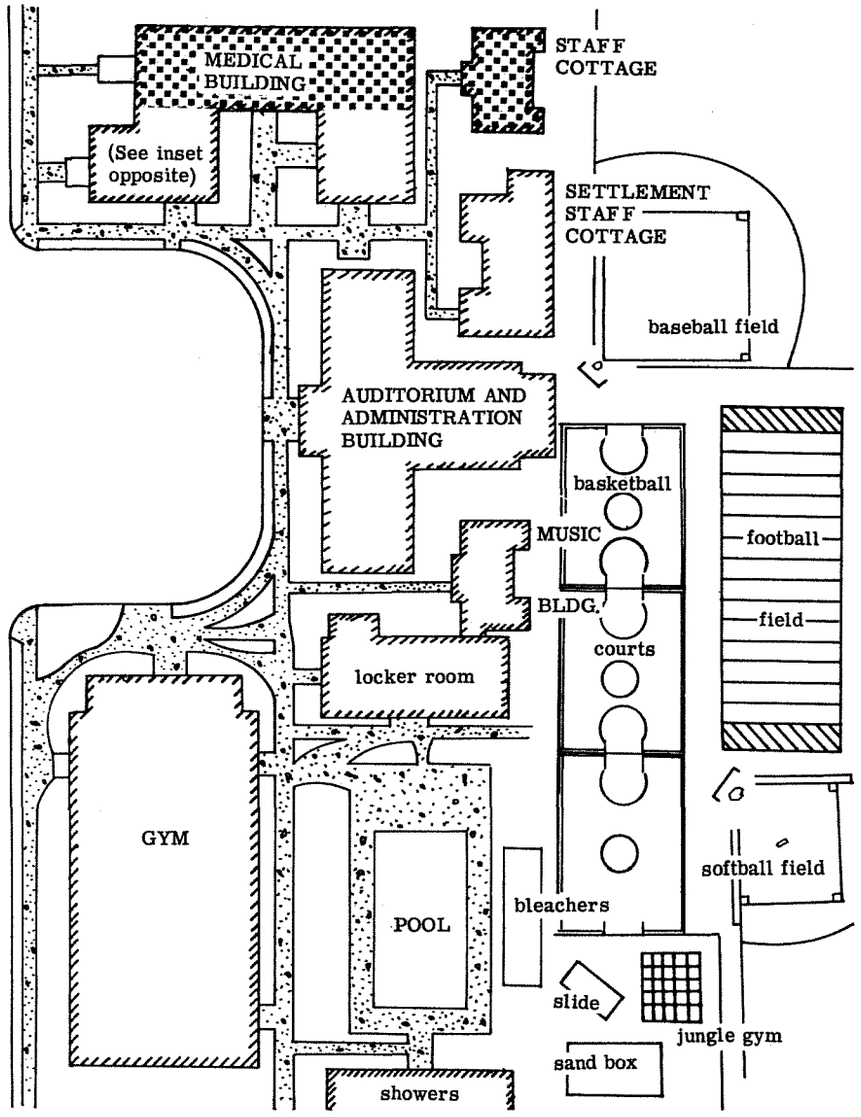
LEGEND

6, 8, 9 Toilets
10, 11, 12 Offices and
15, 16, 21 Interviewing
24, 25 Rooms
22 Waiting Room
23 Receptionist
26, 27 Playrooms

Not Used by Center

Not Used by Center

INSET OF THE MEDICAL BUILDING



INDICATES EXCLUSIVE USE BY TREATMENT CENTER

in the near future when the scheduled widening of Vineyard Street takes place. Some carports and other small structures now occupying much of this land would have to be moved or demolished, but the Settlement's trustees have informally indicated their willingness to entertain a proposal for the rental, lease or sale of this land to the Territory for the establishment of a residential treatment center program, should suitable financial and other arrangements be reached between the Territory and Palama Settlement.

The construction and age of the Palama medical building would make it unsuitable for actual residential purposes by maladjusted and antisocial adolescent boys, but it would provide--at least for some years[4]--the necessary offices, interviewing rooms, play therapy rooms, and other facilities for a study and treatment center program. The expense of converting this portion of the medical building for such uses would be minimal, and need not be disruptive to any of the ongoing programs of the Settlement.[5]

Living accommodations for some of the treatment center staff might be provided in a two-story, frame cottage situated just *mauka* of the medical building. Inasmuch as some members of the staff should be near at hand in the event of night-time or weekend emergencies, obtaining use of this additional unit is recommended if a treatment center is established at Palama Settlement.

REQUIRED CONSTRUCTION

All residential patients in actual residence in such a treatment center should be housed in cottages which could be constructed on one acre of land on the *makai* side of Vineyard Street, should it be made available. This portion of the center might be connected to the main Palama Settlement plant by a pedestrian underpass following the forthcoming widening of Vineyard Street. It would appear to be feasible to construct initially only two of the cottage units indicated in Figure 8. These units would accommodate approximately 24 boys; and, assuming optimal operation of the program, a reasonable rate of turnover should make it possible to handle some 30 to 35 boys annually. Kitchen and dining facilities would have to be provided in one of the two residential cottage units until such time as the central building indicated in the upper left of Figure 8 could be constructed. If operation of the program fulfilled expectations but did not meet the need, then additional two-cottage units might be authorized along with the central building. It is estimated that a total of some four cottages of the size and shape indicated could feasibly be placed on the acre of land. These units could provide accommodations for approximately 50 children at one time, thus providing treatment of from 60 to 70 boys annually.

It is not recommended that a treatment center developed in conjunction with Palama Settlement consist of more than four cottages. Aside from considerations of decentralization, the concentration

of an excessively large program at Palama would be potentially disruptive to other Settlement program and overtax the cooperative arrangements that have been suggested. The treatment, initially at least, of *either* adolescent boys or girls might well be considered in view of the added difficulties associated with working with both groups simultaneously in a new program. Among these difficulties would be the somewhat greater complexity of scheduling the shared use of Palama Settlement facilities, of staff selection and training, and of controlling contacts between the two groups within the center. The experience of Fritz Redl and David Wineman in their Pioneer House Treatment Center where college girls served as some of the counselors in a program for maladjusted boys points to a few of the problems of redirecting the misdirected libidinal energies of such patients. On the other hand, some of these difficulties could be overcome through adequate staffing, and a coeducational program would have some positive advantages. Among these would be the creation of an atmosphere within the center that would facilitate the development of normal social relationships, while the value of the treatment center to the community would be enhanced in that it could meet a broader portion of existing needs.

With the addition of any further residential cottages beyond the two initially recommended, or in the event of the projected demolition of the Palama medical building, the central unit of the residential treatment center should be constructed. This building would provide adequate kitchen, dining and indoor recreational areas on its first floor, and office, treatment and other facilities on the second floor. While the residential portion of the treatment center program would then be self-contained, there is no implication that arrangements with the Settlement for the shared use of its programs and staff should in any way be diminished.

DETAILS OF COTTAGES

Each of the proposed cottages would be of sufficient size to provide living quarters for approximately 12 boys, each of whom would have a room of some 8' x 10' dimensions, thus conforming to the air-space requirements for child-care institutions established by the Department of Public Welfare. [6] By the same standards, the lavatory facilities of each cottage should consist of at least four showers or bathtubs, three wash basins and three water closets. The remaining space within one cottage would provide recreational facilities, while in another there would have to be kitchen and dining room facilities until such time as the central building were constructed.

On the basis of local experience with the maintenance and repair of detention homes it may be urged that construction of all new treatment center units should be of an extremely sturdy and heavy type. Preference might well be given to poured cement construction throughout, with an absolute minimum of easily destroyed or-

namentation. It has been established with disconcerting regularity that emotionally disturbed adolescent boys, especially, may wreak havoc with lightly or poorly constructed buildings. Speaking of the initial behavior of one group of severely disturbed boys in his treatment center, Aichhorn reported that

> their aggressive acts became more frequent and more violent, until practically all the furniture in the building was destroyed, the window panes broken, the doors nearly kicked to pieces. . . . The dinner table was finally deserted because each one sought a corner in the play room where he crouched to devour his food.[7]

He found that "it is characteristic of the delinquent that he possesses little capacity for repressing instinctual impulses and for directing energy away from primitive goals. . . ."[8]

Every precaution should be taken to minimize potential damage. Heavy items of furniture, such as beds, wardrobes and large tables might well be permanently fixed to floors or walls, and plumbing fixtures of a design most resistant to damage should be chosen. The suggested layout of the Palama residential units is designed to afford maximum security, for the outside walls of each cottage would run close to the land boundaries, and the intervening space is intended to be enclosed by high fences. Security within each residential cottage is fostered by the "L" shape of the units, with the houseparents' room placed at the corner in such a way that one staff member could oversee the entire unit.[9]

There would, undoubtedly, be periods during the treatment of the residential treatment center children during which the separate use of certain Palama facilities would be necessary. Again, the nature of the Settlement's program would lend itself to such cooperative, though separate, arrangements, since during the school year the swimming pool, gymnasium, craft and other facilities are little used during the morning hours. At other times the treatment center children who were not yet ready for participation in outside activities could be scheduled for activities within their own area.

ESTIMATES OF COSTS

Although it is especially difficult to make an exact estimate of either construction or operational costs for an entirely new program of the type recommended, the attempt should be made. Adaption of the ground floor of the Palama medical building would probably cost between $5,000 and $10,000. Some partitions would have to be added or removed, some additional plumbing fixtures would have to be installed, and the bulk of the rooms redecorated. Additional furniture and equipment would have to be purchased, especially those items necessary for record keeping and other administrative functions; however, the total cost of putting this portion of the unit into operation should not exceed the maximum figure indicated.

Construction of the residential cottages, each of which would have an area of some 2,500 square feet, would, at going costs of about $14 per square foot, require an appropriation of some $35,000 per cottage. Furnishings and equipment for the cottages, including the provision of kitchen-dining room facilities in one unit and recreational facilities in the other, would perhaps cost another $10,000. Landscaping, fencing and equipping the grounds might require an additional $5,000. Because these estimates are necessarily approximations, it is suggested that provision be made for extra costs up to 20 per cent beyond the figures here suggested. Overall cost estimates for this portion of the program would then be:

(1) Conversion of the ground floor of the Palama medical building	$ 10,000
(2) Conversion of staff cottage for occupancy by residential treatment center staff	5,000
(3) Construction of two residential cottage units at $35,000 apiece	70,000
(4) Furnishings and equipment for the cottages	10,000
(5) Landscaping, fencing, equipment for the grounds	5,000
Total	$100,000
With 20% leeway for possible underestimation	$120,000

MONTHLY PER CAPITA COST OF CHILD CARE

Additional costs of which account must be taken, beyond those connected with the construction and staffing of the residential study and treatment center, would vary with the number of children in residence at any given time. The most feasible way of estimating the monthly per capita cost for each child is probably that of averaging the costs of several of the local child-caring institutions of comparable size. For this purpose, the following data is useful as a guide; shown are budgeted per capita costs for 1955.[10]

Institution	*Estim. Pop.*	*Food*	*Other*	*Office & Bldg. Maint.*
St. Anthony's	65	$307.69	$ ..	$ 95.72
Salvation Army Boys'	68	382.35	25.74	181.76
Salvation Army Girls'	41	369.44	35.98	256.34
Susannah Wesley	20	400.00	...	208.60
Average (mean)		$364.87	$30.86	$185.60
Total of average costs				$581.33

The rounded, averaged total figure of $600 has been used to estimate the annual per capita cost for basic non-staff expenses of providing residential treatment.

OVERALL COSTS: FIRST BIENNIUM

In keeping with the general recommendation of progressive implementation of any residential study and treatment center operation which may be undertaken in this community, the following suggestions are made regarding the expenses of operation at a Palama treatment center during its initial biennium. Inasmuch as a year or more would be required for the detailed planning and construction of a center at Palama, it is believed that during most of this period only the services of the director would be required. Full responsibility for designing and overseeing the construction of the center should be vested in him, and secretarial assistance, along with a limited appropriation for minor administrative costs, would probably suffice to enable him to carry out this initial phase of the program. Estimated expenses for the first year of the biennium would, then, be approximately as follows:

(1) Salary of director	$ 10,000 to $15,000
(2) Salary of medical secretary	2,700
(3) Office and other expenses	1,000
(4) Construction of center	120,000
Total Expenses for First Year	$133,700 to $138,700*

Among the responsibilities of the director during the initial, organizational year of operation would be staff recruitment, with the expectation that the key members of the treatment team would be secured by the beginning of the second year. Development of the staff into a functioning treatment team would probably be sufficiently advanced only by the initial quarter of the second year, but the outpatient phase of the program could be initiated as quickly as the clinical staff was in residence. (This outpatient service, the need for which was strongly indicated by a substantial number of the survey questionnaires returned from the Palama-Kalihi area, would make it possible to determine at minimum expense what services particular children might require for their rehabilitation. Some of the children classified as in need of further diagnosis in this survey might well be found to be in need of a period of residential treatment. The outpatient service would thus facilitate the "intake process" of the residential program, which could begin limited operation during the second quarter of the year.) During the last half of the second year, the treatment center might accept 25 residential patients.

Total expenses for the second year of the biennium, with staff costs estimated on the same basis as for a program at Kawailoa,[11] would be approximately as follows:

(1) Staff	$100,000[12]
(2) Cost of residence for 25 patients during second half of year, and operation of outpatient services	7,500
Total Expenses for Second Year	$107,500*

The total expenses for the first biennium, utilizing the higher estimate wherever there are variables, would then approximate:

(1) First year	$138,700
(2) Second year	107,500
Total Expenses for First Biennium	$246,200*

*These estimates of operating expenses do not include any provision for the rent, lease or purchase price which would be required by Palama Settlement for the use of its land and facilities.

OVERALL COSTS: SECOND BIENNIUM — By its second biennium, a Palama center program should be capable of operating almost at maximum capacity, during which time it might provide treatment for some 60 to 70 children in residence and some 200 to 400 outpatients. Assuming an efficiency of operation such that the average period of residence would be only nine months, operating expenses during the second biennium would be approximately as follows:

(1) Staff	$200,000
(2) Cost of residence for 90 patients for an average treatment period of nine months each	40,500
Total Expenses for Second Biennium	$240,500

Once such a program is well established, it is estimated that the biennial cost of providing residential study and treatment facilities for a group of adolescent children of the size revealed by this survey as being in need of them would be approximately a quarter of a million dollars.[13]

ADMINISTRATION — It is recommended that if a residential treatment program is established at Palama it be incorporated into the program of the Department of Health, which now administers these related services: the Bureau of Clinical Services (formerly the Bureau of Mental Hygiene) and the Bureau of Community Services of the Division of Mental Health, Bureau of Maternal and Child Health and Crippled Children, Bureau of Public Health Nursing and an Office of Health Education. The staff of the Division of Mental Health, in particular, has had extensive experience in the outpatient treatment of emotionally disturbed, malad-

justed children. This staff presently includes psychiatrists, psychologists, psychiatric social workers and others whose skills would be required for a residential treatment program. The Division does not have sufficient personnel to operate both its present program and a residential treatment center, but, of all territorial agencies it should be able to most readily recruit and train a treatment team.

FOOTNOTES

1. For his generous assistance during the final inspection of these facilities we are indebted to the deputy director of the Department of Public Works, Mr. Harold W. Butzine. His experience and professional skills have been drawn on in the discussion of proposed construction.

2. *1936 Statistical Report, Palama Settlement*, p. 4.

3. *Annual Report for 1952, Palama Settlement*, p. 2.

4. There is a strong likelihood that the present buildings of Palama Settlement will be replaced within a ten-year period.

5. A short-term lease is presently in effect with the Department of Public Instruction for the use of a portion of the medical building for its hotel management program. This lease arrangement will expire in 1957, and use of some other small portions of the main floor by temporary programs could also be terminated by that time. The ground floor of the two wings of the building would continue to be used for present purposes, but have separate entries.

6. See *Standards for Child-Caring Institutions in the Territory of Hawaii*, issued by the Department of Public Welfare, January 1, 1949 and reissued, March 1, 1952, especially p. 8.

7. Aichhorn, *op. cit.*, p. 173.

8. *Ibid.*,p. 148.

9. Since these precautions regarding construction details and security may strike a rather ominous note, it should be mentioned that a necessary portion of the rehabilitation of many of these adolescent boys generally includes the release of feelings of hostility and resentment which in less well controlled situations may be the source of substantial damage to themselves or others. However, the relatively short phase of destructiveness which is likely to be encountered as the patient moves along the road to recovery need present no lasting difficulties if the entire program, staff and physical plant are designed in anticipation of this phenomenon. Nor should these security requirements present basic difficulties for the operation of Palama Settlement's regular programs, since the size and type of staff in attendance at the treatment center would make possible continuous observation and direction of the activities of children in residence.

10. From *A Report of the Institutional Board Rates Committee*, Family and Children's Division, Honolulu Council of Social Agencies, July 1, 1955 (mimeo.).

11. Footnote 6, p. 49.

12. Additionally, provision would have to be made for medical and other services, a portion of which might be secured on a cooperative arrangement with Palama Settlement. A dental clinic is operated there, and maintenance of buildings and grounds might be contracted for with the Settlement.

13. Estimates of expenses have been based on the suggestion that a residential treatment center program at Palama would be under the direction of the Board of Health. Alternatively, the director of Palama Settlement has suggested that there might be considered a contractual arrangement through which Palama Settlement would establish and operate a treatment center under contract subsidy arrangements with the Territory.

Chapter 9

CONCLUSION

The discussion of the preceding three chapters has been designed to present pertinent data on three suggested treatment center units. Although none of these suggestions is ideal when judged by the criteria of decentralization as set forth in Chapter 5, each of them may be seen to have certain advantages. If the recommendation that units such as these be activated over a period of time is accepted, then some indication of the further advantages and disadvantages of each of these potential programs may be useful. The criteria proposed in Chapter 5 will serve as a guide for this comparison.

STAFFING In comparing the Susannah Wesley Home program with those suggested for Kawailoa and Palama on the question of staffing, it may be recalled that one advantage inherent in a subsidized private program is potentially greater freedom in hiring and firing. This advantage may be contrasted with a possible advantage of the suggested public programs, namely that the staff training potential is likely to be much larger, in part because of the closer working relationships that would be established between the treatment center units and the Department of Institutions or the Department of Health, as the case might be. This matter of personnel policy is of such importance as to warrant further consideration, for staff recruitment, inherently the most difficult aspect of developing adequate treatment center programs, would be faced with certain added difficulties in Hawaii. At any given time there are locally available few, if any, of the qualified professional people required for a treatment center program. Initially, there would almost necessarily have to be recourse to mainland recruiting for professional staff, and the national supply of qualified staff is far short of the rapidly developing demand.

A long run advantage of either of the publicly operated programs outlined in the two preceding chapters is that they could probably function more usefully than a private institution in developing personnel resources for the staffing of additional treatment center units. Since the bulk of the requisite skills which could be developed locally are those related to the field of social service, it is suggested that arrangements might be made with the School of Social Work of the University of Hawaii to incorporate student field work into any

treatment center program which may be initiated. Such a procedure could draw into the field some of the more promising young people in the Territory, for they would bring to it an interest in social service, strengthened by completion of an undergraduate program, and at least one year of basic education in social work through which they would have been familiarized "with the fundamental principles underlying all fields of practice in the profession."[1]

Participation in a treatment center program would provide unusually profitable opportunities for students' field work assignments, given the emphasis on team therapy and the importance attached to operational research. Through the establishment of sufficient field work assignments and a full-scale program of in-service training it should be ultimately possible to fill locally all positions in the categories of psychiatric-social workers, social group workers and houseparents. The first two categories would probably require extended training beyond graduation, but in some localities the positions of housefathers or housemothers are often filled directly by such graduate students in social work. Some centers have found this arrangement highly contributive to the overall success of their programs, and it may be noted that many of the graduate students of social work at the University of Hawaii are married couples. An indication of willingness to consider such training arrangements has been given by the chairman of the University of Hawaii School of Social Work, by the director of the Division of Training Schools and by the director of Palama Settlement. Satisfactory field work assignments have been made in the past at the Territorial (mental) Hospital and in the Division of Mental Health, the agencies which are recommended for establishment of the Kawailoa and Palama programs respectively.[2]

It has been further suggested that somewhat comparable training programs might be established with the Departments of Education and Psychology at the University of Hawaii, since they have some students receiving training in such fields as remedial education and clinical psychology whose programs might be related to service in a treatment center. While these suggestions have not been investigated, they indicate the possibility of a number of areas of cooperative staff training.

INTER-AGENCY COOPERATION

Comparing the advantages of each of the three suggested treatment units by the standard of "treatment in breadth," i.e., the development of sound cooperative relationships with other child-caring services, it is probable that Susannah Wesley Home and the Palama center would be preferable to the Kawailoa center. The locus of territorial social services is in Honolulu and its immediate environs. This is especially true of the location of central offices and higher level administrative personnel.

A treatment center unit located in the Palama-Kalihi area would therefore facilitate contact work with both public and private agencies, a matter that would continue to be of importance for the therapy program itself. "Treatment in breadth" implies steady contact between the staffs of the treatment center and those of cooperating agencies; hence there would be conferences called frequently to discuss particular cases. Generally speaking, it is likely that it would be more convenient to hold such conferences in Honolulu rather than at a treatment center located in an area removed from central Honolulu.

HIGH COOPERATION NEIGHBORHOODS

Related to the above consideration and of more fundamental importance is the criterion of establishing treatment center units within or close to neighborhoods characterized by acceptance and cooperation with such services. In the Palama-Kalihi area, which has long had a high rate of juvenile delinquency, there have been gradually developed a number of excellent community services to deal with the problem. This neighborhood has been described as one of high cooperation and substantial numbers of residents of this community have shown willingness to cooperate actively with remedial programs designed to cope with delinquency. These businessmen, educators, youth workers and others living or working in the neighborhood are in a position to render invaluable assistance in the reintegration of children into the community during the long period of outpatient treatment which follows residential therapy.

Location of a treatment center in a relatively rural area near Waimanalo would be disadvantageous from this viewpoint. Not only would it be somewhat removed from other community services, but there is the probability that very few of the patients in the treatment center would come from nearby homes. There would be the associated problem of engendering understanding and sympathetic support from a populace in nearby communities. It is suggested that this might well be more difficult than gaining such support in the Palama-Kalihi area; however, there is no implication that it would be an insurmountable problem. In an unpublished statement describing his success in securing organized community support for the outstanding California state treatment center at Camarillo, the director has indicated that

> we have several organizations of volunteer women . . . who send their members regularly on prearranged schedules to take the children on picnics, hikes, informal chatting in the ward, and other social activities. For instance, during the winter the volunteers provide our children on different occasions with entertainment by professional and amateur players. We have also received from them contributions in the form of expensive equip-

ment like the puppet show, wire recorder, etc. They made it financially possible for us to have a dancing teacher to start our dance program. Besides saving the taxpayer money and helping our children directly, such a program has created a mental health awareness in the community with promising potentialities. Some of the mothers of our patients have joined their local organizations with the result that they gained a better understanding of their own children by being able to come in contact with children of other parents, and the parents themselves.[3]

PREVENTION OF CHRONIC CONDITIONS

A final consideration may be raised by way of concluding this study of the need for the establishment of residential study and treatment center facilities. The size of the need was established and program suggestions made for meeting at least a portion of it. It may be urged, however, that programs in this field should go beyond the treatment of those children whose maladjustment and antisocial behavior has become so serious and so firmly established that they require residential treatment. The ultimate objective should rather be that of *prevention*--of preventing acute disorders from becoming chronic. To the extent that this long range goal were realized, the need for treatment programs would be diminished.

The objective of preventing cases from becoming chronic--or, in medical terminology, of reducing chronicity--and also some of the difficulties involved in reaching this objective, have been discussed by the director of the territorial Division of Mental Health in his recent report on public mental health services in Hawaii. Dr. E. W. Haertig contends that:

> In the present state of our knowledge, it is not realistic to speak of completely preventing mental illness, delinquency, etc. This must await further research, here and elsewhere, to show us how. While gaps in knowledge are still great, there is much tested information which is not being used in the Territory.
>
> It is possible to prevent chronicity in the majority of all types of mental health problems. The program of services which prevents chronicity most successfully will be the cheapest in the long run. As in all of medicine, higher priced early care is cheaper than lower priced late care.[4]

OPERATIONAL RESEARCH

Progress in the prevention of chronicity can be achieved in large part by the operational research carried on within functioning treatment programs. Continuous research makes possible, among other things, the discovery of existing community resources, the evaluation of new treatment techniques, experimentation with different types of staff and the testing of various cooperative arrangements

with other community agencies. Given the rather new and experimental aspects of residential study and treatment center programs, it is highly desirable that provision be made for ample operational research of this character. Sufficient emphasis on this aspect of any such treatment center programs as may be established in the Territory would also mitigate the perennial problem of attracting and holding a first-rate staff.

Whether or not public treatment center programs are established in the Territory in the near future, recognition of the importance of this field points to the desirability of continued study of the problem of locating emotionally disturbed, antisocial children and determining the general causes of their maladjustment. In this connection it is suggested that an appropriate territorial agency be authorized to gather and analyze research materials, including the coded questionnaires collected in the course of this survey. Techniques of case finding should be further refined and applied continuously so that the extent of the need for treatment center facilities might be ascertainable at any time.

FOOTNOTES

1. Candidates for the degree of Master of Social Work spend approximately half of their time in advanced classes, and half in supervised field work, totaling some 750 clock hours. For details of this program, see *University of Hawaii, General Catalogue*, 1955-56, pp. 98, 169-171.

2. The carrying out of field work assignments at a Kawailoa center would face the difficulty of its somewhat distant location from the University. This problem may be somewhat mitigated by the fact that quarters for student trainees were provided when the new dormitories at the Koolau Boys School were constructed. Each of the units provides three small rooms, kitchen and lavatory facilities. They would be suitable for either a couple or several single occupants. At present these units are not being used, and the superintendent of the Division of Training Schools has indicated that they could be made available if a program of field work or other training assignments were established.

3. N. I. Rieger, "Camarillo State Hospital Children's Unit," pp. 5-6 (unpublished typescript on file at the Legislative Reference Bureau).

4. Department of Health, Division of Mental Health, *Public Mental Health Services in Hawaii*, A Preliminary Report (Honolulu, June, 1956, processed), p. 7.

APPENDICES

Appendix A

PRELUDE TO THE STUDY

(The following information was compiled early in this study in order to determine the background leading to the legislative directive for a survey. For much of the development summarized, we are indebted to the Honolulu Council of Social Agencies, which kindly made available non-confidential files relating to residential treatment programs considered for Hawaii. Quotations are from minutes or reports included in the Council's files.)

Interest on the part of child welfare workers in providing special facilities for maladjusted children for whom existing community facilities have not sufficed extends back to at least 1945. In that year the Council of Social Agencies made a study of the group of children who were in need of special care, and it made a second study in 1949. Recommendations for more adequate care of this group were presented to the House Finance Committee of the 1949 Legislature, however, no funds were appropriated.

Subsequently, the Honolulu Council of Social Agencies established a Residential Treatment Home Committee, stating that "for many years the community, especially the court, has felt that children undergoing psychiatric treatment needed special care in a controlled environment. Experience has indicated that neither a foster home nor an institution is the proper setting for such children."

In November, 1951, Judge Gerald R. Corbett, who had then served for some five years as judge of the Juvenile Court of the first circuit, (serving also as an ex-officio member of the Commission on Children and Youth) called a meeting in his office with representation from six of the agencies most directly concerned with seriously maladjusted children. "At that time it was agreed that the Detention Home could not continue serving in a custodial capacity for emotionally disturbed children."

Among the steps taken following this meeting was the establishment by the Honolulu Council of Social Agencies of a fact-finding committee to study the needs for a residential treatment center in Hawaii, to review the experience of mainland cities that had established such centers, and to make recommendations. This fact-finding committee undertook extensive research early in 1952 and concluded that Hawaii was in fact in need of a residential treatment center. It recommended that a small "pilot" unit be established to demonstrate the operation of such a center to the public and to the legislature. Continuing its work as a committee of the Family and Children's Division of the Council of Social Agencies, the group held a number of meetings in mid-1952 and had consultations with Mr. Kenneth Foresman, Child Welfare Consultant, Children's Bureau of the Federal Security Agency, during the latter's visit to Honolulu in July of that year. "Mr. Foresman stressed the necessity of 'moving slowly', pointing out that the 'residential treatment or special foster home' was only one of the unmet needs. Community resources [and] foster homes for the care of this group when ready for other placement, if unable to return to their own homes, must be developed, thus avoiding difficulties encountered in other communities where children remain [in the treatment center] longer than is necessary."

The Committee explored the possibilities of making use of existing institu-

tional facilities in meeting the need for a residential treatment center, but reported negatively. It then "agreed to work toward establishing a residential treatment home on a small basis (capacity for four to six children), utilizing existing social work and treatment facilities." In October, 1952, subcommittees were appointed to explore the problem areas suggested by their titles: (1) "Admission and Treatment," (2) "Administration and Fund Finding," and (3) "Foster Parents and Location of the Home."

The problem of rehabilitating maladjusted children was again brought to the attention of the Legislature in 1955. The Youth Development Program Committee of the Kalihi-Palama Community Council brought about the introduction of a proposal for a study of the need for residential treatment facilities. This proposal was subsequently incorporated into Joint Resolution 34, which directed that this study be made.

Appendix B

SELECTED CHARACTERISTICS OF VARIOUS CHILDREN'S STUDY AND TREATMENT CENTERS

A second preliminary step in the preparation of this report was to collate information concerning what treatment centers are, how they are staffed and how they operate, and whom they treat. Useful data were obtained from the U. S. Children's Bureau and the Child Welfare League of America publications cited in the first section of the bibliography.

Key to use of chart:

(1) Each organization has been assigned a code number which is used to designate it on the accompanying tables; e.g., Berkshire Industrial Farm is indicated by the number "1."

(2) A single asterisk is used to indicate "with reservations," e.g., an institution whose admission policies permit acceptance of *some* children with brain damage would be checked in the appropriate space as follows: "X*"

(3) The double asterisk is used to indicate that interns, or other personnel still in a training capacity, are employed on the staff.

(4) # indicates observation through psychological study.

1 Berkshire Industrial Farm
2 Child Guidance Home
3 Children's Aid Society of Cleveland
4 Children's Service Center of Wyoming Valley
5 Emma Pendleton Bradley Home
6 Hawthorne Cedar Knolls School
7 Ohio Bureau of Juvenile Research
8 Ryther Child Center
9 St. Christopher's School
10 Sonia Shankman Orthogenic School
11 Southard School
12 Arthur Brisbane Child Treatment Center
13 Bellefaire
14 Boys Republic Clinic
15 Chicago Home for Girls
16 Child Study Center of Maryland
17 Children's Services of Connecticut
18 The Children's Village
19 Donald M. Whaley Home
20 Evanston Home of the Illinois Children's Home and Aid Society
21 Forest Park Children's Center
22 George Junior Republic
23 Girls' Service League
24 Herriman Farm School
25 Kansas Receiving Home for Children
26 Marks Nathan Hall of Jewish Children's Bureau
27 Mary Bartelme Club
28 Memorial Foundation
29 Minnesota Children's Center
30 Ridge Farm
31 Secret Harbor Farms
32 Spofford Home
33 Sweetser-Children's Home
34 Tujunga Highland School
35 Vince A. Day Center
36 Wiltwyek School for Boys

	FEES	PRIVATE SUPPORT	PUBLIC SUPPORT	ADMISSION POLICIES: SEX: BOYS	GIRLS	BOTH	AGE	SECTARIAN	NON-SECTARIAN	TYPE OF PROBLEM: BEHAVIOR PROBLEM	BRAIN DAMAGE	PSYCHOTIC	MENTALLY DEFICIENT	PHYSICALLY HANDICAPPED	PHYSICAL PLANT: BED CAPACITY	CENTRAL HOME	COTTAGES	INSTITUTION SCHOOL	COMMUNITY SCHOOL	VOCATIONAL TRAINING FACILITIES	STAFF: PSYCHIATRISTS	PSYCHOLOGISTS	PSYCHIATRIC SOCIAL WORKERS	SOCIAL CASE WORKERS	GROUP WORKERS	TEACHERS	NURSES	COTTAGE PARENTS	PHYSICIAN	DENTIST	MAINTENANCE STAFF	TREATMENT: PSYCHOTHERAPY	CASE WORK TREATMENT	FOLLOW-UP CASE
1	$3.25 day	X	X	X			12-16		X	X	No	No	No	No	150		X	5th-8th grade	High Sch.	X	1 day a wk	1	2	1	1	12	2	14	1	1	Yes		X	
2	$300 Month	X	X			X	6-12		X	X	No	X	No	No	12	X					1 3 pt. time		1	1	1						Yes	X	X	
3	$3.00 day	X				X	6-14		X	X	X*	X*	No	X*	34	X	X				1/3 time	2	2			2		6	1/4 time	1/4 time	Yes	X		
4	$50-$70 weekly	X				X	6-17		X	X	X*	X*	No	X*	18		X		X		1	1	1	4							Yes	X	X	
5	$6-$12 day	X				X	3-12		X	X	X	X	No	X	54	X					1	1 3**	1			3	5	13	Pt. time		Yes	X		
6	$1,200-$3,000 year	X	X			X	8-16	X		X				X*			X	X			4 pt. time	2	12		1	24	2	30	Pt. time	Pt. time	Yes	X	X	X
7	None		X			X	4+18		X	X					115	X					3 pt. time	9 3**		4		7	3	44	1 pt. time	1 pt. time	Yes	X		
8	$265 month	X				X	2+18		X	X	X*	X*		X*	20	X			X		1 pt. time	1		1 + 10 pt. time	1	1		5	1 pt. time		Yes	X	X	
9	$110 month	X				X	6-17	X		X	No	No	No	No	90		X	X	High Sch.		1 day a wk	3 days a wk	6		3		1	17			Yes	X	X	X
10	$4,500 year	X				X	6-14		X	X	No		No	No	40	X		X			1	3	1	1	10	4	1	5			Yes	X		
11	$7,000-$9,000 year	X				X	5-12		X	X		X			20	X		X			4	1 + pt. time	2		2 + pt. time	6					Yes	X		
12	Varies		X			X	5-12		X	X	X	X			64	X					1	1	1			2	3	19			Yes	X	X	
13	$2,700-$3,400 year		X			X	5-17	X		X	X	No	No	X	109		X	X	X		4 pt. time	1	4	2		4	1	13			Yes	X	X	

	FEES	ADMISSION POLICIES: PRIVATE SUPPORT	PUBLIC SUPPORT	SEX: BOYS	GIRLS	BOTH	AGE	SECTARIAN	NON-SECTARIAN	TYPE OF PROBLEM: BEHAVIOR PROBLEM	BRAIN DAMAGE	PSYCHOTIC	MENTALLY DEFICIENT	PHYSICALLY HANDICAPPED	PHYSICAL PLANT: BED CAPACITY	CENTRAL HOME	COTTAGES	INSTITUTION SCHOOL	COMMUNITY SCHOOL	VOCATIONAL TRAINING FACILITIES	STAFF: PSYCHIATRISTS	PSYCHOLOGISTS	PSYCHIATRIC SOCIAL WORKERS	SOCIAL CASE WORKERS	GROUP WORKERS	TEACHERS	NURSES	COTTAGE PARENTS	PHYSICIAN	DENTIST	MAINTENANCE STAFF	TREATMENT: PSYCHOTHERAPY	CASE WORK TREATMENT	FOLLOW-UP CARE
14	$70 month	X		X			13½-16½		X	X	No	No	No	No	96	X					2 days a week	2		2	1	8	1	4	1 day a week	1 day a week	Yes	X	X	X
15	$30-$60 month	X			X		12-18		X	X	No	No	No	X#	14	X				X	Pt. time		1	1	1		1	1			Yes		X	
16	$75 month	X				X	6-13		X	X	No		No	X#	33	X		X			1		3			3	1	3 + 3 pt. time			Yes		X	
17	$21 week	X				X	6-13		X	X	No	No	X*	X#	60		X		X		1 day a week			1				Yes			Yes		X	
18	$1,200-$2,400 year	X		X			10-16		X	X		No	No	X#	444		X				1	1**	10		18	27	1	40	1 pt. time	2 pt. time	Yes	X		
19	$30 week	X				X	6-17		X	X	X#	X#	No	No	35	X			X				3	1	1 pt. time	1 pt. time	1	6	1 pt. time	1 pt. time	Yes			
20	Varies	X				X	6-12		X	X	No	No	No	No	20		X	X		X	1	1	Yes		1 + assts	1 + assts		Yes			Yes	X		X
21	Varies	X				X	5-17		X	X	No	X#	X#		12	X					Pt. time		1					3			Yes	X	X	X
22	$2,400 year	X				X	13-19		X	X				X#	115		X			X				3	1	10	1	17	Pt. time				X	
23	$15 week	X			X		14-21		X	X			No	X#	28		X		X		Pt. time	Pt. time	5		1			6	Pt. time		Yes		X	X
24	Varies	X		X			9-15		X	X	X#	No	No	X#	55		X	X	X	X	Pt. time			X	1	6		6			Yes	X	X	
25	$1 day		X			X	6-16		X	X			X		43	X					Pt. time	3				2			Pt. time		Yes	X#		

	FEES	PRIVATE SUPPORT	PUBLIC SUPPORT	ADMISSION POLICIES: SEX: BOYS	SEX: GIRLS	SEX: BOTH	AGE	SECTARIAN	NON-SECTARIAN	TYPE OF PROBLEM: BEHAVIOR PROBLEM	TYPE OF PROBLEM: BRAIN DAMAGE	TYPE OF PROBLEM: PSYCHOTIC	TYPE OF PROBLEM: MENTALLY DEFICIENT	TYPE OF PROBLEM: PHYSICALLY HANDICAPPED	PHYSICAL PLANT: BED CAPACITY	CENTRAL HOME	COTTAGES	INSTITUTION SCHOOL	COMMUNITY SCHOOL	VOCATIONAL TRAINING FACILITIES	STAFF: PSYCHIATRISTS	PSYCHOLOGISTS	PSYCHIATRIC SOCIAL WORKERS	SOCIAL CASE WORKERS	GROUP WORKERS	TEACHERS	NURSES	COTTAGE PARENTS	PHYSICIAN	DENTIST	MAINTENANCE STAFF	TREATMENT: PSYCHOTHERAPY	CASE WORK TREATMENT	FOLLOW-UP CARE
26		X				X	2-17	X		X	X			X*	55		X		X		Pt. time			1 | 4 pt. time	Pt. time	1	Pt. time	Yes	Pt. time		Yes	X	X	X
27	$72 month	X			X		13-18		X	X	No	No	No	X*	26		X				Pt. time		1	3	1			5	Pt. time	Pt. time	Yes		X	
28	$10 week	X				X	4½-16		X	X	No	No	No	X*	12	X					Pt. time		Pt. time		Pt. time			3	Pt. time	Pt. time	Yes	X	X	X
29	$4.66 day	X	X			X	6-21		X	X	X		X*	X*	30	X			X		Pt. time			2	1		1	5			Yes	X*	X	X
30	$80 month	X				X	6-12		X	X		No	No	X*	20	X					1 day week	½ time	2	1		½ time		6	1		Yes	X		
31	$250 month	X				X	2-18		X	X	X*	X*	X*	X*	19	X							1		3	1					Yes	X	X	
32	$60 month	X				X	2-16		X	X	No	X*	No	Nc	18	X					1 day week		1		1	3		5			Yes		X	X
33	Varies	X				X	6-18		X	X	X	X*			42		X	X	X		1 day week	4 days month	2	1		1		11	Pt. time	Pt. time	Yes		X	
34	$275 4 wks					X	6-12		X	X		No	No	No	17		X			X	Pt. time	1				2		2			Yes		X	
35	No fees		X			X	1-12		X	X					38	X			X		1	Pt. time		3	9	3	6		1		Yes	X	X	
36	Varies	X		X			8-12		X	X	No	No	No	X*	100		X				Pt. time	1	4	1		1		14			Yes	X	X	X

Appendix C

TREATMENT CENTER SCHEDULE

November, 1955

One schedule is to be completed for each child between ages 2 through 20 who, in your opinion, "can be aided" through the facilities of a residential treatment center. (Joint Resolution 34, SLH 1955)

_____
Code No.

(A)

1. Agency _____

2. Is this child currently being carried by any other public or private agency in the Territory? Yes _____; No _____. If answer is affirmative, indicate agency. _____

(B) VITAL STATISTICS:

3. Child's birth date _____
Month Day Year

4. What grade has this child reached in school? _____

5. Sex: Male _____; Female _____

6. Religion: (a) Buddhist _____ (d) Protestant _____
(b) Catholic _____ (e) Other _____
(c) Jewish _____ (f) None _____

(C) DETAILS ON PRESENT LIVING ARRANGEMENTS:

7. Child is living with: (check) (a) Mother _____ (c) Both _____
(b) Father _____ (d) Neither _____

8. Location and status of parents:

(a) Is mother living? _____; in Territory? _____

(b) Is father living? _____; in Territory? _____

9. Are parents: (a) Living together _____ (e) If none of these, please
(b) Divorced _____ specify _____
(c) Separated _____
(d) Unknown _____ _____

10. Is this child's family or legal guardian probably able to provide monthly support to the extent of:

(a) $200 or over _____ (c) $100 to $50 _____ (e) Nothing _____
(b) $200 to $100 _____ (d) Up to $50 _____ (f) Unknown _____

(C) DETAILS ON PRESENT LIVING ARRANGEMENTS (Cont.)

11. If child is not living in his own home, indicate below his present residence and the date on which it was initiated.

(a) Hanai home: Related _____ Unrelated _____
(b) Relatives (other than Hanai home) _____
(c) Adoption home _____
(d) Agency foster home _____
(e) Non-agency foster home _____
(f) Wage home _____
(g) Work home _____
(h) Boarding school (or home) _____
(i) St. Anthony's Home _____
(j) Susannah Wesley Home _____
(k) Salvation Army Boys' Home _____
(l) Salvation Army Girls' Home _____
(m) Koolau Boys' Home _____
(n) Kawailoa Girls' Home _____
(o) Detention Home _____
(p) Waimano Home _____
(q) Territorial Hospital _____
(r) Other (specify) _____

12. Duration of present living arrangements: Years _____, Months _____, Weeks _____

These living arrangements may best be described as good _____; satisfactory _____; borderline _____; unsatisfactory _____.

13. Has this child had placements prior to his present arrangement? Yes _____; No _____. If answer is affirmative, indicate dates and location, using the categories from question 11 when possible. (Use reverse side of last page of Schedule if more space is needed.)

Location _____; Dates: from _____ to _____

Location _____; Dates: from _____ to _____

(D) DIAGNOSTIC RECORD: Please check off those symptoms listed below which, in your opinion, might affect the placement of this child in a residential treatment center. Please indicate after each item which does not stem from your personal observation the person or agency which made the analysis; e.g., Territorial Hospital, Bureau of Mental Hygiene, private psychiatrist, other case worker, etc.

14. Behavior symptoms:

(a) Severe aggression and/or destructiveness _____
(b) Unmanageable temper tantrums _____
(c) Habitual lying _____
(d) Stealing _____
(e) Incorrigibility (unmanageability) _____
(f) Repeated truancy _____
(g) Habitual runaway _____
(h) Habitual curfew violator _____
(i) Arsonist _____
(j) Pronounced cruelty _____
(k) Unmanageable hyperactivity _____
(l) Sexual deviation:
Homosexual _____
"Peeping Tom" behavior _____
Rape attempts _____
Indecent exposure _____
Promiscuity _____
Sodomy _____
(m) Other (specify) _____

(n) Excessive shyness or withdrawal _____
(o) Avoidance of close relationships with others _____
(p) Inability to express directly feelings of hostility _____
(q) Extreme coldness, aloofness, emotional detachment _____
(r) Other (specify) _____

(D) DIAGNOSTIC RECORD (Cont.)

15. Diagnostic impression:
    (a) Psychotic _____
    (b) Borderline psychotic _____
    (c) Severe psychoneurosis _____
    (d) Incipient character disorder _____
    (e) Phobias (unreasonable and damaging fears) _____
    (f) Homicidal impulses _____: attempts _____
        Suicidal impulses _____: attempts _____
    (g) Excessive fantasy construction (autistic thinking) _____
    (h) Severe functional retardation (e.g., social, educational, recreational) _____
    (i) Undetermined _____
    (j) Other (specify) _____

16. Psycho-physical disorders (Physical symptoms for which no adequate physical causes have been identified):
    (a) Soiling _____
    (b) Enuresis _____
    (c) Upset stomach _____
    (d) Headaches _____
    (e) Allergies (specify type) _____
    (f) Aching muscles, joints _____
    (g) Other (specify) _____

17. Is this child suffering from any diagnosed brain damage, neurological disorder, or feeble-mindedness? Yes _____; No _____. If answer is affirmative, please specify whether there is, for example, hearing loss, vision loss, speech impairment, etc., and indicate source of the diagnosis.

    _____

18. With a view to the symptoms manifested by this child, his past record of placement and other services received, and with a consideration of the treatment facilities <u>presently</u> available in the Territory, would you make one of the following prognoses:
    (a) There is a very good chance that the child will improve _____
    (b) There is a fair possibility that the child will improve _____
    (c) There is virtually no chance that the child will improve; he may just about hold his own _____
    (d) The child will probably retrogress _____
    (e) Cannot say _____

19. Briefly indicate why you believe that the facilities of a residential treatment center are needed to meet the requirements of this child.

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    (NOTE: If additional space is needed to answer question 19 or any other question, please use the reverse side of this sheet.)

Appendix D

TABULATION OF SYMPTOMS

Behavioral, Psychological and Psycho-Physical, by Classification, Sex and Age Group

		TOTAL	CLASSIFICATION					SEX		AGE			
			Definite	Further Diag. A	Further Diag. B	Marginal A	Marginal B	Male	Female	4 - 5 years	6 - 11 years	12 - 16 years	17 - 20 years
BEHAVIORAL	Severe aggression or destructiveness	67	23	7	11	20	6	50	17	3	24	36	4
	Extremely severe temper tantrums	50	20	12	3	14	1	28	22	2	12	28	8
	Habitual lying	65	27	2	4	30	2	28	37	-	13	38	14
	Stealing	120	39	16	9	52	4	90	30	2	21	74	23
	Incorrigibility	82	31	8	10	33	-	54	28	1	13	52	16
	Repeated truancy	88	28	12	5	39	4	48	40	-	12	61	15
	Habitual runaway	105	40	12	8	43	2	42	63	-	12	69	24
	Habitual curfew violation	55	16	6	2	28	3	28	27	-	3	41	11
	Arson	7	3	2	1	1	-	7	-	-	4	2	1
	Sadism	21	9	2	4	4	2	18	3	-	12	8	1
	Unmanageable hyperactivity	30	7	6	8	3	6	24	6	3	19	7	1
	Homosexualism	15	6	2	-	6	1	3	12	-	-	9	6
	Voyeurism	6	-	-	1	4	1	5	1	-	1	4	1
	Attempted rape	5	2	2	-	1	-	5	-	-	1	4	-
	Indecent exposure	1	1	-	-	-	-	1	-	-	1	-	-
	Promiscuity	55	17	6	2	30	-	5	50	-	-	34	21
	Sodomy	5	3	1	1	-	-	5	-	-	-	3	2
	Excessive shyness or withdrawal	65	25	13	9	10	8	41	24	1	18	34	12
	Avoidance of close relationships	84	35	16	9	16	8	56	28	3	21	47	13
	Inability to express hostility	76	33	13	8	13	9	40	36	2	23	40	11
	Abnormal detachment	25	14	6	1	3	1	13	12	-	4	14	7
	Miscellaneous	110	36	19	9	26	20	65	45	4	35	57	14
PSYCHOLOGICAL	Psychosis	7	5	2	-	-	-	4	3	1	1	1	4
	Borderline psychosis	8	4	4	-	-	-	7	1	-	-	5	3
	Severe psychoneurosis	16	12	3	1	-	-	7	9	1	3	9	3
	Incipient character disorder	31	16	5	3	5	2	25	6	-	7	21	3
	Phobias	12	9	1	1	-	1	4	8	-	3	7	2
	Homicidal impulses	9	7	1	-	1	-	7	2	-	2	6	1
	Homicidal attempts	4	4	-	-	-	-	3	1	-	1	2	1
	Suicidal impulses	12	9	2	1	-	-	4	8	-	1	8	3
	Suicidal attempts	7	7	-	-	-	-	1	6	-	-	5	2
	Autism	15	10	2	2	-	1	8	7	-	2	7	6
	Emotional retardation	124	40	19	16	36	13	61	63	2	32	70	20
	Indeterminate	39	4	10	3	19	3	25	14	2	4	26	7
	Miscellaneous	43	24	8	4	5	2	24	19	1	7	23	12
PSYCHO-PHYSICAL	Soiling	3	2	-	1	-	-	1	2	2	1	-	-
	Enuresis	16	9	3	-	4	-	12	4	1	6	7	2
	Stomach upsets	7	3	2	2	-	-	3	4	-	3	2	2
	Headaches	10	4	3	2	1	-	7	3	-	4	3	3
	Allergies	6	4	1	-	1	-	1	5	-	1	3	2
	Arthralgia, myalgia	3	1	1	-	-	1	-	3	-	1	2	-
	Miscellaneous	30	13	6	4	7	-	20	10	1	12	11	6

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