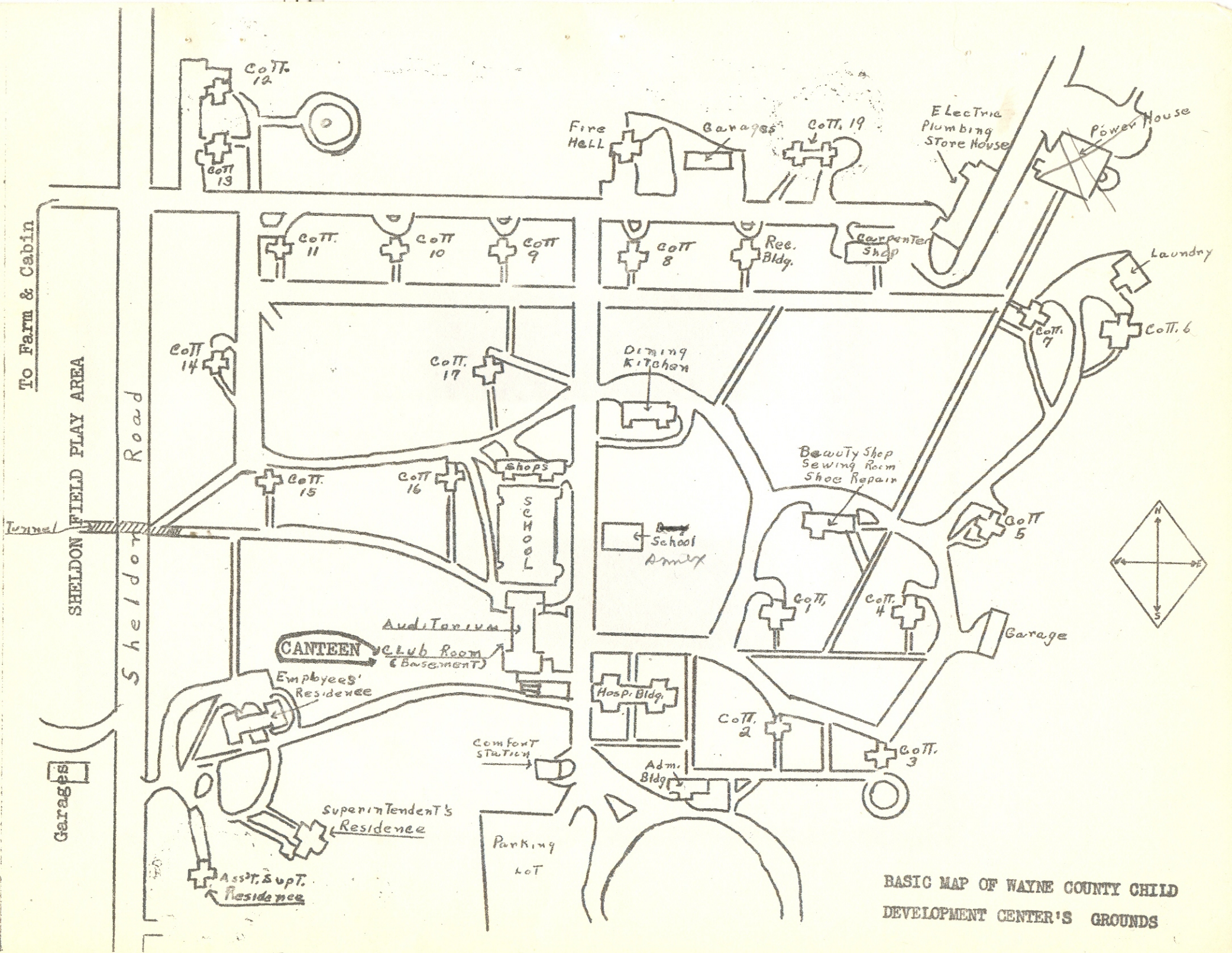
Booklet replaced by Guide Book for new Employees July 1, 1970

A STATEMENT OF ORIENTATION FOR NEW EMPLOYEES

WAYNE COUNTY CHILD DEVELOPMENT CENTER

Northville, Michigan



BASIC MAP OF WAYNE COUNTY CHILD DEVELOPMENT CENTER'S GROUNDS

PURPOSES

The Wayne County Child Development Center (originally the Wayne County Training School) was opened in 1926 as a public facility designed to serve those educable retarded children within the county whose needs were not being met for a variety of reasons by available community services. The objectives of the Training School were initially to admit the children early, thereby exposing them to intensive rehabilitative training and education and simultaneously emphasizing their early return to the community while still being under supervision. When satisfactory progress was seen the child was then to be discharged from the School.

Today, these basic objectives remain the same. However, because a large portion of the current child population is socially maladjusted as well as mentally retarded, the Child Development Center has the added responsibility of providing rehabilitative services from the mental health point of view. The social and emotional growth of the child is regarded of equal importance to his intellectual development.

CHARACTERISTICS OF A MENTALLY RETARDED CHILD

The purpose of this section is to acquaint the new employee with some of the characteristics, background, causes and classifications of mentally retarded children. We feel that all persons working with our children should have some basic understanding of the kinds of defects and limitations identified with them.

Children admitted to the Center are classified as mentally retarded and, in addition, many are socially maladjusted. The mentally retarded are categorized in many ways depending on the profession involved. The physician, for example, may classify a child in terms of his physical defect and its cause. The social worker may group such children on the basis of their community adjustment and the degree of dependency or independency. The psychologist may be primarily interested in the deficit measured by psychometric tests. The educator may group children according to academic achievement. For our purposes, though, we shall class the retarded child in three basic categories: the totally dependent, the partially dependent, and the potentially independent. The Center population is made of the latter two with by far the majority falling within the potentially independent category. From the educator's point of view, this child is termed educable which means that he has sufficient ability to learn some reading, to master some simple mathematics, some spelling, and has some potential capacity for social independence. From an occupational standpoint, the educable retarded child has sufficient potential to compete on the labor market with a moderate degree of success in unskilled and occasionally semi-skilled occupations. Basically, this child can be expected, with help, to ultimately achieve total or partial self-support with minimum capacity in academic skills up to

the fifth grade. They usually do lesser unskilled jobs like food service helpers, mechanical helpers, farm helpers, domestic helpers, and the like.

The following charts are included in order to present a clearer description of the broad general classification, limitations, and expectations of the retarded.

PLACEMENT DATA FOR EDUCATIONAL PURPOSES FOR EDUCABLE RETARDED CHILDREN

IQ 55-80

C.A.	M.A.	PROGRAM
6-9	3-7 yrs.	Usually non-readers, not ready for formal schooling.
9-12	$4\frac{1}{2}$-10	Usually ready to read, take on simple math, and social studies.
13-16	7-12+	Achieve third or fourth grade reading, math. Emphasis on social studies, shop, home economics, physical education, and job analysis.
16-21	12+	Emphasis on shop, home skills, and vocational training, academic skills up to fifth grade.

CHARACTERISTICS OF THE MENTALLY RETARDED

Totally dependent	Semi-dependent	Semi-independent	Independent
Custodial	Trainable	Educable	Dull-normal
"Idiot" *	"Imbecile" *	"Moron" *	"Slow Learner" *
IQ 0-25	IQ 25-50	IQ 50-75	IQ 75-90
May not talk or walk	Most self care	Achieve minimum academic level	Accommodated in regular school programs
Need total care	Can recognize few words	May become independent	Many become dropouts
No educational program except training for self care	Performs household tasks	Employable for unskilled and semi-skilled jobs	Most do not come to attention
Often not trainable for any self care	Special education programs available in some communities	Education programs available in most communities	
Usual mental age under 1½ years		Some accommodated in regular school programs	
None are at WCCDC	Only a few at WCCDC	Majority at WCCDC	A growing population of our children. Many make up our socially maladjusted population (with retardation)
**Occur in approx. 1 in every 1000 children	Occur in approx. 4 in every 1000 children	Occur approx. 28 in every 1000 children	Occur approx. 173 in every 1000 children

*Past terms

**Educating the Exceptional Child by Samuel Kirk, Houghton & Mifflin Company, Boston, 1962, P.92
Estimate Rate for 1000 School Age Children (table 5)

The Center differs from most institutions designed to serve the mentally retarded in that it accepts for admission only potentially educable children. Unlike the Center, most other institutions for the retarded are designed to care for the total mentally retarded population and consequently their resident population includes by far a larger proportion of partially dependent children, and in addition many totally dependent children.

Mental retardation is a condition which may result from many different factors. It may be caused by a variety of diseases, infections, or lack of oxygen, all of which may result in brain damage before, during, or after birth. Other causes are believed to be genetic or inheritance factors. Environment such as social and economic conditions, family child-rearing practices, and effects due to influences from siblings also relate to some types of retardation. All of these can depress or accelerate the child's developmental pace.

The retarded child, by comparison with the normal, develops more slowly and his growth patterns are usually uneven. Physically, the retarded child is usually below average. He may be more awkward, speech and hearing defects are common, his intellectual growth is slower, and he is ready for academics later in life in comparison with the normal child. His attention span is short for most things related to his age; he has a low frustration tolerance; his social values and attitudes are underdeveloped; and often he is subjected to frustrations and emotional problems commonly associated with discrepancies between his capacity to perform and the expectancy of his environment. The retarded child is exposed to pressures from the school, from the home, and from the community, due to his limitations of understanding. He is often noted for truancies, lack of self-control, lack of peer status or acceptance, and a generally underdeveloped personality.

The socially maladjusted child is not always as obvious in terms of his defect as the mentally retarded. Methods of measuring such defects are not as common. Sometimes this youngster may appear completely normal just as the normal child sometimes appears disturbed. An individual is considered normal or adjusted when his behavior does not interfere with his own personal growth or with the lives of others.

Maladjusted children, similar to the retarded, are classed in many ways. Some are severely inhibited or withdrawn. Some are aggressive and exhibit expressions of delinquency. For our purposes, as the child care worker is required to relate to the Center child, we shall group these children in two categories: first, the aggressive, acting-out child whose behaviors may or may not be described as delinquent. Many factors are believed to be involved in the development of this child. Causes may be related to the child's community environment, where he may have been unloved and rejected. He may not have developed loyalty or learned that adults can be helpful and of value; or he may have once been loved and then rejected, and sought out gang membership for acceptance and gratification.

The second group is the inhibited or withdrawn child. He is the youngster who seldom volunteers to partake in activities and does participate in only a limited manner when drawn into group affairs. When left to himself he is usually dull, may play with his hair, look out the window, bit his nails, or may be extremely timid and fearful of his peers or adults. He may be the child the delinquent type pushes around and misuses.

Factors leading up to such withdrawn child problems are believed to be the result of over-protection or restriction with inadequate affection. Such children are not allowed to make decisions for themselves. The parents, often the mother, make even the simple decisions, and the child fails to develop individuality. Similar adult characteristics, known as institutionalization, are common in people trained to live in a rigid institutional environment without rehabilitative training for normal community life.

The children then who come to the Center are mentally subnormal to an educable degree and are performing on a subnormal level academically in a public school setting. Many, in addition, are involved in delinquent acts in the community or in other ways may exhibit inappropriate or antisocial behavior. They may be victims of brain damage, deprivation, limited affection, or may have been subjected to brutality and rejection. They need special help and individualized attention to develop even a minimum of their reserved undamaged growth potential by the time they come to us.

The history of government financed institutions established expressly for care of the mentally retarded began in 1848. These early institutions primarily provided custodial care, comfort and lifetime storage with limited goals for ultimate community return. Usually admission to such facilities was limited to the severely retarded.

In recent years more public attention has been focused on the mentally retarded and this is due in part to society's transition from a simple to a complex life pattern resulting in fewer community opportunities for all limited individuals. Increased needs for more bed space in the institutions for mentally retarded, and the cost factors involved, have brought about different attitudes concerning the role these institutions should fill in today's society. Greater emphasis has been placed on training, rehabilitation and community return. Most institutions have kept pace with these demands; some have not. Since its very beginning the Center has been dedicated to a program of rehabilitation and ultimate early return to the community for all its patients.

To accomplish this we attempt to provide for each child a stimulating, individualized program. We also attempt to offer the child a wide variety of situations in which he can test his skills

and realize varying degrees of success. Our job cannot be accomplished by disinterested non-stimulating custodial care. It requires wholesome leisure-time child activities, constructive and educational in nature; affectionate concern for each child's individual physical and emotional needs; and maintaining reasonable standards of conduct and performance by both child and staff. Our child care and training standards are of the highest. Supervision here is dedicated to the maintenance and ever improvement of these standards.

DISCIPLINE AND PUNISHMENT

For persons working with children, the matter of discipline and punishment probably represents one of the greatest problems, and is an area of considerable confusion. Much is said and written about discipline and punishment and what one should and should not do. Here we try to give the worker some written information to guide him in what is accepted and effective with our children and situation.

First, we need to differentiate between discipline and punishment. Discipline is the framework of limits we place on the child; such as his play boundaries, the cottage rules, conduct at mealtime, mode of dress, amount of noise, regard for others, etc. The regulating and required conformity of them is discipline. It is important that each child know the restrictions, limits, and expectations so that he may develop internal or self-discipline, which is one of our training objectives. It opposes external discipline and is the true stability of thought and action which governs most societies. If police regulations or forced conformity were the only regulation on society we fear the world would not be safe for life. To do right because we know it is right and thereby we all have a better life as an end result of self-discipline.

To force a child to conform may reach an immediate goal but if forcing does not teach him to want to conform, then it is of little value beyond immediate control. It is true, control is necessary for effective teaching. For example, the child who throws paper on the floor and refuses to pick it up may well be forced to pick it up. Removal of privilege, isolation or physical contact all may make him conform. But the more important issue of his wanting to be neat and clean, helpful and cooperative, may be adversely affected as we force conformity. Calling on his sense of fair play or understanding of right, might well get the paper picked up faster. By demonstrating that you or his peers, who are about ready for discharge, do these things without question may impress the offender.

When a child exceeds set limits, a punishment may be taken for the purpose of impressing the child with his violation. Punishment for some settings might take many forms varying from a verbal reprimand to inflicting severe physical pain. The latter, of course, is never permitted at the Center nor is deprivation of any basic need like food or toilet.

There are many views on punishment and its place in child rearing; when it should be used, when it should not be used, what is appropriate, and which method is most effective. A generation ago we passed through a stage which suggested that character building is the consequence of hard knocks--the harder the better. Harsh punishment, physical or otherwise, and ridicule were freely administered and accepted as appropriate. There are some cries today that we should allow physical punishment to become respectable again.

On the other hand, the mental hygiene attitudes toward discipline and punishment emphasize the awareness of the child's unconscious motivations and attention is called to the importance of accepting the child as he is and to help him with his needs while avoiding punishment altogether. Still others take the position that punishment of the normal child is an acceptable teaching method, although negative by nature, and is all right if not used as a sole means of correcting as long as it is tailored to the individual child, the offense, and other related factors. This thinking discourages punishment administered wantonly through malice. It does not, however, recommend punishment for the unstable child who misbehaves because of his needs. He is driven, they claim, by uncontrollable drives seeking satisfaction for an emotional hunger, for affection, recognition, belonging, praise, or independence.

With all the controversy over the question of punishment, one can well understand how reluctance to do anything to enforce discipline can easily become the rule rather than the exception in the day-to-day management problems confronting all persons whose work brings them into direct contact with child groups. This reaction is most wrong for the child care worker.

Until recently we operated two so termed "discipline" units; one for the boys and one for the girls. Private seclusion rooms, located on the upper floors of several of the living units are now available for disciplinary or protective purposes. Use of these rooms is always made under the supervision of a staff physician.

Past studies show, and it may be true today, that reasons for child confinement or seclusion include truancy problems, overstayed leaves, return from convalescent status, severe peer altercations, general defiant uncooperative behavior, and protective custody. Many of these problems are now being avoided by more effective child counseling, less emphasis on the group and more on the individual, better child accounting, constructive activities in place of custodial care, and closer counselor-family relationships. Basically, our aim is to help the child achieve self-discipline.

For the serious offender, we need to reinforce the need to remain within the framework of limitations. The prescription for this reinforcement, we believe, depends on the individual and not on the offense; and what might be appropriate for one in terms of correction may not be for another under exact or similar circumstances.

June 3, 1968

ADMINISTRATIVE BULLETIN #63

TO ALL EMPLOYEES

SUBJECT: Patient Abuse and Mistreatment

This official directive is to replace all previous rules, memorandums and bulletins concerning patient abuse and mistreatment. The official policy with respect to the matter of abuse of patients is as follows:

> "Any employee of the Child Development Center who abuses a patient in any way shall be subject to immediate dismissal." Continued complaints from the patient regarding an employee shall be thoroughly investigated and, if substantiated, his employment shall be terminated."

This communication is issued to further amplify this rule and to establish a uniform and equitable procedure in the implementation of its stated provisions. The rule and policy are both directed to the fundamental principle that no patient shall be abused or mistreated, physically or verbally by any employee.

1. Any deliberate action, incident or behavior shall be considered to constitute abuse or mistreatment for the purposes of this directive if it is intended to be physically or emotionally painful to the patient or detrimental to the patient's care. Examples of abuse or mistreatment include, but are not limited to the following: Physically striking or assaulting a patient; speaking harshly or rudely to a patient; ridiculing, coercing or threatening a patient; or any similar actions or verbalizations. All employees are responsible for safeguarding patients from abuse or mistreatment. It is the assigned duty and responsibility of an employee who has knowledge of patient abuse or mistreatment to report his knowledge to the appointing authority through proper channels.

2. The appointing authority is responsible for having all charges of abuse or mistreatment investigated and making the final determination as to the appropriate penalty action to be taken if the charge is substantiated.

3. When patient abuse or mistreatment is reported and, in the judgment of the appointing authority, information available appears to support the report, the employee involved shall either be reassigned to other duties or suspended from duty pending investigation.

4. When the appointing authority decides that an investigation is called for under 3 above, he shall appoint a special committee in each separate instance (not a continuing or standing committee) to investigate the report or alleged abuse. The committee shall be composed of at least one member of the clinical staff (therapists), one member of the nursing staff, and one member who works in the same Civil Service Classification and pay range level as the employee who has been charged with patient abuse. The committee shall submit a full written report of its investigation to the appointing authority for his consideration and action. The employee is entitled to union representation at all hearings.

5. The penalty action for abuse or mistreatment, including official reprimand, demotion, suspension, reassignment or dismissal, is discretionary with the appointing authority. No employee shall be continued in an assignment involving direct patient care when, in the opinion of the appointing authority, his actions have demonstrated an impairment in judgment or emotional control which may be detrimental to the safety or health of patients.

6. The appointing authority shall conduct an investigation into the adequacy of supervision and methods of patient care in those cottages or other Center areas in which abuse or mistreatment are frequently reported.

7. Whenever a disciplinary action has been invoked according to Civil Service rules, a copy of such action will be given to the employee.

8. A copy of this policy and procedure shall be given to all new employees and reviewed with them during their first week of employment for the purpose of making certain that each employee has full understanding of all of its provision. Supervisors will insure that this policy and procedure are called to the attention of all employees at least annually.

In case of behavior management problems with a child in your charge, we suggest the following:

1. Do not force the issue at the moment. We do not believe one sample of behavior by a child and its management by the employee will make or break the child-employee relationship. That relationship is based on deeper personality interaction over longer periods between the child and employee.

2. Do discuss the issue with the child and your supervisor or senior employee. Try to learn the child's side and from the experience of the senior employee.

3. A Special Report (Form 55) should be written if it is an unusual incident or one of significance to the child's total treatment, such that the situation should be recorded. Your supervisor will help you with these matters.

4. Do not hold a grudge, even though the patient may do so, as you may feel later.

5. Do discuss the child's behavior with you with his counselor, social worker, or psychologist as time and opportunity permits. This is considered an important part of the work of the staff, i.e., learning more about the children in our charge.

TRUANCIES

The problem of truancy is perhaps one of the greater areas of concern. Children truant because of many reasons. Usually truancy is a sign of some adjustment problem which the child attempts to solve by withdrawal and escape. Some children may be concerned about their home or family sickness; some run away because of impulsive reaction to an incorrect or correct conception of mistreatment by peers or staff; and others truant because of underlying emotional problems which may or may not be directly related to Center placement. In any case, the truancy serves the purpose of calling to the attention of staff that a rehabilitative task remains to be done. Underlay of emotions and basic motivations must be evaluated to correct the situation.

We attempt to reduce truancy to a minimum by keeping a reasonably close account on the whereabouts of children at all times, by developing a program that is acceptable and satisfying to the children, and by attempting to understand and remove the cause of truancy in individual cases. The new employee would do well to learn quickly the names of children in his charge. Learn the truancy pattern; learn to recognize signs of discontent in children early and apply related corrective measures. New employees finding a condition of truancy with a child in his charge should report the matter at once to his supervisor and learn the departmental routine in such situations.

Our final objective in the areas of punishment, discipline, self-discipline and management, is guidance toward acceptable behavior in accordance with community standards. To achieve this, even partially, it is often necessary to set the training goal beyond what might be the eventual level of acceptable behavior for the child as a community citizen. This allows for some regression upon discharge.

Steps to be taken in the event of truancy incidents:

1. An immediate effort should be made to locate any child missing from his program assignment.

2. When it is determined that a child is truant, the Child Care Supervisors are notified.

3. A Special Report covering the incident is written by the employee directly in charge of the child and a teletype is prepared by the cottage. Both of these are forwarded to the Child Care Supervisors.

4. If the child is truant after 12 M he is an official truant and so carried on the cottage journal until further written notice. If he is returned before 12 M on the day of truancy he is carried as an unofficial truant.

5. Overstayed leave situations are not considered truancies as such.

6. Again, prevention is the key to care of the truancy problem. Knowing your children, being sensitive to their moods and eliminating and giving the child knowledge of your concern for his problems are all good routines of prevention.

7. It is within the area of possibility to consider an employee neglectful of duty and even abusive to the child where the truancy is a direct result of the employee's ignorance or neglect within the above.

GENERAL CHARACTERISTICS OF THE WAYNE COUNTY CHILD DEVELOPMENT CENTER RESIDENT POPULATION

(Abstracted from a September 30, 1968 report of the Psychology Department for staff orientation)

The Center has been in the process of reducing total population for a number of years. This is done with the same number of staff; therefore, the per child staff time and attention should unquestionably become more favorable. Obviously the cost to the taxpayer increases as the Center population decreases, inflation continues, and salaries consistently use over 87 percent of the total budget.

Table I shows some of these factors:

TABLE I

AVERAGE DAILY ATTENDANCE
MEAN AVERAGE DAILY ATTENDANCE FROM 1963-1967

Year	1963	1964	1965	1966	1967
Mean	571	498	511	493	396
Cost per day per child	$11.74	$13.65	$14.21	$15.02	$19.94

Where do our children come from?

Table II shows that most of our children come from the Wayne County Juvenile Court and the Detroit Public Schools. This has been a more recent trend. Previously the Detroit Public Schools sent the most cases to us. In recent years almost all (often well over 90 percent of admissions) are voluntary commitments. This means the child's parents may withdraw the child at any time. This has both advantages and disadvantages to his treatment. Other factors about the source and kind of child admitted to the Center are reported in Table II.

TABLE II

ADMISSIONS TO WAYNE COUNTY CHILD DEVELOPMENT CENTER
REPORTED AS OF AUGUST 30, 1968

Factor		More	Equal	Less
White			X	
Non-White			X	
Boys		X		
Girls				X
Non-White on public assistance		X		
Family separation and desertion, Non-White		X		
Divorce, White		X		
From court	(42 percent)	X		
From Detroit Schools	(19 percent)	X		
From Out-County				X
From other institutions:				
	Boys			X
	Girls	X		

Residence of the children admitted to the Center is shown in Table III, with their average intelligence. Sixty percent of the Center population comes from Areas I - IV of the Inner City. These areas correspond to the Model City efforts since the riot and the highest crime areas. It is reported that over 40 percent of crimes from these areas are committed by youths.

TABLE III

Percent of Admissions		Average I.Q.
Area I (Model City - See city map)	20%	65.5
Area II	12%	73.4
Area III	19%	75.0
Area IV	9%	74.0

Areas bordering the Inner City provide 20 percent of residents. These boys and girls have an average I.Q. of 76. Out-of-the-city admissions constitute 20 percent of the resident population and an average I.Q. of 76.3. The intelligence (as measured by psychometrics) of residents thus increases in areas outward from the Inner City. Another change in resident characteristics may be noted: from the Inner City center outward, the number of non-white admissions decreases, the number of admissions from families on public assistance decreases, and the number of families receiving attention from social agencies decreases. Families of residents become more intact legally and socially outward from the Inner City.

Intellectual and Academic Achievement Levels of the Children

Half the population falls within the I.Q. range of 70-84, 31 percent between I.Q.'s of 55-69, and 15 percent above the 85 I.Q. Only 4 percent represent the moderately retarded (below 54 I.Q.) and this small group is probably intellectually too dull to respond to the total program. Resident children thus do not require the intensive nursing care characteristics of the more profoundly retarded and only minimal physical handicaps exist within the population.

Almost half the residents represent gross underachievement in academics (as determined by achievement testing as related to their I.Q. and chronological age), while an additional 35 percent are found in the moderate underachievement category. None were considered overachievers.

In general, regardless of race or sex, the brighter the child the higher the educational attainment. However, within I.Q. categories, as the child gets older the academic achievement does not keep pace with expectations based upon intellectual (I.Q.) functioning level and age. Within special education classes in public schools, however, the average grade gains also decrease as students grow older.

A greater percentage of non-white (76 percent) than white boys (64 percent) score within the I.Q. range of 70 and above but the situation is reversed with girls. This sex difference is probably caused by social conditions and selection of particular children for admission. Duller girls, as a group, are less attractive, more protected, more conforming, and less prone to sexual acting out. Girls most often come to the Child Development Center for social correction.

I.Q.'s above 85 - 15 percent of the population cannot be considered retarded as determined by I.Q. score alone. Problems in social adaptability and inadequate academic achievement, however, are present and contribute to the referral and admission. They are functioning below their I.Q. score. In addition to the mental handicap, other factors are to be considered for admission. Thirty percent were admitted below 10 years of age, representative of hyperactive conditions, and 40 percent were grossly deficient in academics. A combination of behavior and academic problems contributed to their referral. The degree of cultural deprivation is apparently unrelated to the admission of this group. No differences were found in the proportions of non-whites versus whites or boys versus girls within this I.Q. range.

In addition to the above, the children have rather serious personality problems that contribute to their need for institutional training. Table IV shows some of these.

TABLE IV

PSYCHOLOGICAL PROBLEMS OF
WAYNE COUNTY CHILD DEVELOPMENT CENTER CHILDREN

1.	Minimal (basically retarded)	8%
2.	Temporary situations causing disturbed behavior (transitional disorders)	27%
3.	Shy, excited, immature (behavior disorders of childhood)	45%
4.	Gross immaturity, suggestibility, dependency, acting out, emotionally deprived, un-socialized, explosive, hysterical, antisocial, and passive aggressive (personality disorders)	14%

5. Anxiety, Fearfulness, shyness and withdrawal beyond (3) 3%

6. Lack of reality thinking - psychoses, awaiting transfer 3%

The above include a high percentage of delinquent and pre-delinquent patterns of behavior in the community by the children. Many times it continues here. Truancy, theft, sexual problems, fighting, and various aggressive or withdrawal behaviors are symptoms that require our daily attention and positive response to remotivate the children to more socially acceptable behaviors.

How old are the children? How long do they stay at the Center?

Table V shows the age and total percent of the 1966-67 population in each age group. It shows that the population is mostly all school age, averaging 13 or 14 years, and with only 8 percent under 10 or over age 18.

TABLE V

Age	Boys		Girls		Total	
	No.	Percent	No.	Percent	No.	Percent
Under 10	19	6	4	3	23	5
10 - 12	109	32	22	18	131	28
13 - 15	156	46	70	58	226	49
16 - 18	49	14	20	17	69	15
18/	7	2	5	4	12	3

Average Age (1967) - Boys 13
Girls 14

Attendance (10-1-68) - Boys 230
Girls 67

Total 297

The period of residence for children varies considerably according to age as illustrated in Table VI. The younger children stay longer, due for the most part to social factors and family status. Most children who are admitted young have experienced a total lack of school achievement and home adjustment. They are frequently foster home failures, in need of several years of a combination of remedial education and training. These children are often hyperactive but non-delinquent.

TABLE VI

RELATIONSHIP BETWEEN AGE AT ADMISSION AND LENGTH OF RESIDENCE

Age in years and months at time of admission	Months in Residence 12 - 18	30 - 36	48 - 54
9-11 and Under	94%	85%	82%
12-0 - 12-11	80%	40%	29%
14-0 - 14-11	64%	20%	31%

The average age of children at admission over a ten-year period has been 12 for boys and 13 for the girls.

Almost all children admitted under ten years old were in residence 12-18 months later and after 48-54 months, 82 percent remained in residence. Older patients, however, the 14-year-olds, return to the community much sooner. Over half of the 14-year-olds are no longer in residence one-and-one-half years after admission. Only 20 percent of them remain for 30 to 36 months. The average length of residence is thus related to the chronological age of the patient. The reason for admission (delinquency in the older patients) may also affect the length of stay. At present, a shortage of work evaluation and work training programs exist in the community which are appropriate for the habilitation of these older adolescents. The Child Development Center is stressing program development in these areas as many resident adolescents do not have adequate homes to which they can return. While the younger patient needs special education and therapeutic services in residence, the older patient also needs vocational education and training.