The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services

Unclaimed Children

with the assistance of Lynn Olson
THE CHILDREN'S DEFENSE FUND exists to provide a strong and effective voice for the children of America who cannot vote, lobby, or speak for themselves when critical policy decisions are made that affect their lives. We pay particular attention to the needs of poor, minority, and handicapped children. Our goals are to educate the nation about the needs of and encourage preventive investment in children before they get sick, drop out of school, or get into trouble. A private organization supported by foundation and corporate grants and individual donations, CDF has never taken government funds.

Our staff of child health, education, child welfare, and child development specialists, researchers, lawyers, organizers, and public education specialists conduct research and publish information on key issues affecting children; monitor the development and implementation of federal policies for children; provide regular information, technical assistance, and support to a network of state and local advocates; pursue an annual legislative agenda for children in the Congress; and litigate on a few selected issues of major importance to children when other avenues for advocacy do not work. We also educate many thousands of citizens annually about children's needs and responsible public policy options for meeting those needs.

CDF is a national organization with roots in communities across America. We maintain state offices in Mississippi and Ohio and have staff who live and work in Massachusetts and New York. We have developed cooperative projects with groups in Georgia, Tennessee, Alabama, New York, New Mexico, Kansas, Maryland, Connecticut, Pennsylvania, and California, and work closely with a range of national networks.

Marian Wright Edelman, President
Rachel B. Tompkins, Executive Director
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We also want to acknowledge individuals without whom this study could not have been done and whose sustained help made the final report possible. First, state and federal children and adolescent mental health officials generously shared the little information available, their victories and frustrations. In particular, Dr. Lenore Behar, Chief of Child Mental Health for North Carolina, was a tremendous help, educating us about the complexities of child and adolescent mental health and making it possible for us to examine the North Carolina system in great detail. We are also grateful to Susan Manduke, former Staff Director of State Mental Health Representatives for Children and Youth, and current Deputy Director of its parent organization, The National Association of State Mental Health Program Directors, for sharing her organization's information with us. And we want to thank William Buzogany, M.D., Chairman of the National Consortium for Child Mental Health Services, for his continued interest and support of the study.

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In addition, we want to acknowledge the generous support and interest of the William T. Grant Foundation, which provided funds for the study, the Commonwealth Foundation, which helped publish the report, and the Itelson Foundation, which made it possible for us to hold a small working meeting with selected public officials, citizen advocates, lawyers, and service providers to explore critical issues affecting child and adolescent mental health.

Finally, this report reflects the help and backup provided unstintingly by CDF staff. I am especially grateful to Lynn Olson, who, with great sensitivity, took on the task of developing and writing the program descriptions in the report, and who cheerfully pitched in to do the editing and see that loose ends were tied; to Franna Diamond, who made a number of site visits and conducted key interviews; to Carol Golubock, who directed the legal research for the report and developed the major memo on litigation; and to Judy Tolmach and, especially, MaryLee Allen, who tirelessly critiqued drafts of the report and provided unfailingly thoughtful advice.

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NECLAIMED CHILDREN is a depressing report at a depressing time. Not only are seriously emotionally disturbed children and adolescents a largely ignored group, but already inadequate state and federal responses to their needs are diminishing in the face of budget constraints. Too little state-level advocacy on behalf of these children is evident, and federal leadership is virtually nonexistent.

Our study attempted to find the answers to eight basic questions:

What problems do troubled children and their families face in searching for mental health services?

What types of mental health programs really make a difference for disturbed children and adolescents?

How do state mental health departments' policies and practices affect what happens to children and adolescents?

What statutory and administrative protections do troubled children and adolescents have to ensure they are not inappropriately treated or placed?

How do state agencies other than mental health departments respond to the needs of troubled children in their care?

What innovative things are states doing in terms of administering, planning, monitoring, and funding mental health services for children and adolescents?

What role have federal policies and dollars played in facilitating or hampering the delivery of appropriate mental health services to children and adolescents?

What advocacy exists on behalf of children and adolescents who need mental health services?

We sensed and now know that public agencies with responsibility for disturbed children and adolescents are spending money on these children too late and often inappropriately. Preventive or intensive community-based services are in scarce supply. Overreliance on costly institutional and residential care is the norm. Although the few dollars available in this area could be used to provide services to children in their own homes and communities, they are not, and large numbers of children remain unserved or inadequately served.

This is the opposite of what should be happening. It is hard to understand why it is so difficult to create a rational system of mental health care for children so obviously in need. We hope this report will focus attention on what we as a nation are doing for troubled children and contribute to a reexamination of both the quality and direction of our efforts.

Despite what is documented here, all is not grim. Scattered throughout the country we found rays of sunshine—programs that work at a reasonable cost and meet individual children’s needs. In Chapter II, we describe some of these innovative, responsive programs. Unfortunately, they are a mere drop in the bucket and are struggling to survive.

At a time when our national government is seeking to shift more and more obligations onto states and localities, child mental health is a good area in which governors and state legislators can take real leadership. They already have primary responsibility for the fate of these vulnerable children and families. However, with a few exceptions, which we applaud, they have not begun to exercise that responsibility.

The general lack of state momentum and absence of federal guidance regarding child mental health has posed a question in our minds: whether without strong federal direction, states will do what is right and needed for their own children. The record is dismal, but we look forward to working with states to see if it can be changed.

Troubled children and adolescents also need to be part of the broader advocacy effort on behalf of children in ways they have not been before. We hope this report lays out some of the ways that advocacy groups focusing on child welfare, child health, education, juvenile justice, or general mental health issues can place the special needs of disturbed children higher on their agendas for action.

We ourselves have gained a great deal of firsthand knowledge during the course of this study by trying to plan and develop, in the District of Colum-
bia, "City Lights," a community-based program for emotionally troubled adolescents. This program will open in the winter of 1982/1983.

Finally, I would like to thank Jane Knitzer, the author of this report, and Lynn Olson and MaryLee Allen, for the tremendous amount of work they have put into producing a perceptive and worthwhile study. I hope it and the children gain the audience they deserve.

Marian Wright Edelman
Overview

Alissa is three years eight months old and already in serious trouble. She is overly active and disobedient at home, demanding and clingy with adults, bites her nails, cannot sleep, and wets her bed nightly. At her day care center she is aggressive and uncontrollable. She actually injured several children, and parents are insisting she be dismissed.

Carlos is in eighth grade. In the sixth grade he was diagnosed as severely emotionally disturbed, but the school had no special teachers so he was placed on homebound instruction. That meant he received one hour of tutoring each day. In the seventh grade he was permitted to return to school. This year his behavior has again become increasingly disruptive; he frequently talks back to teachers and hits other children. At other times he stops paying attention to what is happening around him. The school has repeatedly suspended him for short periods of time. Three months after school started, Carlos was picked up on charges of stealing and placed in a children's center where he attacked two staff members.

Joey, at age 14, is a seriously disturbed Black child. His grandmother is his anguished parent. At age five Joey was described as a cheerful, learning disabled child with a low IQ (56) who was devoted to his mother. When he was seven, he watched as his mother was brutally killed. Not long after, Joey began to stutter badly, refused to pay attention to adults, and stopped making eye contact with anyone. A psychiatric evaluation called for intensive treatment but Joey received none. Two years later, in yet another evaluation, a psychiatrist noted Joey was still preoccupied with his mother's death but seemed to want help. A strong therapeutic relationship was recommended. Again Joey did not get services. Even the agency conducting the evaluation rejected him. His grandmother continued to search for help with no success. Joey has now been rejected by a state facility for the retarded because his problems are emotional; he has been rejected by ten other public and private facilities, including a very good residential treatment center, which said his IQ was too low, and the state psychiatric hospital for children. His grandmother, now quite elderly, is frightened. She fears she will die before Joey gets help.

Our survey of all 50 states and the District of Columbia found mental health services for children and adolescents like Alissa, Carlos, and Joey a scarce commodity. Even the most troubled children are unserved.

Of the three million seriously disturbed children in this country, two thirds are not getting the services they need. Countless others get inappropriate care. These children are “unclaimed” by the public agencies with responsibility to serve them.

The most readily available “help” for these children remains the most restrictive and costly—inpatient hospital care. Studies suggest that at least 40 percent of the hospital placements of children are inappropriate. Either the children should never have been admitted to the institutions or they have remained there too long.

States are emphasizing the development of traditional residential placements. Yet evidence shows intensive nonresidential services in the community benefit children without isolating them and are cost effective. Of the 44 states responding to our survey, 18 were working to increase residential care. In contrast, states had almost no capacity to provide nonresidential services, like day treatment, and were not working to create these services.

Only seven state departments of mental health have taken the first, limited steps to create a range of nonresidential, residential, and case advocacy services for troubled children and to develop the policy, fiscal strategies, and leadership that make effective child mental health programs possible.

States seldom take into account the special needs of troubled children and the protections due them. Although 22 states now differentiate between children and adolescents in procedures for voluntarily admitting minors to psychiatric institutions, only six states routinely mandate child-specific reviews once children are in hospitals. Only 17 provide children and adolescents the right or access to counsel in voluntary admission proceedings.

The federal government has not encouraged states
to create mental health services sensitive to the special needs of children. The bulk of federal funds encourage medically oriented inpatient care, while federal dollars for community-based services have steadily decreased. Only about 17 percent of community mental health center funds are spent on children, and under the new Alcohol, Drug Abuse, and Mental Health Block Grant the amount of money states are required to spend on troubled children is $0.

Yet it need not be this way. Scattered across the country we found a limited number of exciting programs that work with children in their own homes and communities; involve parents in their children’s treatment; show sensitivity to children’s ages, developmental levels, strengths and weaknesses, and ethnic and cultural heritage; and allow children to move easily from one setting to another, if necessary by advocating on their behalf with other agencies. Sadly, these programs have not been replicated in large numbers and many are still struggling for survival.

All the knowledge needed to diagnose and help children with serious emotional or behavioral difficulties is not available. But the ways in which mental health services are now funded, organized, and delivered do not begin to reflect what we do know. As a result, children’s lives are wasted, families experience needless agony, and public dollars are poorly spent.

Many of the seriously troubled children and adolescents needing mental health services will cost the states money, if not in one way then in another. In the absence of mental health services, these children have or will become the fiscal responsibility of other systems, like child welfare, juvenile justice, or education. Some will probably require costly long-term institutional care throughout their lives. The public policy choice is not whether to spend money but how.

Unclaimed Children examines why, when cost-effective community-based services are possible, children and adolescents do not get what they need. And it explores what responsible officials, concerned advocates, and the public at large can do about it.

How We Did This Study

A number of steps were taken in preparing this report. We surveyed mental health departments or their counterparts in all 50 states and the District of Columbia regarding their organizational structure and fiscal policies for troubled children, the services they provide for these children, and the innovative efforts they have made on their behalf. We analyzed each state’s statutes regarding the voluntary commitment of children to psychiatric hospitals and reviewed the major litigation that has been brought on behalf of disturbed children and adolescents.

We read relevant professional literature and state studies; conducted telephone interviews with service providers, lawyers, parents, public officials, and advocates around the country; made site visits to a number of mental health programs; and met with officials in four states. Last, we analyzed the major federal programs providing funds for disturbed children or affording protections to children and adolescents who need mental health services.

We gathered all this data between the fall of 1979 and the summer of 1982. The state survey was done in the spring of 1981.

Highlights of Our Findings

The Children and Their Families

Two out of three seriously disturbed children and adolescents do not get any services. Certain groups of troubled children are particularly unlikely to get appropriate mental health care when they need it: disturbed adolescents, especially those with serious or multiple problems and those who have been in hospitals or may face hospital placement, disturbed children in out-of-home care under the custody of child welfare or juvenile justice agencies, disturbed children from poor, often disorganized families that cannot meet the children’s special needs, and
disturbed children with mentally ill, alcoholic, or substance abusing parents.

Parents receive little assistance in finding services for their children and are either ignored or coerced by public agencies:

respite and support services to relieve the stress on parents are unavailable;
parents with children needing residential care must often give up custody to get them placed;
few parent support groups exist for the parents of troubled children;
few advocacy efforts are aimed at relieving their problems.

**State Departments of Mental Health: Minimal Services**

Only a handful of states are even beginning to meet their service responsibility toward children with mental health needs. For the most part, if states are developing any services for children and adolescents, they are focusing on traditional residential care rather than more cost-effective alternatives.

Only one state was systematically trying to close down psychiatric institutions for children and replace them with less restrictive, community-based services. One third of the states responding to our survey expressed a need for more long- or short-term hospital beds for troubled children and adolescents. In a few states, children and adolescents are still placed routinely on adult wards. Further, states have little information about the quality of care in hospital facilities and do almost no monitoring of these institutions.

Some 18 states reported working to increase the residential treatment available to children, yet even in this area the need far outweighs allocated funds.

States have not used their mental health monies to encourage the development of nonresidential community-based programs that could keep children with their families and in their own communities. Funding patterns often discourage the development of such services. Few states have used fiscal incentives to reverse the barriers to creating community-based programs.

State departments of mental health have focused woefully few resources on troubled infants, young children, and their parents and have not stimulated the development of early intervention services. Only three states have legislation mandating such programs be developed. Just 12 states report systematic statewide efforts to fund or create services to identify and care for troubled children before problems intensify.

States provide virtually no case advocacy to ensure children get services they need in a coordinated fashion. Only one state reported funding case advocacy for troubled children as a reimbursable mental health service and recognized it as such in regulations.

Only seven state mental health departments have taken even the first, limited steps to create a "system of care" for children and adolescents that includes a full range of mental health services, delivered in a coordinated fashion. In these states there has been a sustained effort to increase the range of mental health services available, ensure services are linked together within geographic areas, and counter the rigidity often built into mental health funds.

**State Departments of Mental Health: No Policy Focus**

Few mental health departments reflect a policy focus on children and adolescents in their administration, fiscal policies and practices, planning strategies, standards setting, monitoring, training, or attempts to protect children's rights and advocate on their behalf.

Only 21 states indicated they had a special children's unit within their mental health department, staffed by people solely responsible for and knowledgeable about children's mental health issues.

At best one third of the reporting states could track all or part of their expenditures for children's mental health services. Where such information is available, the amount spent on children is clearly not commensurate with the need.
Few states have tried to do any focused mental health planning on behalf of troubled children and adolescents. Thus, there is no good way to set priorities and make long-range changes in the availability of quality services.

Although 22 states now differentiate between children and older adolescents in their procedures for voluntarily admitting minors to psychiatric institutions, only six states routinely mandate child-specific reviews once children and adolescents are in hospitals.

Other State Agencies: Little Specialized Help

Evidence suggests in some states a significant proportion of the hospitalized children are under the care of child welfare systems, not their own parents. Yet child welfare agencies have done little to prevent the need for removing seriously troubled children from their homes, to reunite troubled children with their families, or to provide less restrictive alternatives than inpatient treatment. Child welfare agencies have also ignored the mental health needs of the many abused children and children of emotionally disturbed parents for whom they are responsible.

States are mandated to provide all handicapped children a free appropriate education under the federal Education for All Handicapped Children Act. Yet implementation of the act on behalf of severely emotionally disturbed children has been limited. Many of these children are still placed on home-bound instruction, excluded from school, or routinely suspended.

There have been almost no attempts to get state mental health, child welfare, juvenile justice, and education departments working together on behalf of disturbed children and adolescents for whom they all have some responsibility.

The Federal Role: A Shadowy Presence

Targeted federal dollars for community-based services for children and adolescents are diminishing. Between 1972 and 1980 federal expenditures in this area were about $20 million a year. In 1980 mental health funding for children under the Mental Health Systems Act was $10 million a year. Under the new Alcohol, Drug Abuse, and Mental Health Block Grant the amount targeted at troubled children is $0. Yet past evidence shows even limited federal dollars have been an important catalyst for developing children's mental health services.

Specific federal initiatives to encourage the development of mental health services for disturbed children and adolescents have been short lived. Between 1972 and 1981 three such programs were created and eliminated. A fourth initiative failed to pass Congress.

When the federal government has funded model programs, it has provided almost no information to states so they could replicate the efforts; nor has the federal government gathered information on the effectiveness or cost of such programs. Even statistical data on the number of children in this country receiving mental health services are unavailable or out of date.

Advocacy: A Still, Small Voice

There is only a limited organized voice on behalf of troubled children and adolescents who need mental health services. Few general child advocacy groups or mental health associations have focused on children's mental health needs. This leaves professionals, who have often been the best advocates for disturbed children, feeling isolated and frustrated.

Children's mental health needs have not been a visible or political issue. No one has systematically urged state agencies and elected officials to make commitments to help seriously disturbed children and adolescents who need their concern.
Key Recommendations

To get public agencies to "reclaim" responsibility for seriously disturbed children is a hard task and involves specific action in six areas:

Strengthening Services and Systems of Care Within State Mental Health Departments

Conduct a mental health inventory to identify specific children and adolescents now served inappropriately or denied or awaiting services.

Develop fiscal incentives at the state and local level to create a coordinated range of services for troubled children and adolescents in which the quality of care is monitored regularly.

Promulgate specific treatment and placement standards for disturbed children and adolescents that ensure children are placed in hospitals only when necessary; are provided the least restrictive care, close to their own homes and communities; have access to advocacy on their behalf; and have their families involved in their treatment as much as possible.

Develop a strategy to increase training for state officials making decisions about troubled children and adolescents and for others working with disturbed children, like case workers, probation officers, and teachers.

Increasing the Mental Health Policy Focus on Children

Establish an administrative unit for child and adolescent mental health within the state mental health department, staffed by knowledgeable professionals with the capacity and authority for leadership.

Ensure that a specific child and adolescent mental health plan is developed, made public, and updated periodically. The plan should include detailed strategies and timetables for expanding intensive nonresidential, residential, and therapeutic case advocacy services as well as interagency service efforts at the state and local levels.

Create an annual child and adolescent budget, based on the mental health plan, with incremental increases in funding for specific, needed services over a set period of time.

Protecting the Rights of Children and Adolescents in Need of Mental Health Services

Enact and enforce statutory protections to ensure hospital placements occur for children and adolescents only after documenting rigorous efforts to identify less restrictive appropriate placements.

Ensure periodic reviews are required for all children in out-of-home placements, particularly those in psychiatric hospitals, and see that, regardless of whether reviews are administrative or judicial, children have access to counsel.

Scrutinize and strengthen, where necessary, existing protections for seriously disturbed children and adolescents in state custody.

Increasing the Response of Nonmental Health Agencies to the Mental Health Needs of Children and Adolescents

Establish state-level liaison efforts among state child serving agencies to facilitate the pooling of fiscal, staff, and program resources and ensure the development of appropriate nonresidential and residential services for seriously disturbed children and adolescents under the care of any state agency.

Establish cross-agency mechanisms for defining policy problems and service gaps facing seriously disturbed children and adolescents and for monitoring the quality of care.

Implement services, training, and other supports in child welfare, juvenile justice, and education agencies to ensure they meet more appropriately the needs of disturbed children in their care.

Maximizing the Impact of Existing Federal Programs

See that disturbed children and adolescents receive
a fair share of funds under the Alcohol, Drug Abuse, and Mental Health Block Grant, including the use of targeted alcohol and drug prevention monies for alcoholic or addicted children or the children of substance abusers.

Ensure that the Education for All Handicapped Children Act, P.L. 94-142, is maintained and that its regulations are left untouched.

Ensure that the Adoption Assistance and Child Welfare Act of 1980, P.L. 96-272, is maintained and that funds are used to help disturbed children remain in their own homes and to get troubled children out of foster care and back with their own families or, where appropriate, into adoptive families.

**Increasing Effective Advocacy**

Strengthen the attention child advocacy groups and mental health associations give to children and adolescents needing mental health services. Develop joint agendas and coalitions with advocacy groups concerned with child welfare, juvenile justice, and education, and encourage the formation of state-level groups on behalf of disturbed children and adolescents.

Establish local and regional forums for professionals, parents, advocates, and others to identify and resolve cross-system administrative, fiscal, and other problems within a specific area.

Give public support to the efforts of child and adolescent mental health officials and other government officials and legislators to strengthen services for disturbed children and adolescents. Oppose efforts to further weaken such services.

Let state and elected officials know child mental health advocates are monitoring state action and inaction on behalf of troubled children and adolescents. Create a visible advocacy presence.

**Notes**

1. Adapted from J. Jones, "Trapped Between the Cracks, Nowhere to Go for Treatment," *Rochester Democrat and Chronicle*, June 3, 1979, Sec. A, pp. 1, 3.
2. See footnote 1, Chapter II for an explanation of this estimate.
4. For instance, in 1975 Texas estimated that on a statewide basis 47.1 percent of the children needing inpatient care were served, compared to 2.1 percent of the children needing emergency care, 4.4 percent of the children needing outpatient care, and 6.8 percent of the children needing day or evening programs. Texas Department of Mental Health and Mental Retardation, "Report of Task Force on Services to Emotionally Disturbed Children," mimeograph (Austin, Tex.: Department of Mental Health and Mental Retardation, May 1976).
5. For example, a 1979 audit of the cases of 25 hospitalized children in the District of Columbia found 44 percent of the children could have been served as outpatients. A 1977 survey of 1,001 children in New York State found only 41 percent were appropriately hospitalized. A 1980 Massachusetts survey estimated 40 percent of the adolescents in state hospitals could have been diverted to community placements had these placements existed. See D.C. Coalition for Youth, "Youth Work News," June 1980; R.P. Ingalls, "Results of the Children and Adolescent Level of Care Survey," mimeograph (Albany, N.Y.: New York State Council on Children and Families, no date); and Massachusetts Department of Mental Health, Children's Division, "Results of State Survey of Inpatients," mimeographed planning draft (Boston: Department of Mental Health, 1981).
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How the Families Fare
The Children and Their Families: Some Profiles

It is hard to talk about children and adolescents who need mental health services. Terms like "mentally ill," "behaviorally disordered," or "psychotic" take away their uniqueness and pain. Discussing the special needs and problems related to their age—preschooler, school-aged, adolescent—helps. But other facts may assume overwhelming importance in their lives, such as whether they are in state custody or in psychiatric hospitals.

In fact, we do not even know how many emotionally disturbed children there are or how many receive services. Estimates vary and none is convincing.

In 1969 the Joint Commission on the Mental Health of Children estimated that 0.6 percent of all children suffer from psychoses, 2 to 3 percent from severe disorders, and 8 to 10 percent from emotional disturbances requiring some treatment.

In 1978 the President's Commission on Mental Health stated that 5 to 13 percent of all children and adolescents, or 3 million to 9 million children, require some type of mental health service.

Whatever the number, we know that too few children are getting what they need. Each year just under one million children and adolescents, or 2 percent of all people under 18, receive mental health or related services.

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Infants

Willie's muscles were more tense at birth than those of most babies. His mother, who had been abandoned as a baby and beaten as a young child, was sure Willie was rejecting her. She became nervous, then angry. When Willie cried, she ignored him. By the time he was one month old, Willie was avoiding his mother's gaze, and she was suspicious and guarded.

Fortunately, Willie's mother was referred to a special clinic where one therapist was assigned to work with her, another to work with Willie. Willie's therapist, a pediatric nurse trained to work with babies, devised a game. Since Willie ignored real faces, she drew a face on cardboard and got him to watch that. Then she would lower the cardboard face to reveal her own. Willie found this interesting and played the game tirelessly. In a few weeks he preferred a human face to the cardboard one. But his mother was still moody and unpredictable. Some days she would not let Willie's therapist into the house. It was several months before she played the face game with Willie herself.

By the time Willie was eight months old, he looked much better, but his mother's progress was lagging. Finally, a breakthrough came. One day as the therapist drove Willie's mother around the neighborhood helping her to find a new apartment, the mother began to talk about feeling isolated. By the time Willie was 13 months old, she showed a heartening change. She looked happy and interested as she helped Willie play with wooden pegs and talked to him on a toy telephone.

Willie and his mother were part of a small, exciting new effort by clinicians to help severely troubled mothers and infants. But there are many Willies with mothers like his who do not get any services. These parents and children get off to a bad start. Sometimes the problems arise because an infant has birth-related difficulties that place too many demands on parents. Sometimes a healthy child is born into a disorganized family that cannot meet his basic needs. And sometimes troubled infants are born into families that already have problems.

Preschool Children

Preschoolers need mental health services for a variety of reasons.

Frankie, at age four, was referred to a therapeutic preschool program by his day care center. He had been expelled from the center for severe behavior problems, disobedience, tantrums, hurting other children, and disrupting the program. At the home he
shared with his 18-year-old mother and alcoholic grandmother, Frankie deliberately drank charcoal starter fluid. At first his mother denied that Frankie had problems. Gradually, she responded to the staff and parents at the therapeutic preschool, and Frankie began to change his behavior.

Sara is seven years old. As a toddler she was identified as psychotic. She could not follow directions, dress or feed herself, had no language, and often screamed uncontrollably. Fortunately, Sara was enrolled in a special home training program. After intensive work it became clear that she was not psychotic but severely language impaired. After a year in the program, she was enrolled in a special kindergarten class. Now she attends a regular first grade class, although the program she was in has been “defunded.”

Frankie and Sara were both lucky. Most troubled preschoolers are not. Although we know how to help troubled three-, four-, and five-year-olds, much of that knowledge remains locked away, hidden in reports of past demonstration projects or carried around by preschool staff whose programs' funding has been eliminated or curtailed. The costs of not reaching children like Frankie and Sara are high but hidden. Without help Sara might have withdrawn further and further into her own world and ended up in residential treatment or a psychiatric hospital when she grew older. If Frankie continued to be disobedient and aggressive as a teenager, he might have gotten into trouble with the juvenile justice system. For many disturbed preschoolers the costs do not become obvious until the children age and make too many demands on parents and teachers or become so “difficult” that placement and high-cost intensive services are required.

Jerry is a small, wiry, very sad third grader. He is performing just below grade level, although an early IQ test suggests he is gifted. For the past two years, Jerry's world has been falling apart. Early in first grade, Jerry's favorite grandfather died, and his mother suffered a miscarriage. During the second grade, his parents were divorced. Concerned about dramatic changes in Jerry's behavior, Jerry’s parents sought help, and Jerry began to see a therapist at a local mental health clinic. Although Jerry’s parents first were told that the school would pay for therapy, the school refused because academically Jerry was doing all right. The parents had some insurance coverage, but it was used up by the time Jerry was in third grade. So Jerry was told he could not see his therapist any more. Jerry was very attached to the therapist. When he faced the prospect of another loss, his school work began to deteriorate rapidly. One day he was found riding his bike in the middle of a heavily trafficked street. His parents again approached the school. This time officials agreed that Jerry needed help and suggested assigning him to an intern who was doing field work as an elementary school counselor. They refused to pay for Jerry to continue with his own therapist.

Jena is six. She has already been in three foster homes. In the last one she began playing with fire. Her foster mother sought help from a local hospital, which admitted Jena to its psychiatric unit—several beds on the medical floor for patients of all ages. After just one day, staff requested that Jena be transferred to a state child psychiatric hospital. At the “children’s” hospital, officials would not let the foster mother go to the ward with Jena. When they tried to separate Jena from her foster mother, Jena began to scream and hit ferociously. As a result, this six-year-old child was placed in seclusion, and her foster mother was prevented from visiting her.

School-Aged Children

Once children become school-aged their emotional or behavior problems tend to involve schools in some way. The children do not learn as they should, do not make friends, or do not behave. Consider Jerry and Jena.

School-aged children like Jerry and Jena account for many of the children served through community mental health centers and fall into the age range most acceptable to those providing residential treatment. They are the most likely to be identified and served under the Education for All Handicapped Children Act and benefit from a range of school-based interventions.
However, to benefit from these services, children must live in the right place, have problems that are acceptable to the helpers (particularly those providing residential care), and live in communities where different agencies work well together on behalf of children. When this is not the case, many school-aged children go without help and continue to show problem behaviors as adolescents.

Adolescents

Daryl is a 14-year-old who was enrolled in the Positive Education Program's day treatment center (see Chapter 11) after going two years without receiving any educational or treatment services. He had been expelled from school for his constant use of abusive language, his inability to stay in his seat for more than three or four minutes, his destruction of school property, and his frequent use of weapons, pipes, bats, and other dangerous objects. Before coming to the day treatment program, he was rejected by ten residential treatment services.

In day treatment Daryl's behavior was initially violent and disruptive. Academically he functioned at a second or third grade level. Gradually, he began to improve, responding to the support of one teacher-counselor and to the incentive of going on camping trips if he worked hard. In the past Daryl's mother had avoided all discussions regarding her son with schools, courts, and mental health personnel. With the aid of another parent in the day treatment program, she became part of the helping team. After one and one-half years in the program, Daryl's behavior was so improved he was able to return to his home school, although serious academic problems remain. (Cited with permission from the Positive Education Program.)

Virtually every state and national report identifies adolescents like Daryl as a desperately underserved population. Simultaneously, data suggest adolescents are being admitted to psychiatric hospitals, especially private ones, at increasing rates.

Adolescents who plague and challenge the mental health system typically are not psychotic or overtly bizarre, but sporadically or chronically aggressive and violent. They have multiple needs, not only for mental health services but for educational, vocational, and health programs. Few traditional mental health agencies report efforts to reach out to these adolescents, who, by the time they are older, constitute some of the mental health system's least favored and least served clients.

Children in Hospitals

Children of any age who end up in psychiatric hospitals or state custody are particularly vulnerable to neglect and inappropriate care.

Ruth has had severe mental health problems since age two. Now she is 12. She is agitated and miserably unhappy, imagines everyone is against her, and strikes out at others at random. In fifth grade she was suspended from school for hitting a teacher and breaking her foot. Since then Ruth has been in and out of residential placements and psychiatric hospitals. She runs away from most placements and once fled in the winter without coat or shoes. Other places push her out. Last fall she was immediately discharged from a private psychiatric hospital when she assaulted a physician. More recently, she was evicted from another inpatient setting where she was described as "dramatically aggressive." Now Ruth is at home and her behavior is deteriorating rapidly. Her parents feel helpless. They alternate between overprotecting Ruth and rejecting her. The programs to which Ruth has been referred recently do not believe their staff can protect both her and the other children in their care. They claim to lack the resources required to provide Ruth the intensive services she needs. Ruth could benefit from long-term care, delivered by staff trained to work with children like herself. No such program has appeared, and Ruth may well end up on the adult ward of a state psychiatric hospital before one comes along. (Ruth's state has no adolescent units.)

Each year a small percentage of disturbed children and adolescents are admitted to psychiatric hospitals or to psychiatric wards in general hospitals. For these children admission is a serious step. Although some really need to be hospitalized...
and benefit from the experience, a large number do not. Like Ruth, many have experienced failure after failure in other programs. They may be hospitalized repeatedly and also spend time in juvenile justice facilities. For children older than Ruth, especially those ages 15 to 17, there is often little to do in the hospital but mark time until age 18, when they can be placed in adult facilities. These older adolescents account for fully two thirds of all hospitalized children.

Children in State Custody

Peter is 11 years old and is severely disturbed. His father, who deserted the family some years ago, was an alcoholic and frequently abused Peter and other family members. Recently, Peter’s mother beat Peter severely for not listening to her. She was charged with child abuse. While the court decision was pending, the mother made a serious suicide threat and was hospitalized. Then, while the court decided whether it was in Peter’s best interest to remove him from home, he was placed in jail for five days. At that point the court gave legal custody of Peter to the child welfare department. But the department had no place to put him. The state’s emergency shelter staff felt they could not handle him. There are no residential treatment programs in Peter’s state and no therapeutic foster homes. So the court sent Peter back to his mother when she returned home from the hospital. It arranged no services for mother or child but left legal custody of Peter with the child welfare agency.

Cheryl was 14 years old and sexually active when the elderly aunt she lived with refused to have anything to do with her. The aunt committed Cheryl to a local community mental health center as an adolescent inpatient. She petitioned the court to declare Cheryl “incorrigible.” This would have made Cheryl a ward of the court, transferring responsibility for her to the child welfare system. Cheryl liked this idea because it meant a chance to live in a foster home. For three months while she waited for the court’s decision, Cheryl was a model patient. Then everything fell apart. The court decided not to make Cheryl its ward and refused to provide any services for her through the child welfare agency. So Cheryl remained in the hospital for three years. Her behavior worsened dramatically; she became combative and hostile. Her cognitive skills deteriorated so badly that an IQ test found her retarded. Ironically, at that point the court decided to declare Cheryl its ward and, at taxpayers’ expense, sent her to an out-of-state facility in a rural area 2,000 miles from home. Cheryl ran away, back to her own city. Shortly after, Cheryl, now 18, was picked up as a prostitute, sent to jail, and released. Her behavior became increasingly bizarre. Ultimately, she was placed in the state psychiatric hospital on a ward for chronic schizophrenics.

Cheryl and Peter dramatically illustrate the ways agencies fail to assume responsibility for children whose own parents cannot care for them. In Cheryl’s case an inappropriate hospital admission was compounded by a three-year stay and no attempt to explore less restrictive options. Since no one reviewed Cheryl’s case, no one questioned the need for her placement. The child welfare agency was excused from responsibility, leaving Cheryl abandoned. In Peter’s case the child welfare agency proved unable to respond to the needs of a child in its care. Both children received inadequate services as a result.

Minority Children

Other factors in children’s lives may also lead to their being denied appropriate services, although this certainly is not always true. Such factors include membership in a minority group, having mentally ill or alcoholic parents or ones too disorganized and poor to provide basic needs, or being born with a handicap. We want to emphasize that not all poor, minority, or handicapped children need mental health services—most do not. But for those who do, services are often unavailable.

Pablo is an adolescent whose father died young. Pablo’s stepfather, with whom he is very close, was recently disabled. Now Pablo has begun to fight with other children and is increasingly fresh to his teachers. School personnel say he is a “discipline problem.” At home he is often depressed, cries easily,
and is readily angered. He lives in a city rich in psychiatric resources. But he primarily speaks Spanish, and a search for a Spanish-speaking male therapist has proved futile. An educational advocate trying to help Pablo said bitterly, “No one sees them until they learn English.”

For Pablo the absence of bilingual mental health personnel posed an insurmountable barrier. Other minority children with mental health problems are never identified or go without the treatment appropriate to their special needs.

Sowder reports that nonwhite children are less likely than white children to receive all forms of treatment, especially family therapy. While 31 percent of the white children received no treatment beyond an evaluation, this was true for 39 percent of the nonwhite children.

The President’s Commission on Mental Health reported Blacks under 18 are over twice as likely to be admitted to state and county mental hospitals as whites, who are treated more often on an outpatient basis.

Minority children who need services are also particularly likely to be excluded from the mental health system and find their way into correctional facilities.

According to 1970 census data, minority children were placed in health, psychiatric, and educational facilities at a rate about 20 percent higher than white children; they were found in correctional facilities at a rate 300 percent higher than white children.

Such data on discrimination have been gathered primarily for Black children. But anecdotes and informal reports suggest discrimination affects the access that all minority groups have to mental health services, although the degree of discrimination varies by group and region. In some regions minority and nonminority children may suffer equally from the failures of public agencies.

Children of Disturbed, Alcoholic, or Substance-Abusing Parents

The number of children potentially affected by parents with serious mental illnesses is startlingly large. For example, in 1975, 833,000 adults, many of them parents of one or more children, were admitted to psychiatric hospitals. Countless adults are being discharged from hospitals back to their families, sometimes resulting in an unpredictable and scary world for their children, who must make sense out of bizarre behavior, adapt to dramatic withdrawals of parental affection and involvement, and manage routine tasks with limited or no parental guidance. Some children are resilient and manage well; yet few adult inpatient or outpatient services make an effort to work with mentally ill patients in their role as parents or to determine whether the children of patients get needed help.

The children of addicts and alcoholics suffer a similar fate. Those who work effectively with adult alcoholics or substance abusers often have little training or interest in working with children or adolescents; those who work with children and adolescents generally have no experience with alcoholism or substance abuse. Further, alcoholic or addicted parents frequently are unwilling to have their children receive services and refuse to grant their permission. When providers find evidence that an alcoholic parent has mistreated a child, they face conflicting mandates about what to do next. Under child abuse reporting laws, instances of abuse must be reported, but the requirements for treating alcoholics stress keeping such information confidential.

Other Unclaimed Children

Limited data point to other children who may need, but not get, mental health care. These include children with multiple handicaps or severe or chronic physical
illnesses; children experiencing a traumatic crisis, such as child abuse, the death of a family member, or a bitterly contested divorce; and children coming from poor and disorganized families that are unable to provide basic nurturance or see that their children get health care and other services. Experience also suggests that children from groups undergoing unique stresses, such as immigrants, may also need special mental health services.

Obviously, most children in poor families or with mentally ill, divorcing, or immigrant parents do not need mental health care. In fact, research is beginning to show that children have tremendous strength and resilience for coping with handicaps, difficult family situations, environmental stresses, and even combinations of these factors. Yet when children do need help, services often are not there or are unresponsive to the particular needs and stresses of the children and families.

How the Families Fare

Jamie is a 12-year-old boy. During his preschool years he developed slowly, withdrew in class, was sometimes uncontrollably aggressive, and claimed he heard voices telling him what to do. A mental health clinic diagnosed him as “borderline schizophrenic.” However, no program was available to serve him; his parents were told the community mental health center recently had eliminated a special program for young, disturbed children. Two years later when Jamie showed escalating problems in school, his parents were told he was hyperactive. He was given Ritalin, but the drug made little difference. In fourth grade Jamie was placed in a special classroom for emotionally disturbed children. But by the time he was in seventh grade, he had exhausted both the school personnel and his parents. The community mental health center, to which Jamie was referred for yet another evaluation, recommended that he attend a day treatment center. Again, no program existed. Instead, Jamie received home tutoring. Six months later he was picked up by the police for stealing comics and candy. This time the court assessment team evaluated Jamie’s needs; the team strongly recommended placing Jamie in residential treatment. Jamie’s parents had already sought legal help to get him into a day treatment program they had identified on their own. Now they were distraught and confused. They no longer knew whom to believe. They only knew their son’s mental health was getting worse.

Parents with troubled children often face anguish and confusion. It is hard for them to know when problems warrant specialized care. Since behavior in children and adolescents changes constantly, both parents and professionals may be unable to tell if a child will outgrow troubling conduct. Moreover, professional and parental tolerance and awareness of deviant behavior vary; what evokes concern in one parent or professional may not be problematic for another.

When children and adolescents do need mental health treatment, there is little assistance in finding services, particularly for those who are seriously disturbed. Too often children and parents undergo a tragic chronology of events that includes evaluation after evaluation but no treatment until a crisis results in the child’s being hospitalized or even imprisoned. For poor parents, the experience may be even more troubling.

Mrs. Carlton, a single parent, unemployed, and on welfare, is the mother of five-year-old twins. One twin was doing well; the other was having severe problems. She frequently refused to eat, had temper tantrums, and woke up sobbing several times a night. Mrs. Carlton sought help from her caseworker, who suggested the children be evaluated. The startling recommendation was that Mrs. Carlton place the troubled child in foster care. Feeling desperate and with nowhere to turn, the mother requested placement. She had no framework for evaluating such “expert” advice. Fortunately, she became increasingly anxious about what she had done and before two weeks went by approached legal services for help. Her lawyer helped her get the even more traumatized child out of placement and referred Mrs. Carlton to an excellent child mental health clinic where the family began to receive therapy.

Some parents are not as perceptive or persistent as Mrs. Carlton. Despite the concern of teachers and others, they may deny difficulties, refuse or drop
out of treatment, or exacerbate their children’s troubles. But more parents simply receive no help. The absence of respite and support services for parents of seriously disturbed children is one of the most glaring gaps in services that we identified.

Increased attention has been paid to respite services for the parents of multiply handicapped, retarded, or autistic children, so that families can take vacations and reenergize their commitment to their children. Yet we were unable to identify similar respite programs for the parents of emotionally disturbed children. Good summer programs for disturbed children are also hard to find, although some exist.

There are few parent support groups for families with hospitalized children or adolescents or for parents whose disturbed children are in the community. When children are discharged from psychiatric facilities, parents and other family members often receive fewer after care and support services. A New York study found that deinstitutionalized adults were more likely to get after care services than children and their families.

In general, parents of disturbed children have less access to case advocacy than parents of children with other types of handicaps. This puts a tremendous burden on already stressed parents and is particularly harmful for children from “disorganized” families in which parents simply cannot function as advocates and cannot see that children get to therapy, get medication, or get services they should receive.

The efforts of parents to find care for troubled children is marked not only by an absence of help but by harassment and even coercion.

Surely one of the cruelest ironies of “helping” systems is the anguish of parents forced to hand legal responsibility for their children over to states to get services. Further, too many parents report being treated as if they caused their children’s problems. The persistence of this attitude is a tragic legacy of early efforts to explain children’s problems as resulting from poor parenting. Today we know that many complex factors, hereditary and environmental, may cause mental health problems in children. Yet although many behavior modification techniques rely on parents to provide nurturance and teaching to their disturbed children, the myth of bad parenting persists, and parents’ attempts to help children are constantly frustrated.

The parent of a hospitalized adolescent bitterly stated that when nursing shifts at the psychiatric hospital changed, debriefing sessions lasted 45 minutes; but when her daughter came home for a weekend, despite repeated requests, staff would not tell her anything about what to expect or whether anything important had happened to the child. Another parent spoke of continual, unsuccessful attempts to get information on the side effects of various psychotropic drugs prescribed for her son, who had to be hospitalized repeatedly. She encountered only resistance.

Not all parents are harassed or made to feel guilty about their child’s problems. Some are able to secure continuing, quality help for their child. However, scarce fiscal resources, a lack of appropriate services, vestiges of a “blaming the parent” mentality, and the stigma and fear still felt by many parents whose children need mental health care engender grief and helplessness in countless families that are already stressed by the demands of living with a disturbed child.
Mental Health Needs
community organizations in 25 catchment areas were surveyed.
also reported 16.8 percent of the population to be less severely
disturbed parallels the Joint Commission estimates closely. They
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Their estimate that 2.6 percent of the population was severely
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1978), p. 39. Elsewhere, the President’s Commission estimates 16
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Services in Four Organized Health Care Settings,” mimeographed report
of Selected Literature From 1970-<979,” mimeographed ground paper for the World Health Organization and the
4. President’s Commission on Mental Health, Task Panel Reports, Vol. II (Washington, D.C.: U.S. Government Printing Office, 1978), p. 39. Elsewhere, the President’s Commission estimates 16 percent of the population under 18 will at some point need mental health services, although no references are cited. Interestingly enough, several years after the Joint Commission report, community organizations in 25 catchment areas were surveyed. Their estimate that 2.6 percent of the population was severely disturbed parallels the Joint Commission estimates closely. They also reported 16.8 percent of the population to be less severely disturbed but in need of mental health services, considerably higher than the Joint Commission estimates and closer to those of the President’s Commission. B. J. Sowder, Assessment of Child Mental Health Needs (McLean, Virginia: General Research Corporation, 1975), Vol. 1. 5. In 1976, 659,000 children and adolescents under 18 received some kind of care through traditional mental health agencies. Of those children who were admitted for care, 87 percent were admitted for outpatient care (nonresidential care), and 12 percent were admitted for inpatient care (residential care in a hospital). B. Rosen, “Distribution of Child Psychiatric Services,” in Handbook of Basic Child Psychiatry, ed. J. D. Noshpitz, Vol. IV (New York: Basic Books, 1979), pp. 485–500.
6. To arrive at this figure, the Children’s Defense Fund calculated that 5 percent, or 3 million, of all children and adolescents are seriously behaviorally or emotionally disordered. This reflects the lower point of the estimate by the President’s Commission on Mental Health, the half point of Gould’s prevalence estimate of 11.8 percent (based on a review of 28 studies), and the half point of the prevalence rates identified by Jacobsen et al. in a study of pediatric populations. See the President’s Commission on Mental Health, Task Panel Reports, Vol. II, p. 39; Gould, Wunsch-Hitzig, and Dohrenwend, “Estimating the Prevalence of Childhood Psychopathology,” and Jacobsen et al., “Diagnosed Mental Disorder in Children.”
7. For instance, a 1973 survey in 25 catchment areas found that 50 percent of the children judged to be seriously emotionally disturbed were receiving services compared to 38 percent of the less seriously disturbed children. Sowder, Assessment, Vol. I. 8. Adapted from S. Okie, “Psychiatrists Probing the Mental Health of Newborn Babies Here,” Washington Post, December 1, 1980, Sec. C, pp. l-4.
9. For descriptions of infant mental health intervention projects, see Zero to Three, the bulletin of the National Center for Clinical Infant Programs, (National Center for Clinical Infant Programs, 733 15th Street, N.W., Washington, D.C. 20005).

Notes
4. President’s Commission on Mental Health, Task Panel Reports, Vol. II (Washington, D.C.: U.S. Government Printing Office, 1978), p. 39. Elsewhere, the President’s Commission estimates 16 percent of the population under 18 will at some point need mental health services, although no references are cited. Interestingly enough, several years after the Joint Commission report, community organizations in 25 catchment areas were surveyed. Their estimate that 2.6 percent of the population was severely disturbed parallels the Joint Commission estimates closely. They also reported 16.8 percent of the population to be less severely disturbed but in need of mental health services, considerably higher than the Joint Commission estimates and closer to those of the President’s Commission. B. J. Sowder, Assessment of Child Mental Health Needs (McLean, Virginia: General Research Corporation, 1975), Vol. 1. 5. In 1976, 659,000 children and adolescents under 18 received some kind of care through traditional mental health agencies. Of those children who were admitted for care, 87 percent were admitted for outpatient care (nonresidential care), and 12 percent were admitted for inpatient care (residential care in a hospital). B. Rosen, “Distribution of Child Psychiatric Services,” in Handbook of Basic Child Psychiatry, ed. J. D. Noshpitz, Vol. IV (New York: Basic Books, 1979), pp. 485–500.
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three to develop an analysis of cost benefit and cost effectiveness. Similarly, a cost-benefit analysis of Greenspan's program is in progress.

10. A growing number of parents and professionals are interested in programs for troubled infants. Over 4,000 participants attended a recent training workshop sponsored by the National Center for Clinical Infant Programs. In Ohio a new organization, United Services for Effective Parenting, has emerged specifically to bring together over 170 parenting programs in that state. The organization, which provides referral services and a newsletter, is designed to help parents provide the optimal developmental opportunities for children from birth to age three. A survey conducted by the organization found parenting programs annually reached about 16,000 Ohio children and families, or 3 percent of the population. For more information write United Services for Effective Parenting, Department of Pediatrics, University of Cincinnati, College of Medicine, Cincinnati, Ohio 45267.

11. For example, as early as 1966 the League School in Brooklyn had developed a home-based intervention program for seriously disturbed (autistic, schizophrenic, and psychotic) three- to seven-year-old children. From its inception in 1953, the League School rejected the then prevailing view that parents caused emotional problems in their children. In keeping with this orientation, the home-training model involved one of the earliest attempts to rely on parents to help their disturbed children. Initiated with demonstration funds, the project proved so successful that several years later the school was asked to set up similar programs elsewhere. Unfortunately, in 1978 the League School had to abandon its own effort because of funding problems. See M. Doernberg, B. Rosin, and T. Walker, A Home Training Program for Seriously Disturbed Children (Brooklyn, N.Y.: The League School, no date).

12. On the other hand, as Naylor thoughtfully points out, expectations of inoculating either infants or preschoolers against any further difficulties are unrealistic, and the programs should not be oversold on these grounds. See A. Naylor, “Early Intervention: Panacea or Challenge. Characteristics of Parents in a Mental Health Clinic for Young Children,” in The Child in the Family, eds. E. J. Anthony and C. Chiland, Vol. VI (New York: John Wiley and Sons, 1980), pp. 409-422.


15. Particularly innovative school-based mental health services were developed in the 1970s in low-income schools. See, for example, S. K. Schiff, “Free Inquiry and the Enduring Commitment: The Woodlawn Mental Health Center 1963-1970,” in Handbook of Community Mental Health, eds. S. E. Golann and C. Eisdorf (New York: Appleton-Century Crofts, 1972). It is somewhat sobering to note that many of these projects were ideas of the 1960s and 1970s and yet few such projects are reported in current literature.

16. In fact, residential treatment centers are reluctant to serve many children with serious mental problems. A survey of residential treatment programs found that the centers were more likely to take delinquent children than serious mental ones, although residential treatment is generally seen as a mental health service. In fact, 46 percent of the programs excluded psychotic children. Rosen, “Distribution of Child Psychiatric Services,” pp. 490-491.

17. The 1980 report of the President's Commission on Mental Health singled out adolescents as the "most underserved population group in the U.S." The President's Commission on Mental Health, Task Panel Reports, Vol. III, p. 623. Similarly, in our own review, state studies frequently singled out the needs of adolescents as especially critical.


19. It should be noted that antisocial behavior in children and adolescents may reflect the most consistent pattern of behavior to continue from childhood into adulthood. Although most antisocial children do not grow into antisocial adults, the vast majority of adults who exhibit such behavior exhibited it first in childhood. For a discussion of this pattern, see M. Rutter, Changing Youth in a Changing Society: Patterns of Adolescent Development and Disorder (Cambridge, Mass.: Harvard University Press, 1980); and L. N. Robbins, Deviant Children Grown Up: A Sociological and Psychiatric Study of Sociopathic Personality (Baltimore, Md.: Williams and Wilkins, 1966).


21. In 1976 the American Psychiatric Association surveyed all 50 states and the District of Columbia regarding hospitalized children and adolescents. It found that at the end of 1976, 8,289 children and adolescents were in state or county mental hospitals. American Psychiatric Association, Task Force on Children and Adolescents in State Mental Hospitals, “Children and Adolescents in State Mental Hospitals,” mimeographed status report (Washington, D.C.: American Psychiatric Association, November 1981). Sowder reports that in 1975, 89,356 children and adolescents were hospitalized; 25,834 of these were between ages 10 and 14; 54,648 were between ages 15 and 17; and the rest were under age 10. Sowder, Utilization, p. 84.


23. An Ohio study followed 58 youth in Cuyahoga County who
either were admitted to the adult wards of the Cleveland Psychiatric Institute, rejected for admission to the regional child and adolescent psychiatric hospital, or placed on the waiting list for that hospital. The monitoring team found that 45 percent of these youth had been hospitalized previously and 45 percent had received outpatient therapy that usually was terminated after one or two visits. Further, 33 percent of the youth had been referred to the psychiatric hospitals either by Ohio's juvenile justice agency or by county juvenile courts. Child Guidance Center of Greater Cleveland, "Final Report of the Most In Need Project," mimeograph (Cleveland: Child Guidance Center, August 1981), pp. 39, 48.

In North Carolina a 1980 report found that 56 percent of all youth in state psychiatric hospitals previously had been involved with the juvenile courts on serious charges. Statewide Planning Task Force for Children, "Critical Issues in Child Mental Health in North Carolina," mimeograph (Raleigh, N.C.: Division of Mental Health, Mental Retardation, and Substance Abuse Services, January 1980), p. 19. In the District of Columbia, from November 1980 to March 1981, a study followed the placement of 35 children and adolescents after their discharge from St. Elizabeth's Hospital and found that of the 20 children who were discharged from the hospital during that time, 12 were placed in the city's juvenile correction facilities. Yet the hospital had recommended such incarceration for only one of the 12. See M. Beyer, "An Overview of DCAS Court-Ordered Admissions, 11/80–3/81," xerox (Washington, D.C.: St. Elizabeth's Hospital, April 30, 1981).

24. Sowder, Utilization, p. 84. This is not exclusively the case. In doing this study we learned of very young children "stuck" in psychiatric hospitals, even in communities with supposedly "good" child mental health resources. For example, we learned of a six-year-old child whose discharge from the ward to foster parents was delayed for months while the local public school and the psychiatric hospital squabbled. The school personnel said they could not do an Individualized Education Program (IEP) until the child literally lived in the district. The psychiatric hospital staff said they would not discharge the child until there was an IEP.


27. The President's Commission on Mental Health, Task Panel Reports, Vol. III, pp. 831–833. The Commission's information comes from unpublished 1975 data from the National Institute of Mental Health. The Children's Defense Fund's analysis of this data suggests that, compared with white children, Black children are less likely to have had outpatient care prior to entering the hospital. For data on alcohol abuse and suicide among Black teenagers, see Task Panel Reports, Vol. III, p. 854.

28. Rosen, "Distribution," p. 492. Unfortunately, the relevant 1980 census data have not yet been analyzed. An analysis of admission data by sex for one psychiatric hospital in California found a decrease in minority admissions between 1971 and 1976. In 1971, 76 percent of hospitalized youth were white, compared with 51 percent of the general child and adolescent population. By 1976, 82 percent of hospitalized youth were white. J. Schain et al., "Characteristics of Children Admitted to a State Mental Hospital," Hospital and Community Psychiatry, 1980, 3 (1): 49–51.

29. For example, see D. O. Lewis, D. Balla, and S. Shanker, "Some Evidence of Race Bias in the Diagnosis and Treatment of the Juvenile Offender," American Journal of Orthopsychiatry, 1979, 49 (11): 53–61. For other data related to how minority children fare within the mental health system, see Sowder, "Issues." As Sowder points out, much of the research on mental health discrimination has focused on adults, not on children. Further, minorities are not always comfortable with traditional mental health services and may avoid using them.

A review of the literature on the underutilization of mental health services by Mexican Americans does not cite any data specifically on children. D. G. Ramirez, A Review of the Literature on the Underutilization of Mental Health Services by Mexican Americans: Implications for Future Research and Service Delivery (Austin, Tex.: Intercultural Development Research Association, 1980). However, according to Ramirez, an analysis in progress suggests that Mexican-American children may underutilize services more than any other age group. The mental health needs of New York City's Puerto Rican children have also been analyzed. Although the study provides little analysis of the kinds of services that children receive, it did not find discriminatory patterns in service delivery. L. A. Canino, B. F. Early, and L. Rogler, The Puerto Rican Child in New York City: Stress and Mental Health, Monograph No. 4 (New York: Hispanic Research Center, 1980).

It has been documented repeatedly that Indian children, particularly adolescents, and migrant children have trouble gaining access to both social and mental health services. The President's Commission on Mental Health, Task Panel Reports, Vol. III, pp. 969, 1234.

30. This figure includes 360,000 persons over age 18 who had been admitted to state and county mental hospitals, and 473,000 persons over age 18 who had been admitted to the inpatient psychiatric units of general hospitals. Rosen, "Distribution," p. 492.


32. For example, estimates suggest that the risk of schizophrenia in a child is 10 percent if one parent is schizophrenic and 30 to 40 percent if both parents are schizophrenic. W. W. Bolman and C. G. Bolan, "Crisis Intervention as Primary or Secondary Prevention," in Handbook of Basic Child Psychiatry, ed. Noshpirz, Vol. IV, p. 234. Research is also beginning to show that children of depressed parents who withdraw from interaction with the child and fail to show affection may be even more vulnerable. See, for example, M. Weissman, "Depressed Parents and Their Children: Implications for Prevention," in Handbook of Basic Child Psychiatry, ed. Noshpirz, Vol. IV, pp. 292–299; and D. Belle, Lives in Stress: A Context for Depression (Cambridge, Mass.: Stress and Families Project, Harvard Graduate School of Education, January 1980).

33. See E. P. Rice, M. C. Ekdahl, and L. Miller, Children of Mentally Ill Parents (New York: Behavioral Publications, 1971). There are exceptions. For example, one community mental health center in Michigan has a program providing outreach services to the children of mentally ill parents to determine how
they are managing, help them deal with the reality of their situation, and, where appropriate, provide concrete assistance.


35. There is also confusion about who should treat already addicted, alcoholic, or problem-drinking children, and what the role of mental health agencies should be toward them. Clearly, there are too many such children. One estimate suggests 3 million teenagers between ages 14 and 17 are problem drinkers. Another study found close to one fifth of the students in grades 7 to 12 were problem drinkers, that is, they were drinking at least six times in one year or had difficulties with teachers, friends, police, or cars. Reported in E. P. Noble, ed., Alcohol and Health: Third Special Report to the U.S. Congress (Rockville, Md.: U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, June 1978).

36. A study of the mental health needs of a pediatric population found that above one half of all children with chronic physical illness were identified as having emotional or behavioral problems. I. D. Goldberg et al., "The Role of the Pediatrician in the Delivery of Mental Health Services to Children," Pediatrics, 1979, 63 (6): 898-909. Under the leadership of Dr. Nicholas Hobbs, a study of children with chronic illnesses is underway at Vanderbilt University.


40. There are also surprisingly few articles in the literature dealing with how to help parents of hospitalized children. For some exceptions, see S. Rubin, "Parents Groups in a Psychiatric Hospital for Children," Social Work, 1978, 23 (5): 416-417; and L. P. Levy, "Services to Parents of Children in a Psychiatric Hospital," Social Casework, April 1977: 204-213. One parent we talked with, whose own son had been repeatedly hospitalized in a setting where there was no help for parents, decided to do something about it and not only formed a parents group but developed a handbook for parents. We also found a very sensitive video tape entitled, "Parents of Disturbed Children." (It is available through Martha Stewart Communications, Inc., 66 Bank Street, New York, N. Y. 10014).


42. Coercive relinquishment of custody as a condition of service appears to be a widespread problem. For example, a Cleveland project working with a group of seriously disturbed children and adolescents reported that 15 percent of the families of the youth were required to give up custody as a condition of placement. In Massachusetts a legal advocacy group was so alarmed at the number of complaints regarding coercive placements that they sought administrative relief but were not successful. In New York State the issue has been the subject of litigation.

43. These parents' experiences are not atypical. A 1973 report by the National Society for Autistic Children surveyed 450 facilities that served mentally ill children. It found that 15 percent of these facilities imposed rigid restrictions on parents, such as forbidding them to visit the child's eating and sleeping quarters, denying them access to information about the child, and prohibiting them from talking to the child's therapist. Some of these same facilities required that parents participate in therapies. R. C. Sullivan, "Report of Data Analysis Project," mimeograph (Washington, D.C.: National Society for Autistic Children, December 1973).
II:

Profiles of Programs That Work

Serving Children of Different Ages
Providing Alternatives to Institutional Care
Serving Minority Children
Serving Children of Mentally Ill and Alcoholic Parents
Supporting Families
The Services: Definitions and Profiles

To most people, mental health services mean inpatient care or once-a-week outpatient therapy. But effective mental health services for children and their families encompass a range of other options. Some involve working with children and families in their own homes and communities. Others involve placing children apart from their families in specialized foster homes, therapeutic group homes, or residential treatment centers. At times, hospitalization may be necessary. When traditional mental health care alone is not enough, other services like education or vocational training should be tailored and coordinated for disturbed children. And mental health staff may have to ensure families receive very basic services and help them locate housing, apply for food stamps, learn to budget money, or get other forms of assistance.

In thinking of what troubled children need, we have found it useful to group mental health care into three kinds of services that should be accessible to children of all ages: nonresidential, residential, and therapeutic case advocacy.

**Nonresidential Services** fall into three types: early intervention efforts, traditional diagnostic and outpatient services, and intensive programs in the home or community.

- **Early intervention efforts** include educational activities like parent counseling; consultation to help agencies identify and cope with children’s problems; telephone hotlines offering parents or adolescents support, advice, or referrals; preventive services that keep children out of restrictive residential placements; and programs to prevent emotional problems in particularly vulnerable children like those with multiple handicaps or mentally ill parents.

- **Outpatient therapies** reach more children than any other mental health service, with just over 50 percent of the services for children directed toward those ages 5 through 14. Outpatient therapies have no residential component and can be provided on an individual basis, to an entire family, or to groups of children of similar ages or with comparable problems.

- **Residential Services** for children traditionally include inpatient care in psychiatric hospitals or the psychiatric units of general hospitals, and specialized care in residential treatment centers. Supposedly, psychiatric hospitals are reserved for seriously ill children who hear voices, engage in bizarre behavior, are suicidal, or endanger the lives of others, while residential treatment centers provide carefully structured, therapeutic programs of treatment, education, vocational training, and fam-
Treatment Philosophies

Mental health services may reflect different philosophies about how children can be helped: psychodynamic, behavioral, or ecological. Professionals may use these philosophies alone or in combination. Those with a psychodynamic view see problems as resulting from psychological conflicts within children or families and generally rely on verbal or play therapy. They believe changing the way children feel or think about themselves will change their behavior.

Those reflecting a behavioral philosophy say problems occur because children have been rewarded in some way for problem behavior; for example, given attention even if it meant being yelled at. For this group, therapy involves altering the pattern of rewards and punishments children receive from their environment, so behavior will change.

The ecological view reflects a belief that helping children extends beyond psychodynamic or behavioral therapies. Instead, children are seen as part of a larger community that must be understood and often restructured to encourage their growth. This process may necessitate therapy but also includes working with other people in the children's world, like teachers, doctors, and peers, or coordinating activities with other agencies and groups that provide services to the family, like churches, social service agencies, schools, and community centers. The focus is on what is happening in the children's world now, not what happened in the past. The children's competencies are identified and strengthened, helping them cope with difficulties or problems.

Mental health services, whether residential or nonresidential, also reflect a “medical” or “nonmedical” philosophy. Under the medical model, children are “diagnosed” and a treatment plan developed to stabilize or cure their mental “illness.” This model places the physician or psychiatrist in a central role. Critics say it focuses more on children's weaknesses than their strengths. Yet funding for mental health services often reflects this approach and requires children be “diagnosed” to be eligible for care.

Nonmedical approaches emphasize children's strengths, avoid diagnoses, and use nonmedical personnel as key staff. Services using this model often find themselves shut out from mental health funds, fighting charges that they are not “really” mental health programs. This has been true for several of the less traditional programs described in this chapter.
and families need one person they can trust and count on for effective advocacy on their behalf.

This kind of advocacy goes beyond traditional case advocacy, which does not require special clinical sophistication or sensitivity by the advocate. And it is more than case management, because it requires knowing not only what services are available but also how to work with the various systems involved to ensure that quality services are provided. We have named this special combination of case advocacy and management "therapeutic case advocacy."\(^{12}\)

**Skilled Staff** are needed to design and provide responsive mental health services for children and adolescents. Yet the pool of trained professionals is very limited.

Of the 28,000 psychiatrists in this country, a little more than 10 percent are child psychiatrists.\(^{13}\) These psychiatrists are not evenly distributed around the country, and several states have no or few child psychiatrists.\(^{14}\)

The American Psychological Association estimates that although children under 18 make up about 30 percent of the population (based on 1970 census data), less than one percent of psychologists are devoted primarily to serving children.\(^{15}\)

No specific data are available on the number of specially trained psychiatric social workers or psychiatric nurses, but there is no reason to believe patterns are very different from those described for psychiatrists or psychologists.\(^{16}\)

States estimate they can meet only 5 to 50 percent of the need for teachers for the 300,000 emotionally disturbed children identified and served in 1979, while there are some 700,000 such children who are still unserved.\(^{17}\)

The number of specially trained people working with children and adolescents in residential settings is growing, but the need for such child care workers is still greater than the supply.\(^{18}\)

Even where specially trained providers are available, there is no guarantee they will choose to work with seriously disturbed children or be trained to provide any but the most traditional mental health services.\(^{19}\) Moreover, many trained professionals never work with children who are the responsibility of public agencies; others do so only for a short time.

Thus, increasing the corps of people skilled in planning and providing mental health care for children and adolescents remains a serious issue, particularly because staffing needs and staff costs may be greater for children and adolescents than for adults.\(^{20}\) Further, as children age, their developmental needs change, and the role parents play in caring for them alters. Thus, the clinical skills and knowledge needed in helping infants and preschoolers differ from those involved in working with adolescents.

### Profiles of Programs That Work

Scattered around the country, we found innovative programs with committed staff reflecting new ways to respond to troubled children and families, and meeting many of our criteria for quality care. Some provide intensive nonresidential services for children, others have created a range of smaller, less restrictive residential placements. Almost all reach beyond the therapist's office to provide case advocacy for children and families caught between numerous caring systems and help families with needs like food, child care, and shelter. The majority are nonresidential and place a strong emphasis on working with parents, even training them as para-professional therapists.

To varying degrees, each program incorporates traditional clinical sensitivity and expertise, adapted to the special needs of the children, adolescents, and families they serve. Taken together, these programs affirm the legitimacy, value, and cost effectiveness of mental health services for children and adolescents.

Programs are grouped to correspond to the needs of children discussed in Chapter I.

### Serving Children of Different Ages

**The Primary Prevention Program**

The Primary Prevention Program in Madison, Wisconsin, provides help to very young children at
Criteria for Evaluating Services

Based on clinical and programmatic innovations, growing knowledge, and legal challenges, five general principles have emerged for evaluating the quality of mental health programs for children and adolescents. Mental health services should reflect the child or adolescent's problems, age, developmental level, and specific strengths and weaknesses, be delivered in the least restrictive setting appropriate for the child's specific needs, involve the child's family as much as possible, be delivered by people comfortable with the particular cultural or ethnic background of the child, and enable the child or adolescent to move easily from one program to another, including from more to less restrictive settings.

Three other principles for evaluating quality care have gained substantial acceptance among all but the most traditional service providers. Mental health services should involve the child's family in treatment planning as well as others who work with or make decisions about the child, include consideration of the educational, vocational, and other needs of the child or adolescent, particularly when the child is seriously disturbed or multiply disabled, and include the advocacy capacity to make both mental health agencies and other systems work for the child or adolescent.

The public schools developed a similar project, the program shifted its focus to children under three whom other agencies seem particularly reluctant to serve. These include children with severe emotional problems whose parents are uncooperative or are themselves mentally ill or retarded, and children who have been abused or neglected. Today about half the program's referrals come from social service agencies, 30 percent from hospitals and pediatricians, and the rest from community agencies and parents. The program only works with families who participate of their own accord and will not accept cases in which the referring agency plans to remove the child from home.

Parents referred to the program all have marked deficiencies in parenting skills. They cannot meet their children's basic physical needs, do not know about child development, do not interact positively with or stimulate their child, or cannot manage the child's behavior. These parents are unlikely to benefit from purely educational services. About 44 percent are intellectually slow or retarded; an additional 44 percent previously have used mental health services (including outpatient, inpatient, alcohol, and residential treatment programs); 11 percent have emotional as well as intellectual difficulties. Most have not graduated from high school. Almost all are low income and on welfare; half are single parents; and many are young mothers.

Most children in the program, whose mean age is six and one-half months, exhibit some problem in one or more of the following areas at the time of referral: 20 percent have physical problems such as palsy, failure to thrive, or difficulties associated with premature delivery; 30 percent show developmental delays in language, sensorimotor, cognitive, or social skills; 20 percent exhibit behavior problems and may be aggressive, out of control, or hyperactive, and 10 percent are emotionally withdrawn or depressed or show emotional disturbances related to child abuse.

The program emphasizes serving children and families in their own homes, where staff train parents to interact positively with and stimulate the child and manage the child's behavior.²¹ Initial
assessments of the child and family occur in the home over three to four weeks. Each of the program's diverse staff—a special educator, a social worker, a psychologist, a child psychiatrist, a nurse, and an occupational therapist—participates in the assessment. Based on the results, parents and staff sign a contract stating the program's goals for the family and the methods to be used.

Families stay in the program about one and one-half years. Often staff work with families until children enter school for part of each day, and pressure on the family has been reduced. Fully 90 percent of the program takes place in the family's home in hour-long sessions occurring at least twice per week. If a spouse, boyfriend, or girlfriend is regularly in the home, they are encouraged to participate. Sometimes extended family are asked to join.

One staff member works directly with the family as their case manager. Other staff are available for consultation and exchange information about families in weekly meetings. Besides working directly with the family, case managers may work closely with the family's primary physician and with the child's teachers. They also help parents get welfare checks, drive families to appointments, arrange counseling for couples, and, in general, assist families in meeting their basic needs.

Using cognitive tests and videotapes of how parents and children interact, staff evaluate a family's progress at least every three months. And the program continues to follow a family's progress for 6 to 12 months after they have left the program, finding most families sustain the gains they have made.

Despite its good work, the program had to spend several years fighting for funding and recognition. As an outpatient program, it does not generate as much income or Medicaid reimbursement as Mendota's inpatient services. Most families in the program are covered by Medicaid or private insurance. Some pay a minimal sliding fee that never exceeds $4 per day. The entire program operates on about $125,000 per year, 90 percent of which comes from Wisconsin's Division of Mental Health. Today the program's funding appears relatively secure, although in 1980 the Division of Mental Health instructed the program to decrease its caseload from 24 to 12 families and increase its training and dissemination efforts.

For more information write the Primary Prevention Program, The Child-Adolescent Building, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wisc. 53704.

The Regional Intervention Program

Parents can be effective teachers of their own children, according to findings of the Regional Intervention Program (RIP) in Nashville, Tennessee. RIP, which serves children under age five who have behavioral problems or developmental delays, trains parents to be both teachers and volunteer staff members.

Referrals to RIP come from the families themselves, friends, private pediatricians, public health centers, psychologists, psychiatrists, and community agencies in the 26-county area the program serves. For a child to participate in RIP, one adult from the family must agree to come in and work with the child in individual behavior management and tutoring sessions on a regular basis, usually five mornings or three evenings per week. The same adult must also volunteer to spend time in one of the four classrooms where children stay when not in individual sessions.

In the individual sessions, based on play, each parent works with his or her child on behavior management tasks or specific learning problems. For example, the parent of a child with a language disorder may teach the child to form vowels through imitation. Some of the earliest sessions occur in the family's own home to ensure that tasks focus on the family's "real life" problems. Most sessions take place in a mock apartment in the RIP building. Tasks for the sessions are designed with the close assistance and supervision of RIP's five clinical staff, but parents receive most training from volunteer "case managers," parents who have already gone through the RIP program with their own children and are assigned to work with a particular family. At the end of each session, parents receive feedback from their case manager. They are also taught how
to take data-based measurements of their child's behavior and learn other specific skills from video training tapes. As parents gain confidence and knowledge over time, they gain more control of the sessions and begin to make decisions about what they want to work on with their child.

Families do not pay for RIP's services in cash but in in-kind support. They usually stay in the program 9 to 12 months, at the end of which a parent "pays back" RIP in volunteer hours, generally spent as a case manager or teaching assistant in the classroom. Thus RIP constantly replenishes its supply of parent/teachers and creates a key self-help group for parents of handicapped children.

A 1972 evaluation of RIP found that parent volunteers saved the state Department of Mental Health and Mental Retardation, which funds the program, $675,000 over a three-year period when compared with the cost of having the same services delivered solely by professionals. That same evaluation compared RIP's cost for serving ten children and their families to the projected cost of care in institutions for these children over the course of their lives (all of the children had been identified as needing institutional care prior to involvement with RIP). Results showed that for every $1 expended on RIP, the state saved $7.79 over time.

Begun in 1969 with federal funding, since 1972 RIP has been funded exclusively through Tennessee's Department of Mental Health and Mental Retardation as one of three Child and Youth Programs administered by the Middle Tennessee Mental Health Institute. Last year the program had an operating budget for direct services of $275,000. It saw 99 families with 101 disturbed or developmentally delayed children and 45 preschool siblings whom the program also served in the classrooms. Thus the cost was about $2,800 per family per year.

RIP's success goes beyond financial gains to the state. The most recent evaluation of the program followed 40 children who had been in RIP three to nine years ago (now in first through sixth grade) and 200 of their peers. Direct measures were taken of the children's behavior in school and at home. No significant differences were found between the two groups of children, even though the RIP group had shown very deviant behavior at ages two to four. Further, the younger children had been when they first entered RIP, the better they seemed to be doing at the time of follow-up.

Since 1974 RIP staff have been working with the help of state funds to replicate their program elsewhere in Tennessee and around the country. Starting in 1978 they also received federal money for replicating the program from the Bureau of Education for the Handicapped. Two RIP staff now work on the expansion project full time, and RIP-type programs have sprung up in eight locations: four in Tennessee (three funded and administered by community mental centers and one administered by a local university with Department of Mental Health and Mental Retardation funds); two in Cleveland, Ohio (see the description of the Positive Education Program); one in Hartford, Connecticut; and one in Brantford, Ontario, Canada.

Despite its success and its status as a "star" in the state's programming for children with problems, RIP has not managed to turn around Tennessee's mental health policies for young children. Funding, particularly for early intervention programs, is still minimal. Further, a Tennessee state law that prohibits the Department of Education from paying the Department of Mental Health and Mental Retardation for services has prevented agencies from effectively coordinating services for handicapped children. In particular, as the Department of Education and local school systems have been scrambling for resources to serve older handicapped children, they have grown reluctant to participate in joint ventures with other departments that might identify more handicapped students and thus place greater demands on their already scant resources.

For more information, write the Regional Intervention Program, 2400 White Avenue, Nashville, Tenn. 37204.

Project Enlightenment

Troubled preschoolers in Wake County, North Carolina, can get early help to lessen their problems through Project Enlightenment, a comprehensive
mental health program for children from birth to age six, their teachers, and parents. A child psychiatry training program and the local school system originally started the project in 1969 to provide clinical services to children and classroom experience to residents in child psychiatry. Today the program focuses on educational approaches that help children and train parents and teachers to provide primary support for disturbed preschoolers. The project also tries to prevent mental health problems in children, identify problems early, and train other professionals and university students to work with children who need mental health care.

The project's staff, the equivalent of some 15 full-time workers, evaluate and screen hundreds of young children for mental health problems. Staff regularly discuss parents' concerns about their children and provide some counseling for parents and families who have more serious difficulties. A telephone line, open three days a week, allows parents to call in with questions and get immediate responses.

A demonstration nursery school, run by the program, integrates a group of seriously disturbed children with a comparable number of preschoolers without difficulties and serves some 22 children at any one time. (This school has such a good reputation that it has a long waiting list of children with and without emotional disturbances.)

Project Enlightenment also provides training and program consultation to teachers in 43 local elementary schools and 93 preschools and to personnel in other community agencies as well as parents. Each year the project runs workshops on subjects related to child development, early childhood education, and mental health. A newly established Parent-Teacher Resource Center, funded with a grant from the Junior League of Raleigh, North Carolina, provides an array of books, learning kits, audiovisual aids, and instructional materials on mental health and developmental issues. The center serves as a clearinghouse for community resources for the young child, houses a production center for making materials for children, and offers a variety of training opportunities.

Through all these activities, the project has become an accepted service within the community, with ties to many of the county's public agencies. Although Project Enlightenment is administratively part of the county's public school system, it is also an affiliate of the area mental health program, with a contract to provide mental health services to the county's young children. Further, Project Enlightenment staff created the Wake Area Parent Education Council (WAPEC), an informal group that tries to coordinate local mental health services and plan for new services that could fill gaps in care. One of the project's staff, together with another local professional, has now started monthly meetings with area agencies on issues related to mental health in infants.

Indeed, though Project Enlightenment has provided direct help to substantial numbers of children, the program's real impact has been through its outreach to parents, teachers, child care workers, and other professionals. For example, because school counselors received training from Project Enlightenment, some now run their own parent education groups and, where qualified, provide family therapy. This intensive work would never have been done in the past. Further, all of Wake County's public health nurses, who regularly see many young children and parents, have been trained by Project Enlightenment regarding the mental health needs of children.

Project Enlightenment also served as a catalyst for North Carolina legislation encouraging the development of early intervention programs in the state. As a result of this legislation, passed in 1975, the state has funded 21 smaller programs based on Project Enlightenment, which are administratively part of the mental health system. To an even greater extent than Project Enlightenment, they find themselves fighting for funds to survive.

Funds for Project Enlightenment come from Wake County's public school system, a state mental health grant, a contract with the area mental health program, other smaller community contracts, federal grants, and community and individual contributions. The project charges for participation in workshops and the nursery school; fees are deter-
mined on an individual basis and scholarships are available.

For more information, write Project Enlightenment, 501 S. Boylan Avenue, Raleigh, N.C. 27603.

The Positive Education Program

Daryl is a 14-year-old Black child who had not received education or treatment services for nearly two years because of his aggressive behavior toward teachers. He read at a second grade level and did math at a third grade level. He finally received help from the Positive Education Program (PEP), a comprehensive school-based network of day treatment programs, serving all the Cuyahoga County school districts in Ohio. PEP has the unique status of being both a chartered mental health agency and a special education program. Begun in 1971 to provide teacher training and consultation regarding children with learning or behavior problems, PEP expanded to provide direct services in 1975. In fiscal year 1980 the program served 442 seriously emotionally disturbed children between the ages of 6 and 17. It also runs two early intervention programs serving 100 families (modeled after the Regional Intervention Program described earlier).

The program reflects an adaptation of the Project Re-Ed model; it gives primary treatment responsibility to front-line teacher/counselors working in the classrooms; seeks to build on children's strengths and competencies; avoids psychiatric labeling; and assumes a strong responsibility to work with parents, teachers, and others in the child's world. To a much greater extent than is true of most Re-Ed programs, it has a structured behavior modification component.

Each day treatment center serves 55 to 80 children of varied ages who work in classrooms of some ten students (usually with a four-year age span). Each center has a coordinator, a psychologist, and two or more liaison staff who work with the children's parents, teachers, and others in the children's community; each classroom has a teacher/counselor who is teacher certified and an associate teacher/counselor.

Five hours of the children's seven and one-half hour day are generally spent on academic work. Classrooms operate much like those in public schools except that all work is highly individualized. As children enter PEP, they are given a battery of psychological and educational tests; academic tasks are then designed based on these tests and work with children's public school teachers.

The classroom is the focal point for changing children's behavior. Teachers write behavioral objectives based on frequency counts of maladaptive behavior during a child's first few weeks in the program. Each classroom uses a "levels" system of rewards and punishments through which children progress, and teachers may make individual behavior contracts with children. Behavior is also shaped through the group; children participate in group meetings that focus on problem solving, goal setting, and positive social interaction, and go on camping and field trips that take their behavior from the classroom to other settings.

From the start, parents are closely involved in working with their children. Weekly two-hour parent training meetings with the psychologist, the coordinator, and the liaison staff emphasize child management techniques and communication skills that parents can use at home. Individual goals for parents to work on with their children may be set as parents and staff work together. For parents who cannot or will not attend group meetings, PEP has developed a "parent-training-parent program," in which parents who have shown particular success in learning behavior management skills go into the homes of other parents to provide support and teach them what they have learned. Work in the home may also be done by staff, followed by regularly scheduled phone calls.

After about 14 months, when a child is ready to return to his or her home school, a liaison staff helps make the transition. For example, staff may introduce the child's text books into the day treatment program when return to the regular classroom is imminent, or may help a public school teacher cope with the student in ways that prevent problems from developing.
The day treatment centers are funded with both state mental health (20 percent) and special education (40 percent) funds, and also receive support from local education, child welfare, and youth agencies. Increasingly, referrals to the program are coming not just from schools but from psychiatric facilities, courts, and social service agencies. The cost of the program is approximately $7,600 per child. To avoid the problem of accounting for every specific clinical intervention, when part of the work consists of directly helping the child and part working with parents and community agencies involved with the child, PEP has developed and gained acceptance for a reimbursement approach based on a "standard service day." This includes all direct and indirect efforts made on behalf of the child, including work with parents, probation officers, case workers, and others.

Theoretically, children enrolled in PEP are supposed to be less disturbed than children in residential treatment, but many of the students have been rejected not only by their own schools (either getting no schooling or homebound instruction) but also by residential facilities. The results of PEP's work with these children are highly impressive. In the 1979 to 1980 school year, 83 percent of the children who graduated from PEP remained in their home school placements and attended school at least 80 percent of the time. While in PEP, 7.9 percent of the students made academic gains of 1.5 months or more per month in treatment; 30.4 percent made gains of 1.0 months or more per month in treatment; and 69.6 percent made gains of 0.5 months or more, based on scores from several standardized achievement tests. Students who returned from PEP to their home schools showed similar academic gains based on measures taken at least four months after the children's return to regular classrooms. Most students accepted back into the regular classroom showed appropriate behavior at least 80 percent of the time. Parent's management skills also increased substantially.

For more information write to the Positive Education Program, 1827 East 101 Street, University Circle, Cleveland, Ohio 44106.

The Rose School

Located in Washington, D.C., the Rose School combines a psychoeducational day treatment program with a certified public school for severely emotionally disturbed children. The program operates from 8:30 to 4:30, 11 months of the year. Costs of the psychoeducational program, approximately $386,000 per year or $8,300 per pupil, are shared by three agencies. The D.C. Department of Human Resources, through one of its local community mental health centers, purchased the program's building and provides the overall structure, administration, clinical staff, and supplies. The D.C. public schools refer children to the program and provide transportation, supplies, and four classroom teachers. And American University's School of Education, which uses the school to train graduate students in special education, underwrites the program's training, evaluation, and research components, and pays for the year-long involvement of 9 to 12 interns in the program.

The school serves some 33 children between the ages of 6 and 13 referred by the school system's Child Study Team as eligible for services under the federal Education for All Handicapped Children Act. Aggressive behavior is the most common reason for referral, but many children also have severe learning disabilities or medical problems. The school will not accept children who are psychotic, need residential care, or come from families so tenuous that parents cannot be involved in the program. Children generally remain at the school for two to four years.

Each of three classrooms contains 7 to 11 children, a classroom teacher, two classroom interns, and a remedial reading intern. Education takes place in groups and individually, with subject areas determined by the public school curriculum and the diagnostic assessment of the child. In addition to classroom instruction, students participate in individualized remedial reading programs, art classes, music classes, and adapted physical education lessons. Further, the academic curriculum is combined with an affective and behavior modification program and with group therapy in the classroom called "class meetings."
Class meetings, held each day for at least 20 minutes, serve as a support group for children, an opportunity for them to recognize accomplishments or discuss problems at home, a forum in which to voice common concerns and anxieties and a place to discuss general issues of concern to everyone, such as racism, sex, parental abuse, or being "crazy." Although teachers try to keep the meetings grounded in concrete, real-life events and decisions, children generally decide on a meeting's agenda. Meetings can be held as needed, thus responding to children's problems and crises as they occur.

Crises that cannot be handled in the class meetings, because they are too individually oriented, take time away from other students, or require greater attention than a teacher can give, are referred to the crisis room. This is a place students go when crises interfere with group learning, when they cannot control their behavior or are unable to do something they know they should, or when they are sad or depressed. The crisis teacher is an advocate for the child, not a disciplinarian. She helps students talk about their feelings and uses a highly structured problem-solving process to teach them how to handle stress, called "Life Space Interviewing." Crisis sessions can provide an immediate response for children in need and always have some positive resolution so children can return to class.

Most children at Rose School also participate in individual psychotherapy sessions held at the school during the school day. Though the budget funds only one psychiatrist part time to serve 33 children, this psychiatrist has bartered his own services to increase the number of therapists available to the program. In exchange for two hours of work per week with a Rose School child, graduate students and professionals receive one hour of his supervision. This has allowed most children to see a therapist twice a week at no additional cost to the school.

While therapists and classroom staff focus primarily on the children, social workers meet the parents on a weekly basis to bridge the gap between school, home, and jobs. They try to understand the relationship between the child's problems and his family situation. Social workers meet with parents in their homes, near their workplaces, almost anyplace that is convenient. Since parents have not sought out services, but see the social workers as a condition of their child's attending Rose School, workers make a special effort to reach out to parents and motivate them. Most families have multiple problems, so social workers often find themselves coordinating services and acting as case managers. They may help families get medical services, financial assistance, food stamps, day care, housing, and even jobs. Social workers also try to get parents more involved with the school. For instance, they have tried to make Parent-Teacher Association meetings more enticing by offering supper, bringing in speakers, and advertising each meeting well in advance. And they try to ensure parents attend monthly staff meetings focusing on their children.

Collaboration among staff at Rose School is high and structured into the program through frequent interdisciplinary staff meetings, case conferences, and intensive supervision. The school tries to ensure consistent treatment for children among the various disciplines involved in providing care. Rose School also coordinates its program with children's eventual transition back to their home schools. Initially, upon leaving Rose School, most children go to another supportive program or to a special education class within their own public school. In preparation for return to their home schools, about 20 percent of the children attend these schools one day per week.

For more information write the Rose School, 4820 Howard Street, N.W., Washington, D.C. 20016.

The Adolescent Day Treatment Center

Elise is a 17-year-old Caucasian girl who was out of school for a year after attempting suicide. Both she and her mother had been severely depressed since the death of Elise's father two years ago from cancer. Danny is a 16-year-old Chinese-American who spent long hours in a fantasy world, locked in his room, watching tv, eating alone, and sleeping. He
became enuretic and refused to bathe or change clothes. His school work deteriorated and efforts to communicate with him failed. 

Until the 1970's San Francisco families with severely disturbed adolescents such as Elise and Danny had two treatment choices for their children—state hospitals or juvenile court placement.

Then in 1973 the Adolescent Day Treatment Center opened in southwest San Francisco. It provides a partial day program for emotionally disturbed adolescents ages 10 to 21. Run by Children's Hospital of San Francisco, the program treats adolescents in the context of their family and community and tries to prevent hospital placement. It also attempts to strengthen the adolescents' ties to people and agencies that can provide support for them once they leave the day program.

In the past nine years, the center has served 145 severely emotionally disturbed adolescents, most of whom had been in hospitals or clearly were not making it at home, at school, or in the community. The adolescents, who must be enrolled in the program before their eighteenth birthday, may be schizophrenic, depressed, or have borderline or character disorders. Delinquent and sociopathic youth do not succeed in the program.

Adolescents come to one of two partial day programs, each providing four hours of intensive treatment. The morning program serves ten nonverbal, withdrawn, and behaviorally regressed adolescents. The afternoon program serves 12 more aggressive, articulate, and street-wise adolescents.

The center combines psychoanalytic therapies with exposure to the real world. Adolescents receive individual therapy a minimum of twice per week, group therapy three times per week, and family therapy, run by male and female cotherapy teams, once per week.

Most of the adolescents' families have multiple, severe problems and are either in continual crises or have learned to create crises as part of their lives together. In general, they are two-parent, blue-collar families, characterized by a sense of "loss," whether of spouse, parents, siblings, other relatives, or their homeland.

Since 1978 the center has required all parents to participate in family therapy. Staff found when families did not attend recommended therapy, adolescents dropped out of the program after six months of treatment and made little progress. Today families can choose where therapy is held. Many sessions are in the families' homes, where families seem easier to engage, are less threatened and more open to change. Family meetings are also held with group home workers and foster parents when appropriate.

Adolescents continue in both individual and family therapy with center staff for an additional 18 to 24 months after their formal participation in the day program ends.

Besides therapy, the day program includes activities like art and music; outings; community meetings in which adolescents are required to take an active role by generating agenda, keeping minutes, and making suggestions regarding program activities; life skills, such as grooming, budgeting, cooking, and using leisure time; tutoring; prevocational training through an in-program work experience, for which adolescents receive a stipend of $2.50 per hour; and vocational counseling.

The center has remained only a partial day program in order to encourage adolescents to use existing community resources. Center staff have put particular effort into having adolescents attend public or private schools or vocational training programs outside the day program, and will assist adolescents in getting and coordinating services. Staff also take a leadership role in planning, launching, and seeking funds for programs that could fill gaps in services. Thus, the center has served as a model for a local adolescent residential treatment program, a second day treatment program for adolescents, and one for younger school-aged children. Staff also were active in creating a therapeutic school for educationally handicapped adolescents and a city-wide crisis service for children and adolescents. And the center provides consultation and evaluations of individual children to other agencies in the area.

In addition, the center participates in local Child Problem Solving Meetings in which the heads of all children's services in the vicinity meet bimonthly to discuss all hospitalized children. They plan and coordinate services for the children, work out their
transitions to outpatient care, and ensure that they are not lost in the system.

The total cost of the center is $19,125 per adolescent over an 18-month period. The cost for 18 months of care in a state hospital for an adolescent with similar needs is $98,550 per child. The center is funded through a contract between Children’s Hospital and the local Mental Health District based on units of service (four hours per day equals one unit of service at $52). Funding to cover contract costs comes from California’s Medicaid program, sliding fees charged to families, third party insurance, and other state and city funds. Children’s Hospital also supplies psychiatric, medical, and administrative consultation to the center as well as business services and training for staff. All the program’s money flows through the hospital, which also sends interns to train at the day program.

Although no comprehensive study has been made of the program’s effectiveness, staff believe institutional care has been prevented in at least half the cases. However, one of the center’s concerns is that children now are being released from hospitals too quickly, before they are stable enough to make progress in the community, thus setting some children up “to fail.”

For more information on the program write the Adolescent Day Treatment Center, 4319 Geary Boulevard, San Francisco, Calif 94118.

The Community-Based Intensive Treatment Program

Housed in the Providence Mental Health Center in Rhode Island, the Community-Based Intensive Treatment Program (COBIT) is an alternative to placing seriously emotionally and behaviorally disturbed teenagers in residential settings.

Most have chronic psychiatric problems, are seriously depressed and withdrawn. Though some have had acute short-term stays in institutions, COBIT’s focus is on reaching teenagers before placement and on providing what in many cases is “end of the line” help in the community to families with chronic problems rather than immediate crises. COBIT is “end of the line” in that most services have already been tried with the adolescent; COBIT is one last attempt to keep him or her out of long-term institutional care.

Adolescents are not accepted into the program until their families show a minimal level of cooperation. COBIT’s seven staff, the backbone of the program, provide intensive psychotherapy for the adolescent and family. Therapy can occur in the COBIT offices, the family’s home, or anyplace in the community where the client can be reached. Particularly in the early stages, therapists may spend recreational time with a client to develop trust. Therapists also actively pursue clients when they are reluctant to be helped.

During the year or more that adolescents are formally in the program, therapy is combined with case management and advocacy to get the child and family needed services from the larger community—jobs, schooling, visits to the doctor or welfare worker. Staff place strong emphasis on consultation and on organizing services. This is achieved through a discussion of territorial boundaries and responsibilities among representatives of the different agencies involved in a child’s case, with COBIT’s staff recognized as the managers of any case they work on. They are not necessarily the final decision makers but must know what is going on elsewhere.

After adolescents have been in the program for a while, getting these other services can take up a large proportion of staff time. For example, for one client, staff spent almost two months getting his mother into an adult education program, getting him a part-time job in a community center, and placing his younger brother in an afterschool program. This emphasis on meeting all of the family’s needs helps the families maintain what they have gained through COBIT. For teenagers who have
been in the program for some time, COBIT focuses on setting up helping systems in the community that involve relatives, neighbors, and other social services, so that COBIT’s role can gradually be reduced. However, COBIT staff recognize many clients will need to touch base with the program continually after most active involvement with the program has ended. This may mean as little as one hour per week of therapy over several years, so that crises do not recur, or staff time to check upon how the adolescent is doing with other agencies. Staff are also realistic about the future for some of their clients, who eventually will move into Providence’s adult mental health system and require support services for much of their lives.

Though other agencies initially showed skepticism regarding COBIT, staff’s willingness to do consultation, serve on advisory boards, and play other community roles has had positive spinoffs. Not only has it led to more appropriate referrals to the program but to “bartering and brokering” among service providers. Thus, the emergency shelter in a local runaway house keeps one bed open for COBIT clients at all times in exchange for an hour per week of group therapy with its own clients and one hour of consultation by COBIT staff per month. Community centers and day care centers have also offered jobs with stipends to COBIT’s clients and their families in exchange for consultation from COBIT staff.

COBIT has also developed an unusual working relationship with the schools. In addition to a $169,000 per year contract from the Department for Children and Their Families to serve 20 adolescents, COBIT has a $33,000 per year contract from the Providence School Department to work with six elementary and middle-school children who are referred by the schools. These are children whom the schools have identified as their most trying but “treatable” cases. The schools see COBIT as an alternative to paying for more expensive and often less effective residential treatment for these children COBIT staff were also influential in getting the education system to develop a special class for disturbed high school students (not just COBIT clients).

COBIT has had growing success and has gained recognition from the Department for Children and Their Families that severely disturbed children can be treated in the community. The department has also developed contracts with two other private agencies to replicate the COBIT model, with the assistance of COBIT staff, in two other locations in the state.

For further information write COBIT, Providence Mental Health Center, 160 Broad Street, Providence, RI 02099.

North Shore Children’s Law Project

We are not here to save the children; you never save the children; you just try to keep them alive long enough to fight another day.

Forcing numerous state agencies to plan and pay for appropriate services for unclaimed children with multiple handicaps or severe emotional problems cuts to the heart of the difficulties facing these children. Since 1977 the North Shore Children’s Law Project, a nonprofit community legal resource center in Essex County, Massachusetts, has taken on the challenge. Calling its strategy “stuck case advocacy,” the Project seeks to serve children from the North Shore, typically adolescents, who nobody wants to serve, and who reflect the failures of parents, helping systems, or both. The vast majority of cases involve adversarial work not against parents but against agencies—negotiating with, threatening, cajoling, and, if necessary, taking legal action against agencies that have mandated responsibility for disturbed children but are not living up to those responsibilities. For example, in the instance of an inappropriately hospitalized and secluded 15-year-old, staff had to threaten a lawsuit against the Commissioner of Mental Health on grounds of child abuse.

North Shore’s staff, the equivalent of one and one-half attorneys, a paralegal, and student interns, take a number of different avenues to get services for children. Drawing on accumulated experience with the agencies, staff make choices about what to do by weighing the strengths and weaknesses within each...
agency to provide needed services. For example, the Department of Social Services has great flexibility in funding and can write individual contracts, but the Department of Mental Health, with less monetary flexibility, is the only agency that can pay for psychiatric treatment. The Department of Education has a great deal of flexibility in funding for the special education needs of disturbed children but is reluctant to finance residential placements. Often, staff may push one agency to provide services on behalf of a child technically under the wing of another agency. Thus, project staff have come to be seen by agencies as useful, if adversarial, outsiders. The advocates themselves continually confront a service system that fails to assign case management responsibility to one state agency for a child receiving multiple services.

Contrary to the stereotype that advocates are opposed to any out-of-home care, the North Shore advocates spend almost as much time trying to get children into residential placements, preferably in the community, as out of them. Often a child cannot live at home or a residential placement provides a key to getting the child more services (though staff sometimes feel they are "forced" to choose residential programs because no proper respite care, 24-hour crisis intervention, or other alternative programs are available).

Only a small portion of the North Shore Children's Law Project's work involves representing "stuck children." The project also represents children in dependency and neglect proceedings, mental health commitments, and special education hearings. In March 1981 the project had 22 active stuck children's cases. About 80 percent of these cases involve the Department of Mental Health; virtually all involve the schools. Initially, one third of the project's "stuck cases" were referred from the Office for Children. This figure is now down to 10 to 15 percent, with almost 45 percent of the cases referred from the courts; 40 to 50 percent referred from attorneys, the police, state hospitals, and other community agencies; and the remainder self-referred from clients.

Since virtually none of the children or families pay for the project's services, funding is on a catch-as-catch-can basis. In 1980 to 1981 the project ran on some $120,000, about one third of which came from a National Institute of Mental Health demonstration grant for advocacy projects; one third from a private foundation; and one third in court fees paid to the project's individual attorneys. In 1983 federal funding will end, and the budget will drop to some $70,000.

Because of the nature of the children's problems, stuck cases can continue for years. Staff average well over 120 hours per case, with some 40 hours spent just getting to know all the parties and agencies involved. The staff are committed to their work without illusions about what can be salvaged for many of the children. In their own words, "one of the problems with doing this 'stuck case advocacy' is that you don't get your clients to heaven; you get them out of hell and you put them in purgatory. But at least you give them the hope that there's a better chance."

For further information write North Shore Children's Law Project, P.O. Box 710, Lynn, Mass. 01903.

Providing Alternatives to Institutional Care

The Family Advocacy Council

In the last few years a number of innovative community-based programs that use multiple strategies to help children have sprang up around the country to serve hard-to-place children with numerous problems. Located in New Jersey, Pennsylvania, Washington State, Illinois, Maryland, and Massachusetts, the programs are modeled on the "Family Advocacy Council" (FAC). Although each is independent, the programs share two premises. First, specific behaviors may be unacceptable, but children and families are not. Second, the programs mold to meet the disturbed children's needs and not vice-versa.

The programs work with children who are seriously disturbed, autistic, acutely schizophrenic, set fires, or have extensive juvenile court histories. These children have struck out in numerous other
placements. They have either been rejected by facilities at intake because they failed to meet selection criteria or have been ejected by programs later on when their behavior became unmanageable.

Programs modeled on FAC have a completely open intake process and accept any child of any age. Usually, they only require that children come from the surrounding community so that families can be involved in the treatment plan. Once in the program, children are not kicked out regardless of behavior. For example, if they go to jail or are placed in a psychiatric hospital, staff continue to work with them and advocate on their behalf until the children can return to the program. If children run away, staff follow them. In each instance, the children's needs come first.

To make this philosophy work, each program modeled on FAC has developed its own continuum of care, a range of services that can meet both the diverse needs of a varied group of children and the needs of an individual child as they change with time. At the core of the continuum are therapeutic foster homes. Foster parents in these homes are paid more than most foster parents, receive more training, and can get relief from their responsibilities and emergency services through the programs. The foster parents are considered to be counselors for the children and part of the treatment teams. Frequently, they have contact with the children's natural families.

Different programs may also run group homes, independent living situations for older adolescents, diagnostic treatment centers, and schools. Each residential setting houses no more than four or five children and is designed to reflect a natural family. Thus, each setting contains children whose ages, sex, and needs are not alike. A 16-year-old delinquent girl may be placed with a 19-year-old autistic boy and a 10-year-old schizophrenic boy and so on. FAC believes the more people there are in a child's world, the more alternative behaviors he or she can learn. For example, supporters claim many "tough" children learn to care for the autistic or multiply handicapped children with whom they live; in doing so, they also learn it is acceptable to show emotions and be vulnerable. Each setting operates by establishing clear limits and logical consequences for behaviors. For example, if a child breaks a window, he or she must pay to have it fixed. The programs do not use artificial point systems or behavior modification techniques.

Except in rare instances, when a child cannot be returned home or no natural family exists, the programs work closely with the child's parents and try to reunite families as soon as possible. Staff frequently advocate to get services on families' behalf. They also help families make better use of existing community resources like churches, schools, and local mental health centers.

For more information write the Family Advocacy Council Training Center, 771 Cumberland Street, Westbrook, Maine 04092. For a program incorporating some of FAC's concepts, write the Baltimore Family Life Center, 101 West Read Street, Suite 721, Baltimore, Md. 21202. This program, which primarily services minority adolescents, has been in existence for over eight years and serves severely disturbed children with multiple problems.

**Homebuilders**

Homebuilders, in Tacoma, Washington, is an emergency service program focusing on families where a child is at imminent risk of being removed from home due to intense family conflicts, suspected child abuse, the child's commitment of a status offense, or the child's serious emotional problems or developmental disabilities. Homebuilders' staff go into a family's home and work with them intensively over a short period of time until a crisis situation has stabilized. Originally, the program worked only with children in the child welfare or juvenile justice systems and did not serve severely emotionally disturbed children. However, Homebuilders had so much success with families, that in 1979 Washington state legislators asked Homebuilders' director to submit a proposal extending the program to serve children with serious emotional problems.

As a result of the proposal, Homebuilders was given a $132,000 per year contract with the Division of Mental Health to serve 25 children under age 18
who are in immediate danger of placement in a psychiatric facility. Most referrals to the program come from Washington's Office of Involuntary Commitment, which must approve all placements in state psychiatric hospitals; some referrals come from schools and community mental health centers. The program tries to serve children before placement in a hospital occurs.

A fair number of these emotionally disturbed children are nine- and ten-year-olds who are "out of control," tearing furniture, beating up parents and others, threatening to jump off the roof. Homebuilders also serves children who hallucinate; who are very withdrawn, depressed, or suicidal; or who have had bad experiences with angel dust, other drugs, or alcohol. According to Homebuilders' director, the problems of severely disturbed children are not that different from those of other children whom Homebuilders serves. Many of these other children are also violent, depressed, or withdrawn, but their problems are not as intense. Homebuilders' goals for all these children are similar.

The program tries to keep children with their families and provide support through the immediate crisis so that placement can either be avoided or, where necessary, be made in the least restrictive setting. Homebuilders also tries to involve children in a productive school or work program; decrease the probability of violence; improve children's self esteem and behavior; and resolve immediate problems while teaching children and parents coping skills they can use in the future.

Family members voluntarily participate in the program, which includes several home visits per week. Homebuilders' staff, three therapists/administrators and three full-time therapists, all work directly with the families and respond rapidly to reach a family in crisis. A face-to-face interview is done with each family within 24 hours of referral, and referrals are accepted seven days a week, 24 hours a day. Therapists, who only work with two or three families at a time, are on call round the clock and can be in a family's home within a few hours. Staff make it a point to see clients when needed, for as much time as needed, and at the clients' convenience; if necessary, they may spend up to 48 straight hours with a family.

Staff have found that by working with families in their own homes, they can increase the number of family members who choose to participate in counseling. Staff also feel their ability to go into families' homes enables them to reach a wider range of more disturbed clients and see them at the time of crisis. This is particularly important; many of the families have had unsuccessful experiences with social or mental health services in the past and are ambivalent about receiving help.

Staff may work alone or in teams and combine an eclectic range of approaches, including teaching relaxation and assertiveness techniques, asking family members to keep records of problem behaviors and events leading to these behaviors, developing behavioral contracts among family members, and developing "crisis cards" that list alternative behaviors family members can use in stressful situations. Therapists model behavior, role play, and provide very specific instructions. They monitor a family's progress in person and over the phone and will advocate for the child and family with schools and other community agencies.

Homebuilders' director equates the probability of which public agency ends up serving a child to a giant pinball game, yet the public agencies operate without much knowledge of each other's activities. In some cases, children in Homebuilders have had up to 15 different case managers from various agencies. In these instances, unraveling the chain of responsibility actually becomes part of the treatment plan.

For families with an emotionally disturbed child, staff spend an average of 135 hours on the case over a period of about eight and one-half weeks. Families may stay in the program from one to five months. They are also contacted regularly after leaving the program to see where the child is living and how the family is faring. Though cases may be reopened or may last longer than five months, Homebuilders' staff have found most changes that are going to occur usually occur fairly soon.

Staff may try to get children into an outpatient
program, a big brother program, or some kind of special school placement after they have left Homebuilders. However, by the time families have finished the program, they generally are not looking for further help and feel they can make it on their own. Sometimes Homebuilders will make referrals to programs only to have the family or child drop out of treatment. Other times staff cannot find a suitable program for a severely disturbed child because many programs will not bend to make room for the specific needs of these children.

Homebuilders does not work for a small number of young children who are “out of control.” In these cases staff try to work with the family to develop a safe place in the house where the child can go during bad episodes. But in some cases the frequency of negative behavior is so high a room can never be made safe enough. In the end, families are forced to place such children in institutions that Homebuilders’ staff fear are more restrictive than necessary.

According to Homebuilders’ director, one of the most difficult things about working with disturbed children is the past training of mental health professionals. “All of us have been taught that ‘oh, that kid’s psychotic,’ and that gets our adrenalin going, it has a mystery to it that gets us scared.” Homebuilders spends a lot of time deprogramming psychiatric “labels” with staff and families. Even so, the noise these labels make and the ways in which everyone reacts to them are terribly difficult to overcome. Frequently, a child’s problem behavior lessens, yet parents continue to say “yeah, but he is still crazy, he is still mentally ill.”

Yet Homebuilders has managed to overcome many obstacles with amazing success. In 1979 to 1980, 52 of the severely disturbed children whom Homebuilders served were initially assessed as needing placement in a psychiatric hospital either in the very near future or immediately. Of these, 41 avoided placement altogether (based on follow-up at one year following intake or to date). And only 4 of the 11 children who were placed out of their homes ended up in psychiatric hospitals.

Based on information from private placement agencies and the Department of Social and Health Services, Homebuilders has also compared the cost of its program to that of serving children in the children’s unit of the state psychiatric hospital or in a private placement agency. The average cost per child in the state psychiatric hospital was $25,000; in a private facility, $17,623. Homebuilders’ cost averaged $5,000 to $5,500 per child, a full $20,000 less than the state hospital. Despite this, the hospital has been reluctant to refer cases to Homebuilders and refuses to acknowledge the program’s results, allegedly because Homebuilders’ staff are not doctors. Homebuilders could have received 13 referrals from the hospital in the first six months of 1982 but was told hospital officials did not think it “worthwhile” to refer so few children, even though the state could have saved some $260,000 in service costs.

For more information write Homebuilders, c/o Behavioral Sciences Institute, 32020 First Avenue, South, Federal Way, Wash. 98003.

The Child Advocacy Treatment Team

“It’s very frightening when I think what would happen if we didn’t come along,” says the associate project director of the Child Advocacy Treatment Team (CATT) about children who fall between the cracks of different public agencies and do not get needed services. CATT, a unique program located in the Jersey City, New Jersey, YMCA, each year serves some 59 Hudson County children, ages 9 to 17, who are already in or at risk of being placed in psychiatric hospitals and ensures they get needed services in a coordinated fashion.

Funded at about $73,500 per year by the state’s Division of Mental Health and Hospitals, CATT’s emphasis is on children from Hudson County who are in the state psychiatric hospital in Trenton.33 CATT’s staff are notified automatically of all these children as they enter the hospital. Staff then get in touch with the child’s family, make arrangements to meet with the child and appropriate hospital staff, review case records, and use this information to begin developing a discharge plan for the child that will allow him or her to be integrated into the com-
munity. Workers with emergency services at community mental health centers, the Department of Youth and Family Services, the juvenile court, or youth homes also have discretion to refer children to CATT, and CATT's staff are beginning to work with some clients prior to hospital placement. All referrals are responded to within 72 hours.

Often the role of CATT's three staff members is to keep up the momentum on specific plans for a child—for example, a follow-up phone call can get communication started between hospital staff and a therapeutic home to which an adolescent is supposed to be discharged. During the first month a child is involved with CATT, staff work intensively with all other agencies and the child to develop an individual service plan. Then, each month (and frequently more often) CATT staff follow up to make sure that things are going smoothly and services agreed to are provided. Sometimes CATT staff even provide transportation to get the family to services or allow family members to visit the hospitalized child.

CATT staff also provide supportive services to the child, such as counseling, help with daily living skills, assistance with job searches, recreation, and special group therapy or workshops. All CATT children can use the YMCA's many services, including emergency shelter, a 24-hour phone line, and special projects like art contests.

Even after a child's formal involvement with the program ends (after about 9 to 12 months), CATT maintains contact with the child to see gains are maintained. All this close involvement pays off. Thus, in one case where an adolescent girl revolved in and out of hospital care and was even arrested once, CATT staff were able to continue to help her, finally getting her placed in a day treatment program and a therapeutic classroom.

In another case, CATT staff spent most of their time trying to get a 13-year-old child admitted to the state psychiatric hospital. The child had been on the caseload of the Division of Youth and Family Services for several years, during which time the division had recommended residential placement but taken no steps to ensure it occurred after the parents resisted. For two years the child remained at home without going to school or getting any but minimal services. Finally, a local medical center, which had tried to work with the family and failed, referred the case to CATT. CATT worked with a community mental health center to get the child accepted into the hospital and has since transported the child's siblings to visit him there, found a tutor for one of the siblings who was having problems in school, and has been working to find individual therapy for the mother.

The primary difference between CATT and community mental health centers is the emphasis on outreach and work with the entire family. Too often in traditional mental health agencies, staff have been trained to do individual psychotherapy and are uncomfortable taking on an entire family or going into the community or the family's own home to reach them. In contrast, CATT's broad interpretation of what "mental health" services mean is crucial. As one staff member says, "If you don't have food, that's mental health. You can't just sit in an office and talk to someone if they're hungry. You have to take care of the basics first or there is no mental health . . . and sometimes you can't wait for a child to come into your office."

Because CATT staff see themselves as working for system changes as well as changes in individual cases, they frequently write letters to agencies they work with pointing out gaps in services or problems in policies or practices and request a follow-up meeting. Staff feel it is important to keep these lines of communication open to work through problems. This too is paying off. They are starting to be seen as a vital part of the system because they are available, show concern, and provide a real service. Since CATT began its advocacy, the number of inappropriate referrals to the state psychiatric hospital has decreased and children have moved out of the institution more quickly.

For further information write Director, CATT Program, YMCA of Jersey City, 654 Bergen Avenue, Jersey City, N.J. 07304.
Serving Minority Children and Families

The Children, Youth, and Family Services Program

The Children, Youth, and Family Services Program (CY and F) at Meharry Community Mental Health Center in Nashville, Tennessee, is particularly effective at reaching out to low-income and middle-class Black children and their families. The program, which got under way in 1974 through an eight-year federal grant under the National Institute of Mental Health's Part F program (see Chapter V), is unique in several respects.

The Meharry Community Mental Health Center of which it is a part is the only community mental health center in Tennessee that has a majority of minority staff (60 percent) from the director on down, reflecting the center's 60 percent Black service population and the 30 percent Black surrounding community. CY and F is attached to the psychiatry Department of the Meharry Medical College, the oldest institution in the country that primarily emphasizes training minority health care providers. According to CY and F's director, "Meharry has been a center for health and mental health and related services to the Black community for over 100 years." The program is able to provide "one stop" care to the children and families it serves. It has close working relationships with the schools, the Department of Human Services, and its next-door neighbor, the Meharry Medical complex.

The program's goals are to preserve, rehabilitate, and reunite families; to remedy the neglect, abuse, or exploitation of children; to provide a community-based system of mental health services that prevent or reduce inappropriate institutional care; and to secure referrals to residential care when other forms of care are inappropriate.

Over the years, CY and F has addressed a number of problems that get in the way of making mental health services accessible and functional for Black families. The program is located in an area physically accessible to Black families. Further, because many poor Black families do not have transportation to get to therapy, a $50,000 Title XX grant to the community mental health center allows CY and F to use the center's vans and drivers to transport people door to door. CY and F also has made it very attractive to come to its program, reducing the stigma often attached to mental health treatment. The center includes a community gym and pool and well-kept, noninstitutional offices and waiting rooms.

The program staff broker with various systems that serve or should be serving a family—schools, courts, housing agencies, the welfare system—before they begin working on behavioral issues. Families learn to navigate the various service systems on their own, plan, and make hard choices in the initial period of therapy.

The program's more traditional services include psychological evaluations and prescreening for residential placements; individual and group therapy for children; family therapy and parent counseling; and consulting psychiatric services. It also provides comprehensive medical evaluations and treatment for all children who come for mental health services regardless of their families' ability to pay. Medical care is provided through a written agreement with the Department of Pediatrics' Primary Health Care for Children and Youth program at the Meharry Medical complex. The two programs have mutual referral procedures, share children's records, and do joint case management for children's health and mental health problems.

From 1980 to 1981 CY and F ran Nashville's first day school for autistic children, ages 5 to 15, who previously had no option except totally self-contained residential care. Meharry contracted with the public schools to develop the program, then turned it over to the schools to run. Today the program is entirely school financed and serves 30 children, many of whom can now live at home or in specialized foster care. Under another contract with the public schools, CY and F operates a day treatment program for 12 behaviorally disturbed adolescents. And it runs a summer enrichment program for 6- to 17-year-old children with academic or behavioral problems.
One of CY and F's less traditional components is a youth services program using citizens in their 40's and 50's, with high school diplomas, as advocates for families involved with the courts. The advocates accompany children and their families to court to negotiate solutions other than detention for troubled children whose disruptive behavior has pushed them into the juvenile justice system.

Another major effort of CY and F, started with a three-year grant from the National Center on Child Abuse and Neglect (NCCAN), involves increasing the Black community's awareness and information about child abuse and neglect. To do this, CY and F has worked closely with Nashville's Black media, especially Black representatives of the major radio and television networks and newspapers. Staff also have been developing a voluntary support network for Black families who have abused their children or may do so. CY and F tries to get members of the Black community to agree to assist families in meeting such fundamental needs as housing, food, child care, jobs, and social relationships with others.

The project also includes a training program for Nashville's protective service workers, 80 percent of whom are white, to increase their awareness and knowledge of Black language and culture and help them overcome any discomfort at working in Black neighborhoods. A CY and F community liaison worker is on call 24 hours a day to assist protective service workers who have seriously troubled families in their caseloads or families where there is a lot of hostility toward the worker. By going to the family's house with the protective service worker, the community liaison diffuses potential crises. CY and F is able to use its high community visibility and reservoir of trust to move into these confusing and tense situations as people who are viewed by both sides as inherently "fair."

In addition, CY and F has started a parent support group for 15 Black parents who formerly abused their children. With assistance from a professional consultant, parents work on child management and discipline problems and other agendas they select. The project is trying to learn what makes such groups useful and workable for Black families, and hopes to get community-based organizations like churches to sponsor their own parent support groups with consultation from people in the initial group.

Funding for CY and F, with the exception of the NCCAN grant, was severely reduced in the spring of 1982 due to state and federal budget cuts. Simultaneously, the state changed its standards regulating community mental health centers. The new standards do not stipulate that children’s services be coordinated or offered. In fact, a mental health center could meet the standards even if children were completely excluded from its programs. Many mental health centers in the state may use this flexibility to save money by firing children's staff. In April 1982 CY and F lost 70 percent of its children's staff. Where it once had 30 full-time staff, it was left only with those in the adolescent day treatment program and the NCCAN project, and the equivalent of one and one-half staff to handle all other requests for children's services on an outpatient basis.

Before the cuts CY and F had about 100 visits per week and a caseload of some 600 children and adolescents. Now its caseload is down to 200 children and adolescents, one third its former size, and urgent referrals are having to be turned away. Staff have been forced to make hard decisions about whom they will serve and have prioritized prescreening services for residential referrals, family intervention and counseling for families actively involved with protective services (children in these families often have serious mental health problems), and maintaining the adolescent day treatment program. At a time when CY and F was learning more and more about creating a system of mental health and health care for children, things have come to a sharp standstill.

CY and F is monitoring the frequency of admissions to residential and inpatient care for children and finding growing waiting lists. Department of Human Services workers say there is a clear increase in foster care and that requests may soon exceed available placements.

CY and F's director is particularly upset about the unnecessary and costly placement of children who could be served in the community. In Tennessee day
treatment costs $1,000 per month per child (including all related services) or $10,000 per school year. Inpatient psychiatric care costs $300 per day per child, or $9,000 per month, and $90,000 per school year, and the cost is steadily climbing. A year-long placement in one of Tennessee’s juvenile corrections facilities costs $50,000 to $100,000 with virtually no therapeutic services. Even foster family care exceeds the cost of day treatment or counseling and advice given to an entire family.

The state has begun to recognize some of the problems regarding its policies toward troubled children and adolescents. A state Task Force on Children’s Mental Health Services has been convened at the request of the Department of Mental Health and Mental Retardation and the Children’s Commission, an interdepartmental cabinet-level advisory group to the Governor regarding children’s issues.

For more information write Children, Youth, and Family Services, Meharry Community Mental Health Center, 1005 Eighteenth Avenue, North, Nashville, Tenn. 37208.

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Serving Children of Mentally Ill and Alcoholic Parents

**Parent and Child Education Family Centers**

PACE Family Centers provide day treatment and parent education for emotionally disturbed adults and a remedial and preventive nursery school for the adults’ preschool children.

PACE (Parent and Child Education) began in 1968. It is part of the Bronx Psychiatric Center, a state institution in New York City, funded by the New York State Office of Mental Health. PACE operates two clinics, one on the hospital grounds, the other in the community, with an annual staff budget of some $170,000. During 1981, PACE served 177 mothers and children from throughout the Bronx borough. Most mothers attended the program with one preschool child; a few came with two and occasionally three children.

A young mother who had been in and out of psychiatric hospitals exemplifies the kind of patients served at PACE. The mother was constantly threatened with abuse by her husband, who is also emotionally disturbed. She was both afraid of her husband and reluctant to leave him. Unable to cope with her situation any longer, the mother entered PACE. She brought her child with her. The child was then over two years old but could not speak and was socially withdrawn.

Four years after the family’s formal involvement with PACE has ended, mother and child have kept gains made in the program. The mother is still in the community, has gotten a divorce, and is doing volunteer work; the child has developed language skills and attends public school.

Like the mother just described, most mothers in PACE have histories of psychiatric inpatient or outpatient treatment. Typically, their own childhoods reflect emotional and physical deprivation, isolation, and early separation from one or both parents. Many have themselves been abused or neglected and have spent part of their childhood in foster care or residential placement.

About half the mothers admitted to PACE reportedly have abused or neglected their children in the past. Nearly half have had one or more children in foster care. About half live alone with their children; one third live with a spouse or common-law mate; the rest live with their parents. Many of the mothers live with their children when they first start at PACE. Sometimes the children are still in foster care and are expected to return home shortly. In these cases, involvement in PACE is part of an interagency plan to reunify the family. Participation in the program is voluntary. About 90 percent of PACE mothers receive public assistance and for them Medicaid reimburses the Office of Mental Health for the services provided. The remaining mothers are charged on a sliding-fee basis; some pay nothing.

The core PACE service combines a four-day per week day treatment program for the mothers with a preschool program for the children. The preschool
provides mothers with “hands on” chances to improve parenting skills. PACE involves mothers in all planning and decision making related to themselves and their children.

In addition to individual counseling and group therapy, the program’s ten paid staff provide mothers with supervised time with their children in a supportive classroom setting. Further, in weekly mother-child workshops, each mother is given a specific task to work on, such as verbally rewarding her child for good behavior. After each session, staff and mothers discuss what has occurred and model or suggest alternative behaviors.

Mothers may also be assigned additional time in the classroom to serve as teaching assistants working with their own or other children. Periodically, parent-teacher conferences are scheduled to reinforce what happens in the nursery setting. Also, staff periodically videotape mother and child in a play session so mothers can see their own behaviors, assess change over time, and set goals accordingly. The women participate in parent education seminars focusing on issues they or the staff have suggested like budgeting, nutrition, family planning, health care, and child development.

PACE provides a 24-hour hotline to respond to program participants’ crises, and staff even make home visits when needed. To prevent a lengthy waiting list from building up, PACE has developed a one-day per week entry group. Although most mothers move into the four-day core program a few weeks after admission, some remain in the entry group for several months. During this time, efforts are made to tie the families to PACE while a comprehensive assessment is done to ensure that each family receives the most appropriate services. Although at one time PACE had a long waiting list, mothers can now become involved with the program within one or two weeks of referral.

Once in the program, mothers stay an average of six to eight months. During that time other family members may be involved in the program on a less intensive basis. For example, the child’s father may be involved in couple therapy, staff may accompany a mother to school to discuss an older child’s problems with a teacher, and older children may come to the program over holidays and vacations.

PACE has also developed an open-ended follow-up support group for mothers who have left the program but still lack other forms of emotional support. Staff encourage mothers in the program to provide support for each other. Some mothers use the follow-up group as a safe base to which they return in times of impending crises, other more chronic patients remain in the follow-up group for a year or more.

During 1981, 53 percent of all PACE admissions were referred by a psychiatric inpatient or outpatient facility. Some 18 percent came from Special Services for Children and other child protection agencies. Another 18 percent were referred by health services, often in connection with suspected child abuse or neglect. The remaining admissions were referred by family services and other social service agencies, with a small proportion of self referrals.

Women who have been involved with PACE seem better able to use community resources. They are less isolated, less likely to be on medication, and better able to separate their own problems from those of their children at the time of follow-up.

Bronx Psychiatric Center and the New York State Office of Mental Health have provided consistent support for PACE. The program has received national recognition, including the American Psychiatric Association’s 1980 Gold Achievement Award. However, in a period of tight budgetary reins, PACE, like other mental health programs, has felt the pinch of a general pattern of funding cuts.

PACE’s director feels the program is vulnerable in that prevention does not receive the recognition and support it deserves. At the same time, part of PACE’s strength is its ability to reach beyond more traditional models of mental health service to address the psychological as well as the social needs of its patients.

For more information write PACE Family Treatment Centers, Building 13, Bronx Psychiatric Center, 1500 Waters Place, Bronx, N.Y. 10461.
Cambridge and Somerville Program for Alcoholism Rehabilitation

“There are perhaps 20 million youngsters whose parents’ drinking is the central fact of their lives; kids whose feelings, personalities, and behavior are molded more by that one reality than by any other. And no one with whom these children have contact is paying that fact even the slightest attention,” according to the director of CASPAR (Cambridge and Somerville Program for Alcoholism Rehabilitation, Cambridge and Somerville Mental Health and Retardation Center). To remedy this problem, CASPAR, which is part of a comprehensive alcoholism program in Massachusetts, began an alcohol education program to reach children through the schools and their own peers.

The program has two basic components. The first, an education curriculum, “Decisions about Drinking,” presents students in grades 3 through 12 with images of responsible drinking. The curriculum focuses on alcohol use and helps students recognize problem drinking and understand and cope with alcoholism in their families. It also teaches students where to seek help. The second provides peer groups for children involving basic alcohol education and support for the children of alcoholics or problem drinkers.

For the past eight years CASPAR has trained public school teachers to use its curriculum as part of their regular classes. The Somerville school system provides teachers who participate in the training with credit toward a salary increment and with a small honorarium. So far, nearly one third of Somerville’s 600 teachers have participated in the 20-hour training program, and one third of these have gone on to take an additional 20 hours of more advanced training.

CASPAR’s director sees distinct advantages in training teachers about alcohol use. “A teacher can initiate help in a way that no guidance counselor can because a teacher talks with 30 children and singles out none. A teacher initiates alcohol education as a subject; a counselor responds to it as a problem. And, of course, many of the youngsters most in need of help are those who are not yet in visible trouble: the super-achievers and the withdrawn. Because the teacher raises the subject of family alcoholism in full view of everyone, an atmosphere is gradually created in which it is ‘okay’ to talk about alcoholism.” In addition, teachers are trained to recognize and aggressively identify children of alcoholic parents and refer these children to the second component of CASPAR, its peer groups.

Each year CASPAR selects 12 students, about half of whom are children of alcoholic parents, and trains them to become peer group leaders for a two- to three-year period. They receive substantial amounts of training and supervision so they can conduct two types of groups for children ages 12 to 18. One type of group provides basic alcohol education and is not necessarily for the children of alcoholics (although about one third of the children in these groups have alcoholic parents). The other type of group is specifically geared toward the children of alcoholics.

The groups are psychoeducational in nature and limited to ten, two-hour sessions that occur after school. Children who come to the first session of a group become its permanent members for the remaining sessions. Once a student has participated in the basic alcohol education group, he or she can join the more intensive group. Children whose parents are alcoholics can be referred directly into this second group by teachers, social service agencies, or themselves. One third of all referrals to the groups are made by peer leaders.

Both peer leaders and other students in the groups are paid for their participation. This encourages them to come and reduces the potential stigma of attending. CASPAR is careful to avoid the fear associated with seeking help from a mental health center. The program is located in a house apart from the mental health center, and there are usually lots of children coming and going.

The vast majority of CASPAR children who have alcoholic parents come from homes in which neither parent is in treatment. Often, the sober parent denies the problem and cannot help the child to understand or cope with what is happening. Many
of the children wind up with unhealthy attitudes about alcohol, and drink or use drugs irresponsibly. Some have no interest in school; others are super-achievers who are excessively responsible, taking on all the adult chores their parents have dropped.

Although some of the children have serious emotional problems, for which CASPAR refers them to the community mental health center, CASPAR’s director says, “Alcoholism is so apt to produce crazy behavior that we interpret this behavior differently from the way the mental health clinic probably would. You just know that there are some behaviors that kids in alcoholic families have to exhibit. They have to feel guilty that they helped contribute to the parent’s alcoholism problem; they have to feel that if only they had done something differently, maybe the parent wouldn’t drink, etc. They really believe these things; they are inculcated in them as part of the illness. There’s such denial on the part of the person who’s drinking that they usually try to project the blame onto anybody who’s within view, and kids are very ready targets.”

CASPAR works hard to combat children’s guilt and isolation and spends a lot of time teaching children that their main responsibility is to themselves, no matter how much they would like to help their parents. Students receive some guidelines about what to do when crises occur, gain an understanding of alcohol as an illness, travel to see local alcohol rehabilitation programs, and learn about available resources. They are also encouraged to join other peer groups such as Alateen. Perhaps equally important, participation in the groups shows students they are not alone. CASPAR tries to combine a healthy mixture of fun with work on relating to other children.

CASPAR has developed similar alcohol education groups in three elementary schools. These are taught by trained resource room teachers and CASPAR staff. They are not as intensive as the groups for older children and include some children from alcoholic families and some from nonalcoholic families, so certain children are not separated out for help. Unlike older children, younger children must get their parents’ consent to participate in the groups.

Surprisingly few of the children in CASPAR are referred from other parts of the alcoholism treatment program, which is run out of the mental health and retardation center. CASPAR’s director feels that for many patients in these programs “talking about their children is a very difficult area in which to get any acknowledgment. You can imagine how hard it is for a parent to admit that their illness has damaged a child.” Further, staff who work with alcoholic parents may be reluctant to bring up issues that either could damage the therapeutic relationship or cause their patients to feel more guilty.

CASPAR operates on a budget of approximately $150,000 per year. For the past six years some of this money has come from the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Other funds come from a contract with the Somerville public schools to train teachers and work with the children of alcoholic parents; from the state Departments of Public Health and Mental Health; from training done with other community agencies; and from selling CASPAR’s educational curriculum to other groups. To date CASPAR has not been replicated elsewhere in the state, although NIAAA has funded replication sites to conduct the in-school and peer group components of the program in Connecticut, Virginia, and Georgia.

For more information write CASPAR Alcohol Education Program, 226 Highland Avenue, Somerville, Mass. 02143.

Supporting Families

Parents Supporting Parents

In 1979 three women from Kansas City, Missouri, wondered why they could never get the support and help they needed as parents of troubled children and decided to do something about it. With the help of a small United Way grant and funding from the Kansas City Association for Mental Health, they began “Parents Supporting Parents,” a group run by and for parents whose children have emotional problems.

Besides publishing a newsletter for parents that includes lists of local resources and useful publica-
Parents Supporting Parents holds monthly discussion and program meetings that draw anywhere from 12 to 30 people. At every meeting new faces appear; other people have been coming for over a year. In about one third of the families both parents participate.

The meetings provide a forum for parents to share frustrations and concerns and exchange information about available resources and how to tap into them. At each meeting a mental health or social service professional, who has donated his or her time, gives a presentation on topics such as peer pressure, childhood depression, psychological tests and how to use them, drug and alcohol abuse, and ways to manage family tensions that come from raising a troubled child. Parents also have a chance to learn about strategies they can apply day to day, such as what to do when parents disagree about discipline, rules, or privileges for their children.

Parents feel a strong sense of support and relief after coming to meetings, according to one of the organization's founders, who stated, "Our culture says a good mother and a good father produce a good child, a child without problems." Parents often come to the sessions feeling guilty and inadequate, with their self-images shattered. Frequently, they are angry at schools, psychiatrists, or relatives but do not feel they have the right to these feelings—even when they have been treated abominably.

Many of the parents have struggled alone with their problems after relatives or friends failed to respond to their needs and so made them reluctant to talk about what was happening. A lot of people come to the meetings at a point when they are deciding what to do next—for example, whether to wage a battle with the school system, seek professional help, or stop the child from running the household. They get suggestions, ideas, and encouragement from the group. Although two thirds of the parents are drawn to meetings by media announcements and referrals from social service agencies, one third come after hearing about the group from parents themselves.

One woman came to a meeting after seeing a pamphlet about the group in a mental health center. She and her family found their first therapist when they heard him give a talk at one of the sessions. Through Parents Supporting Parents the family also got advice on various financial arrangements they could use to pay for therapy. And the organization gave the mother a crisis phone number she could and did use during times of extreme stress. Eventually, Parents Supporting Parents would like to set up a formal hotline.

Recently, Parents Supporting Parents has formed its own governing board to make decisions about ways the group can expand beyond monthly meetings. In particular, Parents Supporting Parents is interested in getting parents to become stronger advocates on mental health issues at the state and local level, so they can work to create new resources and surmount barriers to getting services.

For more information write Parents Supporting Parents, Kansas City Association for Mental Health, 4049 Pennsylvania, Kansas City, Mo. 64111.

Notes

1. There is a great deal of confusion about when prevention efforts end and early intervention efforts begin. Both terms have been used to describe programs for young children at risk of developing emotional problems and programs designed to "prevent" children's need for restrictive treatment or placement. In our view, much of what has been called prevention is more accurately defined as early intervention.


3. During 1975, the last year for which data are available, an estimated 358,000 children were treated or evaluated as outpatients by traditional mental health agencies. B. J. Sowder, et al., *Utilization of Psychiatric Facilities by Children and Youth* (Bethesda, Md.: Burt Associates, Inc., 1980), p. 2. Another 190,000 children were treated or evaluated by community mental health centers. National Institute of Mental Health, "Provisional Data on Federally Funded Community Mental Health Centers 1974 to 1975," mimeograph (Rockville, Md.: National Institute of Mental Health, Survey and Reports Branch, May 1975), Table 15. 1977 to 1978 data suggest admissions of children and adolescents were up to 230,970. National Institute of Mental Health, Survey and Reports Branch, "Provisional Data on Federally Funded Community Mental Health Centers 1977 to 1978," mimeographed draft (Rockville, Md.: National Institute of Mental Health, Survey and Reports Branch, May 1980), Table 14. Sowder's analysis suggests approximately two thirds of the children received more than just evaluations.

5. Sowder reports that in 1975 of the 243,482 children and adolescents under 18 receiving therapeutic services from outpatient settings (excluding federally funded community mental health centers), 54 percent were in individual therapy, 34 percent in family therapy, 8 percent in group therapy, 3 percent in drug therapy, and 4 percent in other psychiatric treatment. Sowder, *Utilization*, p. 19.

6. For example, in an analysis of outpatient facilities in 1975 (excluding federally funded community mental health centers), Sowder found 24 percent of the child and adolescent clients had only one visit: 45 percent, two to five visits: 19 percent, six to ten visits; and only 12 percent, more than ten visits. Sowder, *Utilization*, p. 108. At the University of California at Davis, 2,000 children and adolescents are admitted for services each year with a median number of 4.8 visits. H. C. Zingale et al., “Therapeutic Effects on Parents of Children in Treatment,” unpublished manuscript (Davis, Calif.: University of California, Department of Psychiatry, no date).


8. It is estimated that 590 federally assisted community mental health centers are now operational. This may seem like a lot but such centers are accessible to only about 43 percent of the population. The President’s Commission on Mental Health, *Task Panel Reports*, Vol. I (Washington, D.C.: U.S. Government Printing Office, 1978). Some states also have developed state-funded mental health centers.

9. For example, in 1979 the Judge Baker Child Guidance Clinic in Boston established a Family Support Center to help children and families cope with life-threatening diagnoses or situations of sudden death, anticipated death from illness or aging, or jailing. During its first year it provided services to 89 families with 109 children. See S. Fox, “Helping Families Cope With Death, Dying, and Incarceration,” mimeograph (Boston: Judge Baker Child Guidance Clinic, October 8, 1980).


12. Aid to Adolescents, run by the North Shore Child Guidance Center in Nassau, New York, provided this type of advocacy for adolescents. The report of the President’s Commission on Mental Health cited the program as exemplary because it helped adolescents by ensuring, through phone calls and meetings, that all those working with the adolescents worked together. However, the program could not get funding from the state mental health agency on the grounds that it was not doing “therapy” and was not a mental health program. For a description of the application of the therapeutic case advocacy concept in adult services, see H. R. Lamb, “Therapist-Case Managers: More Than Brokers of Services,” *Hospital and Community Psychiatry*, 1980, 31 (11): 762-764.


14. In recognition of the magnitude of the problem, the American Academy of Child Psychiatry has established the Project Future to reexamine the nature and foci of current training strategies for child psychiatry. The project task forces include child psychiatrists and other professionals concerned about child mental health. For further information write the American Academy of Child Psychiatry, 1424 16th Street, N.W., Washington, D.C., 20036.

15. This is based on a 1979 survey that found about 19,000 psychologists were licensed, relevantly trained, and actively providing mental health services. At least one half of all such providers do not see children. Of the remainder, only a small proportion see children for 75 percent or more of their time. Although this excludes school psychologists, the data are still startling. See G. VandenBos, “Proposal for a Conference on Professional Training for Clinical Child Psychologists,” mimeograph (Washington, D.C.: American Psychological Association, no date), p. 15.

16. In a 1976 internal memo the then assistant director for children and youth at the National Institute of Mental Health estimated there were 5,000 child psychiatrists, 5,000 clinical child psychologists, 7,000 child/family-oriented social workers, and 1,000 child/family psychiatric nurses. National Institute of Mental Health, internal memo (Washington, D.C.: National Institute of Mental Health, Office of Child Health Affairs, October 5, 1976).

17. See J. Grosenick and S. L. Hunter, *National Needs Analysis in
Behavioral Disorders: Severe Behavior Disorders (Columbia, Mo.: Department of Special Education, University of Missouri—Columbia, July 1980), pp. 1–25.


20. The Manpower Division of the National Institute of Mental Health, in a recent shift in its training strategies, identified children as an underserved population. However, funding cuts have sharply limited any new training initiatives.

21. The program’s behavior management techniques are modeled closely on those of another highly innovative program at the Mendota Mental Health Institute. The Home-Community Treatment Program (HCT) provides training in their own homes to parents with seriously disturbed children ages 3 to 12. These children would be placed in residential treatment programs if HCT was not there to help them. Many of the children already have spent time in institutions. The Primary Prevention Program has modified HCT’s techniques to work with children at a lower developmental age who have fewer language skills. The program also spends more time than HCT in modifying the child’s physical environment so that it is safe for the child. Both programs work closely together and refer children and families to each other for services. For more information on HCT write the Home-Community Treatment Program, The Child-Adolescent Building, Mendota Mental Health Institute, 301 Troy Drive, Madison, Wisc. 53705.


24. Total professional staff include one director, one principal, three classroom teachers, three social workers, one crisis teacher, one full-time physical education teacher, one full-time art teacher, one remedial reading teacher, one learning disabilities teacher, one part-time speech therapist, one part-time psychiatrist, 9 to 12 interns in special education, 7 to 10 volunteer therapists, and a liaison worker between American University and the program.


27. In 1970 a Task Force on Children and Youth, appointed by the Director of District V Community Mental Health Center of San Francisco, ranked day treatment as the number one priority among 18 mental health needs of children in the catchment area.

28. The ratio of staff to clients is one to three. Staff spend over 65 percent of their time working directly with the adolescents and their families. Staff include a director, a social worker, a milieu therapist, an activities coordinator, two part-time psychiatrists, a part-time psychologist, and graduate interns and volunteers.


30. Despite the intensity of their involvement, staff have not experienced the typical worker “burnout,” and turnover in staffing has been low. In part, this is because staff are held to a 35-hour per week job, with hours flexible enough so staff can be available when and where the adolescents and families need them most. Families also have 24-hour access to the community mental health center’s emergency services and COBIT staff then can be reached if this is not sufficient.

31. The North Shore Children’s Law Project is currently merging with a direct service program, Mentor, Inc., which is based on the model of the Family Advocacy Center. Mentor now has contracts to serve individuals under the Departments of Youth Services, Social Services, and Mental Health and Mental Retardation.


33. New Jersey has strong mental health regulations and recognizes in funding as well as principle the importance of case advocacy to the effective delivery of mental health services. However, they have not made an effort to establish programs like CATT in other parts of the state.
III:

Implementing a Range of Services for Children: Few Advances
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The Tenuous Commitment: Mental Health Departments

Over 600 severely disturbed children in Georgia need residential care. There is one state-supported group home available, serving five to six children.¹

Southern Nevada reported serving only 18 percent of the children needing services. Over 200 children were on waiting lists for programs.²

In Florida about 81 percent of the children needing mental health services in 1979 did not get them.³

In Mississippi, children and adolescents have access to inpatient care, but the state has no residential treatment facilities. Ten of the state’s 15 mental health regions have no day treatment programs or group homes.⁴

In Colorado a 1979 survey estimated 8.8 percent of the children and 21.1 percent of the adolescents who needed mental health services received them.⁵

In Massachusetts, state department of mental health officials found close to 400 children needing care in community inpatient wards had been denied services or were on waiting lists. An equal number had been refused day treatment, including more than 50 percent of the 13- to 17-year-old adolescents.⁶

State departments of mental health have four basic responsibilities to troubled children and adolescents: to ensure a range of specific services are available for children of different ages; to see services are integrated into “systems of care,” enabling children and adolescents to move easily from one program to another as their needs change; to define and protect the rights of troubled children and adolescents; and to create a policy framework that ensures children and adolescents receive a fair share of policy attention.

Overall, states are failing to meet these responsibilities. Children’s needs are unmet, and families unserved. Just as scattered programs exist to help troubled children and families, a few policy efforts have been made to improve mental health services for them. Yet after surveying officials in 51 state mental health departments during the spring of 1981 (see Appendix A), reviewing state reports, and interviewing selected state officials, our findings are largely bleak.

Implementing a Range of Services for Children: Few Advances

Nonresidential Services

Early Intervention

State departments of mental health have done little to stimulate the development of early intervention services for children.⁸ Only Florida, Michigan, and North Carolina have legislation mandating such programs be developed. Just 12 states report systematic statewide efforts to fund or create early intervention services.⁹ Departments of mental health in these 12 states have tried to identify troubled children early on, reach out to disturbed children and families, educate parents and professionals about child mental health, or prevent residential placements.

The Michigan Office of Prevention has funded a number of demonstration projects focusing on infant mental health, teen parenting, preventing substance abuse, aiding children of divorced or emotionally disturbed parents, helping low-income women to manage stress, and providing parent training for low-income families. Michigan also has developed certification standards for preventive services.¹⁰

South Carolina has used its limited funds to enable community mental health staff to serve on primary prevention teams in hospitals. Projects emphasize crisis intervention for children of psychotic or hospitalized parents and parent training for families of children at risk of developing emotional disturbances.

Tennessee has established regional preschool programs for children under five that use parents as teachers and as volunteer staff.

North Carolina has funded 21 projects for children ages three to six, providing services like parent training, consultation to local programs, and community education.
Intensive Services in the Home or Community

States have virtually no capacity to provide intensive nonresidential programs like day treatment and home-based care. Startlingly few states use their mental health funds to support programs enabling children to remain with their own families.

Of 27 states able to provide information on state-supported day treatment, 15 percent reported no day treatment programs; 48 percent, less than 10; 33 percent, between 11 and 20; and only Pennsylvania, over 20 programs. Twelve states did not know whether they had any day treatment programs or not. Only Florida reported a systematic attempt to expand day treatment services. An initial program was developed by the Florida Mental Health Institute to serve children in foster care and those who had committed status offenses. Subsequently, the program was opened to other children, and six similar day treatment programs were developed through schools or community mental health centers.

Efforts to develop intensive home- or community-based services have been even rarer, although Rhode Island, Maine, and Wisconsin have funded a limited number of intensive nonresidential programs. Maine, in particular, has six home-based crisis programs operating in different parts of the state.

Funding problems have discouraged states from supporting intensive community services, even though keeping children at home and out of costly residential care saves money. It is hard to get third-party reimbursement for the delivery of home-based services or for the travel costs entailed in going into families' homes. Costs involved in coordinating services delivered to children and families in the community also are “nonreimbursable.”

Funding for day treatment as a mental health service is restrictive and discriminatory. Reasonable Medicaid funding has been available only for hospital-based programs. Reimbursement rates for day treatment are extremely low compared to the costs of running such programs and to the rates paid for inpatient care. For instance, in Pennsylvania, inpatient care for children and adolescents was reimbursed at $300 a day; a day treatment program run by an affiliated child guidance center was reimbursed at $24 a day. Yet during the day, children in day treatment and those in inpatient care participated together in the same activities. Such fiscal patterns make it more “cost effective” for state departments of mental health to hospitalize children than to offer quality day treatment services.

Because day treatment combines educational and clinical services, funding disputes have also arisen between mental health and educational agencies about which department should pay for program costs. In many places such disputes have hindered the development of programs. Increasingly, mental health agencies are simply turning responsibility for day treatment over to the schools.

For those disturbed children and adolescents who cannot participate in the usual range of afterschool activities, the end of the school day means long hours with little to do. Only Massachusetts and Illinois reported developing special afterschool programs for troubled children; only Massachusetts was developing weekend programs. Summer programs for troubled children are also scarce. Clearly, if disturbed children have access to part-time programs outside of school hours, they may be able to avoid costly 24-hour residential care. Yet such programs are the exception.

Inexplicably, we heard of state officials not only ignoring the need for day treatment but actively opposing the development of such services.

In one state a community-based mental health program for children prevented the state from destroying a vacant state-owned building that it hoped to use for a day treatment center. Alerted to the building's potential value, the state decided to accept commercial bids for use of the property. Since the mental health program could not afford the new prices, it was once again without facilities for a badly needed program.

In another state a community mental health center spent years trying to develop a day treatment program. The state claimed this program would not fit into plans to regionalize day treatment services. Unfortunately, whatever “plans” the state had were never carried out,
and five years later children in need of day treatment still had no place to go.

In another state a community mental health center with an excellent reputation for its children's services has unsuccessfully sought to start a day treatment program for adolescents. Despite a professed commitment to children's mental health, the state has not found a way to provide relatively minimal start-up funds, although operating funds are available. As a result, adolescents remain unserved.

Residential Services

Residential Treatment Centers

In contrast to minimal efforts to create nonresidential services, 18 of the 44 states responding to our survey were working to increase residential care.16

Some states have established their own facilities for disturbed children. Others have created policies permitting the purchase of private residential care only for certain groups of troubled children. Still others are contracting with private providers for a range of residential care as just one part of a broader effort to expand programming for emotionally disturbed children. The number of children served and the amount of dollars allocated for residential treatment vary considerably between states.

Arkansas committed $1.4 million to create six residential facilities for children and adolescents. In response to a report by a child mental health task force, the state developed an overall plan for funding different kinds of residential care and is testing licensing standards for such programs.17

In California, child and adolescent mental health officials piggybacked on new funding available to create residential alternatives to hospital care for adults.18 Officials used a small portion of this money to develop or enrich mental health programs for children and adolescents. The state primarily has funded residential programs but also some nonresidential services.

In New York recent legislation authorized the development of up to 900 new residential beds to provide intensive treatment for children and adolescents.19 The state has described these beds as halfway between inpatient and residential care. New York has drafted but not promulgated regulations for these programs and plans to establish regional committees to oversee how children are admitted to them.

In Washington a joint venture between the state and private facilities led to the creation of a 60-bed residential treatment program for children and adolescents. Admission to the program is jointly determined by facility representatives and state mental health officials. Washington is currently working on standards for the facility.

Other states reported a need for more residential care but had not mobilized enough political support to take concrete steps or expand existing programs.

Massachusetts identified some 800 disturbed children awaiting residential placement through the department of mental health, but no programming had been authorized.

Indiana authorized funds in 1968 to develop six residential treatment facilities for children and adolescents; only one facility has been constructed.

Mississippi had requested but not yet received funds to create the state's first group home for troubled children.

With the exception of New York, the number of children reached by new residential treatment programs is low: 14 in Arizona, 45 in Georgia, 35 each in Louisiana and Vermont. Only Florida, Illinois, New York, Rhode Island, and Washington reported serving over 50 children. Funding levels vary from $260,000 in Arizona to an anticipated $5.6 million in New York. Not surprisingly, most states reported long waiting lists for services.

Generally, state departments of mental health have developed residential treatment facilities as an alternative to more restrictive hospital care. Thus, Florida's regulations do not permit children to be hospitalized unless all purchase-of-service monies for residential treatment in the child's community have been exhausted, or the court has specifically ordered hospital placement.

Every state allowed residential treatment funds to be used for in-state residential care; some permitted pur-
chasing out-of-state care; only two states with purchase-of-service programs permitted funds to be diverted for nonresidential services. Yet evidence suggests intensive community-based programs may be more appropriate for many troubled children and adolescents identified as needing residential care.

In general, funds were used to develop long-term residential care, with few efforts to support or create emergency shelters, respite care programs, or specialized foster care for disturbed children and adolescents. However, Florida reported a network of specialized foster homes with the capacity to care for over 330 emotionally disturbed children and adolescents; North Carolina reported 31 therapeutic group homes; and Massachusetts reported it had increased emergency residential services in some communities by purchasing specialized beds in shelter programs.

States have not emphasized continued monitoring of children’s care once they are in residential treatment. In a small number of states, including Florida, Washington, and New York, admission to programs must be approved by special community-based committees, but only Florida’s committee continues to monitor a child’s stay in care. In Illinois, admission and monitoring are done by regional office staff and include direct observation of children in the facilities and assurances against abuse and neglect. The general absence of monitoring is serious. Local, state, and national exposes and litigation regarding the quality of care in residential treatment centers have shown that some programs promise high-quality treatment but deliver low-level custodial care. There have been reports of children being abused and behavioral “therapies” being overused or misused. Such therapies may do little more than systematically punish children, or, under the guise of treatment, deprive them of basic civil and constitutional rights.

Inpatient Care

The most readily available “help” for seriously disturbed children remains the most extreme—inpatient hospital care. Hospital care not only is the most restrictive treatment but often the most costly. Data from a range of states suggest at least 40 percent of the hospital placements of children are inappropriate.

A 1979 audit of the cases of 25 children whom the District of Columbia court had referred to a psychiatric hospital found 44 percent of the children could have been served as outpatients.

A 1977 survey of 1,001 children in New York State found only 41 percent of the children were appropriately hospitalized. According to the authors, 25 percent of the inpatients should have been in outpatient care or day treatment; 10 percent, in residential care; and 24 percent, in facilities for the mentally retarded.

A 1979 report from New Jersey, summarizing earlier studies, found little change in that state’s patterns of hospital placement between 1975 and 1979. According to the report, less than 20 percent of the children admitted to hospitals were psychotic. About 40 percent were inappropriately admitted to hospitals or remained in care too long while awaiting other placements.

A 1980 survey from Massachusetts estimated 40 percent of the adolescents in state hospitals could have been diverted to community placements had these placements existed.

Despite these findings, one third of the states responding to our survey indicated a need for more long- or short-term hospital beds. These reports are hard to interpret, as no uniformly accepted ratio of beds to population exists. However, those states with the fewest alternatives to inpatient care were generally the ones that wanted more beds; those with a number of alternative programs saw less need to fund more hospital placements.

Data from our own survey suggest states spending 50 percent or more of their child mental health funds on inpatient beds spent little or no money on alternatives and vice-versa.

In Fiscal Year 1979 Massachusetts reported some 257 children and adolescents were denied acute inpatient
beds or were on waiting lists for these beds. When state officials analyzed this data by region, they found the region with the most comprehensive system of crisis intervention services, emergency shelters, and residential care for children recorded only 12 children denied treatment. Another region that did not have any emergency shelters or residential alternatives in the community had 79 children denied care, or 40 percent of the state total. Moreover, in two regions that developed community-based crisis beds and an outreach screening program for the state hospital, admission rates were reduced substantially.31

Only New Jersey reported a planned effort to reduce the number of hospitalized children and adolescents in the state and return them to the community.32 Backed by documentation showing children were inappropriately placed in hospitals, the state closed three of four children's units and expanded its purchase-of-service contracts in the community.33 A number of other states have reported closing or consolidating state beds for children and adolescents as the result of funding pressure. In these states, funds were not reallocated for less restrictive services.

States do not know much about the quality of care provided to children in hospitals.34 Few states reported specific strategies to monitor the quality of care for hospitalized children or ensure their right to an appropriate education. Only Missouri reported specific, detailed regulations developed by the mental health agency regarding how to notify families of their children's educational rights and carry out these rights.35 The absence of state attention to the quality of educational programming for hospitalized children is particularly disturbing because evidence shows teachers in state hospitals are less well-trained and paid than other teachers.

Equally troubling, children and adolescents are still placed on adult wards.

Of the 39 states responding to this question, 24 reported statutory or administrative rules against placing children or adolescents on adult wards. (See Appendix A, Table VI). However, 21 states reported children or adolescents actually were placed on adult wards, and of these, only ten indicated that placement was limited to a few children and adolescents or used only in special circumstances.36

In one year over 700 Massachusetts children were hospitalized on adult wards. Massachusetts does not have any rules against placing children on adult wards nor does it have specialized adolescent units within its state hospitals.37

In Florida in Fiscal Years 1978 and 1979, 40 percent of the children and adolescents admitted to hospitals were placed on adult wards.38

These children and others like them experience terrifying situations.39 They are often exposed to seriously disturbed adults who have spent years in institutions, may be severely impaired, and show extremely bizarre behaviors that the children begin to mimic. Further, children on adult wards are particularly likely to be denied suitable education and other services, as activities on these wards are oriented toward adults.

When it comes time for children to leave the hospital, most states reported fiscal and other barriers to coordinating hospital and community-based services for the children.

A recent study of Colorado's continuity of care policy in regard to children and adolescents found serious deficiencies. The study recommended that staff of community mental health centers within 60 miles of a hospital attend planning conferences for hospitalized children, while staff beyond a 60-mile radius be required to participate in meetings over the phone. The report noted that failure to reimburse community mental health centers for the time staff spent traveling to the hospital and meeting with hospital officials substantially discouraged coordination, and recommended such time be reimbursed.40

An audit of the records of 32 children discharged from St. Elizabeth's Hospital in Washington, D.C., found that those discharge criteria present in records at all were often administrative. A follow-up study of 22 child patients discharged from the hospital within a five-month period found 44 percent of the children followed their after care plans in whole or in part; 50 percent did not.41

In view of evidence that care for hospitalized children breaks down exactly when these children can return to the community, the absence of state initiatives in the area of after care planning and follow-up
is tragic. Either no one ensures needed community services are planned and received by children, or efforts to find alternative community-based residential placements fail. Only Georgia, North Carolina, and Florida reported explicit statewide efforts to increase the coordination between hospital and community-based staff delivering mental health and other services to children.

In each of Georgia’s mental health regions, the director of the community mental health center’s child and adolescent program meets monthly with hospital staff to discuss administrative issues and individual children’s needs.

In North Carolina periodic meetings between staff of community mental health centers and hospitals are chaired by area children and youth coordinators, employed by the state. As in Georgia, the state director of child and adolescent mental health attends the meetings as often as possible.

Pennsylvania is trying to replicate statewide a demonstration project providing backup services to children discharged from hospitals to foster homes. 42

**Therapeutic Case Advocacy**

Only New Jersey and North Carolina reported efforts to define and fund specialized case management or advocacy services for at least some disturbed children and adolescents. New Jersey’s regulations acknowledge the importance of case advocacy for troubled children. The state has developed one program, the Child and Advocacy Treatment Team (described in Chapter II), but has not tried to replicate it statewide. 43 In North Carolina specific funds are available for case management services for the class of children covered by the Willie M. lawsuit (see Chapter VI).

**Creating Systems of Care for Children: The Unmet Challenge**

It is not enough to develop a range of nonresidential, residential, and case advocacy services for children. These services must be organized so individual children can move easily from one to another depending on their age and needs, and so multiple services can be delivered to children, adolescents, and families in a way that is helpful rather than confusing or overwhelming. We have called such coordinated services “systems of care.” The effort to move adults with chronic mental illnesses from hospitals into community services has led departments of mental health to acknowledge that disturbed adults need systems of care, but states have been slower to recognize troubled children need the same thing.

Only seven states have departments of mental health that have taken even limited, explicit steps to create systems of care for children and adolescents. In these states there have been sustained efforts to increase the range of mental health services available, reduce the fragmentation of services, and counter the rigidity often built into mental health funds.

At best another 18 states responding to our survey recognized the need to strengthen the range of services available to children, coordinate services between mental health and other departments, and focus more attention on children and adolescents. But these states have only been able to move forward in one area. 44 A few have allocated funds for early intervention efforts or for noninstitutional residential services. A few have tried to work with other state agencies serving disturbed children or have taken specific steps to identify and plan for children in need of mental health services. For example, the Mississippi Department of Mental Health analyzed the needs of disturbed children, sought a staff person to work on children’s issues, and appropriated $1 million for child mental health services. Vermont has tried to respond to severely disturbed children and adolescents, primarily autistic ones, by creating specialized foster families in which highly trained
Examples of States Trying to Develop Systems of Care

Florida has tried to limit the institutional placement of children by purchasing alternative services and developing a network of day treatment programs and specialized foster homes.

Georgia's department of mental health has created a multiagency focus on troubled children at the state and local levels. The state has developed regional consortia, including staff of community mental health centers and state hospitals, to address policy issues and form treatment and outpatient plans for children placed in the state's seven psychiatric hospitals.

Maine's mental health officials have used discretionary money for children's services to fund pieces of a system of care. They have six home-based crisis programs and are developing a comprehensive residential program for children. This has enabled children who cannot be adequately helped in the short-term program to move into residential settings of various kinds. They are also planning for infant mental health intervention projects.

Massachusetts has done a detailed analysis of the unmet mental health needs of children. The state has tried to create a range of nontraditional services like crisis residential care and develop statewide systems of care for abused children and violent disturbed adolescents.

New Jersey has tried to reduce the number of children in psychiatric hospitals and treat them in the community. It has closed three child and adolescent units in its state psychiatric hospitals and sought to develop community-based alternatives. A children's bureau was created within the state mental health agency to oversee this process. New regulations have been developed identifying children in hospitals or at risk of placement as a high priority group. The state has funded one therapeutic case advocacy project, and, in awarding contracts for community-based care, has tried to encourage the creation of systems of care by requiring that each contractee develop affiliation agreements with related service providers.

New York has worked to increase traditional residential treatment and less restrictive options. Under limited circumstances the state will fund in-home treatment, and it has been conducting a study to see if more day treatment programs are needed. In addition, the department of mental health has tried to strengthen the capacity of the juvenile justice and child welfare agencies to meet the needs of mentally ill children and adolescents. In the juvenile justice system this has been done through a staff sharing program with the office of mental health. In the child welfare system the reimbursement rate for social services for adolescents in group homes has been supplemented for those needing more intensive treatment.

North Carolina, partially in response to a lawsuit, has divided the state into zones and worked within each zone to develop a plan for a continuum of services. Each zone will receive state funds in a lump grant. The grants are flexible; zones can use them to fund different levels of care depending upon the area's current needs. Further, the grants will cover both start-up and operating expenses for programs.
parents are given support staff and respite services. The state is also considering a planned way to deinstitutionalize its hospitalized adolescents. The majority of states in this group have only expanded residential care.

Nineteen state departments of mental health responding to our survey reported no attempts to create a system of care. These states have played a minimal role in shaping services for children and adolescents. Their departments of mental health may or may not take responsibility for the activities of community mental health centers. Often they do not have a children’s unit or specialized children’s mental health staff. They report having no residential treatment centers or early intervention programs. Available services generally consist of traditional inpatient and outpatient care. They have expended minimal or no efforts to plan children’s services and made no attempt to work with other state agencies.

Even in states moving toward a system of care, efforts are very limited. Although New York and Florida have tried to develop a range of services for children, programs remain fragmented and few efforts at coordination are visible. Maine’s progress hinges on how state-level staff choose to allocate $1.7 million in mental health funds not already set aside for community mental health centers or inpatient care. New Jersey seems to be moving children from state institutions to communities, but there have been charges the state is using its funds to develop inpatient care in local hospitals and community mental health centers rather than less restrictive services. Moreover, the state has emphasized helping only the most disturbed children, even though some counties do not even have child mental health specialists in their community mental health centers. Massachusetts started a child abuse project but could not sustain it due to funding problems, and its programs for violent disturbed adolescents were criticized so sharply, the state had to close them down.

Although most money for children’s mental health care comes from state funds, only a handful of states have tried to use monies flexibly and creatively on behalf of individual children, provide incentives to local areas to develop systems of care, or establish routine mechanisms for pooling interagency funds. Only a few states have included children in state definitions of chronic mental illness and targeted funds on their behalf. Yet chronically mentally ill children fill the pages of this report. They include children with very serious problems, who are often on hospital wards or in state custody, are likely to need intensive services periodically or continuously, and may become users of the adult mental health system when they grow older. States have been slow to acknowledge these children need more than short-term treatment and require systems of care comparable to those states are setting up for chronically mentally ill adults.

Most state mental health departments also have failed to work with other state agencies. Many troubled children and adolescents are not the primary responsibility of mental health agencies. They fall under child welfare, special education, or juvenile justice auspices. Some of them move among the systems. Mental health departments should be providing help to these other agencies, particularly through joint programming and training efforts. Yet state departments of mental health have done little to reach out to other agencies. Only five state departments of mental health reported that they have focused on cross-agency projects.

The New York departments of mental health and youth services (juvenile justice) have established mobile mental health teams. Based in regional children’s psychiatric centers, the teams provide services like assessment, crisis intervention, and treatment planning for children in juvenile justice facilities, and training and consultation for juvenile justice staff.

Pennsylvania has approved mental health funding for diagnostic services at 12 county juvenile courts, and mental health staff can provide services to children in state juvenile justice facilities. The departments of mental health and child welfare are also working together to create group and host homes for mentally ill children and adolescents.

The Massachusetts departments of mental health and social services have jointly founded seven projects, one in each region of the state, to provide mental health...
services for abused children and their families. Informal data from one region suggest the projects have reduced turnover among caseworkers and led to fewer court petitions for abuse and neglect. \textsuperscript{53}

Georgia, partially stimulated by citizen advocacy, has established an interagency “Troubled Children’s Committee” to focus attention on cross-system policy issues affecting the delivery of services to disturbed children. \textsuperscript{54} The state has also created a “Troubled Children’s Benefit Program” to enable agencies to pool resources and fund placements and services for disturbed children. \textsuperscript{55} Georgia has encouraged local areas to develop similar committees to create placements for children and arrange for multiple agencies to fund them. To the extent possible, the state has provided seed money for programs and run workshops on troubled children to stimulate local committees. Some 24 local groups, varying in effectiveness and organizational skill, have been formed. Even the most unsophisticated are a forum for decision makers and caseworkers from different agencies to meet and talk. The more sophisticated groups have addressed policy barriers to providing children’s services.

In Maryland, cross-agency planning efforts involving the departments of human resources, health and mental health, and education have culminated in an executive order establishing a “state coordinating committee.” Its mandate is to pull together resources, determine eligibility for services, and use a state data bank to monitor the care of children in residential treatment, regardless of the department through which the children enter care. Multiagency meetings have also acted as a support network for service providers and led to other positive steps like the development of a training program for foster parents and a more vigorous commitment by regional hospitals to ease children’s return from institutions to their communities. \textsuperscript{56}

Establishing a Policy Focus: An Evasive Goal

For state departments of mental health to create systems of care for troubled children and adolescents and provide leadership to other agencies on their behalf, they must have a visible policy focus on children and adolescents within their own department. It is a sad commentary on their commitment to disturbed children that few mental health departments reflect this policy attention in their administration, fiscal policies and practices, planning strategies, standards setting, monitoring, training, or attempts to protect children’s rights and advocate on their behalf.

Token Visibility for Children’s Services

Most state departments of mental health or their counterparts\textsuperscript{57} do not have staff solely responsible for and knowledgeable about children’s mental health issues.

In our own survey, only 21 states indicated they had a special children’s unit within their department of mental health. \textsuperscript{58} Only eight states required such units by statute. Most of the units were new; ten were created between 1978 and 1981. Given current fiscal pressures, their continued survival is of grave concern. \textsuperscript{59} (See Appendix A, Table II).

Where children’s units exist, they are uniformly understaffed.

Most states with children’s units reported no more than two central staff; many, only one. Only five states reported field staff (regional, district, or area coordinators) specializing in child mental health, and in the course of this study, positions were eliminated or vacant in two of these states.

Child and adolescent mental health officials and units tend to function in isolation.
For officials seeking innovative ways to respond to the needs of children and adolescents, there is little organized help. Good models become known primarily through word of mouth; there is no central repository for information related to child mental health in the federal government or through advocacy organizations, nor is there any organized way of transferring the knowledge of states with more developed child and adolescent mental health policies to those with less experience.\(^{60}\)

Clearly, the administrative commitment to children and adolescents within state departments of mental health is almost without exception a token one. Yet data from our survey suggest even limited attention can benefit children. States with organizational units for children tend to know more about what money is available for child and adolescent services and are more likely to work toward developing child-specific standards for mental health programs.\(^{61}\)

**Minimal Accountability for Funding Practices**

State departments of mental health know shockingly little about how much money there is for children's mental health services and how it is spent. Yet such information is basic to restructuring existing children's programs and creating new ones to serve children more appropriately.

At best one third of the reporting states could track all or part of their expenditures for children's mental health services. Only 7, or 15 percent, of the 46 responding states reported a complete, identifiable children's budget, including the ability to identify how much money was spent for different types of care (such as residential and nonresidential services). Another eight states reported partial children's budgets, typically including all funds except those spent by community mental health centers. A startling 31 states reported no ability to identify separate children's mental health funds.\(^{62}\) (See Appendix A, Table III.)

The 15 states that could account for mental health expenditures, including those for children's services, reported spending only 3 to 25 percent of their funds on children.\(^{63}\)

To our knowledge only two states recently have tried to directly increase the low funding for children's mental health services.\(^{64}\) New York State's latest five-year plan set a goal of increasing the children's share of the mental health budget from 7 to 10 percent. This goal was so limited, the state has already exceeded it. California recently amended its mental health legislation to require that 50 percent of any new categorical monies for mental health be spent for children and adolescents until each county is spending 25 percent of its mental health funds for them. Unfortunately, there is no way to enforce the legislation, and neither the state nor individual counties are in compliance with the statutory mandate.

**Little Specific Planning**

Over the years, planning how mental health services will be developed, funded, and delivered has become increasingly elaborate, requiring the involvement of health planning agencies and the development of state mental health plans. For the most part, children and adolescents have not benefited from these changes. Our review of state mental health plans suggests most address children's needs perfunctorily, with generalities substituting for concrete goals and timetables.

Only a few states have tried to do any focused mental health planning on behalf of children and adolescents.\(^{65}\)

In Wisconsin, at the initiative of the Commissioner of Mental Health, a special task force was appointed leading to the development and publication of an "Action Plan for Children's Mental Health."\(^{66}\) The plan analyzed barriers to delivering mental health services to children, including barriers outside the mental health system, and identified specific strategies and timetables for overcoming these barriers.

In Massachusetts, staff of the children's division of the Department of Mental Health evaluated the service needs of troubled children. The state conducted five separate surveys, sent to area directors, staff of
outpatient clinics, directors of residential programs, staff of day treatment programs, and staff of state hospitals. In each survey, respondents were asked to identify by age specific children who had been denied services or were awaiting care, as well as those served inappropriately. Findings were compared with inventories of existing services to provide a basis for setting priorities and justifying budget requests.67

North Carolina conducted a detailed planning process to establish state priorities for expanding services. Under the impetus of a lawsuit (see Chapter VI), the state has generated a careful process for involving local communities in planning children's mental health services.

Other states' planning efforts have focused on more limited issues.

Arkansas, partially as the result of a citizen task force, developed a plan to create a range of residential services for children and adolescents. This plan is being used as the basis for budget requests.

The Montana legislature appointed a special task force on emotionally disturbed children and adolescents. Comprised of citizens and state officials, the task force tried to identify specific children who were either underserved or served inappropriately. It then sought legislative support for a residential treatment facility in the state.

In the above instances, states have used the planning process to set priorities based on a careful look at which children need services and what they need.58 However, in the end, unless plans like these lead to concrete changes in services, they are meaningless. Neither Wisconsin nor Massachusetts allocated funds to carry out their plans. In contrast, planning in Arkansas and Montana has been the first step in legislative efforts to create needed services.

### No Differentiated Standards

Few state mental health standards include program and staffing requirements that recognize the specialization involved in providing quality mental health services for children. There is little acknowledgment of the need for skilled staff who understand child development and are committed to working with parents, teachers, and others in the child's world.

In over 40 percent of the reporting states, standards for treating children and adolescents did not differ from standards for treating adults. (See Appendix A, Table IV).

Almost 60 percent of the states reported they had or were developing specialized standards for children's services, primarily for residential care. At least six states reported residential standards were already in place. Georgia had developed but not promulgated specific staffing standards; several other states reported child-specific standards for community mental health centers. (See Appendix A, Table IV).

Most child-specific standards we reviewed were very general. A few states required that children be placed as close to their homes and communities as possible and that families be involved in treatment.69

Neither national organizations nor the federal government have provided clear guidelines for states developing specific standards for children's services. In fact, the only guidelines for nonresidential services we identified were done by the New England Children's Mental Health Task Force in 1978. These define community mental health services for children as consultation and education, screening and evaluation, outpatient and day treatment services, partial hospitalization, 24-hour care, transitional services, follow-up, and services for substance abuse.70 For residential care, there have been more models, including the child-specific standards developed by the Joint Commission on the Accreditation of Hospitals71 and standards for residential treatment developed by a multistate consortium.72
Haphazard Attempts at Monitoring

Standards are only useful if they are specific, cover significant aspects of service delivery, and are used as part of a monitoring or licensing process. Yet responses to our survey suggest states rarely do monitoring of children's mental health services other than following general requirements in state and federal law.73

Of the reporting states, 23 percent indicated children's mental health staff were never involved in monitoring. About 30 percent said these staff were involved only as needed. Just over 23 percent indicated children's mental health staff were routinely involved in monitoring.74

Neither mental health facilities nor officials with responsibility for children's services reported useful feedback when monitoring occurred. Citizens rarely got a chance to hear about a state's actions regarding children and adolescents. Only Hawaii reported a statute requiring that the work of its child and adolescent mental health division be made public.75

In some ways a state department of mental health's ability to oversee and monitor children's services depends upon larger organizational and jurisdictional issues within the state. For example, in some states, counties are seen as virtually autonomous, and state mental health agencies are reluctant to do even minimal monitoring. In other states, the state system does not include community mental health centers, and officials know little about what is happening in them. These states often have not tried to coordinate the children's services provided by community-based and institutional facilities. Regardless of the causes, the absence of sustained and meaningful state involvement in monitoring is a crucial inadequacy that may have harmful consequences for disturbed children and adolescents.

Ignoring Training

Competent staff are essential for the delivery of quality children's services, but state departments of mental health have not assumed responsibility for training those who work with or make decisions about disturbed children and adolescents. Nor do they train mental health professionals about the resources available to them from other systems. There were a few isolated exceptions.76

South Carolina reported a limited budget to support the training of child psychiatrists.

Hawaii's legislation on child mental health requires the division of child mental health to provide in-service training to those working with children. The children's unit has interpreted this to apply to staff within the mental health division, and, to the extent possible, to staff in other agencies.77

For states to ignore training undermines the effects of their own service dollars. Even if a state allocates funds for a range of services, unless those who provide services are well-trained, the programs may fail.78 The lack of commitment to training is a problem not only for child mental health but for other children's services such as child welfare and child care. But for disturbed children and adolescents, who have serious problems relating to others and may go to great lengths to challenge any relationships, the needs for staff training and support are critical.

Defining the Rights of Children: Limited Action on Their Behalf

In the past decade, people have spent a lot of time defining the rights of mentally ill people, developing ways to enforce these rights, and strengthening state mental health statutes.79 For children and adolescents, attention has centered on how they may be admitted to psychiatric hospitals and retained there, an area that has sparked much controversy.80
When and how children and adolescents can be voluntarily committed to psychiatric hospitals has been the focus of particular concern. Although states have begun to treat older adolescents' rights in these procedures somewhat differently than those of younger children, there are still at least 13 states that allow minors to be voluntarily admitted to psychiatric hospitals upon the request of a parent or guardian, with no provision for the minor to object or for the objection of another on the minor's behalf. Further, states requiring mandatory reviews regarding the care of hospitalized children and adolescents and the appropriateness of their continued stay in the hospital are still in the minority. Our analysis of states' voluntary commitment statutes revealed the following:

Twenty-two states treat older adolescents differently from children in their voluntary admission procedures. Typically this involves giving adolescents either the right to apply for admission on their own or to object to the admission. Yet in 13 states, parents can still admit minors of any age to psychiatric hospitals. (See Appendix B, Table II.)

A limited number of states mandate reviews to determine whether it is appropriate to voluntarily admit children to psychiatric hospitals. Four states routinely apply their general admission review procedures to children; only nine states mandate child-specific review procedures. In all but four of these 13 states, reviews are conducted by hospital personnel, other administrators, or community mental health center staff. In an additional eight states, voluntary admission procedures provide for reviews at the time of admission for children of certain ages or in particular circumstances. Two other states have general admission review procedures that are applicable in selected circumstances. (See Appendix B, Table III.) Only six states routinely mandate child-specific reviews once children and adolescents are voluntarily placed in hospitals. Twenty-four states presumably subject children and adolescents to the same reviews required for adults; five of these states also provide for child-specific reviews for children of certain ages or in special circumstances. In 19 states there are no statutory requirements for periodic reviews of voluntary admissions. (See Appendix B, Table IV.)

Only 17 states provide children and adolescents the right of access to appointed counsel or to a mental health advocacy service in proceedings related to voluntary admissions. Of these, 11 states have specific provisions addressing the rights of children and adolescents to representation. (See Appendix B, Table V.) Only four states, Arizona, Colorado, Connecticut, and Maryland, have specific statutory provisions in their mental health codes governing the admission and review of children in state custody to psychiatric hospitals.

In general, states are slowly beginning to address, through statutes, the special needs of children and adolescents who may be placed in psychiatric hospitals or are already in them. (For examples of responsive legislation, see Box at p. 56.) But even when states have strengthened one aspect of their statutory provisions regarding the psychiatric hospitalization of minors, other aspects remain unchanged. For example, only Illinois, New Mexico, and North Carolina require both child-specific admission and periodic reviews of all voluntarily admitted minors. In most other states that have child-specific reviews, the reviews generally do not apply in all cases, and may apply at admission or periodically once the child is in care but not at both times. (See Appendix B, Table I.) Voluntary and other commitment procedures comprise the major foci of states' child mental health statutes. Some states include additional protections for children and adolescents. For example, a number of states have bills of rights for hospitalized patients or others receiving mental health services that include specific rights applicable only to children and adolescents, like the right to an appropriate education. Other states explicitly require that children be notified of their right to be discharged and told how to request discharge.

States generally have not protected children's rights through mechanisms like ombudsmen and interagency dispute resolution teams. Where such mechanisms exist their role is limited.

Selective queries to states with ombudsman programs or other programs to protect patients' rights indicate...
that ombudsmen generally have little time for children and adolescents or little specialized training regarding how their rights differ from adults' rights.85 For example, patients' advocates typically are not mandated to deal with such crucial issues as the timely placement of children in less restrictive settings or educational programs.86

Most advocate programs only cover people in institutions. However, there are some exceptions. For example, under California law, advocates cover both inpatient and community-based services, and in at least one county there are specialized advocates who are paid by the county to deal with the mental health problems of children and adolescents.

In a few states, disturbed children have access to case advocacy services through state agencies other than departments of mental health. For example, nine states reported formal interagency mechanisms to resolve disputes or develop services for hard-to-serve children and adolescents.87 A similar number reported informal dispute resolution mechanisms, and two reported such mechanisms were planned. The need for tangible ways to assure children receive the services they are supposed to and have someplace to go if their rights are violated is crucial in a system of care that typically involves multiple agencies and services and restrictive placements. For the most part, state procedures to do this are nonexistent or ineffective.

**Statutory Provisions Related to the Psychiatric Hospitalization of Children and Adolescents**

**Admissions**

**New Mexico** allows minors 12 or older to voluntarily admit themselves to residential treatment programs for mental disorders for no more than 60 days. To have a minor voluntarily admitted for treatment, minors and their parents or guardians must knowingly and voluntarily execute a document, which includes clear statements of the minor's right to voluntarily consent or refuse to consent to the admission, to request an immediate discharge from treatment at any time, and to be ensured certain rights if the minor requests discharge and the physician or program director determines the minor needs continued care. The document must be completed before admission occurs. Each statement must be clearly explained and initialed by the minor and the parent or guardian. Consent to admission must be filed in the minor's hospital record within 24 hours of admission, and the program director must notify the district court or special commissioner of the admission, giving the minor's name and birthdate and the date and place of admission.

An attorney representing the minor shall meet with the minor to explain the right to counsel; the right to terminate a voluntary admission and the procedures for doing so; the effect of terminating a voluntary admission and the option of the physician and other interested parties to petition for an involuntary admission; and other rights under New Mexico statutes.

No minor seeking voluntary admission to a residential treatment program shall be represented or counseled by an attorney who, in the previous two

*For detailed analyses and citations, see Appendix B or the state statutes themselves.*
years, has advised or represented the minor’s parents, guardians, or the residential program, or would otherwise have a serious conflict of interest.

**Illinois** allows any minor to be admitted to a mental health facility for inpatient care upon applying to the facility’s director and having the director find a mental illness or emotional disturbance requiring hospitalization and determine that the minor is likely to benefit from inpatient care.

Except in emergencies, a psychiatrist or clinical psychologist who personally has examined the minor must state in writing that the minor meets the standard for admission, include detailed reasons for such conclusions, and state any alternatives to hospitalization explored.

**Reviews**

**Arizona** requires the medical director of a mental health agency to review the case progress of all minors admitted voluntarily to the agency at least every ten days to establish whether continued placement is appropriate according to the minor’s progress in care and the expected benefits of continued inpatient care and treatment. The review must include an interview with the minor.

The medical director shall state in writing in the minor’s clinical record the reasons for continued inpatient care and the desired objectives. Records of the review shall be available to the parent or guardian on request. When the child is a ward of the juvenile court or in custody, the case review record shall be forwarded promptly to the juvenile court and the court-appointed custodian of the child.

**Connecticut** states that children 14 or older who have been hospitalized by a written request of their parents may request a hearing in writing to review their status as voluntary patients. The hearing must be held within three business days of the request. Children 14 or older must be informed in writing of their right to a hearing within five days of their fourteenth birthday.

At the hearing, the child shall have the right to be present, to cross-examine all witnesses testifying, and to be represented by counsel. The hearing shall be held by the court of probate in the district in which the hospital is located. At the end of the hearing, unless the court finds clear and convincing evidence that the child suffers from a mental disorder requiring hospital treatment, that such treatment is available, and that there is no less restrictive available alternative, the court shall order the child released from the hospital. Otherwise, hospitalization may continue. No request for a hearing shall be granted more than once in each 90-day period.

**Pennsylvania** provides that minors under 14, their parents, legal guardians, or persons standing in loco parentis may effect the minor’s release from voluntary inpatient care. If any responsible party believes it would be in the minor’s best interest to be withdrawn from voluntary treatment or afforded care in a less restrictive setting, the party may file a petition in the Juvenile Division of the court of common pleas for the county in which the minor resided, requesting a withdrawal from or modification of treatment. The court shall promptly appoint an attorney for the minor and schedule a hearing to determine what inpatient treatment, if any, is in the minor’s best interest.
Recommendations

To strengthen mental health services and systems of care, each state mental health department should

Conduct a mental health inventory to identify specific children and adolescents now served inappropriately or denied or awaiting services.

Develop specific plans and timetables for increasing the range of services needed locally, regionally, and statewide to serve those children and adolescents identified through the inventory.

Target new funds or reallocate old ones for intensive nonresidential services. Develop fiscal incentives for local areas to create systems of care, including intensive nonresidential, residential, and therapeutic case advocacy services for disturbed children and adolescents. Ensure funds for residential services can also be used for intensive nonresidential care.

Promulgate specific treatment and placement standards for disturbed children and adolescents that embody the following principles:

If placement is needed, it is in the least restrictive setting appropriate to the child or adolescent’s needs, in or as close to the child’s community as possible, and involving the child’s family to the extent possible.

Prior to placement, documentation should be required of efforts to provide services in a nonresidential program, like home support or day treatment.

Every child and adolescent served through the mental health system should have access to an appropriate level of therapeutic case advocacy services.

Treatment and treatment planning should involve, as much as possible, the child’s or adolescent’s family and others important in the child’s life.

Develop ways to monitor the quality of care provided to children and adolescents in nonresidential and residential programs.

Ensure the state’s definition of chronic mental illness permits targeting resources at chronically mentally ill children and adolescents as well as adults.

Take specific steps to ensure policies affecting hospitalized children include discharge planning; continued monitoring of care; access to patient advocates in the hospital; prohibitions, in all but exceptional circumstances, of placing children or adolescents with adults; and, to the extent possible, requirements that young children be separated from adolescents.

Develop a strategy to increase training for state officials making decisions about troubled children and adolescents and for others working with disturbed children, including caseworkers, probation officers, and teachers.

Take the lead in establishing specific means for resolving interagency disputes and pooling financial and other resources from multiple agencies to provide services for troubled children and adolescents. Pay special attention to children in state custody or at risk of hospital placement, and to those for whom no one state agency is responsible.

Fund therapeutic case advocacy and other efforts to see children and adolescents do not linger in hospitals and do receive needed treatment, education, housing, and other services after discharge.

To increase the mental health policy focus on children, each state mental health department should

Establish an administrative unit for child and adolescent mental health services, staffed by professionals with the capacity and authority for leadership. Mandate, in policy or legislation, that the unit develop detailed planning strategies for children’s services. Include funding for the unit in an annual child and adolescent budget request.

Establish specific goals for increasing the children’s and adolescents’ share of mental health funding over a five-year period.
Ensure that a specific child and adolescent mental health plan is developed, made public, and updated periodically. The plan should include detailed strategies and timetables for expanding intensive residential and nonresidential services and interagency service efforts at the state and local levels.

Examine new approaches within state mental health departments to provide leadership (including training, supplemental funding formulas, and joint programming) to other state agencies serving troubled children and adolescents.

To protect the rights of children and adolescents in need of mental health services, each state should

Enact and enforce statutory protections to ensure hospital placements occur for children and adolescents only after documenting rigorous efforts to identify less restrictive appropriate placements.

Ensure periodic reviews are required for all children in out-of-home placement, particularly those in psychiatric hospitals, and see that, regardless of whether reviews are administrative or judicial, children have access to counsel.

Inform all children and adolescents in hospitals and residential treatment programs and their parents and surrogate parents about the specific treatment and educational rights of children and where they can go for help with complaints or violations.

Scrutinize and strengthen, where necessary, existing protections for seriously disturbed children and adolescents in state custody.

Notes

1. Memorandum from the Commissioner of Georgia's Department of Human Resources, cited in Troubled Children in Georgia: An Overview With Avenues for Action (Junior Leagues of Athens, Atlanta, Augusta, Columbus, DeKalb, Macon, and Savannah, no date).
2. Division of Mental Hygiene and Mental Retardation, "Mental Health Progress," draft (Reno, Nev.: Division of Mental Hygiene and Mental Retardation, March 1981).
4. Mississippi State Department of Mental Health, "Planning Project for Child Mental Health Services," draft mimeograph (Jackson, Miss.: State Department of Mental Health, Spring 1980).
7. The survey sought information about basic fiscal and organizational patterns, commonly perceived problems, and innovative legislative, administrative, and programmatic efforts on behalf of children and adolescents in need of mental health services within state mental health departments. We received partial or complete information from 44 states. See Appendix A for a copy of the questionnaire and state-by-state findings.
9. See Appendix A, Table VII, for the 12 states. In addition to those identified, Kentucky and Nebraska reported using state funds for early intervention but provided no other confirming data. Maine reported no targeted funds but a slow steady effort to reallocate child/adolescent monies away from residential services toward prevention and early intervention. Arizona reported funding levels of approximately $200,000; Maryland $507,000; Michigan $800,000; South Carolina, $58,000; and Florida, $1.2 million. The other states did not provide similar information.
11. Evaluations of such programs, however, have reported positive results. For example, a follow-up study of 102 children in North Carolina's early intervention program found that at the time of termination, 42 percent were judged to have made much change, 29 percent moderate change. At the time of follow-up, 78 percent were in a regular classroom, 13 percent in a regular class with some specialized programming, and 9 percent in a special class. C. Fuller, "Early Intervention for Emotionally Disturbed


The literature on day treatment includes two outcome studies. One ten-year follow-up of a day treatment program found that at the time of follow-up 75 percent of the initial group of 18 children were in regular or special classes, only 25 percent were in special schools. W. I. Halpern, S. Kisel, and J. Gold, "Treatment as an Aid to Mainstreaming Troubled Children," Community Mental Health Journal, 1978, 14 (4): 399–326. A follow-up of 67 seriously disturbed preschool children enrolled in a special day treatment program found the majority were at home, with 6 percent in residential facilities (primarily because of family disintegration), 15 percent in therapeutic day schools, and the rest in regular public schools and often in regular classes. (A movie about one of the children, "For Dawn—And Others Like Her" is available from the Illinois State Library, Springfield, Ill.) See E. H. Baumann, "A Day Treatment Program."

13. An evaluation of the programs suggests they are moderately successful in stabilizing the lives of disturbed children and are cost effective. In particular, only half as many children needed psychiatric placements after participating in the programs as before enrollment. The programs cost about $4,600 per student, only about $2,550 more than public school programs and substantially less than hospital costs in Florida, which range from $20,000 to $75,000 per year. Florida Mental Health Institute, "Adolescent Project: Summary of First Two Years of Day Treatment Program," mimeograph (Tampa, Fla.: Department of Health and Rehabilitative Services, Mental Health Institute, Adolescent Project, December 1980).


15. In one instance we learned of in conducting this study, the staff of an about-to-be-transferred to the schools preschool day treatment program expressed grave concern that the schools would not be able to cope with the behaviors and needs of the children, and as a result, the children would end up with only homebound instruction. The school personnel, on the other hand, believed that the children were doing so well in the mental health program they could readily cope with school. For an interesting perspective on the precipitous removal of disturbed children from specialized programs, see M. Silverman, "Beyond the Mainstream: The Special Needs of the Chronic Child Patient," American Journal of Psychiatry, 1979, 49 (1): 62–68.

16. See Appendix A, Table VII, for a list of the states. Missouri, Texas, and Wisconsin also reported public-private contracting for residential care but did not provide information about budgets, guidelines, or the number of children served.

Although the insufficient supply of residential treatment facilities has long been noted, until recently departments of mental health seemed to take little responsibility for the problem. This is changing because of the involvement of mental health agencies in disputes about fiscal responsibility for residential placements under P.L. 94-142, and because of widespread concern about the excessive use, cost, and appropriateness of out-of-county placements for emotionally disturbed and multiply handicapped children in the absence of in-state programs. See L. Behar, " Interstate Placement: An Unwritten Policy," in Major Issues in Juvenile Justice Information and Training, eds. J. Hall et al. (Ohio: Academy for Contemporary Problems, 1981).

17. Arkansas, Division of Mental Health Services, "Mental Health Systems Profiles," mimeograph (Little Rock, Ark., Division of Mental Health Services, Office of Program Support, no date).

18. Known as the Bates Program, the legislation (AB3052) authorized the development of community residential treatment systems, incorporating eight program elements that must be linked.

19. In justifying such a large program the state polled all relevant agencies. It found 100 children in out-of-county facilities or on waiting lists, 200 children inappropriately served in social service facilities, 50 children inappropriately served in youth facilities, 125 children and adolescents in mental hospitals, and 25 children served under special education. Ultimately, New York anticipated needing 800 to 1,000 beds distributed throughout the state. The initial idea was to develop the equivalent of intermediate care facilities for mentally ill children and adolescents; the state hoped to use federal dollars and seek special Medicaid funding. "New York State Status Report on the OMH Residential Treatment Facility Project," mimeograph (Albany, N.Y.: Office of Mental Health, February 24, 1981).

20. See Illinois Department of Mental Health, "Individual Care Grant Guidelines, Mentally Ill Children and Adolescents," mimeograph (Springfield, Ill.: Department of Mental Health, no date).


22. For instance, in 1975 Texas estimated that on a statewide basis 47.1 percent of the children who needed inpatient care were served, 21 percent of the children who needed emergency care, 4.4 percent of the children who needed outpatient care, and 6.8 percent of the children who needed day or evening programs. Texas Department of Mental Health and Mental Retardation, "Report of Task Force on Services to Emotionally Disturbed Chil-
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23. For example, Ohio reported that in Fiscal Year 1980 the annual costs of one child/adolescent psychiatric bed was $64,000; in Massachusetts it was $47,000; in D.C., $123,840; and in North Carolina it ranged from $45,000 to $70,000. This suggests a range of average daily costs between $126 and $338. Hospital care for children and adolescents tends to be more costly than for adults because higher staff ratios are required.


27. Massachusetts Department of Mental Health, Children's Division, "Results of State Survey of Inpatients," mimeographed planning draft (Boston: Department of Mental Health, 1981). Similarly, in a case challenging Georgia's procedure for committing minors to hospitals, evidence was presented showing that over half the children then hospitalized would not have needed to be if alternative forms of care were available. J. L. v. Parham, 412 F. Supp. 112, 122 (M.D. Ga., 1976), rev'd, Parham v. J. R., 442 U.S. 584 (1979).

28. Of the 15 states reporting a need for more inpatient beds, three states, Kentucky, New Mexico, and West Virginia, justified the need based on waiting lists; three, Louisiana, Montana, and Vermont, justified the need based on various types of surveys (Louisiana surveyed requests for placement, Montana surveyed providers and identified children in need, Vermont surveyed children's coordinators); and five, Minnesota, Mississippi, Wyoming, Rhode Island, and South Carolina, did not justify the need. Maine reported a limited need for secure beds and South Dakota reported children being refused placement or being admitted to adult wards.

29. There are few guidelines to help states determine how many beds are appropriate. A Texas task force report took the position that there ought to be ten alternative beds available for every one psychiatric inpatient bed. "Texas Task Force. California developed guidelines for services to be used throughout the mental health system, including the child and adolescent components. California Department of Mental Health, "A Model for California Community Mental Health Programs," mimeographed draft (Sacramento, Calif.: Department of Mental Health, October 21, 1981). New Jersey took the position that one psychiatric bed is necessary for every 100,000 children. The American Psychiatric Association has been studying the placement of children in state psychiatric hospitals in order to develop guidelines for such placement. See the Task Force on Children and Adolescents in State Mental Hospitals for The Council on Children, Adolescents, and Their Families, "The Status of Children and Adolescents in State Mental Hospitals," mimeographed draft (Washington, D.C.: American Psychiatric Association, March 1, 1980).

30. The pattern for 11 states providing analyzable data to the Children's Defense Fund showed the following:

<table>
<thead>
<tr>
<th>State</th>
<th>Percentage of Expenditures Reported for Inpatient Care</th>
<th>Percentage of Expenditures Reported for Alternative Residential Care</th>
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<td>11</td>
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32. New Jersey Department of Human Resources, "Reorganization Plan."

33. Of the 229 children discharged from the closed units, 30 percent were placed in less restrictive facilities by other state agencies; 28 percent, most of whom had been hospitalized for under six months, were returned home; 18 percent were transferred to the remaining hospital units for children or adolescents; 11 percent were transferred to adult units; 13 percent were placed with relatives, out of state, etc. Of the children placed in state hospitals, over two thirds subsequently returned home or to less restrictive settings. New Jersey Department of Human Services, "Report on the Disposition of Children in Residence at the Children's Units at Ancora, Greystone, and Marlboro Psychiatric Hospitals," mimeograph (Trenton, N.J.: Department of Human Resources, no date).

34. Our own data gathering did not focus on quality of care, but we repeatedly heard of situations that concerned us. In one hospital we visited, adolescents were severely punished for giggling after the lights were turned out. Elsewhere we learned of a 12-year-old who was in partial seclusion for three months, of a six-year-old who was hospitalized for over a year because the child welfare agency could not decide whether to return her to her mother or place her in foster care, and of hospitalized, overmedicated runaways.

35. Missouri Department of Mental Health, "Compliance Policies and Assurances for Public Law 94-142 and Educational Rights for School-Aged Residents of the Missouri Department of Mental Health," mimeograph (Jefferson City, Mo.: Department of Mental Health, no date).

36. According to a national survey conducted by the Council on Children, Adolescents, and Their Families of the American Psychiatric Association, only 18 states have units designed for children under 14, only 30 states provide separate adolescent units, and several states (number unspecified) permit mixing of chil-

37. Massachusetts, "Psychiatric Bed Need."

38. Reported to the Children's Defense Fund by the Florida Center for Children and Youth (FCCY) in Tallahassee. FCCY has supported legislation responsive to problems affecting hospitalized minors in Florida.

39. Special circumstances may require placing individual adolescents on adult wards, but such placements should occur only after a high-level approval or hearing process and should always be time limited.

40. Colorado Division of Mental Health, "Analysis of the Division of Mental Health's Progress Toward Reaching the Goals for Children's Services," preliminary report, mimeograph (Denver, Colo.: Division of Mental Health, June 1984).

41. Researchers found that close to 75 percent of the children discharged to their families had no after care. In contrast, 64 percent for whom other agencies had responsibility had after care plans carried out in whole or in part. St. Elizabeth's Hospital, Division of Child/Adolescent Services, Quality Assurance Committee, "Narrative Summary Utilization, Systems Review Group, Study on Discharge Planning and Continued Stay," xerox (Washington, D.C.: St. Elizabeth's Hospital, no date), pp. 17, 18.


43. New Jersey Mental Health regulations require systems advocacy that may include individual support, lay advocacy, legal representation, companionship, and service procurement for underserved populations. New Jersey Department of Human Resources, Division of Mental Health and Hospitals, "Rules and Regulations Governing Community Mental Health Centers and State Aid" (Trenton, N.J.: Division of Mental Health and Hospitals, September 1, 1980).

44. For a list of the 18 states, see Appendix A, Table VIII.

45. For a list of the 19 states, see Appendix A, Table VIII.

46. For example New York State's five-year plan says "The present mental health system for children and youth is characterized by a lack of continuity and coordination, an overreliance on service delivery in protective and restrictive settings, and an absence of a comprehensive range of services and supports to severely mentally disabled youngsters and their families. There are several subsystems of service delivery in New York State, each of which generally functions in an autonomous fashion without adequate linkage and integration with other subsystems." New York State Office of Mental Health, "Five Year Plan for the Children and Youth Population: Mental Health Services—1980," mimeograph (Albany, N.Y.: Office of Mental Health, October 1979).

47. Some states are trying to shift the balance between funds for institutional care and community-based care, but in many states the imbalance remains in these areas too. For example, in New Jersey in Fiscal Year 1982 the Governor approved the state's request for $112 million for institutional care but cut $5 million from a $26 million request for community-based care.

48. In Wisconsin, for example, the state plan for children and adolescents noted a growing number of children with long-term emotional disturbances and disabilities are being identified but few resources have been allocated to serve or plan for them. Wisconsin Department of Health and Social Services, Division of Community Services, Bureau of Mental Health, An Action Plan for Improving Wisconsin's Children and Adolescent Mental Health Services, mimeograph (Madison, Wisc.: Bureau of Mental Health, June 1980), p. 9. The state's regulations permit use of funds for chronically mentally ill children and adolescents.

49. The national plan for the chronically mentally ill, completed in the last days of the Carter Administration, estimated there are 70,000 children with chronic mental illnesses. These include those hospitalized for more than 90 days or in residential treatment centers, and nonhospitalized children and adolescents who are autistic, schizophrenic, or mentally retarded and severely disturbed. Department of Health and Human Services, "Toward a National Plan for the Chronically Mentally Ill" (Washington, D.C.: U.S. Department of Health and Human Services, ADM Pub. 81-1077, December 1980), p. A44.

50. An article on the growing number of young adult schizophrenics noted that of the 294 chronic schizophrenics between the ages of 18 and 35 who were studied, 55 percent had received mental health treatment before age 18. B. Pepper, "The Young Adult Chronic Patient: Overview of a Population," Hospital and Community Psychiatry, 1981, 32 (7): 465. In the early 1960's a descriptive study of 63 children in a psychiatric hospital in New York found that 46 of the children later were placed in public institutions, including psychiatric hospitals and penal facilities. L. C. Kovar, Wasted Lives (New York: Gardner Press, 1979).

51. The American Academy of Child Psychiatry, however, recently established a committee on chronically mentally ill children.

52. New York State Office of Mental Health, "Manual; OMH Mobile Mental Health Teams Serving the Division for Youth Residents" (Albany, N.Y.: Office of Mental Health, no date).

53. See F. L. Ahearn and K. J. Wilk, "Final Evaluation of the Department of Mental Health's Seven Demonstration Protective Service Treatment Projects," mimeograph (Boston: Boston University School of Social Work, June 30, 1981). Preliminary findings showed the projects, which provided services to about 1,100 individuals, seemed to reduce "no-show" and drop-out rates. And while families were involved with the projects, the incidence of abuse and neglect decreased.

54. The original report, which formed the basis for the "troubled children" focus, was conducted by the Mental Health Association of Atlanta. It defined troubled children as "children who are emotionally, behaviorally and/or socially malfunctioning and whose needs cannot be met by the normal community resources—family, school, church, medical services, and the like. Among these are children with serious emotional disorders, whose behavior is intolerable in school, resulting in exclusion and/or expulsion of the child; who are neglected and abused;
who violate the law, defy authority or injure others or themselves; who fail in one or another of the tasks of childhood—in learning, in human relationships, in social adaptation; without adequate homes or families to provide healthy growth experiences.” Mental Health Association of Metropolitan Atlanta, “Children in Trouble” (Atlanta, Mental Health Association, April 1979), p. 5.

The Troubled Children’s Committee includes representatives from all relevant agencies (including the divisions of Family and Children’s Services, Child/Adolescent Mental Health/Mental Retardation, Youth Services, and Vocational Rehabilitation).

55. In 1981 those benefits were used for the placement of 45 children. Georgia reported the only statewide effort to pool resources on behalf of emotionally disturbed children and adolescents. In other states some counties have initiated similar efforts. In Los Angeles County, under the active leadership of the Deputy Director of Child and Youth Mental Health Services for the Los Angeles County Department of Mental Health, a program called PACT has been initiated. It not only pools funds but selects and monitors the care of individual children eligible for the program. Decisions are made by a cross-agency committee.

56. Similar efforts can have a significant impact at the local level. See Interdepartmental Task Force on Services for Acutely Disturbed Children and Youth, “Report on the 1980 Survey of Hard-To-Place Children and Youth,” mimeograph (Los Angeles: Los Angeles County Department of Mental Health, Program Development Bureau, April 1980).

57. Administrative responsibility for mental health within states reflects many varied patterns. According to a recent survey by the National Association of Mental Health Program Directors, nine states have departments of mental health; five states have combined departments of mental health and mental retardation; ten states have placed mental health agencies within umbrella human resource agencies; six within health agencies; eight within health and welfare agencies; five within social service or welfare agencies; two within rehabilitation agencies; and five within agencies primarily responsible for institutions. National Association of State Mental Health Program Directors, “State Report,” mimeograph (Washington, D.C.: National Association of State Mental Health Program Directors, January 1979).

58. In two states, Connecticut and Rhode Island, responsibility for children’s mental health services has been transferred from the state department of mental health to generic children’s services departments; in Florida the responsibility is split between a children’s services division and mental health. The impact of such arrangements on children’s mental health services is not clear.

59. For example, of the states not reporting special units, three, Kentucky, Tennessee, and Rhode Island, indicated that such a focus had existed but was eliminated as part of a broad reorganization (Tennessee and Rhode Island) or for fiscal reasons (Kentucky).

60. The National Association of State Mental Health Program Directors sponsors a division focused on child and adolescent mental health, the State Mental Health Representatives for Children and Youth (SMHRCy). However, it functions primarily as a support group and an educational forum rather than a rigorous source of technical assistance. Its members are probably among the most knowledgeable about child/adolescent mental health policy.

61. For example, of the 15 states in our survey able to provide full or partial children’s budgets, 11 had children’s units. Of the 51 states that reported no children’s budget, only 9 had children’s units. (See Appendix A, Table III). Of those states with a children’s unit, 17 reported that they had or were developing standards for staff and programs that serve children. This was true for only nine states without children’s units. (See Appendix A, Table IV). There was no discernable relationship between the proportion of mental health funds expended for children and adolescents and the existence of an identifiable child/adolescent administrative unit.

62. Several states responding to our survey reported sustained but unsuccessful attempts to get legislative support for line-item authorizations for children’s mental health services, and in another state we learned of efforts to eliminate an already existing line item.

63. The 15 states reporting total children’s expenditures and total mental health expenditures included the seven with full identifiable children’s budgets; the eight others were not the same as those reporting partial capacity to identify and track children’s funds. We did not attempt to evaluate the accuracy of the figures provided.

64. Wisconsin uses another strategy to ensure children and adolescents receive their share of services. It requires that 50 percent of community mental health center outpatient staff time be for children and adolescents. See Wisconsin Department of Health and Social Services, Division of Mental Hygiene, “Standards for Community Mental Health, Children and Adolescents, Additional Requirements,” Wisconsin Administrative Code, Chapter PW-MH 60, effective April 1, 1977.

65. Rose Jenkins, Deputy Director of Child and Youth Mental Health Services, Los Angeles County Department of Mental Health, is currently working on a paper regarding planning for children’s mental health services and the guidelines states should use. (R. Jenkins, Child and Youth Mental Health Services, Department of Mental Health, 1106 S. Crenshaw Boulevard, Los Angeles, Calif. 90019).


67. Massachusetts Department of Mental Health, “Planning for Children’s Services.”

68. We also know examples of careful local planning, initiated by public officials, citizens’ groups, or some combination. See, for example, United Way of Greater Richmond, “Joint Mental Health Mental Retardation Project on the Acute Needs of Children,” mimeographed final report (Richmond, Va.: United Way, October 1978).

69. For example, Wisconsin requires that “no child or adolescent shall be admitted to any inpatient facility more than 60 miles from home without departmental permission,” and that inpatient care involve the family’s participation. Wisconsin Department of Health and Social Services, Division of Mental Hygiene, “Standards for Community Mental Health, Children and Adolescents.” See also Pennsylvania Office of Mental Health, “State Mental Health Plan,” draft mimeograph (Harrisburg, Pa.: Office of Mental Health, 1982, Chapter 7; Hawaii Department of Health, Mental Health Division, “Five Year State Plan for Com-
prehensive Mental Health Services for Children and Youth," mimeograph (Honolulu, Hawaii: Department of Health, Mental Health Division, September 1980); and North Carolina Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse Services, "Standards for Area Programs," mimeograph (Raleigh, N.C.: Department of Human Resources, no date), see especially Sections 1200–1500.


71. In 1979 the Joint Commission on Accreditation of Hospitals (JCAH) eliminated its separate child/adolescent specific standards and incorporated them into generic standards. Joint Commission on Accreditation of Hospitals, "Consolidated Standards for Child, Adolescent, Adult Psychiatric, Alcoholism and Drug Abuse Programs" (Chicago, Ill.: Joint Commission on Accreditation of Hospitals, 1979).

72. See Interstate Consortium of Residential Child Care, Residential Child Care Guidebook (Trenton, N.J.: Interstate Consortium of Residential Child Care, September 1980).

73. Evaluating the quality of care in facilities serving severely disturbed children and youth is not easy. For programs venturing beyond the traditional medical model the task is especially difficult and disputes periodically arise, with such programs mobilizing both defenders and those who are vigorously opposed. This can be seen in differing state responses to controversial programs, such as Elan in Maine, or in internal state disputes, such as that which pitted New York City against New York State in a city-initiated, state-opposed effort to have a specialized group home closed despite protests of the emotionally disturbed adolescents who were in the program. See "Mentally Disturbed Adolescents Seek to Reopen Foster Home," New York Times, March 10, 1980, B 14.

74. Arkansas, Kentucky, Massachusetts, Mississippi, Nevada, New Jersey, North Carolina, Oregon, Rhode Island, and South Carolina indicated specialized children's staff were routinely involved in monitoring. States that under special circumstances (e.g., only for residential treatment or purchase-of-service or institutional care) involve specialized children's staff in monitoring children's services are Arizona, Florida, Georgia, Hawaii, Illinois, Maine, Maryland, Nebraska, New Mexico, North Dakota, Pennsylvania, Vermont, Virginia, and Washington. States reporting no child-specific monitoring are Alabama, California, Delaware, Idaho, Iowa, Michigan, Montana, New York, South Dakota, Tennessee, Texas, West Virginia, Wisconsin, and Wyoming. The remaining states did not respond or provided unclear responses.


76. For an interesting locally initiated effort to train nonmental health personnel, see the training program developed by St. Francis Community Mental Health Center in Pittsburgh. S. Forque, E. Witzinekas, and R. P. Kane, A Training Program in the Primary Prevention of Childhood Mental Disorders, mimeograph (Pittsburgh, Pa.: St. Francis General Hospital Community Mental Health Center, 1980). There have also been attempts to reach across systems. Some mental health associations have developed training programs for school personnel. For instance, the Colorado Mental Health Association has developed an early intervention program for children's mental illness that involves workshops for early elementary and preschool teachers and day care staff. The Los Angeles County Bureau of Mental Health has developed a training program for mental health professionals (particularly those working with abused children) on how the court system works.


79. For an overview of the central legal issues, see the President's Commission on Mental Health, Task Panel Reports, Vol. IV. According to a recent survey, 45 states report patients' rights are specified in state statutes. In the survey only Alabama, Arkansas, Hawaii, and Mississippi reported no such provisions (the District of Columbia and Massachusetts did not respond to the survey). National Association of State Mental Health Program Directors, "Status Report on Current Mental Health Legislation, as of January 1, 1979," mimeograph prepared for the Patient Rights and Advocacy Program, Division of Mental Health Service Programs, National Institute of Mental Health (Washington, D.C.: National Association of State Mental Health Program Directors, 1979).

80. For example, in a decision about the procedures accorded children and adolescents facing admission to psychiatric hospitals, the U.S. Supreme Court held that due process does not require a formal or quasi-formal hearing prior to commitment, emphasizing the authority of parents over minor children, although the two named plaintiffs were both in state custody. Parham v. J. R., 442 U.S. 584 (1979).


81. Children can also be admitted to psychiatric hospitals through involuntary admission procedures. In one state, of the approximately 100 hospitalized adolescents, 40 percent were emergency admissions, 30 percent voluntary admissions, and 30 percent court-ordered observations. Our resources did not permit a state-by-state analysis of involuntary commitment procedures for emergency or long-term admissions.

82. There has been little study on the effect of hearing procedures related to the admission of minors to psychiatric hospitals. Of two articles reviewed, the first one concludes the process is helpful; the second, destructive. See M. Weinapple, J. E. Keefe, and P. Manto, "Legal and Psychiatric Issues in the Hospitalization of Children: The New Jersey Experience," unpublished manuscript (Rutgers, N.J.: Rutgers Mental Health Center, no
83. In Colorado and Connecticut children in state custody can be admitted to psychiatric hospitals only if they meet involuntary admission standards. In Arizona there must first be a mental health evaluation to determine whether a child who is in custody meets voluntary admission standards and whether inpatient treatment is recommended. If inpatient treatment is recommended, a court hearing must be held to determine the most appropriate treatment alternative for the child. The continued appropriateness of a mental health placement is then reviewed every 30 days. In Maryland a child in state custody may be hospitalized only when it is established by clear and convincing evidence that the child has a mental disorder and needs inpatient care and treatment to protect himself or others, and no less restrictive alternative is available. The department of mental health must make progress reports to the court every six months and send a copy to the child's attorney. Arizona Rev. Stat. Ann. §§36-518.01(B), 8-242.01 (Supp. 1981); Colo. Rev. Stat. §§19-8-103, 27-10-101 et seq. (Supp. 1980); Conn. Gen. Stat. Ann. §§17-205c to 205f (West Supp. 1981); Md. Ann. Code §§8-800(e), (f), (g).

The Children's Defense Fund did not systematically examine due process and other protections accorded children and adolescents facing placement in psychiatric hospitals in child abuse or neglect statutes or in statutes governing the transfer of children from correctional facilities to psychiatric hospitals.

84. A critical issue is whether or not hospitalized children and adolescents are informed of their rights. For an example of one hospital's attempt to do so, see St. Elizabeth's Hospital, Division of Child and Adolescent Services, "Patients Rights" (Washington, D.C.: St. Elizabeth's Hospital, 1981).

85. According to a recent survey, 28 out of 47 reporting states had some kind of specific state advocacy program directed toward the mentally ill. However, not all of these programs are actively funded and not all include on-site patient representation in the hospitals. National Association of State Mental Health Program Directors, "Status Report."

86. There are some exceptions. For example, at the time we began this study Michigan had a specialized children's rights advocacy program and had developed a special orientation for staff advocates that defined a child's basic civil, treatment, and environmental rights. J. Coye, "Children's Rights in Michigan: New Law and Old Paternalism," Hospital and Community Psychology, 1979, 32 (27): 132-134.

87. In Maine and South Dakota, Commissioners meet formally to resolve disputes; in Tennessee the Governor has approved a cross-agency committee; in Maryland there is a state coordinators council; in Montana and Georgia cross-agency committees focus specifically on emotionally disturbed children; in Massachusetts the statutorily mandated Office For Children has created a centralized independent review team; and in New York, by executive order, the Council on Children and Families is empowered to provide assistance in determining which state agency is responsible for children. In Illinois, as part of the Governor's
IV:

Child Welfare and Mental Health: The Ignored Mandate
Education and Mental Health: The Confused Mandate
Juvenile Justice and Mental Health: The Forgotten Mandate
Other Systems
Recommendations
Other State Agencies: Roles and Responsibilities

The reasons for children becoming delinquent and dependent are the same reasons that make them highly vulnerable to emotional illness: poverty, abuse, neglect, or mental or physical handicaps. 1

Chance often determines whether disturbed children and adolescents become the responsibility of state mental health agencies. They are just as likely, if not more so, to fall under the auspices of state child welfare, juvenile justice, or education agencies, or even public agencies serving mentally retarded persons or alcohol and drug abusers. 2 In part, which system ends up with primary responsibility for a disturbed child rests upon whether the child has an intact, functioning family, or whether the child has been picked up for a status offense or a delinquent act. It may also depend upon the way various state agencies are organized.

In this chapter we examine the ability of nonmental health agencies to respond to troubled children and adolescents for whom they are responsible. Our findings are based largely on data provided by state mental health officials and selective discussions with administrators from other systems. We did not systematically survey nonmental health agencies, but what we learned is discomforting. For the most part these agencies have little to offer children and adolescents in their care who need mental health services.

Child Welfare and Child Mental Health: The Ignored Mandate

Estimates suggest over one-half million children are in out-of-home care under the auspices of the child welfare system; that is, they have been placed in state custody by parental request or as the result of a court order. 3 Some children in placement have been neglected or abused by their families; some have such poor relationships with their families that in desperation parents sought placement; and some are placed by default because more appropriate alternatives to help stressed families were not available. A surprisingly large number of children enter care because of the mental illness of one or both parents; some children are placed because of their own emotional problems. 4

Thus, many of the children for whom child welfare systems have primary responsibility may also need specialized mental health services, either because of their experience prior to entering foster care, or, sadly, as a result of their experiences while in foster care. 5 The inability of child welfare systems to respond to their special needs compounds the difficulties almost all children experience in foster care. 6

Systemic problems are visible at all points in the placement process. Initially, when the need for placement becomes visible, few appropriate preventive services are available.

Although large numbers of children are placed in care because of their parents' emotional problems, state and local social service agencies have made minimal or no attempts to develop intensive family support programs to prevent the need for placement. 7 Few of the child welfare programs that have emerged to prevent a child's removal from home have a mental health component intensive enough to help children whose own behaviors or emotional problems may lead to placement. 8

At the point of or during placement there are four basic problems. First, to get help, parents of disturbed children must often give up custody of the children. Child welfare agencies typically will not place a child without a transfer of custody. Mental health agencies will, but often have nothing to offer except inpatient care. Thus, parents are often forced to “voluntarily” surrender custody of children who need placement either because there are no satisfactory alternatives or because placement is clinically appropriate. The anguish this causes parents is limitless, yet the practice is widespread, and states generally have not addressed the problem. 9

Second, not enough specialized placements exist for disturbed children and adolescents in state custody. Social service agencies have done little to ensure the availability of specialized therapeutic foster homes or
Inadequate parenting "were described within a few months as children who needed to remain in care because of their own personal inadequacies." 

Even at the point when decisions should be made about permanent homes for troubled children and adolescents, child welfare agencies fail them.

Over 30 states have mechanisms in place to periodically review the status of children in foster care and ensure that permanent plans are made for them. However, hospitalized children in state custody are often excluded from these reviews as are children placed out of state.

Judges are often reluctant to terminate the parental rights of mentally ill adults. They are equally hesitant to return the children home. Social service agencies have a hard time developing plans that would help these parents care for their children. As a result, children are left in limbo.

Special adoption services for children with handicaps rarely focus on seriously disturbed children and particularly ignore children in psychiatric hospitals. We even heard reports of mental health professionals blocking efforts toward permanent homes for such children. Further, parents who adopt troubled children have access to few supportive mental health services.

The picture is not all bleak. Some models for preventive programs with a therapeutic orientation are developing, just as some new approaches to therapeutic foster and group homes are emerging. But overall, child welfare agencies have done little to develop specialized alternatives.

Education and Mental Health: The Confused Mandate

In 1975 landmark federal legislation was enacted guaranteeing children with handicapping conditions the right to a free appropriate education. The Education for All Handicapped Children Act, Public Law 94–142, explicitly includes seriously disturbed children in its mandate. It requires that for each disturbed child, as for all other handicapped children, an Individualized Education Program...
Important Definitions from
The Education for All Handicapped Children Act

P.L. 94–142 defines related services as:

"transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of handicapping conditions in children."1

"Counseling Services" mean:

"... services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel."2

"Medical Services" mean:

"... services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services."3

"Psychological Services" include:

"(i) Administering psychological and educational tests, and other assessment procedures;
(ii) Interpreting assessment results;
(iii) Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
(iv) Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and
(v) Planning and maintaining a program of psychological services, including psychological counseling for children and parents."4

(IEP) be prepared detailing the specific educational and related services to be provided. The law further provides that handicapped children be educated in the least restrictive setting appropriate to their needs, and spells out the due process protections that must be available for children and their parents.23 The passage of this legislation probably marks the single most significant policy commitment to handicapped children this country has made.24 Prior to the law's enactment children with handicapping conditions were too often denied schooling, and parents had no resources to compel schools to serve such children.

Implementation of this key piece of legislation on behalf of severely disturbed children has been limited. Below we highlight the most widespread problems around implementation.

In the 1980 to 1981 school year, according to the latest federal data, 348,954 seriously disturbed children ages 3 to 21 received special education under the mandates of P.L. 94–142 and P.L. 89–313.25 Using prevalence estimates that 2 percent of the total child and adolescent population has emotional problems serious enough to warrant specialized treatment, this still reflects less than one third of all potentially eligible children.26 Seriously disturbed adolescents are especially likely to receive inappropriate services or no services at all. They are often expelled, suspended from school,27 given shortened school days, or placed on homebound instruction.28 Children living in group homes or returning from residential settings like hospitals or residential treatment centers are often refused services by schools. This is especially true for children living in group homes outside their original school districts. For
example, we learned of one school district that refused to serve children who were living in a specialized group home within the area but were originally from outside the district. The state department of mental health funded the group home, but the state would not pay the local school system to educate the children. The children's original school districts also refused to pay. Some of the children's parents were so desperate to keep their children in the group home that each day they transported the children back and forth to schools in their original communities. Other children simply stayed in the group home all day without any schooling. Disturbed children in mental hospitals or correctional facilities are likely to have untrained teachers or be excluded from educational programs, despite evidence of great need. And as we noted in Chapter III, psychiatric hospitals do not always inform children or parents of the children's educational rights.

Implementation of the law has been hindered by substantial confusion in three areas.

First, it is unclear how severe children's disturbances must be for them to be covered by P.L. 94–142. One study reported that different states may or may not cover children with mild, moderate, or severe difficulties. It estimated only 20 percent of the troubled children served under 94–142 are seriously disturbed. Further, the law explicitly excludes children who are "socially maladjusted" but not seriously emotionally disturbed from its mandate. Yet clinicians agree any distinction between these children and other disturbed children is meaningless.

Second, although disturbed children may need psychotherapy to learn, the obligation of schools to provide or pay for therapy is uncertain. The law requires schools to provide those educational and related services needed to ensure a child's learning. But neither the law nor the regulations clarify whether therapy is a related service and, if so, under what conditions. It is also unclear if there are any circumstances under which parents can be charged for such services. As a result, schools and states are avoiding the issue. Children who could benefit from psychotherapy are not getting it.

Third, there is confusion about the responsibility of schools to pay for residential treatment when children and adolescents cannot be served in regular or special local schools. Parents, advocates, and state officials have expended a lot of energy resolving these disputes, while the children generally have gotten nothing. Some schools have sought to pay only for the educational costs of such placements. Other schools have tried to escape any obligation by arguing the children needed placement for noneducational reasons and, thus, that the placements are not covered under the law's mandates.

Beyond these implementation problems, the law's effect on children and adolescents who need mental health services varies among states and school districts. Generalizations are difficult. However, we repeatedly heard at least two additional concerns. Partially because of the law's emphasis on diagnosis and evaluation, many school psychologists are being asked to function exclusively as testers. Any time they otherwise might have had to work with teachers or counsel students has been eliminated or reduced. Further, the emphasis on serving severely handicapped children has meant fewer schools have tried to develop mental health programs focusing on early intervention. To contain the costs of psychological services, some school districts are developing these services themselves. They are using staff who are less well trained than those in existing mental health programs, such as community mental health centers. In other districts, schools are not referring children for services.

Generally, states have taken few affirmative steps to address implementation problems like those just described. State departments of education often have not identified staff to work intensively to ensure that disturbed children receive an appropriate education and related services. This sharply reduces opportunities to cooperate with state departments of mental health and plan specialized training for teachers and administrators. It also lowers the chances that interagency disputes will be resolved expeditiously. States have not developed adequate training programs to help teachers cope with the most disturbed children or to increase the pool of specially educated teachers who could serve troubled children and adolescents.

Typically, departments of education and mental health have given low priority to monitoring the quality of
OTHER STATE AGENCIES: ROLES AND RESPONSIBILITIES

education available for children and adolescents in hospitals or the extent to which hospitals comply with P.L. 94-142. 37

Juvenile Justice and Mental Health: The Forgotten Mandate

Children who are charged with status offenses or delinquent acts and show a range of emotional or behavioral disorders pose a complex and unsolved challenge for the juvenile justice and mental health systems. No good national data exist on the number of children within the juvenile justice system who have serious emotional or behavioral problems or need mental health services. State data are spotty. For instance, Pennsylvania estimates 30 percent of all adjudicated delinquents may have severe emotional problems; 38 a New York study of a sample of children within the state's juvenile justice facilities found 58 percent had at least one psychiatric diagnosis. 39

According to a recent survey of state officials, there is no clear pattern to how children in the juvenile justice system receive the few services they do get. Generally, they get them through mental health facilities, juvenile correctional facilities, and services purchased by juvenile correctional facilities. 40 The services largely are limited to diagnostic evaluations or special programs serving only delinquent children; some programs are offered through the courts. 41 We know of no study that systematically examines the quality of these services, number of children served, or benefits to the children and adolescents.

Although children often move back and forth between mental health and juvenile justice facilities, departments of mental health and juvenile justice seldom engage in joint monitoring or programming. 42 One exception is a New York project supporting teams of psychologists, community mental health nurses, and social workers, who provide assessments, treatment plans, and referrals for children in juvenile justice facilities, and consultation and training for staff of these programs. The teams are jointly recruited by the Department of Mental Health and the Division for Youth. Teams do not do long-term therapy, but may provide up to three counseling sessions to stabilize a child's behavior or prepare him or her for a move to a different facility. Teams are affiliated with and supervised by regional children's psychiatric centers. 43

Only one group of juveniles in the juvenile justice system has received a good deal of attention—"violent" children. These children make up a small proportion of those housed in juvenile justice institutions, but are a highly visible group whose behavior is viewed as dangerous.

The Massachusetts departments of mental health and youth services (juvenile justice) tried to establish 12-bed programs in each region of the state to serve the most violent children. Referrals to the programs came from both departments. The programs proved extremely controversial. Some people believed they were too restrictive because they used secure facilities. Others argued the state had not developed timely regulations for the programs and had not done rigorous monitoring of how they actually worked. In the spring of 1981 the state abandoned the effort under great political pressure. 44

New York State tried to set up a special program for the same population of children in New York City. Known as the Bronx Court-Related Unit, the program was based on the grounds of a psychiatric hospital. It was evaluated closely, and its clients were followed up after leaving the program. Evaluators reported some children, as disturbed and violent as those in Massachusetts, showed positive changes in behavior. But the state legislature decided to discontinue the program's funding. 45

Colorado's Closed Adolescent Treatment Center still operates. Originally started under mental health auspices, the program now falls under the juvenile justice system. It provides long-term treatment to serious offenders through an intensive, structured program. (Some 50 percent of the 26 children in the program at the time of this report were rapists or murderers.) Based on informal follow-up of its clients, the program's director believes about 65 percent of the adolescents who have graduated from the program have had no further contact with the law. 46
In Wisconsin a small eight-bed program, optimistically named Project Try (Treatment and Rehabilitation of Youth), was set up under state auspices in 1978. The program provided secure treatment to troubled violent children referred by the state's two juvenile institutions. Treatment averaged nine months, and children's progress was followed for up to two years after discharge. The project also set aside one day per week during which children participated in activities in the community. This project has also been eliminated.

Since 1978 Oregon has run secure treatment programs for children ages 6 to 17. Before being placed in these programs, children must be screened by a team of representatives from the various state agencies, the juvenile courts, and the schools. Screenings may include interviews with the children and their families, and alternative placements for the children must be explored. A central community liaison is designated for each child finally accepted in the program. Priority is given first to children who are physically dangerous to others or engage in severe self-destructive behavior; then to children who “toy” with situations that could threaten their lives or show impulsive rage; and finally to children who are in other placements but need short-term services from the program. Treatment averages nine months.

In North Carolina, pressure from the Willie M. lawsuit (see Chapter VI) led the department of mental health to create a small treatment program for violent disturbed children within the state's maximum security training school. The program is based on Project Re-Ed, a psychoeducational program developed by Nicholas Hobbs in Tennessee.

Other Systems

We did not gather extensive information about the role other state agencies play in delivering mental health services to troubled children, although many disturbed children and their families come into contact with health, mental retardation, and alcohol and substance abuse agencies. More work needs to be done examining the mental health needs of children and families within these systems and the responsibility the systems take regarding the delivery of mental health services. The few positive examples we encountered make it clear these agencies could play a larger role than they do now in identifying mental health needs and delivering mental health services.

Particularly important are efforts to integrate primary and mental health care. Despite interest in the cost savings and psychological impact of such integration, few joint efforts have been made. In doing this study, we visited one community mental health center that was actually part of a neighborhood health center. Every pediatrician there had a consulting relationship with someone on the children's staff of the mental health center; one pediatrician attended weekly child mental health meetings, and a representative from the children's mental health unit attended pediatric meetings.

In contrast, children in other mental health centers often do not get physical examinations they need on a routine basis. State health dollars may also be used for early intervention programs for young children at risk of developing emotional problems.

Children who are retarded and disturbed often have no appropriate programs. The service needs of these children are left to haphazard solutions made on an individual basis without state-level attention. Yet effective programs for such children are possible.

We learned of one intensive residential program for young severely disturbed and retarded children. The program provides residential care for 20 children and day treatment for five more. Children must be three to ten years old and generally remain in residential care for one to six months.

In Los Angeles County the director of the bureau of child and adolescent mental health spearheaded the creation of a program serving retarded disturbed adolescents. The departments of mental health, retardation, and juvenile justice all contribute funding.

Similar attempts to pool funds and resources could help provide mental health services for troubled children who abuse alcohol or drugs. Substance abuse is a serious, unaddressed problem for many children referred for mental health services.

Further, children who now receive services solely
through departments of alcohol and substance abuse may have mental health needs that are not being met. (See the CASPAR program, Chapter II, for an alcohol abuse program for children with strong ties to a local mental health center and the schools.) The mental health needs of many children now served through residential drug abuse programs also should be examined in greater depth.

**Recommendations**

**To increase the response of nonmental health agencies to the mental health needs of children and adolescents, each state should**

Establish state-level liaison efforts among state child serving agencies to facilitate the pooling of fiscal, staff, and program resources and ensure the development of appropriate nonresidential and residential services for seriously disturbed children and adolescents under the care of any state agency.

Establish cross-agency mechanisms for defining policy problems and service gaps affecting seriously disturbed children and adolescents and for monitoring the quality of care.

**To improve mental health services for children and adolescents in the care of child welfare agencies, each state should**

Develop, in states or jurisdictions where many children enter care because of their parent’s emotional problems, support services for children and intensive family-based services to prevent such placements.

Develop joint programming with mental health departments to serve abused children and adolescents and provide services to parents. Assess general child abuse efforts to see if they are applicable to disturbed children and adolescents. Critically assess mechanisms that review the appropriateness of placements and permanency plans to see if the reviews work for disturbed children and adolescents, particularly those in out-of-state placements or psychiatric hospitals.

Use state funds to develop a range of intensive nonresidential and residential services for troubled children and adolescents in state custody.

Permit seriously disturbed children and adolescents to receive residential treatment services without requiring parents to transfer custody of these children to the state.

**To strengthen mental health services for children and adolescents in the educational system, each state should**

Increase training and support services for teachers serving emotionally disturbed children, especially those serving adolescents.

Clarify policies regarding the fiscal responsibility of education agencies for educating children and adolescents in out-of-home placements.

Establish high-level interagency or legislative committees to resolve problems between education and mental health agencies in funding, staffing, and certifying intensive day treatment services.

**To further address the mental health needs of children and adolescents in the juvenile justice system, each state should**

Ensure mental health agencies work with children and adolescents in the juvenile justice system, especially those in detention facilities or training schools.
Assess the frequency of transfers between juvenile justice and mental health institutions; create mechanisms to prevent the misuse of such transfers and protect the rights of juveniles.

Assess the adequacy of state policies regarding evaluations and crisis mental health services available through juvenile or family courts.

Notes


2. Reviews in states have documented the varied auspices under which children needing services can be found. In 1976, for example, one state reportedly spent $12 million for children's mental health, with less than one third of that expended by the mental health department. B. Sowder, "Issues Related to Services for Children and Youth: A Review of Selected Literature from 1970-1979," mimeograph report to the National Institute of Mental Health (Bethesda, Md.: Burt Associates, Inc., 1980), p. 61.


4. Ibid., p. 84. According to the national survey, 77,000 children received services primarily because of the emotional problems of parents, 76,000 because of the child's emotional problems. Out-of-home care was recommended for 51 percent of the children receiving services because of the emotional problems of parents, for 58 percent because of their own emotional problems, and for 54 percent because of parent-child conflict. Ibid., p. 93.

5. For example, a 1976 Illinois report found 5.6 percent of the children in foster care were emotionally disturbed based on data in their case records. This did not include abused children and adolescents. State of Illinois Commission on Children, Study of Emotionally Disturbed Children (Springfield, Ill.: Commission on Children, January 1976), p. 3. In a more recent survey, 8.2 percent of the children in foster care were clinically evaluated and diagnosed as emotionally disturbed, 19 percent were judged by caseworkers to need some special help. Florida Department of Health and Rehabilitative Services, "Mental Health Services for Children," draft mimeograph (Tallahassee, Fla.: Department of Health and Rehabilitative Services, February 8, 1980). For an empirical study, see G. Frank, "Treatment Needs of Children in Foster Care," American Journal of Orthopsychiatry, 1980, 50 (2): 256–263. Frank studied 50 children, ages 6 to 12, who remained in care for five years or more, to determine the degree of psychiatric impairment at entry and five years later, the treatment needs at both times, and the treatment record. Between 10 and 12 percent of the sample were judged psychotic, 18 percent had been on tranquilizing medication, and initial ratings found close to 80 percent were seriously disturbed. Five years later twice as many children were judged psychotic. Fifty percent of the sample were judged to have received clearly inadequate treatment, with six children never seeing a qualified mental health professional. Further, the rater's estimated half of the disturbed children who remained in care for five years probably would not have needed placement had supportive in-home services been available. Although the study was flawed methodologically (children themselves were not seen nor is it clear whether raters knew how long the children they rated had been in care), the findings suggest a need for much closer scrutiny of the emotional needs of children in care.


7. For example, neither the PACE model (see Chapter II) nor the approach used by the Michigan Department of Mental Health's Office of Prevention (described in Chapter III) appear to have been replicated by any state social service agency.

8. Intensive nonresidential services of the type described in Chapter II can and have been adapted for this population. For example, see D. Haapala and J. Kinney, "Homebuilders' Approach to the Training of In-Home Therapists," and M. A. Fahl and D. Morrissey, "The Mendota Model: Home-Community Treatment" in Home-Based Services for Children and Families, eds. S. Maybanks and M. Bryce (Springfield, Ill.: Charles C. Thomas, 1979), pp. 248–259; 225–236.

9. For a newsletter describing emerging models of intensive home-based services, see generally "Preventive Report" (Oakdale, Iowa: National Resource Center on Family-Based Services, University of Iowa, 52319). The Summer 1982 issue includes an article on the cost effectiveness of such intensive programs.

10. The national study of social services to children estimated approximately 6 percent of children in out-of-home placement, or 29,000, are in residential treatment facilities. Shyne and Schroeder, National Study, p. 113. Calculations by the Children's Defense Fund. For a discussion of a range of issues regarding out-of-state placement, see J. C. Hall et al., eds., Major Issues in Juvenile
11. Of 159 children in residential or inpatient programs reviewed by the Arkansas Division of Mental Health Services, 49 percent were in the custody of Social Services and 38 percent were in parental custody. (The summary report did not account for the remaining 14 percent.) Arkansas Division of Mental Health Services, "Mental Health Systems Profiles." In New Jersey a survey conducted several years ago by the Department of Human Services found 35 percent of the children in state custody in four state hospitals were awaiting appropriate placement by state agencies other than the mental health department. New Jersey Department of Human Services, "Plan for the Reorganization of Mental Health Programs for Children," mimeograph (Trenton, N.J.: New Jersey Department of Human Services, December 15, 1978).

12. For instance, if a teenager in a group home becomes abusive or violent or fails to observe curfew, he may be removed from the home and "temporarily" placed on the acute ward of a state psychiatric hospital. Typically, when the crisis has passed the group home refuses to readmit him, and a new placement must be sought that will involve yet another uprooting for the child.

13. In Washington, D.C., an analysis of the unnecessary days children spent in a psychiatric hospital found that 88 percent were accounted for by children in state custody; 11 percent by children whose discharge required court approval; and only one percent by children who were discharged to their own families. Overall, 32 children spent a shocking 895 days in unnecessary hospital care. At $359 per day per child, the yearly cost of this needless hospitalization was estimated to exceed $1.2 million. St. Elizabeth's Hospital, Division for Child/Adolescent Services, "Quality Assurance Committee Report," (Washington, D.C.: St. Elizabeth's Hospital, no date). Anecdotal evidence from other states and data from briefs filed in a class action lawsuit in Maryland indicate that similar patterns of inappropriate hospitalization occur elsewhere. See Johnson v. Solomon, 484 F. Supp. 278 (D. Md. 1979).

14. Shyne and Schroeder report that the emotional problems of parents or children were cited as factors in 18 percent and 29 percent, respectively, of the cases where child welfare services were sought. Each was cited as a major reason for service in 4 percent of the cases. Although mental health services were recommended for 40 percent of the children with emotional problems, they were provided to only 16 percent. Shyne and Schroeder, National Study, pp. 48, 84.

A special program has been established in Helena, Montana, to train B.A. level social workers in the child welfare system to do behavioral counseling with troubled families they serve. The Family Teaching Center (FTC) counsels some 129 families per year and annually trains about 80 employees of the Department of Social and Rehabilitation Services. The program, which is funded primarily through the department, operated on a budget of some $125,000 in 1981 to 1982.

Program referrals come from the local social service department, the schools, and the families themselves. Children served range from age three through adolescence and present a variety of behavior and discipline problems. Many of the parents have been abusive or are potentially abusive and the children are often in danger of being removed from the home or are already in foster care and awaiting return home. Most of the parents are low-income; many are single. Severely dysfunctional families are not accepted in the program but are referred to the local community mental health center.

FTC's staff, three B.A.-level counselors and one psychologist, prefer to conduct their structured, behaviorally oriented sessions at the center but will go to the family's home if transportation is a problem or if the family is reluctant to participate in the sessions. The staff also work closely with school personnel. For more information write to the Family Teaching Center, 107 Seventh Avenue, Helena, Mont. 59601.


17. Some state termination statutes discriminate against mentally ill parents because they often do not require evidence that the mental illness results in specific harm to the child. In a recent decision in New York State, for example, the judge pointed out that mentally handicapped parents with children in placement are discriminated against in two ways under New York statutes. First, for nonmentally handicapped parents there must be proof that they have permanently neglected or abandoned their children for their parental rights to be terminated. No such finding is required for mentally handicapped parents. Second, for children whose parents are charged with permanent neglect, there is a dispositional hearing to determine the child's best interests; for children of mentally handicapped parents, no such hearing takes place. Further, the judge noted that social service regulations do not require any specific effort on behalf of mentally handicapped parents to facilitate a child's return home. See the judicial decision in Matter of Roth, 109 Misc. 2d 699 (Monroe County Fam. Ct. 1980).

18. There are some exceptions. For example, in Ohio we learned that the Northeast Adoption Service was working with local mental health centers to provide support groups for adoptive parents. In California at the time of our study, the Family Builders Project of the Children's Home Society in Oakland, in conjunction with the Commonwealth Medical Clinic, also provided therapeutic support to families adopting special needs children.

19. For example, two intensive treatment homes for abused children between the ages of two and seven were started with county funds in 1976 in Sacramento County, California. Both the Foster
Parents Association and the child psychiatrist who served as a consultant to the county's welfare department were influential in getting these programs started. Close to 40 percent of the 49 children served in the project have returned home, another 25 percent are in long-term placement, and the remainder have been or are in the process of being adopted. See P. R. Harling and J. K. Haines, "Specialized Foster Homes for Severely Mistreated Children," Children Today, July-August 1980: 16-17. In Canada a foster care program has been developed to provide an alternative to long-term residential treatment for disturbed children. Five foster families, each of whom accepts a disturbed child for placement, work together. Families receive extensive training and are expected to play the roles of both parents and therapists for the children. Together the families function as extended kin for the youth and each other. The program not only tries to provide a therapeutic, nurturing environment for the children but a supportive structure for the foster parents so the children's placements will not be disrupted. For a description see "Institutions Without Walls for Emotionally Disturbed Children," American Journal of Psychiatry, 1977, 28 (1): 848-851, and S. Rubenstein et al., "The Parent-Therapist Program: Alternative Care for Emotionally Disturbed Children," American Journal of Orthopsychiatry, 1978, 48 (4): 654-662. A similar project has been supported by the Michigan Department of Social Services. Children are referred to the program by the Department of Social Services, the Department of Mental Health, or the courts. Families in the project are paid as specialized foster parents and also receive a daily rate as therapists. See Michigan Federation of Private Child and Family Agencies, Federation Newsletter Vol. I. 2 (Lansing, Mich.: Federation of Private Child and Family Agencies, April 1981).

20. Some exceptions have already been discussed. These include New York State's enrichment formula for providing funds from the Office of Mental Health to the Department of Social Services for group home beds for disturbed children, Pennsylvania's effort to ease the transition for children discharged from hospitals, Massachusetts' joint mental health/social services programming for abused children, and Florida's effort to develop day treatment programs that originally were limited to children in child welfare custody. In addition, North Carolina, through the Division of Mental Health, Mental Retardation, and Substance Abuse Services, reports a network of about 30 therapeutic foster homes. Other states are exploring the relevance of the Family Teaching Model to seriously disturbed children and adolescents. However, as the Family Teaching Model is now structured, there are no formal provisions for building in therapeutic approaches or support to the child other than the general behavioral objectives incorporated in the program. The Family Teaching Model was first developed to serve delinquent adolescents and was used by Boys Town in its reorganization of services. There is now a National Family Teaching Association to provide training and oversee the certification of group homes.


22. Federal regulations under the act define serious emotional disturbance as a "... condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance: (A) An inability to learn which cannot be explained by intellectual, sensory or health factors; (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) Inappropriate types of behavior or feelings under normal circumstances; (D) A general pervasive mood of unhappiness or depression; or (E) A tendency to develop physical symptoms or fears associated with personal or school problems. (ii) The term includes children who are schizophrenic. The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed." 34 C.F.R. §300.5 (b)(8).


24. Yet in spite of its promise, at the time this report went to press, the Reagan Administration had proposed both repealing P.L. 94-142 and drastically revising the program's regulations.


Under P.L. 94-142 and Section 504 a number of courts have ruled that when a behavior problem is linked to the child's handicapping condition, the child is entitled to an appropriate education and the full protections of P.L. 94-142. Instead of exclusion and the district's disciplinary procedures, S-I v. Burlington, 635 F. 2d 342 (5th Cir. 1981); Stuart v. Nappi, 443 F. Supp. 1235 (D. Conn. 1978); Howard v. Friendswood Independent School District, 434 F. Supp. 634 (S.D. Texas 1978); Doe v. Koger, 480 F. Supp. 225 (N.D. Ind. 1979).

28. Grosenick and Huntze report that in one state 41 percent of the students receiving homebound instruction were seriously emotionally disturbed. J. K. Grosenick and S. L. Huntze, National Needs Analysis in Behavioral Disorders: Severe Behavior Disorders (Columbia, Mo.: University of Missouri—Columbia, 1980) p. 60. The authors report that adolescents face special problems, but so do younger disturbed children. For example, in the course of doing this study we learned of a teacher who put an emotionally
disturbed six-year-old child in a cab and sent him home alone when she could no longer control him.

29. For example, a study of the inpatient population at a psychiatric hospital in the District of Columbia found that on the average the children and adolescents were five years below grade level regardless of diagnosis, age, length of stay, family responsibility, or other factors. St. Elizabeth's Hospital, Child and Adolescent Division, "Narrative Summary Discharge Planning and Continued Stay," mimeograph (Washington, D.C.: St. Elizabeth's Hospital, no date), p. 9.

30. In at least one county we were told that although psychiatric institutions must have special committees to develop and approve Individualized Education Programs, this responsibility is treated rather casually. One mother whose son had been in and out of hospitals for over 15 months in two years only recently found out about his educational rights by looking up the state law.


32. Initially, the exclusion of "socially maladjusted" children was made to guard against the needless labeling of poor and minority children. In practice "socially maladjusted" children often get disciplined or expelled. For example, a significant proportion of the children identified as needing mental health care in a major class action lawsuit in North Carolina were viewed by the schools as disruptive and no specialized educational planning had been done for them. (See Chapter VI for a discussion of Willie M. v. Hunt).

33. According to a recent survey of 21,657 Individualized Education Programs (IEPs), 1.2 percent of the plans called for psychological services, another 2.2 percent for counseling. Overall, despite the controversies related to psychological handicapping conditions, only 13 percent of the children served under P.L. 94–142 received any related services. Cited in U.S. Department of Education, Second Annual Report to Congress on the Implementation of Public Law 94–142, The Education for All Handicapped Children Act (Washington, D.C.: Department of Education, 1980), pp. 62, 63. In many places we heard of both explicit and implicit instructions to school personnel not to include psychological services in IEPs. On the other hand, a number of judicial decisions have consistently determined that psychological counseling and psychotherapy constitute related services and must be provided to an eligible handicapped child at no cost. See, e.g., Papadodi v. State of Connecticut, 528 F. Supp. 68 (D. Conn. 1981); In the Matter of the "A" Family, 692 P. 2d 157 (Mont. 1979).

34. No clear standards have emerged for determining when public day programs versus residential programs would be appropriate. Rather, such a determination has been treated by the courts as an individual factual issue heavily dependent on the testimony of experts. See, e.g., B. (Gary) v. Crouin, 3 EHLR 552:144 (N.D. Ill., 1980); Michael P. v. Maloney, C.A. No. 78–545 (D. Conn., March 19, 1978) (Consent Decree); and Wallingford Board of Education v. State Board of Education, 3 EHLR 552:305 (Super Ct., Conn., 1981).

35. According to one study, nine states reported a full-time consultant within their state department of education to work on providing an appropriate education to behaviorally or emotionally disturbed students. Huntze and Grosenick, National Needs Analysis, p. 63.


37. For an exception see Missouri Department of Mental Health, "Compliance, Policies and Assurances for P.L. 94–142 and Educational Rights for School-Aged Residents of the Missouri Department of Mental Health" (Jefferson City, Mo.: Department of Mental Health, no date).


40. K. V. Turney, "The Provision of Intensive Mental Health Services to Adjudicated Delinquents: A Survey of State Practices," mimeograph (Cambridge, Mass.: Harvard Law School, 1980), p. 4. Data also suggest children in detention often need mental health services. For example, a recent New Jersey study examined the psychiatric or psychological evaluations of 68 children who were in detention and shelter care facilities. According to the evaluations, 5 to 10 percent of these children had serious mental illnesses; 70 percent had behavioral or personality disorders. L. Wood and G. Moore, Beneath the Labels: Children in Detention and Shelter Care (Newark, N.J.: Association for Children of New Jersey, 1981). For an attempt to provide mental health services to children in detention, see W. I. Halpern et al., "Continuity of Mental Health Care to Youth in the Juvenile Justice Network," Hospital and Community Psychiatry, 1981, 32 (2): 114–117.


42. A recent study of the deinstitutionalization movement within
the juvenile justice system cited the need for a more careful examination of the interrelatedness of the juvenile justice, child welfare, mental health, and chemical dependency and private youth residential systems. Citing data from one state in which, in 1960, an estimated 4,700 to 5,700 juveniles were admitted to inpatient psychiatric units in private hospitals or inpatient chemical dependency treatment programs, the study noted: "One can hypothesize that a 'hidden' or private juvenile correctional system has rapidly evolved for disruptive or 'acting out' youth who are no longer processed by the public juvenile justice control agencies. Moreover this second system may be vastly expanding the net of youth experiencing some kind of institutional control." B. Krisberg and I. Schwartz, *Rethinking Juvenile Justice* (Minneapolis, Minn.: Hubert H. Humphrey Institute of Public Affairs, University of Minnesota, June 1982).


43. New York State Office of Mental Health, "Manual: Office of Mental Health Mobile Health Teams Serving the Division for Youth Residents" (Albany, N.Y.: Office of Mental Health, no date).

44. A preliminary evaluation of the program recorded some "success." For example, one study of 91 "graduates" found that 54 percent of them were successful, that is, were working, attending school, or enrolled in a training program several months after they left the program, and 38 percent of the sample had been committed to a Department of Youth Services secure treatment detention center; sentenced to an adult correctional facility, or committed to a psychiatric hospital since discharge. F. L. Ahearn, "A Study of the Regional Adolescent Programs: Success and Failure," mimeograph (Boston: Boston University School of Social Work, April 24, 1980).

In profiling these graduates the same study found almost four out of five youth previously had an inpatient psychiatric placement. One out of two had been before the courts. More than one out of three were in the custody of the Department of Public Welfare; two out of five were in the custody of the Department of Youth Services; and almost one out of four were status offenders. Each youth had an average of nine placements prior to enrollment in the RAP program, suggesting the same pattern of multiple agency involvement we have identified repeatedly.


48. "Procedures for Admission to the Child and Adolescent Secure Treatment Program at Oregon State Hospital, Rev. 11–26–79," mimeograph (Portland, Oreg.: Department of Human Resources, Mental Health Division, no date).

49. An outcome study of 70 adolescents discharged from the programs in 1979 found that 74 percent were judged to be "successes" in that they were not in jails or hospitals. The treated youths also fared better than a group of youth waiting for admission, 49 percent of whom were in jail or hospitals. Interestingly, in the sample group, 91 percent of the population had prior involvement with the child welfare agency, only 36 percent with community mental health agencies. See, G. Neillson, T. Engle, and S. Latham, "Through the Looking Glass: A Short Term Follow-Up Study of Adolescents Released From Secure Treatment," mimeograph (Portland, Oreg.: Secure Treatment Facility, June 1979).


53. For more information contact The John Merck Program for Retarded Emotionally Disturbed Children, University of Pittsburgh, Western Psychiatric Institute and Clinic, Pittsburgh, Pa. 15261.

54. A brochure is available on this program. See "Dual Diagnosis: A Treatment Program." (Gateway Community Mental Health Center, 1891 Effie Street, Los Angeles, Calif. 90026).

55. A recent Los Angeles cross-agency survey of hard-to-place children found almost 25 percent of the more than 600 children for whom the Department of Social Services had responsibility and 65 percent of the children for whom probation was responsible had problems with substance abuse. Interdepartmental Task Force on Services for Acutely Disturbed Children and Youth, "Report on the 1980 Survey of Hard-to-Place Children and Youth."
V:

Underused Programs
Problematic Fiscal Patterns
Policy Inattention
The Unfulfilled Promise
Agendas for the Future
Recommendations
The Federal Role: The Shadowy Presence

There is no coherent federal policy toward children and adolescents who need mental health services. Although many federal programs impinge upon these children and adolescents, few have been developed specifically to meet their special needs. Instead, federal programs affecting them are ones serving all handicapped persons, or programs for particular groups of children and adolescents that implicitly or explicitly include disturbed children in their mandate. These federal initiatives range from general health care programs to education programs for handicapped children to those protecting the rights of developmentally disabled people. (For a brief summary, see pages 84–86; for a fuller description, see Appendix C.) The diverse programs result in a patchwork of federal funding streams and policies that may or may not work, separately or together, to benefit an individual troubled child.

Underused Programs

Disturbed children and adolescents are under-served by many federal programs, especially entitlement programs that generally serve anyone meeting specified eligibility requirements.

The latest figures show just over 200,000 blind and disabled children receive aid under the Supplemental Security Income (SSI) program. Yet many more children are potentially eligible for benefits. Although SSI includes coverage for serious emotional illness, officials we spoke with felt few disturbed children receive SSI.

Medicaid does not require that states provide mental health services. However, states may claim a federal match for any dollars spent for this purpose, including clinic services in community mental health centers, day treatment, or inpatient psychiatric care for children under 21. Our own data suggest that in any state only a small number of children and adolescents receiving mental health services are reimbursed through Medicaid.

The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) can identify emotional problems through the developmental assessments and health exams it provides for children receiving Medicaid. However, states are not required to provide mental health treatment for emotional problems they find. In contrast, Medicaid mandates treatment for vision, hearing, and dental problems identified during an exam.

The Education for All Handicapped Children Act, P.L. 94–142, guarantees emotionally disturbed children a free appropriate education, but they are often underidentified and underserved.

In Head Start, which serves approximately 372,000 children, staff and parents have received only sporadic training and support to foster the healthy emotional development of children in the program and help those with obvious problems. Supposedly, all Head Start programs are required to have a mental health plan carried out and periodically reviewed for compliance. This rarely happens. Instead, Head Start centers are confused about what mental health services are and what mental health consultants can do for them.

The 1976 amendments to the Vocational Education Act required greater attention to the handicapped. Yet federal officials could not identify any specific efforts directed toward the vocational needs of emotionally or behaviorally disturbed adolescents, despite evidence of great need.

Sometimes the federal government has overtly excluded disturbed children from programs that could help them. For example, the Community Support Program, administered by the National Institute of Mental Health, provided special awards to states to develop a range of community-based services for people with chronic mental illnesses. As of 1979 awards had been made to 19 states and the District of Columbia. However, children and adolescents were explicitly excluded from this program.

Problematic Fiscal Patterns

The fiscal provisions in many federal programs encourage medically oriented inpatient care and have been harmful for disturbed children and adolescents.

Federal policy implicitly encourages states to develop medically oriented mental health services for children,
as opposed to other kinds of care, because Medicaid funds are available to reimburse these services. Medicaid generally will not reimburse nonmedical providers when they give consultation and support to nonmental health professionals working with troubled children, do case advocacy to help “package” services for children and families, or spend time working with others in the child’s world, such as parents, foster parents, and teachers. Although some states have used Title XX funds to create nonmedically oriented mental health services for children, Title XX monies are limited, and these programs increasingly are closing. Medicaid reimburses inpatient expenditures at a rate related to their real costs and reimburses day treatment and partial hospitalization programs at much lower rates. Thus, it has discouraged states from developing alternatives to hospital care for disturbed children. In most states, great discrepancies exist between the reimbursement rates for inpatient services and those for day treatment.

Under Medicaid, states have the option of covering inpatient psychiatric care for children under 21, if they can prove less restrictive alternatives are not appropriate for a particular child. Yet until recently, Medicaid did not permit states to divert funds to create such alternatives.

Confusion about which federal dollars apply when several programs could pay for a particular service has also aggravated and delayed the provision of care for troubled children. Federal officials have not provided states with clear or timely guidance to resolve such disputes. These questions have been particularly problematic with regard to Medicaid and the Education for All Handicapped Children Act. The federal government has also made few attempts to clarify which individual treatment and service plans are required for a child when more than one federal program, each with its own set of planning requirements, is involved in paying for services.

Policy Inattention

Like states, the federal government has paid little policy attention to disturbed children and adolescents. The lack of adequate targeted funding, organizational visibility for children’s mental health services, standards, training, or cross-agency efforts apparent at the state level is repeated at the national level.

The National Institute of Mental Health estimates about 17 percent of federal community mental health center funds are spent on children. This percentage has declined over the past several years. (In the 1980 census, children and adolescents under 20 comprised 32.0 percent of the population.) From 1972 to 1980, federal expenditures for child mental health under the Part F Children’s Services Program totaled $169 million. This reflected over $20 million a year in targeted child and adolescent mental health funds. In 1980, under the Mental Health Systems Act, the total authorization specifically for child and adolescent mental health was $10 million; and under the existing Alcohol, Drug Abuse, and Mental Health Block Grant, $0.

There is virtually no organizational focus on child and adolescent mental health at the federal level. The National Institute of Mental Health established a small children’s unit in 1973. It gave the director only limited authority over central office staff and none over regional officials. Other senior children’s staff were not even part of the children’s division. Under the Reagan Administration this office and its responsibilities have been cut back still further.

Until 1982 community mental health centers were required to provide a program of specialized children’s care, including a full range of diagnostic, treatment, liaison, and follow-up services. However, the federal government never issued guidelines or formal regulations defining exactly what services were needed to meet the requirements. Under the Alcohol, Drug Abuse, and Mental Health Block Grant, these centers are only required to provide specialized outpatient services for children.

Federal agencies with some responsibility for troubled children and adolescents have made few attempts to work together on their behalf. None of the efforts have culminated in new program initiatives.
The Department of Health and Human Services has paid only sporadic policy attention to children's mental health when a specific issue or a proposed piece of legislation has forced it to respond.\(^{25}\)

The federal government has provided only limited technical assistance or training to states to help them improve the delivery of mental health services to children and adolescents.\(^{26}\) No overall plan for such technical assistance has ever been developed.

In areas where a strong federal role seems especially appropriate—disseminating information, collecting national data, and evaluating the cost and effectiveness of programs—the federal government has been just as inactive.

It is virtually impossible to determine from federally collected data those services actually provided for children and adolescents. Whatever information is available is outdated. Moreover, the National Institute of Mental Health cannot routinely provide data on the number of children hospitalized each year, the length of hospital care, the extent to which children are placed on adult wards, the number of children receiving outpatient therapy, or the average length of treatment by diagnostic category.\(^{27}\) Equally troublesome, because of the pattern set in federal surveys, many community mental health centers report they cannot separate out statistical data on children and adolescents except by manual counts.

The National Institute of Mental Health has funded important clinical research on children and adolescents. However, it has not developed any way to evaluate alternative therapies, assess the effect of demonstration programs, examine the extent and consequences of returning children from hospitals to their communities, or develop basic data on the cost and duration of therapy.

Unlike most federal agencies with significant responsibility for children, the National Institute of Mental Health has never published or disseminated information about exemplary children's programs.

Those few federal programs specifically geared to children and adolescents needing mental health services have never been fully evaluated.

In 1976 the federal government spent $37 million on Medicaid's inpatient program for children under 21. Yet no one in the federal government has specific administrative responsibility for the program, and there has never been an audit to see whether states are complying with the program's requirements.\(^{28}\)

The Part F Children's Services Program, the most extensive children's mental health program ever developed by the federal government, provided eight-year grants to community mental health centers and child mental health agencies to develop specialized programs for disturbed children and adolescents.\(^{29}\) Although the programs ran for eight years, Part F was evaluated only once, when it first began.\(^{30}\) No subsequent evaluation was authorized.\(^{31}\) As a result, useful data, which could have helped to strengthen children's mental health services, were lost.

The Unfulfilled Promise

During the past decade two national reports, authored by well-known professionals, have focused on children's mental health needs.\(^{32}\) Neither generated sustained federal changes. On the contrary, the record during the same period reveals three potentially significant federal initiatives that were begun but never continued.

In 1972 Congress modified the Community Mental Health Centers Act to create the Part F program, which provided targeted funds to develop specialized mental health services for children and adolescents. A preliminary evaluation showed services for children increased substantially.\(^{33}\) Yet in 1974 the Part F program was repealed (although grantees continued to receive all eight years of their grants.)\(^{34}\) In its place, community mental health centers were required to include children's services as only 1 of 12 services mandated by statute.

In 1978 the National Institute of Mental Health sought funds to develop mental health programs for those troubled children most likely to be denied services. Called the "Most In Need" (MIN) program, it was supposed to be funded at $7 million. Instead, it was only funded at $800,000 and limited to services for Native American children.

In 1981 the Mental Health Systems Act was enacted by Congress. It included a special grant program to
A Bird’s Eye View of Federal Programs

Health Programs

The Medicaid Program provides financial assistance for medical services to low-income and medically needy people who are certified as eligible by the states. Coverage for mental health services is optional. States may cover clinic services in community mental health centers or day treatment services. They also have the option of providing Medicaid coverage for inpatient psychiatric services for children under 21 (about two thirds of the states have opted for such coverage). These funds can only be used once a state shows that less restrictive alternatives are not available for a child. Further, since 1981, if a child needs a level of care comparable to an intermediate care facility or a skilled nursing home, the state may, under certain circumstances, apply for a waiver to use the funds for community-based services instead of placement.

The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) was established as part of the Medicaid program to provide preventive health care for all Medicaid-eligible children. Children receive regularly scheduled examinations to identify, diagnose, and treat medical, dental, and developmental problems. Emotional problems may be detected under a required developmental assessment. However, EPSDT does not mandate the provision of mental health services for children for whom emotional problems are identified.

The Supplemental Security Income Program (SSI) provides supplemental income, through federal financial assistance, to financially needy persons who are elderly, blind, or disabled, including seriously emotionally disturbed children. Children in foster homes, certain types of institutions, or group facilities serving 16 or fewer people may qualify for this program in the form of direct payments. Some states supplement the federal SSI payment with a state payment. In most states receipt of SSI entitles a child to Medicaid coverage.

The Maternal and Child Health Block Grant provides states with limited money that can be used to fund a broad range of health services for mothers and children. Theoretically, any portion of a state’s block grant funds can be used for preventive and outpatient services available for handicapped children, including disturbed children. However, competition for funds is great.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) provides financial aid for medical care for the dependents of active, retired, or deceased military personnel. Assistance is available for certain services for handicapped dependents, including coverage of residential treatment and inpatient and outpatient services for emotionally disturbed children and adolescents.

The Hill-Burton Act, passed shortly after World War II, gave billions of dollars in grants and loans to hospitals (and some nursing homes and other medical facilities) for building new wings or buildings in underserved areas. In return for the funds, each Hill-Burton hospital must provide a certain amount of free or reduced-cost care annually to low-income people. Hill-Burton hospitals cannot refuse admission to anyone for inability to pay a preadmission deposit and cannot demand cash prior to emergency care. This is the only federal program to ensure that low-income children and families who do not qualify for Medicaid still have access to health care, including mental health services.

The National Health Planning and Resource Development Act of 1974 requires that each state develop a State Health Plan, including a specific mental health component, every three years. The plan is prepared by a council, the majority of whose members must be consumers of health or mental health care, and must address the availability and quality of existing services and those resources that are needed. The councils also review health budgets within the state and any state applications for funds under the Alcohol, Drug Abuse, and Mental Health Block Grant.
Mental Health Programs

The Alcohol, Drug Abuse, and Mental Health Block Grant provides limited funds to states, which must allocate the mental health portion of the grant to community mental health centers, with the exception of 10 percent that can be used for administrative costs. To be eligible for funds, community mental health centers must provide specialized outpatient services for children. Centers can use any portion of the funds to identify, assess, and serve severely disturbed children and adolescents. Funds for the alcohol and drug abuse portion of the block grant may be used for services for alcoholic or substance-abusing children or for children whose parents abuse alcohol or drugs.

Education Programs

The Education for All Handicapped Children Act, Public Law 94–142, requires that handicapped children, including seriously emotionally disturbed children and adolescents, be provided a free appropriate education. Children must be provided with mental health services necessary to ensure their learning. However, children are only eligible for those services included as part of their Individualized Education Programs (IEP), which are to be developed for each handicapped child. The Act establishes certain rights and procedural safeguards for handicapped children and their parents.

The Title I Program for Handicapped Children in State-administered or State-supported Schools provides funds to state agencies to supplement and strengthen education programs for handicapped children, including disturbed children, who are in state-run schools and institutions, like psychiatric hospitals. Emotionally disturbed children are eligible for this program as long as they are under age 20, are considered handicapped by the state, and have not completed grade 12.

Social Services

The Social Services Block Grant provides federal funds to states for a wide range of community or social services for virtually any individual or family. In the past such funds have been used to create some effective, nonmedically oriented programs for troubled children and adolescents, particularly programs related to early intervention or home-based care. However, states are no longer required by federal law to target services at low-income populations or to put any state dollars into the program, so competition for limited funds is keen.

The Adoption Assistance Program provides federal dollars to states to assist with adoption subsidies for certain eligible children with special needs, such as physical, mental, or emotional handicaps, who cannot be adopted without a subsidy. Children who receive federally supported adoption subsidies are automatically eligible for Medicaid.

The Child Welfare Services Program provides states with federal grant funds to support protective services for children and other services to prevent the need for out-of-home care and to reunite families once children are placed. This program may provide needed supports for families in which the parent or child suffers from emotional problems.

The Foster Care Program makes federal funds available to assist with the maintenance of certain eligible children in foster family homes or private nonprofit child care facilities or public facilities serving no more than 25 children. Children eligible for federal reimbursement under the program are also eligible for Medicaid.

The Foster Grandparents Program provides volunteer opportunities for low-income people age 60 and over by having them render supportive services, for which they receive a stipend, to children with special needs who are in health, education, welfare, or related settings. Foster grandparents can serve as a resource for emotionally disturbed children, particularly those in out-of-home placements.
Vocational

The Comprehensive Employment and Training Act (CETA) provides jobs, training, and employment for economically disadvantaged, unemployed, or underemployed people, including handicapped individuals. In the past, it has funded aides and paraprofessionals to work with children and adolescents who need mental health services and their families. However, funds for this program were cut drastically in 1981.

The Vocational Education Program assists states in improving vocational programs for persons of all ages who want and need education and training for employment, including emotionally disturbed children. However, few efforts are made under this program to provide vocational education services to disturbed adolescents.

Protection of Rights

The Developmental Disabilities Program includes a bill of rights for developmentally disabled people, including chronically disturbed children and adolescents, which spells out the right to appropriate treatment, service, and habilitation in the least restrictive setting appropriate, and other rights, such as the right of close relatives to visit institutionalized children at reasonable hours and without prior notice. Further, for a state to receive funds under this federal program, it must have an advocacy program for developmentally disabled people that is independent of the agency serving these individuals and can pursue legal, administrative, and other remedies. Theoretically, this advocacy program should serve disturbed children with chronic disabilities. The program also provides funds for university-affiliated training programs for the various disciplines working with developmentally disabled children.

Section 504 of the Rehabilitation Act states agencies that take federal funds, including schools, cannot discriminate against handicapped people, including children with mental health problems, and cannot exclude handicapped people from programs solely on the basis of their handicaps.

improve the delivery and coordination of services for seriously disturbed children with chronic emotional problems. Yet even before the act was carried out, it was repealed and replaced by the Alcohol, Drug Abuse, and Mental Health Block Grant, which includes no special funding for children’s services.

A fourth initiative died before it ever had a chance to work. The Child Health Assurance Program (CHAP) would have strengthened the Early and Periodic Screening, Diagnosis, and Treatment Program under Medicaid, extending preventive health and dental care to one million poor children and improving services for millions more. CHAP would have mandated that mental health services be provided for all low-income children identified as needing treatment. The bill never passed Congress. Negative reaction to the proposed mental health changes, in particular, sadly highlighted the stigma still attached to mental health care.

This is a sorry record. These four attempts showed a growing recognition that the federal government should play a role in stimulating the creation of innovative child mental health services, as the Part F program did, and in meeting the special needs of the most seriously disturbed children and adolescents, as the Most In Need program did. It is widely acknowledged that many children’s mental health services that started with Part F funds might never have opened without them. The Most In Need program not only reflected a serious effort to ensure the most troubled children got care, but generated the interest of a number of states when it appeared funding was possible.

Agendas for the Future

As we write this report, the federal government has staged a massive retreat from its responsibility for needy individuals, including disturbed children and adolescents. The dollars available for health, education, and social services for troubled children have been drastically cut. New block grants have given states more discretion in how they spend funds but less federal money to spend. Yet current federal
The Federal Response to Child & Adolescent Mental Health: A Chronology of Failed Efforts

1970
The Joint Commission on the Mental Health of Children, authorized by Congress and funded largely by the National Institute of Mental Health, issues a report entitled Crisis in Child Mental Health: Challenge for the 1970's.

1972
The Part F Children's Services Program of the Community Mental Health Centers Act is enacted, providing targeted federal funds for eight years for community mental health centers and child mental health agencies to develop specialized child and adolescent programs.

1974
A preliminary evaluation of programs funded under Part F shows they have had a significant impact in increasing both direct and indirect services for children and adolescents.

The Part F Program is repealed (although grantees will continue to get all eight years of their grants).

Instead, community mental health centers are required to provide services to children, including a full range of diagnostic, treatment, liaison, and follow-up services, as one of twelve required services. No regulations are issued defining the required services in greater detail.

1978
The President's Commission on Mental Health identifies children as an underserved population and reiterates many of the Joint Commission's findings.

An initial attempt is made within the National Institute of Mental Health to fund the Most In Need Program at $7 million dollars. Two years later, $800,000 finally is made available for eight projects for Native American children.

1980
The Child Health Assurance Program (CHAP) fails to pass Congress. It would have strengthened coverage of children's mental health services through a revised Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) under Medicaid.

1981
The Mental Health Systems Act is enacted, providing limited funding for states and communities to improve services and coordination for seriously disturbed children and adolescents.

The Mental Health Systems Act is repealed and replaced by the Alcohol, Drug Abuse, and Mental Health Block Grant, which provides funds for community mental health centers. The block grant only requires that community mental health centers provide outpatient services for children, not the range of services that had been required since 1974. It provides no targeted funds for children's services.
Important Provisions of the Alcohol, Drug Abuse, and Mental Health Block Grant

Under the block grant's provisions:

A state must allocate all but 10 percent of the mental health monies under the block grant to community mental health centers to provide basic or specialized services. No block grant monies may be used for inpatient services.

Community mental health centers are required to provide outpatient services for children and adolescents and chronically mentally ill people and may provide specialized services to severely disturbed children and adolescents. These special services include identifying and assessing such children and providing appropriate services for them.

States are required to do only minimal planning. However, after the first year, the state legislature must hold public hearings on the proposed use and distribution of block grant funds.

States must spend at least 20 percent of the alcohol and substance abuse funds under the block grant for prevention and early intervention activities. There is no comparable targeting for mental health funds under the block grant.

After the first year, the Secretary of the Department of Health and Human Services must develop a formula for distributing mental health, alcohol, and drug abuse monies within the block grant. Starting in Fiscal Year 1983 up to 5 percent of the block grant monies may be transferred from mental health to alcohol or drug abuse and vice versa at state discretion; in fiscal year 1984 up to 15 percent of such funds may be transferred at state discretion.

The block grant does not contain the specific grant programs for disturbed children and adolescents that were under the Mental Health Systems Act. But advocates can make rigorous efforts to see a fair share of funds under the block grant are still accessible to disturbed children, including targeted alcohol prevention monies, which can be used for the children of alcoholic parents. Moreover, states can see that children and adolescents are included in those services designated for the chronically mentally ill and that child and adolescent services are regularly provided by community mental health centers. Further, the prohibition against using block grant funds for institutional care should be enforced for children and adolescents as well as adults.
ate education, must also be maintained at the federal level and within states. The law must remain intact and its regulations strong.

Beyond these efforts, there is another challenge to face. The general loss of federal dollars and programs for low-income families and vulnerable groups of children has been so substantial, state energies and resources once available for troubled children may be diverted. This is particularly true as states seek ways to make up for the loss of federal dollars in other areas.

States are just beginning to accept and appropriately define their responsibilities for disturbed children and adolescents. Severe fiscal pressures could substantially weaken that progress. Thus, the challenge not only is to maintain key federal programs but also to ensure states do not give way under federal cutbacks and renege on their commitment to children in need of mental health care.

This is the immediate agenda. A longer term agenda involves thinking through a more coherent federal policy response toward children and adolescents in need of mental health services and devising ways to focus the needed national attention on what is, in fact, a national problem.

Recommendations

See that each state uses existing federal programs to benefit children and adolescents needing mental health services:

*The Alcohol, Drug Abuse, and Mental Health Block Grant*

Testify regarding the need to fund child and adolescent mental health services at the legislative hearings required before each state distributes its block grant monies.

Ensure a specific child and adolescent mental health plan governs the use of federal block grant monies.

See that the application for federal block grant funds includes specific mention of child and adolescent mental health services.

See that the state definition of chronic mental illness is not limited, so chronically mentally ill children and adolescents receive a fair share of funds targeted at the chronically mentally ill and have needed planning and monitoring done on their behalf.

Ensure the prohibition against using block grant money for inpatient services applies only to inpatient hospital services, not to less restrictive alternatives like small community-based residential treatment programs and group homes.

*Medicaid*

Urge the state to seek a waiver to develop Medicaid-funded community-based services for children and adolescents who would otherwise need care in restrictive facilities.

Monitor changes in the Medicaid program within each state to maximize coverage for nonresidential mental health services for children and adolescents.

*The Education For All Handicapped Children Act*

Ensure states implement the Education For All Handicapped Children Act, P.L. 94–142, so that emotionally disturbed children receive the protections and services to which they are entitled.

Do not allow a state to weaken its implementation of the act or its own state statutes and regulations regarding special education and related services for handicapped children.

Protect the Education For All Handicapped Children Act, P.L. 94–142, and its regulations in their entirety at the federal level.

Monitor any new federal proposals in the areas of health, mental health, child welfare, juvenile justice, or education to determine whether they would harm or benefit children and adolescents who need mental health services.


Notes

1. M. P. Rymer, "Survey of Disabled Children Under SSI Program," Social Security Bulletin, 1980, 43 (1): 9–13. Of the 1,853 children receiving SSI who were studied, 15 percent were identified or served through an SSI program for the same reason. But the survey also found that 20 percent of the children such problems constituted a secondary handicap.


3. As of 1977 only 30 states reported community mental health centers were eligible for reimbursement (no more current data are available). P. Kalmans, "Medicaid Reimbursement of Community Health Centers," mimeograph (Washington, D.C.: Health Policy Center, Georgetown University, Fall 1977).


5. In the spring of 1981 the Children’s Defense Fund sent a survey to Medicaid agencies. We received responses from 94 states. Only 12 provided data on the number of children served. Of these, 73 had 300 or fewer children served. The median number was 1,000 and 2,500 such recipients; one state, over 21,000. Some of these numbers may represent claims for children served, not recipients.

6. Of the seven states that spent over 25 percent, three spent between 5 and 15 percent; three spent between 16 and 25 percent; and four spent between 26 and 50 percent. Of these, one spent just over 4 percent of their total Medicaid expenditures on mental health services.

7. Even the U.S. Department of Education’s conservative estimate that 2 percent of the child and adolescent population is seriously emotionally disturbed, only two states are serving that 2 percent; the vast majority of states are serving one-half of one percent of the target group. For a discussion see J. Grosenick and S. L. Hurttte, National Needs Analysis in Behavioral Disorders: Severe Behavior Disorders (Columbia, Mo.: University of Missouri-Columbia, 1980), pp. 22 ff.


10. In partial recognition of this problem, small child and family mental health projects were initiated in 14 Head Start sites. The purpose was to compare the relative impact of two models for delivering mental health services: purchased services and services delivered through center-based paraprofessionals. See N. W. Stone et al., "Primary Prevention in Mental Health: A Head Start Demonstration Model," American Journal of Orthopsychiatry, 1982, 52 (2): 360–363.


12. See, for example, testimony reported in Youthwork, Inc., Public Forum on the Education and Employment of Handicapped Youth (Washington, D.C.: Youthwork, Inc., January 30, 1979). In interviews for this study we heard complaints about the difficulty of making summer job programs work for disturbed youth because of staff restrictions, and about the absence of demonstration or ongoing vocational programming tailored to emotionally disturbed adolescents.


80-51-1 (Washington, D.C.: U.S. Government Printing Office, May 1981), Table 25. For example, there has been policy involvement by the Department of Health and Human Services around the development of the Community Support Program. It was an outgrowth of the Community Support Program. Although lead children's staff were designated in each regional office, in one state we visited the child and adolescent mental health official was not sure who the regional liaison was. Yet, in another region a high level regional official has been consistently supportive of and taken a leadership role in efforts to improve children's services.

22. Yet many community mental health centers had only token children's services. Thus, in 1976 the United States Civil Rights Commission, based on an analysis of 1975 data from 328 community mental health centers, found that although children under 15 accounted for 28.8 percent of the service population, they accounted for only 16.3 percent of the client population. The commission concluded, "the area of mental health services represents one of the most glaring examples of discrimination on the basis of age. . . . Children under 15 and persons 65 or older are seriously under-represented." United States Commission on Civil Rights, The Age Discrimination Study; A Report of the United States Commission on Civil Rights (Washington, D.C.: U.S. Government Printing Office, December, 1977), pp. 6, 7.

23. The Community Mental Health Centers Act was passed in 1963. Proposed regulations for Grants and Community Mental Health Centers published in 1976 noted that the full range of children's services specified in statutes "had to be tailored to the needs of the children, with particular attention to their needs at various stages of development; and provision for making the services readily accessible to children, including . . . at locations outside ... the center." Federal Register, November 2, 1976. The National Institute of Mental Health then issued draft program guidelines for the act in July 1979, but they were never formally promulgated. Moreover, they included only a general section on child and adolescent services. National Institute of Mental Health, "Draft Program Guidelines for the Community Mental Health Centers Act" (Washington, D.C.: National Institute of Mental Health, July 1979).

24. After extensive negotiations, the National Institute of Mental Health and the Bureau of Education for the Handicapped signed an interagency agreement regarding P.L. 94-142 responsibilities. However, its significance is unclear. In addition, there were beginning efforts to improve coordination among the three Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Institutes, marked primarily by efforts to generate a children's budget. According to that budget, the three ADAMHA Institutes spent $126.8 million or 11 percent of their total budgets for children in Fiscal Year 1979, $12.2 million for research, $9.4 million for training, and $105.2 million for services. See U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, "1979 Report of the Administrator" (Washington, D.C.: ADAMHA, 1979), pp. 19-20.

25. For example, there has been policy involvement by the Department of Health and Human Services around the development of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). The question of whether children should be screened for developmental problems has been the subject of controversy among mental health professionals, advocates, and policy-makers. Under the Medicaid statute, screening for "mental defects" is required as part of...

In 1980, for example, the technical assistance arm of the National Institute of Mental Health provided for the first time several regional seminars entitled "A Management Perspective on CMHC (Community Mental Health Centers) Services for Children and Adolescents."

The National Institute of Mental Health, "Provisional Data on Federally Funded Community Mental Health Centers 1974–75," mimeograph (Rockville, Md.: National Institute of Mental Health, Survey and Reports Branch, May 1976). The 1977 to 1978 data suggest admissions of children and adolescents were up to 280,970. National Institute of Mental Health, Survey and Reports Branch, "Provisional Data on Federally Funded Community Mental Health Centers, 1977–78," mimeographed draft (Rockville, Md.: National Institute of Mental Health, Survey and Reports Branch, May 1980). Overall patient care episodes are reported for inpatient, partial, and outpatient care, including the number of sessions for individual, family, and group therapy; but no breakdown by age is provided. Even a recent study of Community Mental Health Centers by the General Accounting Office failed to address children's services. The study was based on a review of both federally and nonfederally funded community mental health centers and identified a range of problematic areas, many of which are relevant to children and adolescents as well as other populations. Problems included insufficient funds to complete the community mental health center network, to reduce service burdens on community mental health centers, or to increase reimbursement and standardize monitoring procedures. The auditors did telephone interviews with 19 free-standing children's centers, but no discussion of the results was included in this report. General Accounting Office, Legislative and Administrative Changes Needed in Community Mental Health Centers Program (Washington, D.C.: General Accounting Office, May 2, 1979).

In Fiscal Year 1976, the Health Care Financing Administration reported just under 7,000 children and adolescents were hospitalized in inpatient psychiatric facilities at a cost of $37 million. States with over 1,000 children hospitalized in these facilities were Illinois, Michigan, and New Jersey. Health Care Financing Administration, Medicaid State Tables, Fiscal Year 1976 Recipients, Payment and Services (Washington, D.C.: Health Care Financing Administration, 1976), tables 15, 17, 26, and 28. Despite the existence of strong regulations for the inpatient program for children under 21 (42 C.F.R. §§441.150–441.182) the absence of federal oversight can lead to serious abuses. In Oklahoma, for example, the state has recently proposed administratively transferring all state wards to psychiatric facilities in order to claim Medicaid funds. C. Sherwood and J. Hanchets, "State Tags All Young Wards As Mental," Times-Union (Rochester, N.Y.), July 26, 1982, Section A, p. 4.

29. Although, as noted below, the Part F program was repealed shortly after its enactment, the legislation provided that programs be funded for up to eight years.


31. However, a brief mail survey of nine centers was conducted in 1980 by Sowder, author of the 1974 Part F Report. She found over half the components of Part F programs established in these centers continued or expanded, about one fifth drastically curtailed, and the rest terminated. B. J. Sowder and M. Carnes, "A Longitudinal Assessment of Nine Part F Child Mental Health Programs," mimeograph (Bethesda, Md.: Burt Associates, Inc., June 16, 1981).


33. Sowder, Assessment, Vol. IV, p. 165. Comparisons between Part F and non-Part F Programs indicated a significant increase in child-specific staff, referral rates, and the availability of indirect services.

34. Why the program was repealed is unclear. There was no strong support for it from within the National Institute of Mental Health, nor did the children's mental health community organize to oppose its repeal. The initial legislation permitted community mental health centers or free-standing children's service programs to receive funds; the 1974 legislation that substituted for the Part F program permitted funding only for community mental health centers.

35. The mental health proposal was part of a broader and ultimately unsuccessful effort to strengthen the EPSDT program by enacting the Child Health Assurance Program (CHAP). In the proposed legislation, mentally ill, mentally disabled, and mentally retarded children originally were excluded from mandatory coverage on the grounds that it was too costly. The exclusion was then eliminated for mentally retarded and developmentally disabled children but continued for mentally ill children. At that point, with strong advocacy from mental health groups, an amendment requiring the provision of at least crisis and ambulatory mental health services for children was introduced. However, both this and the entire CHAP reform effort failed.
VI:

Advocacy for Individual Children
Advocacy to Change Systems
What Advocates Can Do
Despite the crying need for reform, advocacy on behalf of disturbed children is scarce, whether for individual children or to change public policies affecting groups of children.

Advocacy for Individual Children

Case advocacy is especially important for individual troubled children. These children often require services specially adapted to their needs. "Effective" treatment predictably involves several types of services, with different eligibility criteria, funding streams, and regulations. Thus, the children and their families must navigate various public systems to tailor services to their individual requirements.

We have noted the states' failure to fund case advocacy programs on behalf of individual children. Unfortunately, other organizations have not placed much emphasis on developing these efforts either:

Mental health associations generally provide no case advocacy for individual troubled children. A mental health association in Pennsylvania reported an effort to provide case advocacy on a consistent basis, but although ombudsmen in this program responded to complaints on behalf of children, the advocacy program itself was not focused on them.

The few parent groups we identified were just starting and had not engaged in case advocacy on a formal basis.

Legal advocacy programs focused on individual troubled children are scarce. The North Shore Children's Law Project (described in Chapter II) works on getting state agencies to serve troubled children "stuck" between the cracks of various systems.

Some troubled children have benefited from general case advocacy related to the Education for All Handicapped Children Act, and from fair hearings and litigation concerning this law's mandates.

Advocacy to Change Systems

In 1970 the Joint Commission on the Mental Health of Children identified a "crisis" in child mental health. It proposed creating a national system of child advocacy to address the problem. Ironically, although much advocacy has occurred on behalf of children since 1970, little has focused on the special needs of troubled children.

Few multi-issue state or local advocacy groups have devoted their energies to the mental health needs of children. Few parent-generated advocacy groups exist. In general, only a small number of mental health advocacy groups have given sustained attention to children.

Yet new efforts are emerging at the state, regional, and local levels, involving fact-finding, administrative advocacy, coalition building, public education, and monitoring of children's programs.

In New England a group of professionals and public officials has formed the New England Children's Mental Health Task Force. Although it has not engaged in any political advocacy, the group has tried to raise public awareness about children's mental health needs through a series of conferences. A similar coalition, Mid-Atlantic Partners, has formed in the Mid-Atlantic states.

In Florida, the Florida Center for Children and Youth has been analyzing and monitoring the state's role in delivering mental health services to children and adolescents, and recently has proposed specific legislation to correct problems related to placing children in psychiatric hospitals. In Massachusetts, the Massachusetts Advocacy Center, which in 1972 issued one of the earliest state reports on mental health services for children, recently has begun to reanalyze children's mental health issues. The Institute for Child Advocacy in Cleveland, Ohio, and Kentucky Youth Advocates in Frankfort have also become involved in mental health issues.

A number of cities like St. Louis and Chicago have established children's mental health coalitions. A new regional organization in Missouri, known as the Region VI Children's Mental Health Network and composed of providers of children's mental health services, is trying...
to establish an information and support network. Although operating on a shoestring budget, the group holds meetings and publishes a newsletter.

Mental Health Associations have provided much recent advocacy on behalf of troubled children.

In Ohio the Summit County Mental Health Association and local mental health professionals helped create the Northeast Coalition for Children's Mental Health Services. The coalition was formed to prevent Ohio from eliminating a line item for children's mental health services from the state budget and to fight a severe cut in funding for a local, high-quality psychiatric facility for children. In its budget campaign, the coalition presented legislators with a petition, including over 4,500 signatures, in support of children's mental health services.

The Colorado Mental Health Association has made child and adolescent mental health one of its priorities and has tried to improve the delivery of mental health services, monitor state legislation and budgets affecting disturbed children, and work with advocacy groups focusing on child welfare to pass legislation reforming the state's child welfare system.

The Georgia Mental Health Association, spurred on by a lawsuit challenging their state's procedure for placing children in psychiatric hospitals, held a series of citizen hearings regarding children's mental health services. These hearings led to the appointment of a legislative committee to examine the problems of troubled children in Georgia, and, eventually, to Georgia's "Troubled Children" initiative, described in Chapter III. Although the Mental Health Association no longer focuses on the problems of Georgia's disturbed children, other groups like the Junior League have taken on the issue.

In Maryland the mental health association helped pass a legislative resolution establishing a state commission on emotionally disabled children and adolescents. The commission's goal was to create a comprehensive statewide mental health plan for disturbed children and adolescents and then oversee its implementation for five years, reporting annually to the Governor and General Assembly on its findings. Among the commission's tasks: creating a way to assess children's services, identifying the specific services that need to be developed, and developing a way for agencies to pool purchase-of-service monies for certain troubled children.

In Hawaii the mental health association led a fight to enact legislation focused on the mental health needs of children and adolescents. The legislation passed in the early 1970's. Since then the association has steadily sought funds to translate its mandate into actual children's services. 9

In Illinois the Mental Health Association of Greater Chicago visits and seeks improvements in facilities serving disturbed children. Under the program volunteers, who come largely from the association and the Chicago Junior Leagues, provide detailed reports of their findings to the facilities' administrators and regional mental health officials. Monthly meetings are held with regional officials to see what has been done about the reports' recommendations. 10

In Indiana the Mental Health Association organized and conducted a detailed study of children identified by mental health and other providers as needing mental health services. 11 The association then worked to get some of its recommendations carried out.

There has also been legal advocacy on behalf of disturbed children and adolescents. Some of this involves litigation to help individual children inappropriately placed in institutions, separated from their families, or denied needed educational services. Others involve "class action" litigation on behalf of certain groups of seriously troubled children. Generally, efforts have centered on one or more of the following: improving the conditions in institutions housing juveniles, changing the procedures for placing children in mental institutions, increasing the protections afforded to children who are wards of the court, expanding the range of mental health services available to children and adolescents, and ensuring appropriate educational services are available for emotionally disturbed children. 12

In Idaho a lawsuit has been brought challenging the state's placement of mentally ill children on the adult wards of state psychiatric hospitals and its failure to provide them appropriate mental health and educational services. 13 The suit asks, among other things, that the state (I) develop enough residential placements so children no longer will be placed in adult
Advocacy: What Is and What Could Be

facilities, (2) prohibit the placement of children under 14 on adult wards, (3) ensure older children are not placed on adult wards except after a careful review of their needs, and (4) develop a comprehensive plan for meeting the mental health and educational needs of the class of children addressed by the lawsuit. The state has agreed to develop a plan for meeting the educational needs of the class. Other issues are scheduled for trial in the late fall of 1982.

In Maryland, a lawsuit on behalf of children in state custody who had been found delinquent, in need of supervision, or dependent, challenged the state’s procedures for placing children in state mental hospitals. The court upheld the challenge. As a result, the state enacted new legislation establishing standards and criteria for placing state wards in mental hospitals. The lawsuit also stimulated the development of a specialized unit to represent these children within the public defender’s office.

**Willie M. v. Hunt**

Some legal advocacy has been designed explicitly to stimulate the creation of a system of care for certain groups of disturbed children. Willie M. v. Hunt, a class action lawsuit in North Carolina brought on behalf of Willie M., Ty C., and other children with similar needs, is a successful example of such advocacy.

Willie M. was 11 years old when a lawsuit was brought against officials in the state of North Carolina to secure appropriate treatment and educational services on his behalf and that of other violent and disturbed children. Willie had been in and out of foster care, psychiatric hospitals, training schools, mental health centers, and special education programs. As a young child he was diagnosed as emotionally disturbed and mildly retarded. He could not process information easily or attend to tasks, had poor hearing, and clearly needed remedial education. He feared loud noises and had frequent nightmares. In school he was loud, disruptive, impulsive, and immature, picked fights with other children, and cried easily.

Because of his condition, in 1978 Willie was removed from the public schools and placed in a program for children with learning disabilities and emotional handicaps. While in this program he was brought before the courts on two separate juvenile petitions, one alleging he had committed larceny, the other contending he was abused and neglected. Prior to the court’s decision, Willie’s juvenile counselor and school social worker unsuccessfully tried to find an appropriate placement for Willie. Because of his age, physical size, emotional and behavioral problems, and mental handicaps, programs were unsuitable for him or found Willie unsuitable. For example, one program rejected Willie because his IQ was too high, another because it was too low. The judge finally committed Willie to the state’s division of youth services. He was removed from the home he had been sharing with his grandmother and placed in a state training school where he did not receive appropriate education or treatment and was often placed in seclusion to control his aggressive behavior. Nobody really knew what to do for him.

Ty C. has spent his life in and out of foster homes and child care institutions ever since he was 14 months old. Now 16, he has been charged with kidnapping five women and four infants who reside in a program for single mothers. Ty is a Willie M. child, with a long history of emotional disturbance and violence. By the time Ty was 12, he had been in nine foster families, two child care institutions, and a mental health hospital where he received counseling and treatment for aggressive behavior. At 13 he was sent to a wilderness camp for troubled children, but counselors there were afraid of him. (Ty was 6'10" and weighed nearly 200 pounds.) So Ty was sent to a group home, where he knocked down the door to the counselor’s room and beat and choked a sleeping child. Finally, he was sent back to his mother. When Ty tried to run back to the group home and a crisis center where he had once received treatment, he was temporarily placed in yet another foster home.

In March 1980 Ty was committed to a state training school for assaulting a child and stealing a van. While in the training school, his behavior improved. The stability seemed to help. However, at 16 he was released and again placed in foster care. His behavior got worse. Several days before the kidnapping, Ty called up public officials in an effort to find himself housing and a job. It did not work. So in what may have been his last call for help, Ty took the women and children hostage and in exchange for their release
demanded drugs, a car, and a visit with his infant sister. If Ty is found competent to stand trial for this crime, he faces up to 225 years in prison. The lawsuit comes too late for him.16

The Willie M. lawsuit was brought in October 1979 on behalf of four named plaintiffs and others like them who, according to the complaint, had been denied appropriate treatment and education under both state and federal laws. Like Willie M., each of the other named plaintiffs had been repeatedly placed in either psychiatric or correctional facilities; each came from a family with a history of violence, child abuse, and alcohol or drug abuse.

The Willie M. class is large and diverse. It includes schizophrenic children who strike out in self-defense against perceived threats; depressed and suicidal children who direct their violence inward; neurologically impaired children who react with violence to overly confusing or stimulating situations; self-abusive children; children who have seen so much violence, they know of no other way to respond to stress; and children who reflect combinations of these and other problems.

In the fall of 1980, after extensive negotiations, the state agreed to a settlement requiring that now and in the future it identify, evaluate, develop treatment plans for, and, if the parents consent, provide treatment to all children in the Willie M. class. Technically, the class includes North Carolina children under age 18 who (1) have serious emotional, mental, or neurological handicaps accompanied by assaultive or violent behavior; (2) are not receiving appropriate treatment or education; and (3) are involuntarily institutionalized or placed in residential facilities or have conditions requiring such placement. (All North Carolina children are admitted to treatment programs or facilities as involuntary clients.) The class includes mentally retarded children who meet these criteria but excludes children in the state's adult prisons. It involves the state's divisions of mental health, mental retardation, education, and youth services.

For each child in the class, the state must provide habilitation, including medical services, education, training, and care and treatment within the least restrictive, most normal living conditions. The state is also required to develop a “continuum of care” enabling children to move from segregated facilities and programs to those integrated into the community and from more to less structured settings. Each child must be provided needed services based on his or her treatment plan, not on the availability of services.

A review panel has been established to oversee certification of individual class members, monitor the extent and timeliness of the state's compliance with the decree, and report its findings to the court. As of April 30, 1982, some 2,100 potential Willie M. class members had been identified and interim service plans developed for a substantial number of them. It is too soon to tell what the lawsuit will ultimately mean for this class of children, but its impact thus far has been noteworthy. With the help of strong follow-through by the Chief of Child Mental Health in North Carolina, the state has sought to create a continuum of services that, as much as possible, will place children in the least restrictive setting, close to their own homes and communities, and provide a long-term service commitment to the Willie M. class.

Detailed mental health plans have been developed region-by-region to ensure that within each area of the state a continuum of services from least to most restrictive care is available along with a strong capacity for case management. Most important, because of the political, media, and advocacy attention generated by the lawsuit, the Governor has gone on record in support of funding for services in the continuum. In 1981 the legislature appropriated enough money to develop systems of services in 4 of the 15 zones into which the state has been divided. The Governor has promised well-defined service plans and full funding for all areas of the state in 1982.17

Mounting class-action litigation like Willie M. to affect the development of a system of care within a state is a complex, time-consuming, and often expensive task. Therefore, it is usually not the strategy of choice. Yet when the legal issues are compelling, and political, professional, and citizen support
for change exists within the state, the effect of such lawsuits can be great. In North Carolina, within one year of the settlement as to liability, four comprehensive systems of community-based programs had begun to be implemented in 27 of the state’s 100 counties; the state publicly had acknowledged its responsibility to provide adequate mental health services for a significant group of children; the legislature had provided needed funds; and children’s mental health had been recognized as a matter for serious legislative and executive concern.

Sustaining Advocacy Efforts: What Advocates Can Do

If disturbed children and adolescents are to be “reclaimed” by public agencies, the level and effectiveness of advocacy on their behalf must increase, whether it involves lawsuits like Willie M. or other approaches. To date the most effective advocates for children with mental health needs have often been mental health professionals, who have worked from inside and outside the system, prodded and pushed, and been responsible for small gains. But many more advocates are needed to help redirect the mental health system’s services and policy focus regarding troubled children and adolescents.

Because the issues demanding advocacy at the local and state levels vary depending on how much a state has already worked to improve child mental health services, we cannot recommend one set of specific steps all advocates should take. Instead, we have highlighted a range of activities for advocates that will move us closer to our common goals: to increase the range of appropriate services for disturbed children and adolescents; encourage the development of systems of care for them; ensure their rights are well-defined and protected; and provide a strong, well-defined policy focus on their behalf.

Advocates can get local and state programs started.

Provide data on the types of programs needed.

Advocates can increase local attention to child and adolescent mental health issues.

Find community funds to help start programs.
Go to community or state officials with ideas and proposals.

Advocates can get legislators and public officials to focus on child and adolescent mental health.

Educate local, state, and congressional representatives, governors, mayors, and others about children’s and adolescents’ mental health needs. Hold a legislative evening. Invite legislators to visit good programs. Provide them with examples of what other communities are doing.

Identify legislators potentially interested in mental health. Send delegations to enlist the
Governor's support. Make children's mental health needs an issue in election campaigns.

Meet periodically with officials outside the child mental health unit to discuss concerns regarding services for disturbed children in their care.

Interest local reporters in stories about child and adolescent mental health issues. Write letters to the editor and seek editorials on child and adolescent mental health.

Testify before state appropriations committees regarding decisions about funding mental health services for children and adolescents.

Testify on the implications of proposed mental health or related legislation for troubled children and adolescents. Show how it will facilitate or impede the development of a system of care.

Advocates can speak out when a state is not working to improve children's services.

Conduct a special study of children's needs.

Issue a "white paper" concerning the state's failure to address the needs of troubled children.

Call a press conference, preferably in conjunction with a broad range of child and adolescent mental health advocates, to highlight the state's failure to act.

Be specific about needed changes and monitor the extent to which they are carried out.

Advocates can strengthen child advocacy within general mental health advocacy groups.

Get each statewide mental health association to establish a child and youth committee to monitor state action and inaction on behalf of troubled children and adolescents.

Form regional coalitions composed of mental health association staff and board members concerned about children.

Establish broad-based state-level consortia, with consumer, legal, and provider representation, to create a visible advocacy focus on child mental health and monitor state activities.

Increase advocates' abilities to analyze state documents, comment on proposed state guidelines and regulations, scrutinize budgets, and track legislation by drawing on the expertise of other state and national child advocacy groups.

Advocates can enlist support from existing child advocacy groups.

Encourage child advocacy organizations not currently focusing on mental health to include changes for troubled children and adolescents in the reforms they are seeking.

Form coalitions between child mental health advocates and multi-issue child advocacy groups to define common agendas and strategies.
Develop joint agendas with advocacy groups concerned with child welfare, juvenile justice, and special education to ensure state agencies respond to the needs of disturbed children and adolescents in these systems.

Reach out to other potential advocacy groups like the Association of Junior Leagues, educate them regarding the problems, and interest them in finding solutions.

Notes
1. In April of 1981, the Children's Defense Fund and the National Mental Health Association sent out a joint questionnaire to all directors of local mental health chapters and state divisions regarding children and youth activities and committees. We received no responses from the majority of mental health associations, and found from the 48 responding, that relatively little advocacy was evident. The questionnaires were sent as part of a larger package of materials, rather than separately, which may have affected the return rate. Further, we only sought examples of advocacy efforts designed to lead to systemic or policy change.

2. A new national organization has recently been formed, the National Alliance for the Mentally Ill. For the most part, members appear to be relatives of mentally ill adults. (For information write National Alliance for the Mentally Ill, 500 North Broadway, St. Louis, Mo. 63102.)

3. Such broad-based advocacy efforts have been organized under many auspices, including, in Hawaii, the Mental Health Association, which used CETA volunteers to provide assistance (in many languages) to parents of children with special educational needs.


6. There are a few, such as the Michigan Association for Emotionally Disturbed Children, a parent-citizen statewide organization located in Southfield, Michigan.

7. See Appendix F for a list of national and regional organizations concerned with child and adolescent mental health issues.


10. The project has developed a detailed schedule for its volunteers. For other guidelines to observing in institutions, see R. Bogdan and S. J. Taylor, "Observing in Institutions," and S. J. Taylor and R. Bogdan, "Observing in Community Residences" (Syracuse, N.Y.: Center on Human Policy, Syracuse University, no date).

11. See the Mental Health Association of Indiana, Children in Need: A Mental Health Services Assessment (Indianapolis, Ind.: Mental Health Association of Indiana, 1980).

12. Some questions remain cloudy, such as whether or not a child has a legal right to treatment and what constitutes appropriate treatment. See Morgan v. Turman, 383 F. Supp. 53 (E.D. Tex. 1974), rev'd on other grounds, 535 F. 2d 864 (5th Cir. 1976), rev'd and remanded, 430 U.S. 322 (1977), on remand, 592 F. 2d 993 (5th Cir. 1977). Some have been decided. For example, the U.S. Supreme Court has ruled that due process does not require, but permits, precommitment hearings. See J. L. v. Parham, 412 F. Supp. 112 (M.D. Ga. 1976), rev'd, Parham v. J. R., 442 U.S. 584 (1979).

Emotionally disturbed children have also been part of a broader plaintiff class in cases challenging the care accorded to children in out-of-home placement and seeking increased due process protections, a range of less restrictive placement settings, and more careful monitoring of care, and in cases challenging the appropriateness of educational services for children. See, for example, Bobby D. v. Barry, C.A. No. Misc. 16-77 (D.C. Super. Ct. Aug. 1980) (Consent Decree), a case brought in the District of Columbia on behalf of handicapped children who were adjudicated neglected and in the care of the Department of Human Resources, and Gary W. v. Cherry, sub nom. Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1979), a case brought on behalf of over 400 handicapped children placed by the state of Louisiana in unmonitored and often grossly inadequate Texas facilities.

Within the broader mental health field considerable legal (and other advocacy) energies have been devoted to facilitating the deinstitutionalization of mentally ill persons. Children have been included as class members in some of these but excluded in others. This exclusion has created its own set of serious consequences. In the District of Columbia, for example, both advocates and mental health officials say that because children and adolescents were not included in the landmark deinstitutionalization lawsuit in that city, they have subsequently been ignored in both District planning efforts and resource allocation.


17. For further information regarding Willie M. v. Hunt, contact Sandra Johnson, Johnson and Johnson, Wake County Office Building, 336 Federal Street Mall, Raleigh, N.C. 27602 (Counsel for Plaintiffs); and Child Mental Health Services, Division of Mental Health, Mental Retardation, and Substance Abuse Services, North Carolina Department of Human Resources, 325 N. Salisbury Street, Raleigh, N.C. 27611.
Child & Adolescent Mental Health Questionnaire

March 1, 1981

Person Responding: __________________________ Title: __________________________

Address: __________________________ Phone: __________________________

Organization

1. Is there an identifiable state unit for child and adolescent (c/a) mental health services? _______ Yes _______ No

2. IF yes:
   What is the mandate of the unit re: age, type of problem, and/or service provided? (e.g. six and older, only seriously mentally ill, only institutional care, unclear, etc.)
   Source of mandate: administrative directive _______ custom _______ statute _______ (please give cite)
   other _______
   Year c/a unit created: _______ How created: _______ statute _______ other _______
   Authority: _______ line _______ advisory
   Responsibilities: (check whichever apply)
   _______ operational responsibility for c/a units in state systems
   _______ liaison with c/a services in community mental health centers
   _______ liaison with other state child agencies, e.g. juvenile justice, child welfare
   _______ approving and monitoring contracts; purchase-of-service programs
   _______ direct supervisory responsibility for regional c/a staff
   _______ monitoring c/a mental health services
   _______ development of children's budget
   _______ leadership in planning for coordinated c/a mental health services
   _______ other (please specify)
   Number of full-time (or equivalent) c/a staff:
   _______ central office _______ regional office _______ other (please explain)

3. IF no:
   How are the responsibilities for children and adolescents carried out within the mental health agency? (Describe briefly and/or attach explanatory material.)
Fiscal

4. Please indicate for the last fiscal or calendar year:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total mental health expenditures: $</th>
<th>Total mental health expenditures for c/a: $</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>Not available 19 to 19</td>
<td>Not available</td>
</tr>
</tbody>
</table>

*Note any major exclusions here (e.g. children’s services in community mental health centers)

5. Of the total c/a expenditures for mental health indicate percentages spent for the following categories of services:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Inpatient c/a services</th>
<th>Other residential services</th>
<th>Outpatient services</th>
<th>Other community-based services</th>
<th>Administrative</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

6. What has been the impact of the recent fiscal crisis on c/a mental health services?

<table>
<thead>
<tr>
<th>Impact</th>
<th>Across-the-board cuts</th>
<th>Community-based programs cut most heavily</th>
<th>Institutional programs cut most heavily</th>
<th>Other (please explain)</th>
</tr>
</thead>
</table>

State Role

7. Do you have separate c/a mental health standards for treatment/services/programs?

<table>
<thead>
<tr>
<th>Standards</th>
<th>Yes</th>
<th>No</th>
<th>Being developed</th>
</tr>
</thead>
</table>

If yes, how are these used? Licensing Monitoring Other (please specify)

Have the standards been officially promulgated? Yes No

8. What is the state’s role in helping local communities plan for c/a mental health services?

<table>
<thead>
<tr>
<th>Role</th>
<th>None</th>
<th>Review local plan</th>
<th>Provide technical assistance</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

9. What mechanisms for citizen input exist?

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>State-appointed advisory group</th>
<th>C/a representative on state mental health council</th>
<th>Required public reports</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

10. Is there an identifiable c/a mental health budget?

<table>
<thead>
<tr>
<th>Budget</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

11. What children’s mental health programs are monitored by the state?

<table>
<thead>
<tr>
<th>Program</th>
<th>C/a cmhc programs</th>
<th>Purchased services</th>
<th>State-operated c/a programs</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

Is the monitoring done by specialized child staff?

<table>
<thead>
<tr>
<th>Staff</th>
<th>Yes</th>
<th>No</th>
<th>Sometimes (please explain)</th>
</tr>
</thead>
</table>

How frequently are c/a programs monitored?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Anually</th>
<th>Biannually</th>
<th>When needed</th>
<th>Other</th>
</tr>
</thead>
</table>

Advocacy Rights

12. Does your state have any internal mental health advocacy mechanism? Yes No

If yes, to what extent is there a c/a focus?

<table>
<thead>
<tr>
<th>Focus</th>
<th>None</th>
<th>Specialized staff</th>
<th>Specialized guidelines</th>
<th>Other (please specify)</th>
</tr>
</thead>
</table>

13. Is there a formal state-level mechanism for resolving interagency disputes about c/a?

<table>
<thead>
<tr>
<th>Mechanism</th>
<th>Yes</th>
<th>No (If yes, please describe)</th>
</tr>
</thead>
</table>

14. Is the placement of c/a on adult wards prohibited? Yes No

If yes, by statute Administrative directive Other (explain)

15. Are the commitment and review standards the same for those children admitted by parents and those in state custody? Yes No Unknown
Nontraditional Use of Funds

16. Are specific state c/a mental health monies budgeted for prevention/early intervention? 
   ______ Yes _______ No (If special statute, year enacted: ________)
   If yes, indicate:
   Amount for current and next Fiscal Year: $ ______ $ ______
   Number of projects currently funded: ______
   Nature of projects (please describe briefly):

17. Are child mental health monies budgeted for purchase-of-service for individual children? 
   ______ Yes _______ No (If special statute, year enacted: ________)
   If yes, indicate:
   Amount for current and next Fiscal Year: $ ______ $ ______
   Number of c/a served: ______ Number waiting: ______
   What can the funds be used for:
   ______ in-state residential care ______ out-of-state residential care
   ______ other (please specify)
   Why was the program established?
   What are eligibility criteria?

18. Do you have monies available to contract for or purchase specialized services? 
   ______ Yes _______ No
   If yes, Indicate amount available for current Fiscal Year: $ ______
   Indicate nature of programs funded (e.g. child abuse, autistic c/a):

Services, Gaps, and Problems

19. Please indicate
   a) (by a check mark) which of the following types of services your agency provides funding for (directly or through purchase)
   b) the number of regions in which the following types of services are available (total number of regions in state ______)

<table>
<thead>
<tr>
<th>Agency Provides</th>
<th># of Regions</th>
<th>inpatient c/a services</th>
<th>nonsecure residential care</th>
<th>closed residential treatment</th>
<th>therapeutic camps</th>
<th>group homes</th>
<th>specialized foster care</th>
<th>specialized independent living</th>
<th>day treatment services</th>
<th>outpatient services</th>
<th>emergency/crisis care</th>
<th>early intervention programs</th>
<th>programs for specialized populations (identify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td>________</td>
<td></td>
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</tr>
</tbody>
</table>

20. Do you have any evidence that children in need of hospitalization are not being admitted? ______ Yes _______ No
   If yes, please explain.
   To your knowledge, are there children and adolescents on adult wards in your state?
   ______ Yes _______ No _______ Unknown
   Are case managers routinely assigned to each c/a discharged from the hospital? ______ Yes _______ No
   If no, are there any other formal mechanisms for ensuring aftercare: appropriate educational planning, transfer to less restrictive placements, etc.? (Please explain.)
21. Day Treatment

How many day treatment programs exist in your state?

______ for preschool children
______ for elementary school-aged children
______ for adolescents
______ unknown

What steps, if any, has the mental health agency taken to increase the number of day treatment programs?

What prevents the development of more day treatment programs?

______ not needed
______ funding problems (explain)
______ other (explain)

22. Is the state mental health agency involved in any specific efforts to increase mental health services for:

the child welfare population ______ Yes ______ No
the juvenile justice population ______ Yes ______ No
multiply handicapped c/a ______ Yes ______ No

If yes, please describe briefly (or attach materials).

23. What, if any, specific steps has the mental health agency taken to facilitate the implementation of P.L. 94-142 for c/a in psychiatric hospitals:

c/a being discharged from psychiatric hospitals:

other emotionally disturbed c/a:

24. What are the most problematic current federal policies for ensuring appropriate mental health services for children and adolescents, aside from limited funds? (Please be specific.)

25. What in your view are the most critical (philosophical, programmatic, patterns of fiscal incentives) issues that must be addressed to improve mental health services for c/a?

26. Please note below any special initiatives or ongoing programs in regard to c/a mental health services in your state not already mentioned (e.g. special services, legislation, monitoring, joint programming or liaison efforts with other agencies, case management, etc.). In other words, what are you especially proud of?

We would be grateful for any of the following materials you can provide:

1. Planning documents/reports on children's mental health services (five-year plans, special studies, etc.)
2. Guidelines for purchase-of-service programs
3. Child/adolescent-specific standards
4. Exemplary program reports
5. Organizational chart (showing relationship of c/a unit within mental health agency and relationship of mental health agency to other state agencies)
6. Statistical data regarding c/a mental health services

THANK YOU VERY MUCH FOR YOUR HELP.

Please return questionnaire to:

Jane Knitzer, Ed.D.
Director, Children's Mental Health Project
Children's Defense Fund
306 Hollywood Avenue
Rochester, N.Y. 14618
## APPENDIX A

### Analysis of Responses to CDF's Child and Adolescent Mental Health Survey

**TABLE I**

**Responding and Nonresponding States**

<table>
<thead>
<tr>
<th>State</th>
<th>Responding States</th>
<th>Nonresponding States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Alaska</td>
<td>O</td>
<td>X</td>
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<tr>
<td>Arizona</td>
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<tr>
<td>Arkansas</td>
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<tr>
<td>California</td>
<td>X</td>
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<tr>
<td>Colorado</td>
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<td>X</td>
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<tr>
<td>Connecticut</td>
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<tr>
<td>Delaware</td>
<td>X</td>
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<tr>
<td>District of Columbia</td>
<td>X</td>
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<td>Florida</td>
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<td>Georgia</td>
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<td>Hawaii</td>
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<td>Idaho</td>
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<td>Illinois</td>
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<td>Wyoming</td>
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<tr>
<td>West Virginia</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

X = Written response, 42 states. Xa = On-site interviews, 2 states. Xb = Brief telephone interview on selected questions, 2 states. O = No response (where state information is indicated, it was obtained from several other data sources), 5 states.

**TABLE II**

**Child and Adolescent Units In Departments of Mental Health**

### Spring 1981

<table>
<thead>
<tr>
<th>States Without A Child/Adolescent Unit</th>
<th>States With A Child/Adolescent Unit</th>
<th>Year Established</th>
<th>Reported Basis For Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>States Without A Child/Adolescent Unit</td>
<td>States With A Child/Adolescent Unit</td>
<td>Year Established</td>
<td>Reported Basis For Authority</td>
</tr>
</tbody>
</table>

**Notes:**

1. Alaska did not respond to the survey.
2. Kentucky had a bureau of children's services, but it was eliminated by the time of our survey.
3. Although Maryland has no formal organizational unit, there is a coordinator for child/adolescent mental health services in each of four regions and there is a state-level child specialist in the state planning and evaluation unit. The current Commissioner of Mental Health assumes direct responsibility for child and adolescent services.
4. In New Mexico, the mental health child coordinator is responsible only for residential services.
5. In 1971, Oregon had a professional staff and a half-time psychiatric consultant to address child/adolescent mental health issues. By 1981, there were two full-time positions and a quarter-time psychiatric consultant.
6. Rhode Island, in a merger to create a Department of Children and Families, lost a separate child mental health division for children, and staff positions.

A = Central staff assigned full- or part-time responsibility, but no organizational entity.
S = Statutory authority.
A = Administrative directive.
NR = No Response.
### TABLE III

**States Reporting Child and Adolescent Mental Health Budgets**

<table>
<thead>
<tr>
<th>No Identifiable Children's Mental Health Budget</th>
<th>Children's Funds Partially Identifiable</th>
<th>Children's Funds Fully Identifiable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Arkansas*&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Florida*</td>
</tr>
<tr>
<td>Arizona</td>
<td>Maine*&lt;sup&gt;d&lt;/sup&gt;</td>
<td>Georgia*</td>
</tr>
<tr>
<td>California*</td>
<td>New Mexico*&lt;sup&gt;e&lt;/sup&gt;</td>
<td>Massachusetts*</td>
</tr>
<tr>
<td>Delaware</td>
<td>Oklahoma*&lt;sup&gt;f&lt;/sup&gt;</td>
<td>New Jersey*</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Oregon*&lt;sup&gt;g&lt;/sup&gt;</td>
<td>New York*</td>
</tr>
<tr>
<td>Hawaii*&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Rhode Islands*&lt;sup&gt;c&lt;/sup&gt;</td>
<td>North Carolina*</td>
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<td>Montana</td>
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</tbody>
</table>

* = States having child/adolescent administrative units.
<sup>a</sup> = No responses were received from Alaska, Colorado, Connecticut, Kansas, New Hampshire, and Ohio.
<sup>b</sup> = State reported child/adolescent budget but provided no substantiating fiscal data.
<sup>c</sup> = South Carolina does not routinely develop a budget, but the Director of Youth Services did a special analysis in response to our survey.
<sup>d</sup> = Only contract money identifiable.
<sup>e</sup> = Only purchased residential services identifiable.
<sup>f</sup> = Only inpatient funds identifiable.
<sup>g</sup> = All funds except community mental health center or outpatient care identifiable.

### TABLE IV

**States Reporting Child- and Adolescent-Specific Mental Health Standards**

<table>
<thead>
<tr>
<th>No Child/Adolescent-Specific Standards</th>
<th>Child/Adolescent-Specific Standards Being Developed</th>
<th>Child/Adolescent-Specific Standards</th>
</tr>
</thead>
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* = States having child/adolescent administrative units.
<sup>a</sup> = Slight modification of adult standards.
<sup>b</sup> = Standards for residential treatment.
<sup>c</sup> = Apply standards of the Joint Commission on the Accreditation of Hospitals.
<sup>d</sup> = Standards for outpatient, day, residential, or inpatient care, or some combination.
<sup>e</sup> = Type of standards not reported.

**Notes:**

---

1No responses to this question were received from Alaska, Colorado, Connecticut, Kansas, New Hampshire, Ohio, and Utah.
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<td>No</td>
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</table>

NR = No response to this question was received.
P = Partial tracking of selected funds possible.
S = Standards being developed.
a = State reported child/adolescent budget but provided no substantiating fiscal data.
b = South Carolina does not routinely develop a budget, but the Director of Youth Services did a special analysis in response to our survey.
### TABLE VI

**States Reporting Prohibition on Placing Children and Adolescents on Adult Wards**

<table>
<thead>
<tr>
<th>States Reporting No Prohibition of C/A on Adult Wards</th>
<th>States Reporting Prohibition of C/A on Adult Wards</th>
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<td>Colorado</td>
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<td>District of Columbia&lt;sup&gt;b&lt;/sup&gt;</td>
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<td></td>
<td>West Virginia&lt;sup&gt;b&lt;/sup&gt;</td>
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</table>

A = States reporting children on adult wards.
O = States reporting only a few children on adult wards; occasional placement or placement for youth needing special security.
a = Prohibited by administrative directive.
b = Prohibited by statutes; although in most instances, respondents did not include cite to specific statutory provision.
c = No information provided as to authority for prohibition.
d = Regulations require due process hearing before a child or adolescent can be placed on an adult ward.

NA = No Answer (Existence of day treatment reported, but no specific numbers given).
x = Reported contracting or purchase of services capacity but no further information.

**Notes:**

1. Responses were not received from Alaska, Colorado, Connecticut, Kansas, New Hampshire, Ohio, and Utah.
2. Florida reported day treatment capacity to serve 333 children, 40 percent of the need.
3. In addition, Georgia spent almost $457,000 on therapeutic camping programs for about 68 youth.
4. Represents federal (Medicaid) not state money.
5. Survey in progress.
6. A telephone interview with state staff suggested steadily increasing capacity to serve children and adolescents regionally. This was not indicated in the formal survey.
7. Special targeted monies in Fiscal Years 1981 to 1983 for expansion or development of partial hospitalization programs.
8. Funding request pending.
TABLE VII

**Selected Mental Health Services Reported by State Officials**

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<tr>
<th>State</th>
<th>Targeted State Funds for Prevention/Early Intervention</th>
<th>Number of Day Treatment Programs in State</th>
<th>Special Efforts To Develop Residential Alternatives</th>
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TABLE VIII

Patterns of State Responsibility for Child and Adolescent Mental Health Based on Reports of State Officials

Spring 1981

<table>
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<tr>
<th>States Reflecting Limited Inpatient and Outpatient Responsibility For C/A Mental Health²</th>
<th>States Selectively Expanding Specific Mental Health Services to C/A³</th>
<th>States Seeking To Create C/A Mental Health Service Systems⁴</th>
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* = States having Child/Adolescent Administrative Units.

Notes:

¹This table reflects information reported by the states and, to the extent possible, verification in discussion with state officials and advocates. Nonreporting states are: Alaska, Colorado, Connecticut, Kansas, New Hampshire, Ohio, and Utah.

²These states assume responsibility for inpatient care, and may have responsibility for outpatient care.

³These states, in addition to having responsibility for inpatient and outpatient care, also allocate specific state funds for early intervention and prevention programs, residential alternatives, the development of programs for specialized populations (e.g., abused children, young substance abusers, etc.), and/or cross-system programming.

⁴These states have begun to develop a system of care for children and adolescents in need of mental health services. In some they have included specific state-initiated or directed efforts to fund a partial (e.g., just for residential alternatives) or complete system of care, including community-based nonresidential alternatives, and specific planning efforts directed toward system development or efforts to link a range of children's facilities or providers in some systematic way. None of the states included in this category has operational systems of carefully in place.
APPENDIX B

Analysis of Voluntary Admission Statutes as They Apply to Minors

The tables in Appendix B were compiled on the basis of a review by CDF staff of the statutory provisions for voluntary admissions to psychiatric hospitals in each state and the District of Columbia as of June 1981.

The tables do not reflect provisions relating to the voluntary admission of specific classes of children, such as state wards, or abused, neglected, or delinquent children, which might be reflected in statutes other than those specifically governing voluntary admissions. Neither do the tables reflect voluntary admission procedures that may have been instituted in states as a result of court rules, court decisions, or administrative regulations or guidelines.
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* = Child-specific reviews.
O = Reviews under special circumstances or for special groups.
O = Child-specific reviews under special circumstances or for special groups of minors.

Notes:
1 For further description, see Appendix B, Table III.
2 For further description, see Appendix B, Table IV.
3 For further description, see Appendix B, Table IV.
4 Alabama permits only the involuntary admission of minors.

### TABLE II

**Role of Parent or Guardian and Minor in Application for Voluntary Admission**

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<th>State</th>
<th>P/G Apply For Minor</th>
<th>P/G Apply, Minor Can Object</th>
<th>P/G and/or Minor Can Apply, Consent of P/M Necessary</th>
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<th>Minor May Apply, P/G Can Object</th>
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| a = State has a specific mechanism for assessing voluntariness of the consent (e.g. administrative or court hearings). |
| b = Nonconsent results in application being treated as petition for involuntary commitment. |
| c = Notification of parents required. |
| d = Parents may object to admission or request discharge and minor must be discharged or court proceedings initiated. |
| e = Additional approvals routinely required. (See Table III for details.) |
| f = Minor's objection may trigger discharge, hearing, or involuntary commitment procedures. |
| g = Other may object on behalf of minor. |
Notes:
1. Table II excludes Minnesota, Nebraska, Virginia, and Washington, where the statutes do not mention minors or indicate who may make application for voluntary admission of a minor, and Alabama, which permits only involuntary admissions of minors. It also excludes New Hampshire, where the statute only directs the Division of Mental Health to establish regulations pertaining to the voluntary admission, release, and refusal of specific treatment of minors. N.H. Rev. Stat. Ann. § 135-B:11 (1964).
2. A prior statute permitting parents to apply for admission has been repealed. Current Arkansas law only mentions minors over 14.
3. In Delaware the parents or legal guardian or any institution or agency having the care and custody of a child between the ages of 3 and 18 may apply to have the child admitted to Governor Bacon Health Center, a facility for the care of children, drug addicts, alcoholics, epileptics, and aged bedridden persons.
4. Florida has both psychiatric hospitals and residential treatment centers for minors. The residential centers are for any child ages 5 to 14. Admission procedures to the two types of facilities differ. Minors may apply for admission to psychiatric hospitals, but can be admitted only after a hearing to confirm the voluntariness of the consent. Further, parents may object to admission or request discharge and the minor must be discharged or procedures for involuntary admission initiated. A parent or guardian may apply for admission of a minor to a residential center without the minor's consent. Children over 12 may make application to a residential center with the same provisions for assessment of voluntariness and parental objection as for admissions to psychiatric hospitals.
5. The Idaho statute makes no specific provision for parent or guardian application of a minor under 18.
6. Although statutes provide that a minor under 21 may be admitted upon application of a parent or guardian, New Jersey court rules (Civil Practice Rule 4:74-7) make other provisions. Under Rule 4:74-7 (g), a minor may be admitted to an institute for evaluation or diagnosis by his parent(s) or other person in loco parentis for a period not to exceed seven days; procedures for involuntary commitment must be followed if the minor is to be hospitalized beyond the seven-day period. Applications by minors over 14 on their own must be approved by the court for voluntariness.
7. There are two separate statutory provisions that mention the voluntary admission of minors in Oklahoma. The first permits any state hospital or licensed private hospital for care and treatment of the mentally ill to admit any person between the ages of 16 and 18 who voluntarily makes written application with the consent of the minor's parents or guardians. The second statute provides that minor patients may be admitted to private hospitals or institutions on application of their parents, guardians, or persons having custody.
8. If parents or guardians refuse to apply with a minor age 14 or older, the court must decide, after a hearing, whether the consent is unreasonably withheld.

### TABLE IIII

**Statutory Provisions for Voluntary Admission Review Procedures**

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**Notes:**
- X: Child-Specific
- E: Not Child-Specific
- A: Mandatory
- C: Conditional
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board that visits the hospital every six months. Assuming an admission coincided with a review board visit, theoretically, an admission review might occur. Minn. Stat. Ann. §253A.16 (West 1971).

Notes:
1See accompanying notes for further elaboration of child-specific provisions.
2"Conditional" means a review is required only for children of certain ages or only under certain other circumstances. Once these circumstances apply, the review is mandatory.
3Alabama permits only involuntary admissions of minors.
4The Kentucky Bill of Rights provides that a minor has a right to seek relief from actions for or against hospitalization approved by a parent or guardian, but no mechanism is specified.
5In Minnesota any patient may request to appear before a review

Further Description of Child-Specific Admission Review Procedures

Arizona statutes require that prior to the admission of a minor under 14, the medical director must 1) conduct a psychiatric investigation that carefully probes the child's social, psychological, and developmental background; 2) interview the child; and 3) determine whether the child will benefit from care and treatment and make a record of the reasons for the determination.

Connecticut statutes require that if a minor 14 to 16 seeks admission on his or her own accord, parents must be notified, and if they object, the minor must be released or involuntary commitment proceedings initiated. Further, if parents of a minor 14 to 16 seek application, the minor may request a court review. There is no court review procedure for children under 14 whose parents seek application for them.

Florida statutes require a hearing on the voluntariness of a minor's consent to admission. (By regulation, the hearing is a nonjudicial procedure involving an informal meeting between the minor and the facility administrator or designee. Mental Health Guidelines, 10E:509.) Admission to a residential center requires certification by a comprehensive community mental health center director or mental health clinic director, designated receiving facility (sic), licensed clinical psychologist, or social or child care agency director.

Illinois statutes require that in addition to an exam, the facility director must find that mental illness or emotional disturbance is of such severity that hospitalization is likely to benefit the minor, and that alternatives to hospitalization have been explored. Further, if an interested party or minor over 12 objects to admission, a court hearing is required.

Iowa statutes require that if any minor objects to an application by a parent or guardian, the court must determine admission is based on the minor's best interest and is consistent with his or her rights. Also, as county option, a preliminary diagnostic evaluation at a community mental health center or alternative diagnostic facility can be required of any age patient before admission.

Louisiana statutes require that in addition to an exam, the facility director must find that the minor's mental illness is so severe that hospitalization is necessary and the minor is likely to benefit from inpatient treatment. A minor over 16 has the right to object and be discharged or go through involuntary commitment procedures.

Maine statutes require that an application must be approved by the Commissioner of Mental Health and Corrections for admission to a public but not a private mental hospital.

Michigan statutes require a court hearing if a minor 13 or older or others object to the minor's admission within 30 days.

Nevada statutes, in addition to providing for the voluntary commitment of minors upon the application of parent or guardian, also have a special provision for the admission of emotionally disturbed children to residential facilities. Under that provision, parents or guardians apply to the facility, but the administrative officer must make a determination that the child can benefit from the treatment program and the facility and staff are available to meet the child's needs.

New Mexico statutes require that within seven days of admission to a residential treatment program, a minor must meet with
counsel, and counsel must certify that the minor's commitment is truly voluntary, after explaining to the minor his or her right to counsel, his or her right to terminate the voluntary admission, and the effect of terminating the voluntary admission. A copy of counsel's certification goes in the minor patient's records, and a copy must be sent to the district court or special commissioner for filing.

**North Carolina** statutes require a court hearing within ten days of admission. The court must find by clear, convincing, and cogent evidence that the minor is mentally ill and needs further treatment, and that lesser measures will be insufficient.

**Ohio** statutes provide that upon petition by the legal rights service, counsel, a relative, or one acting as next friend, the court is to determine whether admission (or continued hospitalization) is in the minor's best interest.

**Pennsylvania** statutes provide that if any responsible party believes it is in the best interest of a minor under 14 to be withdrawn from treatment or to be provided a less restrictive alternative, he or she may file a petition in court, and the court must hold a hearing at which the minor is represented by counsel to determine what treatment, if any, is in the minor's best interest. (Parents, legal guardians, or persons standing in loco parentis may effect the release of minors under 14 without court proceedings, however). In addition, whenever the parent, legal guardian, or person standing in loco parentis objects to the treatment of a minor between the ages of 14 and 18 applying on his or her own, a hearing must be held within 72 hours before a mental health review officer (attorney) or court to determine whether voluntary treatment is in the minor's best interest.

**South Dakota** statutes require that if an objection is made to the hospitalization of a minor of any age within 30 days of hospitalization (and subsequently at any 30-day interval following hospitalization), a board of mental health officers must conduct a hearing within seven days or approve the objection without a hearing.

**Tennessee** statutes provide that no person under 16 may be admitted for more than one six-month period in any 12-month period unless the admissions review committee, by a vote of at least three of the four members, approves further hospitalization. The review committee includes two members appointed from the hospital by the superintendent and two by the president of the Tennessee Association of Mental Health Centers. All members must be specially trained in child mental health. Thus, a child admitted more than once during a year would have an admission review.

**West Virginia** statutes provide that no minor under 18 shall be voluntarily admitted to any state hospital until the minor is first reviewed and evaluated by a local mental health facility and recommended for admission.

**Wisconsin** statutes require the courts to determine whether a minor of any age needs psychiatric services and whether treatment in a particular inpatient facility is appropriate to a minor's needs and is the least restrictive therapy or treatment consistent with those needs. The Court may review the petition, which must be filed by the treatment director of the facility to which the minor is admitted within three days of admission or application for admission, or hold a hearing. If any notation of the minor's unwillingness to be placed appears on the face of the petition, or a minor, his or her counsel, parent, or guardian requests a hearing, a hearing must be held and counsel appointed to represent the minor if he or she is unrepresented.

**Wisconsin** statutes also require a court to determine in the case of a minor 14 and over, whether the admission is voluntary, as well as whether the other conditions described above are met. In addition, a minor over 14 who desires admission but who has no parent with legal custody, or whose parent or legal guardian refuses to execute the admission application or cannot be found, may petition the court for approval of the admission. A person acting on behalf of the minor may also petition for the minor. If, after the hearing, the court determines that the parent or guardian's consent is unreasonably withheld or that the parent or guardian cannot be found or that there is no parent with legal custody, and that the admission is proper under the standards for admission, the court must approve the minor's admission without the parent or guardian's consent. A hearing held in such a case eliminates the need for a hearing of the type described above.
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<th>Special Circumstances</th>
<th>Routinely Required</th>
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<td>Administrative review as often as consistent with good medical practice.</td>
<td>Patient may petition court after 30 days, then one year.</td>
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<td>X</td>
<td>Administration review at least once every six months.</td>
<td>Patient may petition court for release or less restrictive placement.</td>
<td>Medical director must interview minor every ten days.⁶</td>
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<td>Administrative review at regular intervals.</td>
<td>Upon petition, court determines need for continued hospitalization.</td>
<td>Annual review by court-appointed psychiatrist.</td>
<td>Minor 14 to 16 admitted by parental application may petition court for review of appropriateness of hospitalization once every 90 days.</td>
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<td>Individual Service Plan reviewed at regular intervals.</td>
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<td>Periodic review of patient and records by health director.</td>
<td>Thirty days, then every 60 days, by director.</td>
<td>Minor must be consulted. Minor and parent must reauthorize treatment after each review.</td>
<td>Minor over 12 or interested party may object to continued hospitalization. If minor not discharged, court must review.</td>
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<td>Administrative review at 30, 90, 180 days, and then every six months.</td>
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<td>Individualized Treatment Plan must be periodically updated; annual reexecution of application.</td>
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<td>Administrative review at three months, six months, and then annually.</td>
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<td>Periodic reexamination at least annually.</td>
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<td>Administrative review of program plan every three months, then by review board every six months.</td>
<td>Patient may request to appear before review board.</td>
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<td>Administrative review every three months.</td>
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<td>Minor must be readmitted annually. Consent by minor and counsel required. Periodic review must precede readmission.</td>
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<td>Patients must be readmitted every two years; reapplication and exam required.</td>
<td>Every 60 days, review by physician. Attorney must certify to minor's consent each time.</td>
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<td>Court hearing if minor objects to continued stay.</td>
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<td>Annual review by Mental Health Information Service (MHIS).</td>
<td>Initial order for 90 days, renewable by court for 180 days. Court recommitment hearing at end of one year.</td>
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<td>Administrative review within 20 days of admission and every 90 days thereafter.</td>
<td>Upon petition by legal rights service, counsel, relative, or next of kin, court must determine if admission or continued hospitalization is in minor's best interest.</td>
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<td>Ohio</td>
<td>Review by treatment team every 30 days.</td>
<td>Court hearing upon petition for minor 14 and under, or objection by parents of minor 14 to 18.</td>
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<td>Review by treatment team every 30 days.</td>
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<td>Administrative review every 90 days. Reapplication every 90 days.</td>
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<td>Review by mental health board after 90 days, 11 months, and every two years thereafter.</td>
<td>Minor or others may object to mental health board every 30 days.</td>
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<td>None</td>
<td>Review every six months.</td>
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<td>Administrative review every six months.</td>
<td>Court review of continued hospitalization upon petition.</td>
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<td>Administrative review every six months.</td>
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<td>Administrative review every six months.</td>
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<td>Review every six months.</td>
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<tr>
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<td>Psychiatric reevaluation every three months.</td>
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<td>usability every six months.</td>
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<tr>
<td>Wyoming</td>
<td>None</td>
<td>usability every six months.</td>
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**Notes:**

1. Alabama permits only involuntary hospitalization of minors.
2. There is no statutorily mandated review. However, New Jersey Civil Practice rule 4:74-7 requires a child-specific review by the court every 90 days.
3. Pennsylvania statutes specify two sets of circumstances that require court hearings. First, upon petition of a responsible party, on behalf of a minor under 14, seeking the minor's withdrawal from treatment or a less restrictive placement, the court must determine what if any treatment is in the minor's best interest. Second, if a parent or person in loco parentis objects to a minor between 14 to 18 applying on his own, a hearing must be held by a court (or mental health review officer, an attorney) to determine whether voluntary treatment is in the best interest of the minor.
4. The Wisconsin statutes specify that minors under 14 (who have no right to discharge upon request as do minors over 14) may request the court for a hearing on the continued appropriateness of their admission, or if the facility director or staff observes conduct by a minor demonstrating unwillingness to remain at the facility a similar request of the court must be made.
5. Rhode Island statutes require the committee to communicate findings to the parent or guardian.
6. Arizona statutes require records of the review be available to the parent or guardian on request.
TABLE V

Statutory Provisions Regarding Minor’s Right to Counsel in Voluntary Admissions

<table>
<thead>
<tr>
<th>No Mention of Right to Counsel</th>
<th>Right to Appointed Counsel</th>
<th>Right to Counsel</th>
<th>Access to Mental Health Advocacy Services</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Minnesota</td>
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<td>Maryland</td>
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<td>Arizona</td>
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<td>Hawaii</td>
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<td>Maine</td>
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<tr>
<td>Massachusetts*</td>
<td>Wyoming</td>
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</table>

* = Makes specific mention of the right of children to counsel or mental health advocacy services.

Notes:
1 A “mental health advocacy service” is used generally to refer to the availability of a specialized unit under state auspices to represent children in mental health proceedings.
2 The person making an application for the minor, who may be a parent or guardian or minor 16 or older, shall be given an opportunity to consult with an attorney regarding the legal effect of a voluntary admission. Mass. Gen. Laws Ann. ch. 123, §10(a) (West Supp. 1981)
3 Although there is no statutory provision for counsel related to voluntary admission, New Jersey Civil Practice rule 4:76-7 gives a minor the right to counsel during court hearings held to periodically review (every three months) the minor’s commitment. For minors over 14 admitted on their own application, the court may engage in summary periodic review of the commitment.

Further Descriptions of Counsel Provisions

Alaska statutes provide that a voluntarily admitted patient may, after 30 days of hospitalization, petition the court to determine if he or she meets civil commitment standards. The patient has a right to appointed counsel at such hearings.

Arkansas statutes require patient advocates at the three major psychiatric hospitals.

Connecticut statutes provide a minor has a right to counsel at any review hearing.

Florida statutes specify that a patient representative must be notified at the admission of all voluntary patients.

Illinois statutes specify that if a minor 12 or over or another person objects to admission, or a minor over 12 or a facility director objects to a release request, the minor has a right to counsel.

Louisiana statutes specify that the Mental Health Advocacy Service is to provide counsel to any patient who requests it. Specific note is made of a minor’s right to so request.

Maryland statutes require that each patient be advised of his right to consult with an attorney and of the availability of legal aid bureaus.
Massachusetts statutes specify that all voluntary patients must be given an opportunity to consult with counsel regarding the effects of voluntary admission.

Michigan statutes specify that if a hearing is held pursuant to the objection of an admission by a minor over 13, or another acting on a minor's behalf, a minor has a right to appointed counsel.

Montana statutes specify that a minor has a right to counsel any time he or she is faced with legal proceedings. This right must be noted conspicuously on admission forms and explained to a minor. In addition, Montana statutes provide that the mental disabilities board of visitors is required to employ full-time legal counsel for the mental patients at the state hospital. Counsel must periodically interview every patient and examine his records. The board may employ counsel to represent patients at other institutions.

New Hampshire statutes provide that patients or persons sought to be admitted have an absolute and unconditional right to the assistance of legal counsel prior to and during any judicial hearing conducted under Ch. 135 of the statutes. If the patient or person sought to be admitted is not able to afford counsel, the court must appoint counsel.

New Mexico requires that all clients be represented by counsel at all proceedings under the code. In addition, the state requires counsel to certify to the voluntariness of a minor's admission.

New York statutes specify that the Mental Health Information Service (MHIS) must be notified within three days of a minor's admission. All patients have the right to communicate with MHIS upon request.

North Carolina statutes specify that a minor has a right to counsel at the initial admission review hearing and any subsequent hearings. §122-56.7 (e) (g). In addition, a minor patient has the right to communicate and consult with private counsel, retained at the minor's expense, at any time.

Ohio statutes create a legal rights service, one task of which is to assume that all persons detained, hospitalized, discharged, or institutionalized, and all persons whose detention, hospitalization, discharge, or institutionalization is sought or has been sought, are fully informed of their rights and adequately represented by counsel in legal proceedings under the code. The legal rights service is authorized to undertake formal representation of minors who have been voluntarily detained, hospitalized, or institutionalized, whether or not such minors request representation.

Oregon statutes provide that a patient has the right to be represented by counsel whenever his "substantial rights" may be affected.

Pennsylvania statutes specify that minors under 14 have a right to counsel at hearings on whether they should be released pursuant to a third-party request.

Rhode Island statutes specify that a mental health advocate is to represent indigent persons and help others secure counsel for matters relating to the application of the mental health provisions, including judicial proceedings.

South Dakota statutes specify counsel shall be appointed for a minor if the Mental Health Board holds a hearing on an objection to the voluntary admission of a minor.

Vermont statutes specify that, if requested by the patient, all hearings by the board on the issue of granting a discharge shall be held only upon reasonable notice to the patient's attorney who shall be afforded an opportunity to attend. In the absence of any attorney the board shall notify the probate court and an attorney shall be appointed.

Virginia statutes specify that all patients have the right to an impartial review of violations of the rights assured in this section and the right of access to legal counsel.

Washington statutes require voluntarily admitted patients be advised of their right of access to legal counsel.

Wisconsin statutes specify that if the court holds a hearing to review a minor's admission, because the minor, minor's counsel, parent, or guardian has so requested, or evidence of the minor's unwillingness to be admitted appears on the face of the petition, the court must appoint counsel to represent the minor if the minor is unrepresented and may appoint a guardian ad litem if the court deems it necessary. In addition, any time there is a subsequent hearing of a minor under 14, the court must appoint counsel and, if the court deems it necessary, a guardian ad litem to represent the minor.
### TABLE VI

Statutory Citations for Admission, Review, and Counsel Procedures

<table>
<thead>
<tr>
<th>State</th>
<th>State Code Reference</th>
<th>Table II Admission Procedures</th>
<th>Table III Admission Review</th>
<th>Table IV Periodic Review</th>
<th>Table V Counsel Provisions</th>
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<tr>
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<td>$5651(f), 6002</td>
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<td>$27-10-103(2), (3)</td>
<td>$27-10-103(5), (6),10-116(1(b)</td>
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<td>$66-322(a)</td>
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<td>$16-14-91.2</td>
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<td>$225B.4, 229.2(1)</td>
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<td>§§27A-8-2, 8-4, 8-5</td>
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<td>Washington</td>
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<td>§71.05.050</td>
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Alcohol, Drug Abuse, and Mental Health (ADM) Block Grant


To consolidate a number of categorical programs in the areas of alcohol and drug abuse and mental health, including Community Mental Health Centers and the Mental Health Systems Act, into a block grant to states that would increase state flexibility in the use of funds and carry far fewer requirements and limited targeting of funds.

The state must allocate all mental health block grant monies, except 10 percent that may be used for administrative costs, to community mental health centers. Any portion of this money may be used to identify and assess the needs of severely mentally disturbed children and adolescents and to provide appropriate services for them. In addition, to be eligible for block grant funds, community mental health centers must provide specialized outpatient services for children. The alcohol and drug abuse portion of the block grant funds may be used for treatment, prevention, and early intervention services for alcoholic or substance-abusing children and adolescents or for the children of adult alcoholics or substance abusers.

Although no funds are targeted at children, in any Fiscal Year a state must use at least 20 percent of the funds allotted for alcohol and drug abuse activities for prevention and early intervention programs designed to discourage use of alcoholic or other drugs, or both; at least 35 percent for programs and activities regarding alcoholism and alcohol abuse; and at least 35 percent for programs and activities regarding drug abuse.

The ADM block grant was created by the Omnibus Budget Reconciliation Act of 1981 and replaced both the Community Mental Health Centers Amendments of 1975 and the recently passed Mental Health Systems Act as well as a number of categorical programs related to alcohol and drug abuse. The Mental Health Systems Act, which passed Congress in 1981, authorized up to $10 million in earmarked funds the first year to coordinate and provide direct services for severely disturbed children and adolescents. It included a number of smaller grant programs that also could have been used to improve mental health services for children. The block grant meant a loss of this targeted money, though it retained a bill of rights for mentally ill persons that was included in the Act. In addition, under both the Community Mental Health Centers Amendments and the Mental Health Systems Act, community mental health centers were required to provide specialized services for children that included "a full range of diagnostic, treatment, liaison, and follow-up services." This came closer to requiring a continuum of services for children than the current block grant requirement, which applies only to specialized outpatient care. Last, like the other block grants, this one provides states with less money to cover more services, making it even more likely that children's mental health services will get lost in the shuffle.
Authorizing Legislation:

**Adoption Assistance**


**PURPOSE:**

To provide federal reimbursement to states under the Title IV-E Program for adoption assistance payments to assist with the adoption of AFDC-Foster Care, AFDC, or SSI eligible children in foster care who cannot be returned home and have special needs, such as physical, mental, or emotional handicaps, which make it difficult to place them with adoptive families without assistance.

**Applicability to Child Mental Health Services:**

The Adoption Assistance Program assists with the adoption of certain children with special needs, including emotionally disturbed or multiply handicapped children, who are in foster care. Children receiving federally reimbursed adoption assistance payments are automatically eligible for Medicaid after adoption regardless of the adoptive family's eligibility for Medicaid. Persons denied services or other benefits to which they are entitled under the Adoption Assistance Program must be provided an opportunity for a fair hearing.

**Child Welfare Services**


**PURPOSE:**

To provide states with federal funds to develop services that can provide alternatives to foster care placement or reunite separated children and families, and to encourage protections for children to ensure they enter care only when necessary, are placed appropriately, provided quality care, reviewed periodically, and provided permanent families in a timely fashion.

**Applicability to Child Mental Health Services:**

As a condition for full funding under the IV-B program, states must develop services to prevent unnecessary placements of children in foster care and to reunify children and families. In addition states must ensure each child in state-supervised foster care has a written case plan; has his progress and continuing need for placement reviewed periodically; is provided a dispositional hearing to determine his future status; and is provided procedural safeguards for himself and his family when parental rights are challenged, or a change in placement or in visitation arrangements is proposed. States must also develop, as a condition for increased funding, an inventory and a statewide information system from which the status, demographic characteristics, location, and goals for placement for every child in foster care can be determined. All of these provisions can clearly be used to provide protections and services for the many troubled children already in foster care or at risk of foster care placement.

**Comments:**

<table>
<thead>
<tr>
<th>Authorizing Legislation:</th>
<th>PURPOSE:</th>
<th>Applicability to Child Mental Health Services:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)</td>
<td>To provide financial assistance for medical care by civilian sources for the dependents of active, retired, or deceased members of the uniformed services; in addition to basic medical care, assistance is available for certain services for handicapped dependents.</td>
<td>Includes coverage for residential treatment services, as well as inpatient and outpatient services, for emotionally disturbed children and adolescents who are dependents of active, retired, or deceased military personnel.</td>
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<tr>
<td>Comprehensive Employment and Training Act (CETA)</td>
<td>To provide job training and employment opportunities for economically disadvantaged, unemployed, and underemployed persons, including handicapped individuals, and to assure that training and other support services lead to increased earnings and enhanced self-sufficiency by establishing a flexible decentralized system of federal, state, and local programs.</td>
<td>Funds aides and paraprofessionals in programs involved with children and adolescents in need of mental health services and their families, though no systematic data exist regarding how many programs for disturbed children actually use CETA workers.</td>
<td>Like many programs, CETA funds were badly cut by the Omnibus Budget Reconciliation Act of 1981. Some 535,000 CETA positions were completely eliminated.</td>
</tr>
<tr>
<td>Developmental Disabilities Program</td>
<td>To provide financial assistance to states for planning, administration, services, and construction of facilities for the developmentally disabled, including specific priority services: case management, child development, alternative community living arrangements, and nonvocational social-developmental services. At least 30 percent of a state's allotment must be used to develop and implement plans for eliminating the inappropriate institutional placement of people with developmental disabilities. Funds are also available for special projects and the establishment of demonstration facilities and training programs through public and private nonprofit agencies or in university-affiliated facilities.</td>
<td>Until 1978 the definition of a developmental disability included a requirement that the condition be attributable to mental retardation, cerebral palsy, epilepsy, or autism. In 1978 the Act's definition was widened to include severe, chronic disabilities attributable to a mental or physical impairment or a combination of the two. Agencies receiving funds under the program must provide developmentally disabled children with individual habilitation plans, reviewed annually. The Act also includes a bill of rights for developmentally disabled individuals that spells out their right to appropriate treatment, services, habilitation in the least restrictive setting appropriate, and other rights, like the right of close relatives to visit, at reasonable hours and without prior notice, children in residential placements. Further, for a state to receive its allotment of funds under the program, it must have a system, independent of the agency providing treatment to the developmentally disabled, to protect and advocate for the rights of developmentally disabled persons, including the authority to pursue legal, administrative, and other remedies.</td>
<td>The Omnibus Budget Reconciliation Act of 1981 cut funding for the program.</td>
</tr>
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</table>
### Authorizing Legislation: **PURPOSE:**

#### Education for All Handicapped Children

**Education for All Handicapped Children Act, P.L. 94-142, 20 U.S.C. §§1401 et seq.**

To establish necessary rights to ensure that all handicapped children receive the free appropriate public education to which they are entitled. Grants are provided to the states to assist them in providing for the education of all handicapped children, with priority given to handicapped children receiving no education and children who are severely handicapped.

#### Foster Care Program


To provide federal reimbursement for certain eligible children placed in foster care, create greater protections for such children and their families, and encourage states to develop services to prevent foster care placement and reunify children in foster care with their families.

As a condition for federal reimbursement for any child receiving foster care payments under Title IV-E, a state must develop a written case plan for that child, periodically review the child's continuing need for placement and the appropriateness of such placement, provide a dispositional hearing to determine his future status, and procedural safeguards for himself and his family when parental rights are challenged, or a change in placement or visitation is proposed. Beginning October 1983, states will only be able to claim federal reimbursement for foster care under Title IV-E for children for whom efforts were first made to prevent foster care placement. Persons denied services or other benefits under IV-E must be provided an opportunity for a fair hearing. These provisions can all help provide services and protections for the many troubled children now in foster care or at risk of foster care placements.

#### Foster Grandparents Program

**Domestic Volunteer Services Act of 1973, 42 U.S.C. §§5002 et seq.**

To provide volunteer opportunities for low-income persons age 60 and over by having them render supportive services, which they receive a stipend, to children with special needs in health, education, welfare, or related settings, both institutional and non-institutional.

Foster grandparents can serve as a resource for emotionally disturbed children and adolescents, and, in particular, can provide services to troubled children in out-of-home placements. However, no data are available on the number of foster grandparents who actually work with disturbed children.

Though the Omnibus Budget Reconciliation Act of 1981 did not greatly affect the Education for All Handicapped Children Act, the Reagan Administration repeatedly has made clear its intent to include the program in a block grant and cut its funding. Further, the Administration has made a concerted effort to undercut the program's services and protections for handicapped children by proposing substantial changes in regulations.
Hill-Burton, Title XVI of the Public Health Services Act

The Hospital Survey and Construction Act of 1946, as amended by the National Health Planning and Resources Development Act, P.L. 93-641, 42 U.S.C. §§3000 et seq.

To provide federal financial assistance to hospitals and other health care providers for capital construction to be done in conjunction with statewide health planning activities.

In return for federal financial assistance, a hospital was required to give assurance that for 20 years after the completion of construction of the facility or portion thereof for which it received Hill-Burton grants, or for the period in which a direct loan, loan guarantee, or interest subsidy remains unpaid, the hospital would provide a reasonable volume of free service for those unable to pay. Hospitals also had to agree that in perpetuity they would make hospital services available to all people residing in the community in which the hospital was built.

Thus, Hill-Burton serves as one of the only sources ensuring free or reduced-cost care to children and families who do not qualify for Medicaid but cannot afford health care. In addition, the community services obligation provides an important tool for community involvement in a particular hospital's decision making regarding the services it will offer. Advocates can lobby for outpatient mental health services for children and adolescents and for other programs to serve troubled children as part of a hospital's community services obligation.

Maternal and Child Health Block Grant


To consolidate a number of health services programs for mothers and children, including Crippled Children's Services, the SSI Disabled Children's Program, lead-based paint poisoning prevention programs, genetic disease programs, sudden infant death syndrome programs, hemophilia treatment centers, and adolescent pregnancy grants. Block grant money can be used very flexibly by states, including: to assure the access of mothers and children (particularly those with low incomes or limited access to health care) to maternal and child health services; to reduce infant mortality, the incidence of preventable diseases and handicapping conditions, and the need for inpatient and long-term care; to rehabilitate children under age 16; and to provide services for crippled children.

Though funding for the block grants is less than what it was for the separate categorical programs, any portion of these funds theoretically can be used for services for handicapped children, including emotionally disturbed children, and for programs aimed at reducing the risk or effects of emotional handicaps. However, given the great demands on this money, extensive use of it for these purposes is unlikely. Funds cannot be used for inpatient services except for crippled children, high-risk pregnant women and infants, and such other services as the Secretary of Health and Human Services may approve.

The block grant was created by the Omnibus Budget Reconciliation Act of 1981. Besides substantially cutting funding for the former categorical programs included in it, the block grant abolished the SSI Disabled Children's program. Though that program reached few seriously emotionally disturbed children, it provided a model for the delivery of coordinated services to handicapped children as well as limited funds to plan and develop needed and nontraditional services for children when they did not exist.
Authorizing Legislation: Medicaid

Social Security Act, Title XIX, 42 U.S.C. §§1396 et seq.

PURPOSE:

Provides health insurance to low-income families who meet certain categorical and financial criteria. States may, but need not, provide Medicaid to all low-income children, whether or not they categorically qualify for aid under AFDC or SSI.

Applicability to Child Mental Health Services:

Coverage for mental health services is optional under Medicaid. States may cover clinic services in community mental health centers; may reimburse for day treatment services; and may choose to participate in the inpatient psychiatric program for persons under age 21.

Comments:

Some positive and some negative changes were made in Medicaid's eligibility and benefit requirements under the Omnibus Budget Reconciliation Act of 1981. States still have the option of covering mental health services. A new Medicaid option allows states to fund community-based services instead of placement in institutional care. Although this could lead to the development of more alternative, non-medically oriented services, states may never pick up on this option and may drop other optional benefits, because of recent reductions in federal Medicaid reimbursement.

Medicaid, Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

Social Security Act, Title XIX, 42 U.S.C. §1396 (a) (4) (B)

To provide preventive health care to Medicaid-eligible children by identifying, diagnosing, and treating medical, dental, and developmental problems.

EPSDT, which is part of the Medicaid Program, requires a developmental assessment of each child on a periodic basis. This can reveal emotional difficulties and problems in behavior development. However, mental health treatment services are optional, not mandated, under EPSDT.

Medicaid, Inpatient Program

Social Security Act, Title XIX, 42 U.S.C. §1396 (d) (A) (16)

To provide states with the option of covering inpatient psychiatric services for children under age 21 under the Medicaid program.

If a state chooses the option of providing Medicaid coverage for inpatient psychiatric services to a child under age 21, it first must document for each child for whom reimbursement is sought that less restrictive alternatives are not appropriate. Under the Omnibus Budget Reconciliation Act of 1981, if a child needs a level of care comparable to an intermediate care facility or a skilled nursing home, the state may use Medicaid funds for community support services instead of placement, if the state gets a waiver from the Secretary of the Department of Health and Human Services.
National Health Planning and Resource Development Act of 1974

To facilitate better health care planning at the national, state, and local levels, including increasing the coordination among plans for mental health, drug and alcohol abuse, and health services, and increasing the input of health and mental health care consumers and professionals into the planning process.

The Act includes a number of national health priorities directed to promote mental health care, decrease inappropriate institutionalization, and ensure access to community mental health centers and other mental health services with an emphasis on outpatient care. In addition, the Act requires that each state establish a Statewide Health Coordinating Council (SHCC), the majority of whose members must be consumers of health or mental health care. The SHCC reviews all local health plans and triennially prepares, reviews, holds a public hearing on, and revises the State Health Plan. The State Health Plan must be coordinated with the state mental health plan, include a specific mental health component, and address the required resources, availability, and quality of services. The SHCC also annually reviews the budget of each health systems agency and advises the state agency on the performance of its functions. Last, the SHCC must review for approval or disapproval any plan, application, or revision thereof submitted to HHS by the state in order to receive funds under the Community Mental Health Centers Act (now the ADM block grant).

Section 504 of the Rehabilitation Act.

To make it illegal for any agency or organization receiving federal funds to discriminate in any way against handicapped people. Any public or private organization receiving federal money must take steps to make it possible for people with mental, perceptual, physical, or emotional handicaps to learn, work, and compete on a fair and equal basis. Noncompliance can mean a cutoff of all federal support to the agency or organization. Regulations for 504 are issued separately by each federal agency under the general coordination of the Justice Department.

Basically, 504 states that agencies taking federal funds, including schools, health and mental health centers, and social service agencies, cannot discriminate against children or adolescents with mental health problems or exclude them from programs solely on the basis of those problems. Thus, 504 is a lever to get agencies to recognize the needs, mental health and otherwise, of disturbed children and adolescents.
Authorizing Legislation:  

Social Services Block Grant  

Social Security Act, Title XX, as amended by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35 §§2351 et seq.

To consolidate federal assistance to states for social services into a block grant that allows states to use the money for almost any community or social services for virtually any individual or family.

In the past, social services funds have been used to create some effective, nonmedically oriented programs for troubled children and adolescents, particularly programs related to early intervention or home-based care. Funds have also been used to pay for residential treatment. However, under the new block grant, states are no longer required to match federal dollars made available to them nor to maintain their current level of spending for social services. Thus, a very real possibility is that less money rather than more will be spent on services for emotionally disturbed children and adolescents.

Supplemental Security Income (SSI) Program  

Social Security Act, Title XVI, 42 U.S.C. §§1381 et seq.

To provide supplemental income, through federal financial assistance, to persons in financial need who are ages 65 or older, or blind or disabled, including children.

One of the disabilities included for coverage under the SSI program is serious emotional illness. Disturbed children in foster care and certain types of institutions may be eligible for SSI as well as children in group facilities serving 16 or fewer people. Aid is in the form of cash payments made to the child or another payee on behalf of the child by the federal government; some states may supplement this with a state payment.

Title I Programs for Handicapped Children in State-administered or State-supported Schools  


To provide funds to state agencies to supplement and strengthen education programs for handicapped children in state-operated and state-supported schools.

Children under age 20 whom a state has classified as handicapped and has provided with a free public education are eligible for services under this program as long as they have not completed grade 12. This includes children with multiple handicaps or serious emotional disturbances.

P.L. 89-313's funding was cut under the Omnibus Budget Reconciliation Act of 1981, but the program remained intact although, technically, it is now under Chapter I of the Education Consolidation and Improvement Act of 1981. The Reagan Administration has proposed including the program, along with the Education for All Handicapped Children Act, in a handicapped education block grant.

Vocational Education Program  


To assist states in improving vocational programs on the local level for persons of all ages who desire and need education and training for employment.

The 1976 amendments to the Act required greater attention to the handicapped, including the emotionally disturbed.
# Appendix D

## Emotionally Disturbed Children Ages 3 to 21 Years Served Under P.L. 89-313 and P.L. 94-142 School Year 1980 to 1981

<table>
<thead>
<tr>
<th>State</th>
<th>Total Number of Handicapped Children Served</th>
<th>Number of Emotionally Disturbed Children Served</th>
<th>Percentage of Handicapped Children Served Who Are Emotionally Disturbed</th>
<th>Percentage of Total Enrollment Who Are Emotionally Disturbed²</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>76,296</td>
<td>3,961</td>
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<td>348,954</td>
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</table>

Notes:
3. Based on number of emotionally disturbed children ages 3 to 21 as a percentage of estimated fall 1980 enrollment (ages 5 to 17).
4. Includes territories, which are not noted above.

APPENDIX E
Examples From North Carolina of the Components in a Continuum of Child and Adolescent Mental Health Services

WM01 Case Management Services
This service component provides planning and direction for the provision of services to a child and his/her family or custodian. Activities include assessment of client needs, planning for services to address those needs, linking and coordinating the flow of services to the client, monitoring the services provided to the client, and advocating for the client.

WM02 Respite Services
This component provides services for the families of mentally retarded or emotionally disturbed children who need periodic relief from the constant and often stressful care of the child. Services may be provided either on a planned or emergency basis. While in respite care, the child receives supervised care with the provision for meeting the child's basic health, nutritional, and daily living needs. Respite may be provided in a variety of models including center-based services which afford the opportunity for continuous care for up to 30 days; contracted services with citizens for use of their home for provision of respite; and availability of companion sitters who can provide respite services in the home of the child.

WM03 Crisis Stabilization/Residential (Short-term)
This component provides a temporary supervised residential environment to children in crisis situations who need temporary residential alternatives and assistance until the crisis is stabilized or a longer term plan can be developed. Children in crisis who do not need the full range of medical staff and facilities as provided in inpatient services are appropriate for this type of care, although medical backup will be available.

WM04 Alternative Family Living: Specialized Foster Care
Children served in this component are placed individually or with one other child in community foster care homes with specially trained and supported foster parents. Foster parents receive a monthly subsidy for services to meet the special needs of these children. Professional mental retardation or mental health workers provide backup training, case management, and treatment services.

WM05 Alternative Family Living: Supervised Independent Living for Older Children
Older adolescents (ages 16 to 18) using this service live with a highly trained alternative parent or supervisor in a home or apartment setting. Activities include parental care or supervision, emotional, physical, and cognitive development, social integration, prevocational skill-building, and either work with the parents to reintegrate children into their families or work toward independent living.

WM06 Alternative Family Living: Intensive Service
Children served in this component are placed individually in community homes, with specially trained and supported professional level foster parents. Training for these parents is more intensive and care-specific than in current specialized foster care models and the parents are actively and regularly involved in providing direct treatment efforts for the youth. Support systems and case management services for these special families are also intensive and youth in their placements are likely to be simultaneously involved in many other services.

WM07 Residential Group Living: Moderate Supervision
This model offers residential treatment to children with moderate to severe problems and includes multiply-handicapped children. These are children for whom removal from home is essential to facilitate treatment. Children in this setting will generally attend public school but may use day treatment or have a job placement while in residence. These group homes provide healthy adult role models, group, individual, and family counseling as appropriate, liaison services to mobilize community and family resources, and social, emotional, and cognitive training. Staffing is sufficient to supply a moderate level of supervision. Length of stay will typically be six to eight months but may be longer dependent upon a child's individual needs.

WM08 Residential Group Living: Extensive Supervision
This model offers highly structured residential treatment to children with moderate to severe problems including multiply-handicapped children. These are children for whom removal from home is essential to facilitate treat-
ment. Children in this setting may use day treatment or have a job placement. Some may be able to attend public school; for others, special education services may need to be offered at times within the residential or day treatment setting. These group homes provide healthy adult role models, group, individual, and family counseling as appropriate, liaison services to mobilize community and family resources, and social, emotional, and cognitive training. Staffing is sufficient to supply an extensive level of supervision including control of most aggressive behaviors. Facility may be locked if needed. Length of stay will be up to two and one-half years according to the child's individual needs.

WM09 Residential Group Living: Extensive Supervision—High Management
This model offers highly structured and secure residential treatment to children with severe emotional or behavioral disturbance including multiply handicapped children. These are generally aggressive children for whom a secure (generally locked) environment is essential to facilitate treatment. These children are too disturbed to attend public school or vocational training, but they may attend a day treatment program. These homes provide healthy adult role models, group, individual, and family counseling as appropriate, liaison services to mobilize community and family resources, and social, emotional, and cognitive training. Services such as emergency services, educational or vocational training, day treatment, and counseling may be provided by the program, from other mental health center components, or from another agency as indicated. Staffing patterns using the shift system or modified shift system may be used, but in general, a “home-like” atmosphere is maintained. Redoing models or other models are used to provide this service.

WM10 Residential Group Living: Intensive Treatment (Nonmedical)—High Management
This model offers highly structured and secure residential treatment to children with severe emotional or behavioral disturbance including multiply handicapped children. These children are highly aggressive and require a secure (generally locked) environment. These children are too disturbed to attend public school or vocational training. Full services are generally provided within the setting, but in some instances, the children may receive services in another setting (e.g., day treatment). Emphasis is placed on containing and controlling the child's violent and aggressive behavior and establishing positive, appropriate behavior to replace negative, destructive behavior. As soon as the child's behavior is under programmatic control, he/she is moved to a less restrictive setting. Length of stay is usually short term. Activities emphasize social skills, emotional and cognitive development, daily living skills, vocational skills, and recreational skills. Liaison services are provided to community and family. The staffing pattern utilized is a shift system employing paraprofessionals, teachers, and therapists.

WM11 Specialized Group Living
This model of service provides residential services for children who have extensive developmental, medical, and behavioral problems. Individualized programming is provided in the facility through an interdisciplinary staff, which provides constant supervision and a high degree of programmatic structure. Often children served by these programs are too multiply handicapped to be appropriately served in the public school classroom.

WM12 Transitional Group Living
This model of residential services provides time-limited behavioral/developmental programming for children who have moderate to extensive skill deficits and behavior problems. Intensive prescriptive behavioral programming is provided in order that the child may return to residence with his own family or other less restrictive living environment.

WM13 Summer Programs for School Children
This component serves school-age children with mental health or mental retardation problems who need summer programs to meet their individual needs and the needs of their families. These children may include those whose difficulties cause them to be “high risk” for court involvement during unstructured summer months and whose needs are not met in other generic summer programs (youth camps, etc.). Activities in these programs occur in a variety of settings, including developmental day centers, community recreational resources, and day camps. These services are supervised by individuals who are knowledgeable about emotionally disturbed children or mentally retarded children. The services include child care, group socialization experiences, and recreation.

WM14 Preschool Developmental Day
This component serves children with mild/moderate and severe developmental deficits in an organized and licensed day center setting. Services are available five days per week for a minimum of eight hours per day. Individualized programming is provided for the child in the skill areas of cognition, self-help, motor, speech, and socialization. Additionally, family support programs are incorporated in the service. A staff child ratio of 1:5 is required; however, a ratio of 1:3 is recommended.

WM15 Day Treatment (Partial Hospitalization): Moderate Services
This component serves children with moderate to severe problems. Children who have difficulty participating in partial or full-day public school programs because of the severity of their problems are appropriately served in this setting as are children who require intensive intervention.
to prevent hospitalization. Day treatment services may often be provided in conjunction with residential treatment services. Day treatment planning, recreation, social skills development, group counseling, services to parents, and client advocacy (sic).

Other services may include individual therapy and educational or vocational training and case management. Services are generally provided four hours per day, two to five days per week. The staff client ratio must be at least at the 1:4 level of intensity.

WM16 Day Treatment (Partial Hospitalization): Intensive Services

This component serves children with severe problems. Children served in this component are often violent and assaultive. They require an intensive staffing level (staff: client ratio of at least 1:2) to enable the control and remediation of these children's problems. Services are often provided in conjunction with residential treatment. Full educational/vocational services are generally provided within the setting. Other services provided include diagnosis and treatment planning, recreation, social skills development, group counseling, services to parents, and client advocacy. Case management and individual therapy may also be provided. The services are generally provided four to eight hours per day, five days per week.

WM17 Emergency Clinical Services

These services are provided for children in acute crisis who require immediate mental health evaluation and treatment. The service setting is nonresidential. Contact may be initiated in person or by telephone at any time. Face-to-face contact with a mental health professional is arranged if necessary. Based on the initial evaluation, preliminary diagnosis is established and treatment with referral, follow-up, and case management, as needed, is provided.

WM18 Outpatient Treatment Services for Child

This component serves children with mild to moderate problems who can otherwise function in their natural environment. In some instances, this service may also be used for children with moderate to severe problems in conjunction with other services of a more intensive nature (e.g., partial hospitalization, alternative family living, residential group living). Outpatient treatment services include screening, evaluation, diagnosis, treatment, follow-up, work with families, case consultation to schools, courts, DSS, and other service providers, and case management.

WM19 Family Support Services—Outpatient or In Home

This component of service includes family counseling, individual counseling for family members, parent training and information, parent support groups, and subsidy for maintenance of the child in his own home. Combinations of these services may be made available to the parents, siblings, and extended family members of children with varying levels of disturbance and who are participating in any specialized treatment program. The purpose of such services is to improve or stabilize the family living environment of the child; to minimize the necessity for out-of-home placement of the child; to assist parent and family members to better understand the effects of the child's disabilities; and to assist parents in better affecting their child's developmental growth.

WM20 Transportation Services

This component provides transportation services to those clients in need of such services in order to participate in the needed programs or services. It includes transportation coordination, the training of clients in the use of public transportation, the provision of segregated transportation when appropriate, and assistance with carpooling and planning.

WM21 Wright School

WM22 Adolescent Re-Ed (NCSCFRC-Butner)

WM23 Inpatient Hospitalization—Short-term/Crisis

This service is appropriate for children with severe emotional or behavioral disturbances who cannot be served appropriately in a less restrictive setting. Services include a) psychological and medical diagnostic procedures; b) observation treatment modalities including medication psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation therapy, and milieu treatment; c) medical care and treatment as needed; d) supportive services; e) room and board. Both voluntary and involuntary clients may be served in this setting.

This service is based on the likelihood of stabilization within a short period of time and transfer to a less restrictive setting for continued treatment.

WM24 Inpatient Hospitalization—Long-term

This service is appropriate for children with severe emotional or behavioral disturbances who cannot be served appropriately in a less restrictive setting. Services include a) psychological and medical diagnostic procedures; b) observation treatment modalities including medication psychotherapy, group therapy, occupational therapy, industrial therapy, vocational rehabilitation, recreation therapy, and milieu treatment; c) medical care and treatment as needed; d) supportive services; e) room and board. Both voluntary and involuntary clients may be served in this setting.

This service is for children with especially intractable problems who require intensive inpatient treatment to achieve stabilization and/or problem remediation. Length of treatment will typically be more than one year.
WM25  Mental Retardation Center

WM26  Wilderness Camp (Short-term)
This component serves children 6 to 12 who have mild, moderate, or serious problems. Services provided include supervised recreational and educational experiences with supervised peer interaction and the provision of healthy adult role models. This service is provided during weekends through the year or six to nine weeks in the summer and includes outdoor living experiences to help the client develop coping skills and behavior control as well as academic and vocational skills. Liaison services are also provided to promote community and family interaction.

WM27  Wilderness Camp (Long-term)
This component serves children 6 to 18 who have moderate to severe problems, whereby removal from the home is essential to facilitate treatment. Services are provided in an emotionally healthy, structured, therapeutic environment in groups of ten or less. Healthy adult role models provide supervision of school activities, peer interactions, and everyday living activities. Other services include recreation, group counseling to clients and parents, and client advocacy. Through outdoor living on a long-term basis (9 to 15 months) the child is helped to develop coping skills, self-esteem, and academic or vocational skills. Liaison services are also provided to promote community and family interaction.

WM28  Training School

WM29  Educational Services Provided by Public School at Mental Health Program Site (day)

WM30  Educational Services Provided in Public School

WM31  Foster Care
This is a legally defined service provided by a county DSS or by a private provider so licensed. This service is a legal substitute for care and child rearing provided by the child’s parent(s) or other relatives.

WM32  Probation
This is a legally defined service of supervision, prescribed by the court in relation to charges brought against a juvenile.

WM33  Before and After School Program
This component provides services for school-aged children who need care and intervention services before and after school hours to meet their individual needs or their families' needs. Services incorporate individualized programming in the developmental skill areas and are provided in a licensed day care setting. Staff who are professionally qualified are required by standards.

WM34  Assessment/Prescriptive Services
This component provides periodic services to individuals in need of diagnostic evaluation, behavior assessment, and behavioral programming and to individuals who are being screened for services or who are in an ongoing service program.

WM35  Advocacy Services
This component provides advocacy services (friendship and emotional support, assurance of quality services, that rights are met, and freedom from abuse) to all individuals in need of such services. It includes the coordination, recruitment, and training of advocates as well as the assessment of client needs for advocacy and the appropriate matching of the volunteer advocate with an individual and his/her needs.

WM36  Other (Specify)
National and Regional Organizations Concerned With Child and Adolescent Mental Health Services

National Organizations

**Consumer-oriented**

Children’s Defense Fund  
1520 New Hampshire Avenue, N.W.  
Washington, D.C. 20036

National Alliance for the Mentally Ill  
1234 Massachusetts Avenue, N.W.  
Suite 721  
Washington, D.C. 20005

National Association for Retarded Citizens  
1522 K Street, N.W.  
Suite 516  
Washington, D.C. 20005

National Center on Institutions and Alternatives  
814 North St. Asaph Street  
Alexandria, Virginia 22314

National Congress of Parents and Teachers  
c/o Mrs. A. T. Leveridge, Jr., President  
700 North Rush Street  
Chicago, Illinois 60611

National Mental Health Association  
1800 North Kent Street  
Arlington, Virginia 22209

National Society for Autistic Children  
1234 Massachusetts Avenue, N.W.  
Suite 1017  
Washington, D.C. 20005

**Professionally oriented**

American Academy of Child Psychiatry  
1424 16th Street, N.W.  
Washington, D.C. 20036

American Academy of Pediatrics  
1300 North 17th Street  
Suite 350  
Arlington, Virginia 22209

American Association of Children’s Residential Centers  
1424 16th Street, N.W.  
Washington, D.C. 20036

American Association of Psychiatric Services for Children  
1725 K Street, N.W.  
Suite 1112  
Washington D.C. 20006

American Association on Mental Deficiency  
5101 Wisconsin Avenue, N.W.  
Suite 405  
Washington, D.C. 20016

American Medical Association  
535 North Dearborn  
Chicago, Illinois 60610

American Orthopsychiatric Association  
1755 Broadway Avenue  
New York, New York 10019

American Psychiatric Association  
1700 18th Street, N.W.  
Washington, D.C. 20009

American Psychological Association  
1200 17th Street, N.W.  
Washington, D.C. 20036

American Society for Adolescent Psychiatry  
23 Green Valley Road  
Wallingford, Pennsylvania 19086

Child Welfare League of America  
67 Irving Place  
New York, New York 10003

Council for Children With Behavioral Disorders  
Council for Exceptional Children  
1920 Association Drive  
Reston, Virginia 22091
Regional Organizations

Children's Mental Health Services Network (Region VI)
c/o Family Guidance Center
200 Corby Building
5th and Felix Streets
St. Joseph, Missouri 64501

Mid-Atlantic Partners
c/o Jacob Armstrong
Youth Services Coordinating Commission
121 North Broad Street
Philadelphia, Pennsylvania 19107

New England Children's Mental Health Task Force
Suite 300
25 Huntington Avenue
Boston, Massachusetts 02116

National Legal Organizations

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1520 New Hampshire Avenue, N.W.
Washington, D.C. 20036

Mental Health Law Project
2021 L Street, N.W.
Suite 800
Washington, D.C. 20036
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