

The background of the entire page is a dark, textured grey. Overlaid on this is a large, stylized sun. The sun's face is a solid dark grey circle. Its rays are made of numerous rectangular strips of paper, torn at the edges, radiating outwards from the center. The strips are of varying lengths and are arranged in a somewhat chaotic but rhythmic pattern, creating a sense of movement and light.

# enhancing **YOUTH** services

*Prepared For*  
**National Association of Psychiatric Health Systems**

*Prepared By*  
**The Lewin Group**

**The National Association of Psychiatric Health Systems (NAPHS)** advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, and adults with mental and substance use disorders.

**For more information,** visit the NAPHS web site at <http://www.naphs.org>.

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# **Enhancing Youth Services**

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## TABLE OF CONTENTS

I.	Introduction .....	1
II.	The Costs of Neglecting The Behavioral Health Needs of Children and Adolescents.....	3
III.	Data on the Prevalence of Behavioral Health Disorders in Youth.....	7
IV.	Challenges in Identifying Youth with Behavioral Health Problems.....	10
V.	Diverse Systems Serving Multiple Needs.....	12
VI.	Expenditures/Funding Sources.....	16
VII.	Advances in Service Delivery/Promising Approaches .....	21
VIII.	Key Problems Still Remain in Addressing Behavioral Health Needs of Youth .....	26

## EXHIBITS

Exhibit 1:	Self-Reported Suicidal Behavior in High School Students.....	5
Exhibit 2:	Prevalence of Serious Emotional Disturbance .....	7
Exhibit 3:	Prevalence of Youth Substance .....	9
Exhibit 4:	Risk Factors .....	10
Exhibit 5:	Behavioral Health Expenditures by Payer.....	18
Exhibit 6:	Estimated 1996-1997 National Educational Enrollment and Expenditures .....	19
Exhibit 7:	U.S. Federal Child Welfare Spending (FY1999-2000).....	20
Exhibit 8:	Funding for Mental health/Substance Abuse Programs .....	21
Exhibit 9:	System of Care Services.....	22
Exhibit 10:	Examples of NAPHS Services .....	25

## APPENDIX

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## I. Introduction

Dramatic events, including recent incidents of school violence, shine the spotlight of public attention on behavioral disorders in youth. This attention is welcomed by professionals engaged in the daily practice of serving children and youth, whose mission is to identify, intervene and treat young people exhibiting signs of such problems. However, in order to understand the troubling incidents that achieve public notice, it is essential to have a clearer picture of the entire problem of mental and behavioral disorders in youth.

The past two decades have produced significant treatment advances, from more potent mental health medications with fewer side effects, to the creation of new home and community-based models of care. With the opportunity to access appropriate care, many youth with behavioral health problems go on to live healthy and productive lives.

The National Association of Psychiatric Health Systems (NAPHS) asked the Lewin Group to produce a report providing baseline information on current knowledge and thinking about care for youth with psychiatric, emotional, and behavioral problems. This report is based on a literature review, tested and reinforced by extensive structured interviews with members of the NAPHS Youth Services Committee (comprised of leading providers serving children and youth). The report highlights the following issues:

- The costs of neglecting the behavioral health needs of children and adolescents;
- The prevalence of behavioral health disorders in youth, as well as the difficulties associated with identifying these youth;
- The diversity and fragmentation of service systems and funding streams;
- Promising services and programs available to treat youth; and
- Remaining challenges associated with addressing behavioral health needs of youth.

Illustrations from the practical experience of care providers ground the presentation of findings from research and data analysis. The report ends with several conclusions drawn from the study. In addition, NAPHS program examples illustrating approaches to providing care are in the Appendix to the report.

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## Primary Findings

- Despite considerable progress over the last two decades in expanding access to treatment for youth with behavioral health needs, **many children are not receiving the care they need from mental health specialists.**
- Mental disorders in children and adolescents include a broad spectrum of behavioral and emotional disorders that require a variety of treatments and services along a **continuum of care.** There is no “one size” that fits all.
- Several discouraging trends indicate that youth with mental health and substance abuse problems are at **greater risk than the general population for dropping out of school, committing crimes, and attempting or committing suicide.**
- The **direct and indirect costs of mental illness to society are significant from both an economic and humanitarian perspective.** The most recent published data estimates the total costs for all mental disorders at \$148 billion in 1990, and new research is likely to set the figure higher.
- Current data on the prevalence of mental illness indicates that **at least 11 million youth have a serious diagnosable mental, emotional or behavioral health disorder.** However, it is likely that this figure underestimates actual prevalence rates. In addition, there is an extremely high prevalence of youth with co-occurring mental health and substance use disorders.
- **Data are lacking** on the prevalence of behavioral health disorders among youth who do not fall within the “priority population”—those with serious emotional disturbances—and on many of the specific costs and funding sources associated with behavioral health disorders in children and youth.
- More than half of the funding for all behavioral health services—and at least that much for behavioral health services for children and youth—comes **from public sources.**
- **Medicaid** is the key public funding source for behavioral disorders. Since states have the freedom to select which optional services they will include or exclude in their benefits, there are **significant variations from state to state** in the services and rates that are reimbursed to providers.
- The adoption of **managed care** in both private insurance and the public sector (e.g., Medicaid) has significantly impacted service systems and funding for child and adolescent behavioral health.
- The creation and testing of the **system of care philosophy** has advanced knowledge about the requirements for effective service systems for children and youth.

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- Members of the NAPHS have broadened the array of services they provide to children and youth to ensure that they can meet the individual needs of youth, as well as remain competitive in the marketplace.
  - Key problems remain in addressing the behavioral health needs of youth: the lack of services and funding to meet demand, the existence of fragmented systems of care, inflexible funding streams, and challenges in recruiting and retaining front-line staff.

## II. The Costs of Neglecting the Behavioral Health Needs of Children and Adolescents

The failure of troubled youth to obtain necessary mental health treatment carries alarming implications for the loss of human potential, as well as the more immediate economic and social costs.

A wide array of social problems, appear to be related, at least in part, to the unmet behavioral health needs of children and adolescents. An abundance of literature suggests that youth with behavioral health problems are at greater risk for: 1) committing crimes that place them in the juvenile justice system; 2) dropping out of school; and 3) contemplating or succeeding in committing suicide.

### Youth Crime/Violence and the Juvenile Justice System

The impact that known behavioral health problems have on children and family members is substantial, but equally significant is the impact on individuals and communities when such disorders are unrecognized or untreated by professionals. Consider the following excerpt from a New York Times article regarding the highly publicized incident of two teenage boys in Littleton, Colorado, who committed suicide immediately after killing 12 fellow students and a teacher.<sup>1</sup>

*“They seemed, people said at the time, like normal children from normal families, rattling along the bumpy emotional road that most people believe represents the normal course of the teen-age years.”*

*“But when psychiatrists investigated the suicides of 27 youths in a similar incident, interviewing the victims’ friends, teachers and family members, their inquiry revealed not normal teen-agers, but severely disturbed youth. These were severely disturbed youth whose psychological problems were longstanding and whose unhappiness had leached out in a hundred clues that were ignored or undetected by those around them.”*

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<sup>1</sup> Goode, E. Deeper Truths Sought in Violence by Youths. The New York Times. May 4, 1999.

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*"This contrast between surface assessment and underlying reality, mental health experts say, is typical of most cases in which teen-agers have committed acts of extreme violence. As the days proceed and these boys lives are put under the microscope we may begin to see a pattern of early difficulties."*

The Littleton, Colorado incident, as well as other recent violence committed by schools and communities, represent extreme consequences of adolescents lacking emotional stability. Although such acts of violence are rare, the literature suggests that youth with behavioral health disorders often commit crimes that place them in the juvenile justice system. It is estimated that 60 percent of the teenagers in juvenile detention have behavioral disorders and approximately 20 percent experience serious emotional disturbances. In addition, some 50 to 75 percent have serious substance abuse problems.<sup>2</sup>

Many Americans report that they view the world as an increasingly dangerous place to live, and widely publicized incidents of youth crime and violence often lead the public to believe that youth-specific violent crimes are on the rise. Statistics suggest, however, that the majority of juvenile offenders housed in correctional institutions have been committed for *nonviolent crimes*. Ninety-four percent of the children in the juvenile justice systems are arrested for property crimes and other less serious offenses, such as burglary and larceny.<sup>3</sup>

The public's perception of youth crime and violence has significant implications for adolescents with behavioral health disorders in the juvenile justice system. For example, numerous states are implementing policies that incarcerate larger numbers of youth for longer periods of time and prosecuting minors in adult criminal courts rather than in juvenile courts. From 1992 through 1995, 40 states and the District of Columbia passed laws making it easier for juveniles to be tried as adults.<sup>4</sup>

In fact, the literature on this topic indicates that the criminal justice system often serves as a "de facto" institution for adolescents with mental health problems, substituting incarceration for needed treatment.

## **School Problems**

School administrators and teachers constantly struggle with how to address the diverse mental health-related needs of their students, which range from mild learning disabilities to the emotional impact of parental neglect or abuse to depression that may lead to suicide. Educators are often overwhelmed and lack the skills to provide assistance to troubled children in their classrooms, particularly children with behavioral health disorders.

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<sup>2</sup> National Mental Health Association. Website Press Release. 1999.

<sup>3</sup> Jones, M., Krisberg, B. Images and Reality: Juvenile Crime, Youth Violence and Public Policy. National Council on Crime and Delinquency. June 1994.

<sup>4</sup>Ibid.



Children with unrecognized or untreated emotional disorders often cannot learn adequately in school or benefit readily from the kinds of peer and family relationships that are essential to becoming a healthy and productive adult. They are also at heightened risk for school failure and drop out, drug use, risk behaviors of HIV transmission, and many other difficulties.<sup>5</sup>

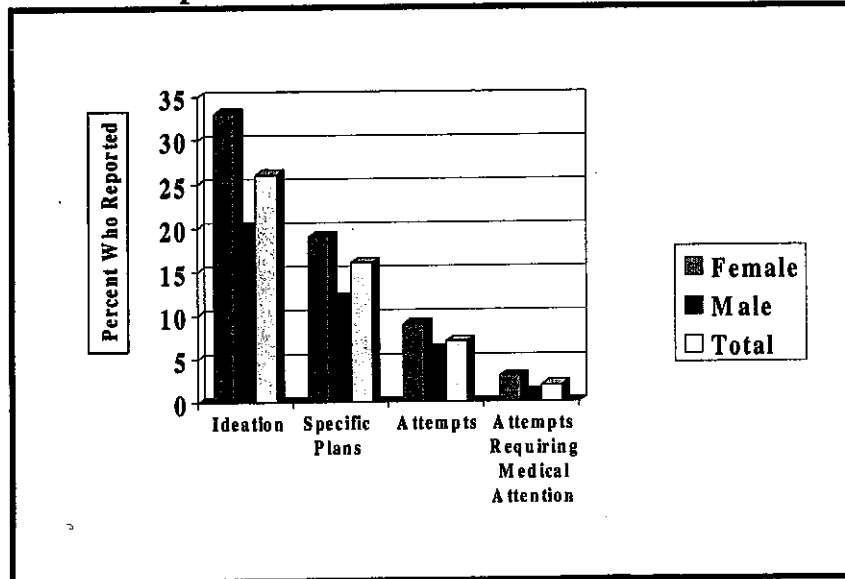
Additionally, almost half of students with serious emotional disturbance drop out of grades 9 to 12, and 20 percent are arrested at least once before leaving school. Overall, students with serious emotional disturbances miss more days of school per year than do students in other disability categories. Of those students with serious emotional disturbance who drop out of school, 73 percent are arrested within five years of leaving school.<sup>6</sup>

## Suicide

Suicide is one of two leading causes of death for children aged 10-19 that has dramatically increased during the past two decades. In teenaged black males, suicide is increasing at rates so striking that they warrant the term "epidemic."<sup>7</sup>

The increased suicide rate among adolescents is reflected in high rates of behavior related to suicide, such as suicidal ideation, making concrete plans for suicide, and actual suicide attempts (Exhibit 1). Major risk factors that are associated with mortality among children include the abuse of alcohol and drug use by children and/or their parents.

**Exhibit 1: Self-Reported Suicidal Behavior in High School Students, 1990**



Source: Youth Behavior Risk Factor Survey, 1991

<sup>5</sup> Hyman, S. Director, National Institute of Mental Health. Testimony on Children's Health. Appropriations Subcommittee on Labor, Health and Human Services and Education, Washington, DC: Oct. 29, 1997.

<sup>6</sup> Ibid.

<sup>7</sup> Health and the American Child: Part 1: A Focus on Mortality Among Children. Risks, Trends and Priorities for the Twenty-First Century. A Report to the Nation from the Public Health Advisory Board. May 1999.

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## Costs to Society

The most recent published information on the costs of mental illness to society is from a National Institute of Mental Health sponsored study conducted by Dorothy Rice and colleagues of the University of California, San Francisco, nearly ten years ago. Key data from the study focuses on the costs associated with adults and children with severe mental disorders.<sup>8</sup> However, separate analysis of costs for adults and children/youth are not available.

Rice's study indicates that in 1990 the core **indirect costs** of severe mental illness in the United States were conservatively estimated at approximately \$44 billion. This cost to society includes lost productivity and lost earnings due to illness, as well as lost earnings due to premature death. The **direct costs** of treating severe mental illness were estimated at \$20 billion. These costs occurred in a context of \$67 billion in direct costs for treatment of **all** mental illnesses, which represents 10 percent of the total \$760 billion direct costs for all health care in the United States in 1990.

The other related costs of severe mental illness include expenditures for social welfare administration, criminal justice, and family caregiving. These were estimated at about \$4 billion. The total costs (core costs, direct and indirect, plus other related costs) of severe mental illness in 1990 were estimated to be nearly \$74 billion. For **all** mental disorders, the total costs were \$148 billion.

More current estimates are likely to show higher costs.<sup>9</sup> It is also notable that mental illness has been identified in the Global Burden of Diseases study as responsible for over 15 percent of the total burden of disease in established market economies such as the United States.<sup>10</sup>

Presumably, a substantial proportion of indirect costs of severe mental disorders can be attributed to the relatively large population that is now untreated. Given the effectiveness of current treatments for mental health disorders, it seems likely that improved access to treatment would decrease indirect costs, possibly offsetting increases in direct costs to a significant degree.<sup>11</sup>

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<sup>8</sup> Health Care Reform for Americans with Severe Mental Illnesses: Report of the National Advisory Mental Health Council. *American Journal of Psychiatry*. 1993.

<sup>9</sup> The National Institute of Mental Health (NIMH) has contracted with The Lewin Group to provide updated estimates of the direct and indirect costs of mental illness to society. Because there have been significant improvements in researchers' knowledge base about mental illness, The Lewin Group's report will likely present figures that are higher than those presented in the past. The report, however, is still in draft form and not yet available for circulation.

<sup>10</sup> Murray, C.L., Lopez, A.D., eds. World Health Organization, World Bank, Harvard University, 1996.

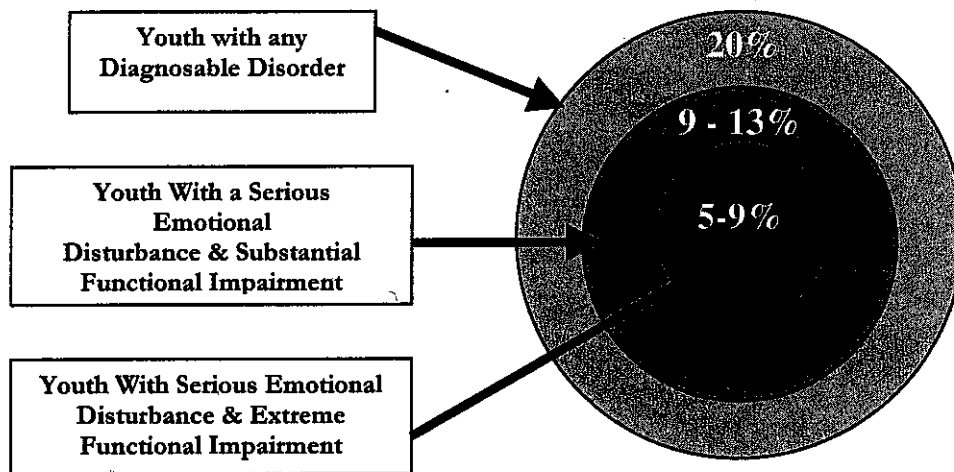
<sup>11</sup> Ibid.

### III. Data on the Prevalence of Behavioral Health Disorders in Youth

The literature indicates that approximately 20 percent of children and adolescents ages 9 to 17, about 11 million youth in total, have a diagnosable mental, emotional or behavioral health disorder, from attention deficit disorder and depression to bipolar illness and schizophrenia.<sup>12</sup>

Mental disorders in children and adolescents include a broad spectrum of behavioral and emotional disorders, which range in severity from minimally severe to more complex and disabling illnesses. Nine to 13 percent of children/adolescents experience serious mental or emotional disturbances that **substantially** interfere with or limit their ability to function in their family, school, and community. Between 5 and 9 percent of children have disorders that **severely** interfere with their ability to function in important life domains. Exhibit 2 illustrates this point.

**Exhibit 2**  
**Prevalence of Serious Emotional Disturbance**



*Source: Meta-analysis, Mental Health, US 1996, SAMHSA Center for Mental Health Services US Department of Health and Services*

The most commonly diagnosed childhood disorders include behavioral, anxiety and affective disorders such as conduct disorder, attention-deficit disorder, and clinical depression. While the names attached to these conditions suggest generally, the child's problem, diagnoses require a finding that the child meets rigorous tests for the severity of a constellation of symptoms.

<sup>12</sup> Manderscheid, R. and Sonnenschein, M.A. Mental Health, United States. Meta-Analysis Study. United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. 1996.

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Estimates suggest that each year 11 percent of youth receive a diagnosis of conduct disorder and three to six million of clinical depression.<sup>13</sup> Attention deficit disorders comprise 50 percent of child psychiatry clinic populations.<sup>14</sup> Less often, youth are diagnosed with psychotic disorders, such as schizophrenia.

Because youth with mental disorders represent such a heterogeneous population, the various disciplines, agencies, and interest groups advocating for, and serving these children, must continuously develop creative strategies to meet their individual needs.

### **Substance Use Disorders**

Substance use disorders - the misuse of alcohol, cigarettes and/or illegal and legal drugs, can reach the level of diagnosable psychiatric disorders. They often co-occur with other psychiatric disorders, and have a substantial impact on the lives of children and youth.

Adolescents with substance use disorders or addictions to alcohol, marijuana, cocaine, opiates, hallucinogens, inhalants, sedatives, or nicotine cannot control their use of a particular drug(s). Such adolescents become intoxicated on a regular basis and often need to use a particular drug for normal daily functioning. Individuals in this population struggle with issues related to family, school and social life. In addition, substance use disorders can cause or aggravate a psychological or physical problem.<sup>15</sup>

There has been little systematic research exploring the natural course of substance use disorders in the adolescent or general population.<sup>16</sup> One study conducted in 1995, however, found that of 1,765 adolescents aged 15 to 24 years, about 3.3 percent were dependent upon some sort of drug in a 12 month period.<sup>17</sup>

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<sup>13</sup> American Psychiatric Association. Let's Talk Facts About Childhood Disorders. Produced by the APA and Joint Commission on Public Affairs and the Division of Public Affairs. 1996.

<sup>14</sup> Attention Deficit Disorder: A Review of the Past 10 Years. *Journal of American Academy of Child and Adolescent Psychiatry*. August, 1996.

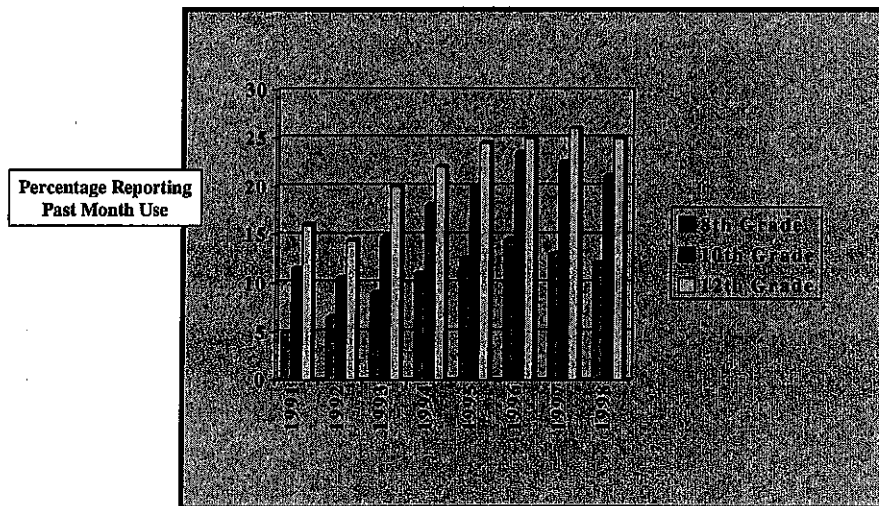
<sup>15</sup> American Psychiatric Association. Let's Talk Facts About Childhood Disorders. Produced by the APA and Joint Commission on Public Affairs and the Division of Public Affairs. 1996.

<sup>16</sup> Weinberg, Naimah, et al. Adolescent Substance Abuse: A Review of the Past 10 Years. *Journal of American Academy of Child and Adolescent Psychiatry*. March, 1998.

<sup>17</sup> Ibid.

In addition, despite a slight drop in the number of youth, who self-report substance use in 1998, the nation's secondary school students and young adults continue to show a level of involvement with drugs greater than any other industrialized country.<sup>18</sup> According to the Monitoring the Future Study (Exhibit 3), in 1998 more than 12 percent of 8<sup>th</sup> graders, 21 percent of 10<sup>th</sup> graders, and 25 percent of 12<sup>th</sup> graders reported using some sort of substance (cocaine, opiates, PCP, marijuana, amphetamines, methadone, barbiturates) in a given month.

### Exhibit 3: Prevalence of Youth Substance



Source: 1998 Monitoring the Future Study

Although there are no large-scale epidemiological studies on co-occurring psychiatric disorders among adolescents, three population-based studies suggest high rates of co-occurrence of alcohol disorders with mental health disorders (depression, anxiety, eating disorders, and conduct disorder).<sup>19</sup> In addition, a number of studies suggest a particularly high prevalence of alcohol disorders associated with conduct disorder and depression, and an even higher prevalence of alcohol disorders when a child is diagnosed with both disorders.<sup>20</sup>

<sup>18</sup> National Survey on Drug Use from The Monitoring The Future Study, 1975-1997. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health.

<sup>19</sup> Weinberg, Rahdert, et. al. Adolescent Substance Abuse: A Review of the Past 10 Years. *Journal of American Academy of Child and Adolescent Psychiatry*. March, 1998.

<sup>20</sup> Ibid.

Youth and adults with co-occurring disorders can be placed into any one of the following categories:<sup>21</sup>

- **Complicated Chemical Dependency:** Individuals diagnosed with alcoholism or drug addiction who have psychiatric complications, though not necessarily major mental illness;
- **Substance Abusing Mentally Ill:** Individuals with exacerbation of mental illness, which is complicated by substance abuse, whether or not the patient views substances as a problem; and
- **Substance Dependent Mentally Ill:** Individuals with mental illness, who also have alcoholism and/or drug addiction, and who need treatment for addiction, for mental illness, or for both.

It is typical for youth with co-existing behavioral health disorders to receive treatment only if the behavior is considered dangerous or disruptive, and to be diagnosed mistakenly with only one of the disorders.<sup>22</sup>

#### IV. Challenges in Identifying Youth with Behavioral Health Problems

Of all the afflictions of children, emotional and behavioral disorders are probably the least well understood. Lack of understanding of these disorders among the general public as well as among policymakers has made it difficult to secure resources for services and supports for this population. The public perception of many youngsters with emotional disturbance is that they are "bad" rather than sick; the children themselves, or in many cases the parents, are blamed for the problems.<sup>23</sup>

Child advocates have attempted to inform the public on the causes of behavioral health problems. Scientists and mental health experts have successfully identified many key factors that place children and adolescents at risk of experiencing behavioral health disorders, including biological and genetic factors, acute or chronic physical dysfunction, and environmental conditions and stresses. Most in the mental health field agree that children's mental health disorders are due to a combination of biological, psychological and environmental factors. The following table highlights some factors that place children at risk.<sup>24</sup>

**Exhibit 4: Risk Factors**

<b>Biological Factors</b>	<b>Psychological Factors</b>	<b>Environmental or Social Factors</b>
<ul style="list-style-type: none"> <li>• Genetic makeup</li> <li>• Brain chemistry</li> <li>• Serious nutritional deficiencies</li> </ul>	<ul style="list-style-type: none"> <li>• Problems with intelligence</li> <li>• Reasoning abilities</li> <li>• Self-esteem</li> <li>• Motivation</li> </ul>	<ul style="list-style-type: none"> <li>• Peer relations</li> <li>• Culture</li> <li>• Economics</li> <li>• Family issues</li> </ul>

<sup>21</sup> Mental Health Issues Today. Volume 1, Number 2. Winter 1997.

<sup>22</sup> Ibid.

<sup>23</sup> Stroul. B. Children's Mental Health. Creating Systems of Care in a Changing Society. 1996.

<sup>24</sup> Community-Based Mental Health Service for Children in the Child Welfare System, Macro International Inc. June 30, 1992.

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In addition, children's emotional health can be affected by system-induced factors such as removing a child from natural parents or siblings, placing a child in multiple out-of-home settings, labeling a child, and/or forcing a child to change schools.<sup>25</sup>

Despite this knowledge, the ability to distinguish between normal aspects of a child's development, and mental health problems that may worsen if not treated, is a challenge for parents, teachers, and mental health care professionals. There is much evidence in the literature that prevalence rates are underestimated.<sup>26</sup> Distinct challenges associated with identifying mental disorders in youth include:

- Professionals may be reluctant to label a child with a mental health diagnosis because they fear the child will be stigmatized;
- The symptoms of neurobiological brain disorders sometimes overlap with other disorders observed in childhood, and children often have a difficult time communicating the symptoms they are experiencing to adults;
- Teenage years may be associated with many developmental changes that are challenging for parents. Such challenges might include a teenager's changing moods and behaviors, drug experimentation, rebelliousness, or difficulty making social adjustments. Parents often accept these behaviors as "phases," of teenage years, but some of the behaviors may mask underlying mental health disorders; and
- Schizophrenia develops primarily between ages 16 and 25, which means many youth may be developing symptoms during high school years. The illness, however, is typically not diagnosed until at least one year after the symptoms begin to surface.

In addition to the challenges associated with identifying behavioral health disorders in youth, there are significant inconsistencies in definitional and diagnostic characteristics among the programs and providers serving children. Within the federal government alone, the Center for Mental Health Services (CMHS) in the Department of Health and Human Services, the Department of Education and the Head Start Program definitions of behavioral health disorders differ from one another.<sup>27</sup> These inconsistencies make it difficult to estimate the actual number of children with mental disorders.

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<sup>25</sup> Ibid.

<sup>26</sup> Husted, June R. *Mental Illness in Children and Adolescents*. National Alliance for the Mentally Ill. June, 1997.

<sup>27</sup> Manderscheid, R. and Sonnenschein, M.A. *Mental Health, United States, 1994. Meta-Analysis Study*. United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. 1996.

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A leading approach to addressing these concerns has been the effort to identify and provide care to youth with the *greatest mental health needs*. Most notably, CMHS has developed a definition to identify the priority population for federal mental health concerns by distinguishing between 1) youth with diagnosable mental illnesses and 2) youth with either substantial or extreme functional impairment. CMHS's definition targets the second group, youth with either substantial or extreme functional impairment, known as serious emotional disturbance. SED criteria include:

- The presence of a "diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R,<sup>28</sup>" and
- The disorder has resulted in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school or community activities.

Because SED children have been targeted as the priority population for federal mental health concern, the majority of federal and state initiatives, as well as research efforts on the prevalence of mental health disorders in youth, focus on individuals with SED. Studies that are specific to children who do not meet SED criteria and/or may be *at risk* of developing mental health problems are much less common.<sup>29</sup>

Advocates and policymakers concerned with children's mental health concur that the identification of a priority population has been a progressive step in responding to children's behavioral health needs. Treatment interventions remain critical for those children who may have less likelihood of successful outcomes because of the complexity of their problem(s). Most would agree that youth with less severe disorders also warrant the public's attention, particularly because they are more difficult to identify.<sup>30</sup> In addition, early identification and treatment of youth with less severe disorders can help prevent children from crossing over a line into the priority population.

## V. Diverse Systems Serving Multiple Needs

A key factor in serving children and youth with behavioral health problems is the range and diversity of systems and funding that must be coordinated. This section provides a brief overview of the major systems involved in delivering care and the following section describes the available funding streams. While each of these systems provides important elements of a service system, their divergent goals and philosophies also ensure fragmentation and inconsistency. Many children and youth simply "fall between the cracks" of these systems. A

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<sup>28</sup> American Psychiatric Association's Diagnostic and Statistical Manual.

<sup>29</sup> Community-Based Mental Health Service for Children in the Child Welfare System, Macro International, Inc. June 30, 1992.

<sup>30</sup> Final Report: Community-Based Mental Health Service for Children in the Child Welfare System. Submitted to Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. Macro International, Inc. June, 1992.



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coherent response to the behavioral health problems of children and youth require creative reconciliation of both the mandates and funding streams provided by these diverse systems.

## Education

The educational system clearly has a stake in assuring that children receive the mental health services they require, not only because healthy children are easier for teacher and administrators to instruct, but also because mental health has a direct effect on a child's potential to learn.

Despite the fact that as many as 20 percent of children have emotional or behavioral problems warranting intervention, less than 1 percent of schoolchildren are identified nationally by the schools as having such problems.<sup>31</sup>

In many ways schools are the ideal place for children to be identified and receive health care, since it is likely that a child's problems will manifest in the school environment. Since nearly all children attend school, schools can provide a significant opportunity to treat children in need, and to enroll children in public assistance programs when they seek treatment.

The goal of prevention and early intervention is to identify troubled children early, provide appropriate interventions for the child and the family, and prevent problems from reaching serious proportions. Although prevention and early intervention require collaboration among the different service systems and agencies, educators probably have the greatest opportunity to increase the number of children identified at an early age.

The Education for All Handicapped Children (EAHC) [PL 94-142], created in 1975, now titled Part B of Individuals with Disabilities Education Act (IDEA), requires that all handicapped children ages 3-21 have access to a free, appropriate public education in the least restrictive environment. Education is to be provided alongside their non-handicapped peers whenever possible and in accordance with an "individualized education program" (IEP).

The majority of children with SED in the school system are removed from mainstream classrooms and placed in special education settings. During the 1992-1993 school year, over 400,000 children and youth identified as SED were served by special education systems, accounting for 8.7 percent of all children receiving special education services.<sup>32</sup> The common denominators among the students in special education programs include poor academic records, extraordinarily high dropout rates, and a high probability of encounters with the juvenile justice system.

*Current Legislative Proposals:* EAHC/IDEA has been amended by various acts over the past several years that have essentially expanded the age groups covered by the act. Congress is currently considering the Smart IDEA Act of 1999 [HR 1672 IH] which

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<sup>31</sup> Stroul, B. *Children's Mental Health: Creating Systems of Care in a Changing Society*. 1996.

<sup>32</sup> Oswald, D., Coutinho, M. Identification and Placement of Students with Serious Emotional Disturbance. Correlates of State Child-Count Data. *Journal of Emotional and Behavioral Disorders*. 1995.

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would require State Medicaid Plans to pay for medical services in IEP's under the IDEA in excess of \$3,500 over a school year.

## **Child Welfare**

Numerous children receive care from the child welfare system, a complex patchwork of state and local laws and agencies and programs that intervene in cases of child abuse and neglect. Child welfare interventions primarily include family counseling, in-home support and training, removal of children from their homes, residential behavioral treatment, and either the child's return to a strengthened family or adoption or other permanent placement.

Title IV is an open-ended federal entitlement that reimburses the federal share of foster care maintenance, adoption assistance, and independent living initiatives. Title IV-B provides a capped federal grant-in-aid program that reimburses states for up to 75 percent for costs associated with child welfare programs including time-limited family reunification services.

The Adoption and Safe Families Act of 1997 [P.L. 105-89] continues the eligibility for the adoption assistance subsidy under Title IV-E to children whose adoption is disrupted. The primary thrust of this act is to improve the safety of children (a goal that is paramount to family reunification), promote adoption and other permanent homes, and to support families.

*Current Legislative Proposals:* The Foster Care Independence Act of 1999 [H.R. 1802], approved by the House Ways and Means Committee May 26, 1999, would extend services and supports for youth transitioning from foster care to independent living.

## **Juvenile Justice**

The historical philosophy of the juvenile court has been to emphasize treatment and rehabilitation rather than punishment and retribution. This has changed in recent years, however, with mounting pressure from communities and legislators to impose harsher penalties and seek retribution from youth committing violent crimes.

The juvenile justice system is largely segregated from other systems such as medical care, mental health services and schools that serve children and families. Few children receive adequate screening, assessment or treatment of behavioral health disorders in the juvenile justice system.<sup>33</sup>

*Current Legislative Proposals:* There are currently several key pieces of pending legislation that will have a significant impact youth with behavioral health needs in the juvenile justice system.

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<sup>33</sup> Coccozza, J. Responding to the Mental Health Needs of Youth in the Juvenile Justice System. The National Coalition for the Mentally Ill in the Criminal Justice System. November 1992.

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The Juvenile Justice and Delinquency Prevention Act (JJDP) of 1974 requires that states receiving federal funds maintain four core protections for children. These core protections include: 1) De-institutionalization of Status Offenders, which disallows secure detention or confinement in excess of 24 hours for status offenders,<sup>34</sup> 2) Separation of children (by sight and sound contact) from adult offenders in confinement, 3) removal or limited detention of children in adult jails and prisons, and 4) Disproportionate Minority Confinement.

The Violent and Repeat Juvenile Offender Accountability and Rehabilitation Act of 1999 would amend the JJDP to: 1) enforce tougher standards for juveniles that commit violent crimes, 2) weaken the language requiring separation of children and adults in confinement, 3) allow parents in rural areas to permit their children to be held in adult jails, 4) establish the National Institute for Juvenile Crime Control and Delinquency Prevention within the National Institute of Justice, and (by the Harkin and Kennedy Amendment) 5) require school personnel to ensure immediate interventions and services to children removed from school for any act of violence.

The Mental Health Juvenile Justice Act, introduced in the Senate and referred to the House Subcommittee on Crime in the House (February 1999), would allow for training of juvenile justice personnel for the assessment and diversion of juvenile with mental health or substance abuse disorders. In addition, the bill would 1) provide state block grants to develop and implement effective screening and assessment of juveniles entering the juvenile justice system, 2) allow states to use prison construction funds to provide mental health screening/treatment services for juveniles and adults in correctional facilities, 3) authorize the remedy of abusive conditions in juvenile justice facilities, and 4) require states to report on the prevalence of mental health and substance abuse disorders of youth in the juvenile justice system

Federal and state laws have established agencies to be responsible for mental health and substance abuse services. Within state agencies, there may or may not be a section or an individual responsible for children's services. (In a few states child mental health services are the responsibility of a statewide children's agency). The federal Substance Abuse and Mental Health Services Administration (SAMHSA) administers an array of programs primarily designed to support state efforts. Block grants form by far the largest elements of this support, leaving funding decisions for children's services largely up to the individual states. SAMHSA also administers several specialized grant programs for children and youth services --- notably the children's mental health services program. PL 102-321 authorizes the Secretary of Health and Human Services to provide grants through the Director of CMHS to public entities providing comprehensive community health services to children with serious emotional disturbances.<sup>35</sup>

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<sup>34</sup> Status offenders are individuals whose behavior (such as running away from home) only constitutes an offense because they are "minors."

<sup>35</sup> This program is the successor to the Child and Adolescent Service System Program (CASSP) that originated the concept of the "system of care" for children.

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*Current Legislative Proposals:* In May of 1999 the Youth Drug and Mental Health Services Act [S. 976] was introduced in the Senate to renew programs within the jurisdiction of SAMHSA. This act would focus the authority of SAMHSA on community based services for children and adolescents, to introduce new prevention and treatment oriented services directed toward youth who are at risk of engaging violent behavior, and to respond to crises, especially those involving youth and violence. In addition the act would provide a six-year extension for grants under the child mental health program.

## **VI. Expenditures/Funding Sources**

Each of these service systems, as well as other more generic support programs (e.g., housing), provide financial assistance to help children and youth with behavioral health problems. The challenge, again, is to reconcile the conflicting requirements and demands of the varied programs in order to fashion a coherent package of services and supports.

Because mental illnesses affect so many aspects of an individual's life, children and adolescents living with such disorders often need an extensive array of services, including assistance with social skills, personal care, housing, education, and medical treatment. Funding for treatment and this wide array of safety net services must come from a variety of private and public sector (local, state and federal) funding sources, each with its own mandates and priorities.

The multiple agencies responsible for reimbursing providers for children's services include state Medicaid agencies, state and county mental health and substance abuse authorities, education, child welfare and juvenile justice agencies. Although some children receive funding for the behavioral health care they need from the private sector (i.e., employer-sponsored health insurance, private foundations), the majority of funding for mental and substance abuse services provided to youth is derived from a variety of public sector programs, and most often from Medicaid.

Until the 1980s, public agencies that provided mental health services to children and families received financial support primarily from state appropriations, augmented by local tax dollars, federal grants, and some first- and third-party payments.<sup>36</sup> In the 1980s, however, states began to experiment with a variety of approaches designed to finance mental health services for children. These efforts have involved identifying new avenues of funding under Medicaid, accessing child welfare entitlement funding, and integrating services and funding streams across child-serving agencies.

In the 1990s, advocates have succeeded in raising the nation's consciousness regarding mental illness through the passage of the National Mental Health Parity Act and adoption of mandated coverage and parity requirements by more than 20 states. However, the overall growth

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<sup>36</sup> Ibid

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of spending for the treatment of mental illness as well as substance abuse has been lower than the growth of health care spending.<sup>37</sup>

While overall mental health and substance abuse spending increased by 7.2 percent annually between 1986 and 1996, estimates indicate that physical health care spending grew by 8.3 percent annually, according to the Health Care Financing Administration. Further, a recent study of the Hay Group found that the value of behavioral health benefits in health insurance continues a decade-long decline of 54% compared with a decline of 11.5% for general health benefits.<sup>38</sup>

These findings may indicate that national trends that are affecting much of the health care sector, such as the growth of managed care and the increasing capacity of health plans to negotiate discounts from providers, are having a proportionately greater impact on mental health and substance abuse services.<sup>39</sup>

The best available data **specific to dollars spent on youth services** indicate that approximately \$4.8 billion was spent in the nation for child and adolescent mental health services in 1990.<sup>40</sup> This accounted for about 7.1 percent of total mental health care expenditures. The author of the study reports that this figure is an overestimate for children under age 15 and an underestimate for those under age 18. To date, no systematic data collection has been undertaken to document the distribution of youth mental health expenditures by payment sources.<sup>41</sup>

The available literature provides clear evidence that the public sector is also the primary payer for **behavioral health services in general**. In 1996 the public sector paid 54.2 percent of total mental health and chemical dependency treatment and in contrast, private insurance accounted for 26.3 percent of all behavioral health expenditures, followed by consumer out-of-pocket expenditures (16percent) and other private spending (3.5 percent).<sup>42</sup>

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<sup>37</sup> McKusick, D., Mark, T., King, E., Harwood, R., *Health Affairs*. September/October 1998, Volume 17, Number 5. Spending for Mental Health and Substance Abuse Treatment, 1996.

<sup>38</sup> Hay Group, Health Care Plan Design and Costs Trends: 1988 through 1998.

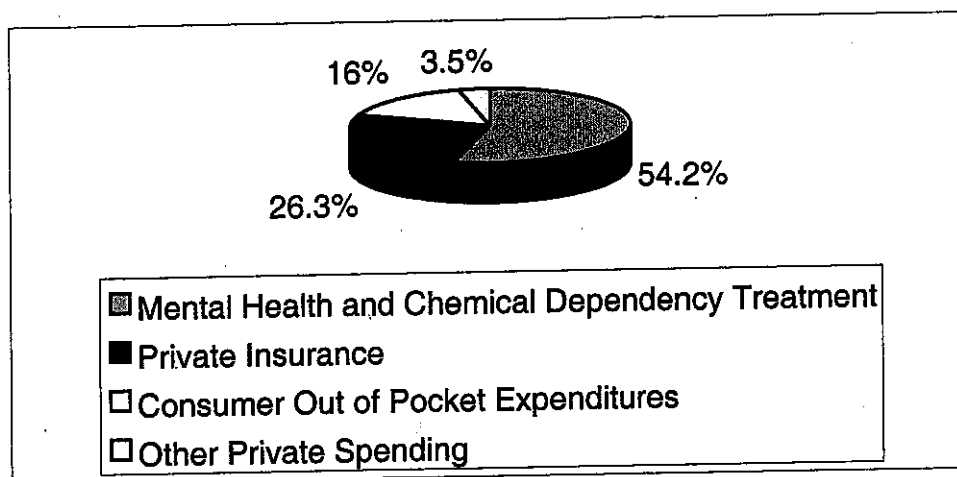
<sup>39</sup> McKusick, D., Mark, T., King, E., Harwood, R., *Health Affairs*. September/October 1998, Volume 17, Number 5. Spending for Mental Health and Substance Abuse Treatment, 1996.

<sup>40</sup> Rice, D.P., Kelman, S., Miller, L.S., and Dunmeyer, S. The Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985. Report submitted to the Office of Financing and Coverage Policy of Institute for Health and Aging, University of California, 1990.

<sup>41</sup> Manderscheid, R., Sonnenschein, M.A., Mental Health, United States, 1994.

<sup>42</sup> National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment. United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 1996.

### Exhibit 5: Behavioral Health Expenditures by Payer



Medicaid is the key source of public funding for child and adolescent mental health services. Medicaid children represent 50 percent of the population receiving Medicaid in the nation, and within the states their use of public mental health services represents approximately 30 to 40 percent of the children served.<sup>43</sup> Medicaid is required to provide: 1) outpatient hospital services, including partial hospitalization, 2) physician services, and 3) Early and Periodic Screening, Diagnosis and Treatment for children with emotional or substance abuse problems. Although Medicaid is a federal program, each state is governed by a State Medicaid Plan, which allows states to provide substantial variations in the types of optional services covered and the rates paid to providers of services.

The Children's Health Insurance Program (CHIP) is another potential funding source available to treat youth with behavioral health needs. Prior to the implementation of CHIP in 1997, children who were ineligible for Medicaid, but whose families had incomes too low to afford private insurance, often lived without basic health care coverage.<sup>44</sup> In 1995, more than 10 million children under the age of eighteen had no health insurance. CHIP has created the opportunity to expand coverage to nearly four million uninsured children from low-income families.

The Department of Education also provides a significant amount of funding allocated to special education for children and youth with disabilities, including those with mental illness. In 1996-97, the United States spent \$339.8 billion on total elementary and secondary education, and 5.2 million children served under special education programs received approximately \$27.6 billion, or 8.14% of this total. In addition, the United States spent \$3.7 billion on special education funding for the 447,000 SED children.

<sup>43</sup> Stroul, B. 1996. Children's Mental Health: Creating Systems of Care in a Changing Society.

<sup>44</sup> SCHIP: The State Children's Health Insurance Program. An Analysis of the Mental Health/Substance Abuse Benefits and Cost-Sharing Policies of Approved State CHIP Plans. National Mental Health Association

**Exhibit 6: Estimated 1996-1997 National Educational Enrollment and Expenditures**

	All K-12 students	All special education students	All SED students	% special education	% SED
Enrollment <sup>45</sup> (in millions)	45.841	5.224	0.447	11.4%	0.97%
Expenditures (in billions)	\$339.800 <sup>46</sup>	\$27.649 <sup>47</sup>	\$3.685 <sup>48</sup>	8.14%	1.08%

The expenditure figures are derived from two separate sources listing per pupil expenditures. Per footnotes, Thomas Parrish, *et al.*, adjusted the per pupil expenditures for special education students from 1985-86 data to 1995-96 dollars. The Lewin Group's adjustment of 1995-96 data to 1996-97 prices uses the CPI-U from January 1996 to January 1997 (1982-84=100). Parrish, *et al.*, adjusted the 1985-86 data for SED per pupil expenditures to 1996-97 dollars. The population data is extracted from 1996-97

The role of the federal child welfare programs, Titles IV-B and IV-E of the Social Security Act, is to assist states in financing child welfare programs.<sup>49</sup> In general grant funds are reserved for foster care "maintenance" costs (e.g., shelter, food, personal needs of children), case work, data systems, staff training and administrative expenses. Medicaid is the single largest source of health care financing for children in the child welfare system.

While the data does not reveal how much of this is specific to behavioral health, the following exhibit provides a summary of key children's programs designed to prevent and improve the adverse conditions of children, as well as 1999 expenditures and proposed 2000 expenditures in child welfare spending.<sup>50</sup>

<sup>45</sup> U.S. Department of Education, Appendix A, Twentieth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, A2-A226.

<sup>46</sup> U.S. Department of Education, Appendix I: Total Expenditures for Education in the United States, *FY 1999 Budget*.

<sup>47</sup> Per pupil expenditures from Thomas B. Parrish, Fran O'Reilly, Ixtlac E. Dueñas, and Jean Wolman, *State Special Education Finance Systems, 1994-95*, Center for Special Education Finance, June 1997, 46. Parrish, *et al.*, report 1985-86 data adjusted to 1995-96 dollars. The Lewin Group's adjustment of 1995-96 data to 1996-97 prices uses the CPI-U from January 1996 to January 1997 (1982-84=100).

<sup>48</sup> Per pupil expenditures from Thomas Parrish, Daniel Kaleba, Michael Gerber, and Margaret McLaughlin, *Special Education: Study of Incidence of Disabilities*, American Institutes for Research, September 1998; Parrish, *et al.*, report 1985-86 data adjusted to 1996-97 dollars.

<sup>49</sup> *Managing Child Welfare: An Analysis of Contracts for Child Welfare Service Systems*. The George Washington University Medical Center. February, 1999.

<sup>50</sup> Industry Statistics. Open Minds. Federal Spending on Children's Services Exceeds \$11 Billion – Clinton Administration Proposes More Spending in FY 2000. March 1999.

**Exhibit 7**  
**U.S. Federal Child Welfare Spending (FY 1999-2000)**

<b>Programs</b>	<b>Services</b>	<b>FY 99</b>	<b>FY 2000 (Proposed)</b>
Head Start	Provides comprehensive developmental services to low income children (three to five years old).	\$4.66 Billion	\$5.267 Billion
Foster Care	Provides a range of services to youth with special needs that are living in foster care homes.	\$3.9 Billion	\$4.5 Billion
Adoption Assistance	Provides subsidies for adopted children with special needs.	\$869 Million	\$1 Billion
Independent Living	Provides funding for youth who are 16 years of age or older and are transitioning to independent living. Federal funds to states support counseling, employment, education and daily living skills training and assistance.	\$70 Million	\$105 Million
Social Service Block Grant	Promotes families' and youth's economic self-sufficiency, to prevent and reverse neglect, to avoid or reduce inappropriate institutionalization, and when necessary, refer children and adults for institutional care.	\$1.9 Billion	\$2.4 Billion
Child Welfare	Prevention of out-of-home placements, alternative placement development and reunification.	\$292 Million	\$292 Million
<b>Total</b>		<b>\$11.691 Billion</b>	<b>\$13.564 Billion</b>

Federal child welfare law currently permits use of grant funds for health care only in limited circumstances. Substance abuse treatment and mental health services are allowable only as "time-limited" family reunification services." Under the law, states may claim federal funds for such services only as long as the child is in foster care and only for the first 15 months that the child is in such care. Should the family continue to need these services in order to avoid out-of-home care, or after a child returns home from such care, other sources of funding must be found.<sup>51</sup>

Federal block grants supplement state funding for mental health and substance abuse programs serving both adults and children. However, these funds, particularly those for mental health, represent only a small proportion of total state expenditures. Block grant funding in fiscal year 1999 totaled \$289 million for mental health and \$1.58 billion for substance abuse. In addition, \$78 million was provided for children's mental health and \$7 million in substance abuse funding was earmarked for high-risk youth. The following provides funding for fiscal year 1998 and 1999, as well as fiscal year requests for 2000.<sup>52</sup>

<sup>51</sup> Ibid.

<sup>52</sup> *Mental Health Report*. 1999 Business Publishers. February 5, 1999.



**Exhibit 8: Funding for Mental Health/Substance Abuse Programs  
(Budget Authority in Millions)**

Types of Grant	Fiscal Year 1998 Actual	Fiscal Year 1999 Estimate	Fiscal Year 2000 Requested
Mental Health Block Grant	275	289	359
Children's Mental Health Services	73	78	78
Substance Abuse Block Grant	1,310	1,585	1,615
High-Risk Youth	6	7	7

## VII. Advances in Service Delivery/Promising Approaches

### Advances in Service Delivery

Seventeen years after the release of a landmark study reporting that two-thirds of 3 million children with SED in the country were not receiving the services they needed, and that many more were receiving inappropriate care,<sup>53</sup> much progress has been made. The 1982 release of *Unclaimed Children*, as well as other key indicators of children's mental health needs, served as a wake up call to people concerned about children and their mental health.

One of the key findings of *Unclaimed Children* was that traditional approaches used for serving children with multiple behavioral problems were often too fragmented to meet their individual needs. As a result, children were often inappropriately placed in restrictive out-of-home treatment settings and/or in the child welfare or juvenile justice systems. Current data reflects that despite successes, there is still a significant gap between children in need of mental health services and those actually receiving treatment. In addition, one study suggests only 11 percent of children at risk receive services in a mental health setting.<sup>54</sup>

In the last two decades the scope and nature of mental health services for children and families have undergone significant changes in philosophy, administration and operation of services.<sup>55</sup> There have been two major change agents in the delivery of behavioral health services to children: the introduction of the "system of care philosophy," and the broad use of managed care. The following briefly highlights key issues related to these two developments.

<sup>53</sup> Knitzer, Jane. *The Failure of Public Responsibility to Children and Adolescents of Mental Health Services, Unclaimed Children*. 1982.

<sup>54</sup> Manderscheid, R. and Sonnenschein, M.A.. *Mental Health, United States, 1994. Meta-Analysis Study*. United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. 1996.

<sup>55</sup> Davis, Yelton, Katz-Leavy, Lourie. *Unclaimed Children Revisited: The Status of State Children's Mental Health Service Systems*. 1993.

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## The System of Care

The system of care philosophy holds that:

*A comprehensive spectrum of mental health services and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families.<sup>56</sup>*

One of several important components of the system of care philosophy is that children should receive treatment in community-based programs that offer less restrictive, more normative environments. This philosophy also acknowledges, however, that 24-hour institutional care is necessary for certain children at various points in time.

The principles underlying the system of care were developed for the SED population, and now have been largely accepted by providers, families, and professionals specializing in care for SED children and youth.<sup>57</sup> The services needed for system of care capacity also provide a template for the service needs of the broader population of children needing treatment. The following identifies key nonresidential and residential services that form the recommended continuum of care.

### Exhibit 9 System of Care Services

Nonresidential Services	Residential Services
Prevention	Therapeutic foster care
Early identification and intervention	Therapeutic group care
Assessment	Therapeutic camp services
Independent living services	Independent living services
Outpatient treatment	Residential treatment services
Home-based services	Crisis residential services
Day treatment	Home-based services
Emergency services	Inpatient Hospitalization

## Managed Care

The penetration of managed care techniques in the public sector has emphasized providing cost-effective services. This emphasis has encouraged the shift of delivery of care from inpatient to outpatient settings, and the use of management techniques to decrease inpatient lengths of stay. The positives and negatives associated with managed behavioral care services for children have received significant attention.<sup>58</sup> Managed care models are thought to encourage:

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<sup>56</sup> Stroul, B. Children's Mental Health. Creating Systems of Care in a Changing Society. 1996.

<sup>57</sup> Community-Based Mental Health Service for Children in the Child Welfare System, Macro International Inc. June 30, 1992.

<sup>58</sup> Scallet, L., Brach, C., and Steele, E., Managed Care: Challenges for Children and Family Services. 1996. Prepared by the Policy Resource Center for the Annie E. Casey Foundation. Stroul, B. Managed Care and Children's Mental

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- More integrated intake, diagnosis and assessment of children and youth with multiple problems;
  - A unified network of agencies providing care for children with serious problems;
  - Pooling of resources across categorical budgets;
  - Use of less costly but effective community-and home-based services.

Conversely, many observers believe managed care has created or exacerbated problems:

- Too limited focus on cost containment may lead to implementation without key elements of an effective service delivery system in place;
- Inadequate cost allocation models and capitation formulas, together with the historic underfunding of children's services, can result in rates that are not sufficient to provide needed care;
- Fiscal incentives may be created for the managed care contractor to re-label problems in order to shift responsibility to other systems, particularly for children and youth needing costly services;
- Short-term contracts do not provide incentives for early intervention and treatment, and may in fact create incentives to deny treatment.

### **Current Promising Approaches**

School administrators, educators, and policymakers face numerous challenges in appropriately identifying and serving children with behavioral health problems. School-based health centers (SBHCs), which primarily serve the physical, and mental health needs of high risk, low-income children, have been successful in providing preventive care and referral to children with mental health needs. There are currently 1,154 SBHCs across the country.<sup>59</sup> Some additional promising responses identified by experts include:<sup>60</sup>

- Making crisis intervention and other mental health support services more broadly available to children in both regular and special education. This can be achieved either through contracts with outside mental health agencies or through the reallocation of the tasks of school mental health personnel, now largely dedicated to assessment and evaluation for special education.
- Ensuring that pre-referral strategies are sufficiently powerful to address the needs of children exhibiting behavioral and emotional problems, as well as learning disabilities.

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Health: Summary of the May 1995 State Managed Care Meeting. 1996. National Technical Assistance Center for Children's Mental Health, Georgetown University.

<sup>59</sup> Literature Review: Key Issues for School-Based Health Centers in Providing Mental Health Services in a Managed Care Environment. The Lewin Group and WESTAT. January 12, 1999.

<sup>60</sup> Knitzer, J., Steinberg, Z., Fleisch, B. At the Schoolhouse Door. An Examination of Programs and Policies for Children with Behavioral and Emotional Problems. 1990.

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- Providing in-service and pre-service training to regular education teachers as well as workshops for school-board members and other school board personnel designed to demystify SED in children and to facilitate appropriate referrals.
  - Strengthening the policy commitment to enhance collaboration between schools and mental health agencies.
  - Encouraging the formation of parent support and advocacy groups and expanding opportunities for parents to collaborate in school-related efforts to help their children.
  - Examining current fiscal strategies at all levels of government to ensure that all of the available dollars for services are being used in the most cost-effective ways, and to develop strategies to increase necessary resources.
  - Ensuring an adequate supply of appropriately trained educators and mental health personnel are available in the schools.
  - Establishing model high intensity school-based interventions, particularly in schools experiencing high rates of sexual and physical abuse among young children and high rates of substance abuse among children and adolescents or their parents.

Members of the NAPHS provide services to children and youth along a continuum of care, based on a continuum of need (i.e., ranging from children with SED to those with less serious disorders). Over a period of years, this continuum has broadened from the traditional inpatient hospital to include a variety of less intensive and restrictive services consonant with the evolving state of the art.

NAPHS members together with other providers continue to deliver inpatient and long-term residential treatment to youth in need of these services, as well as provide community-based services that incorporate a system of care philosophy in their delivery approach. Recent findings from NAPHS's annual survey demonstrate its increased focus on outpatient, community-based programs. In 1997, nearly 1 in every 4 admissions was to a service other than inpatient hospitalization, compared to just 1 in 10 admissions in 1992. In addition, the vast majority of member survey respondents provided partial hospitalization (91 percent) and outpatient services (82.4 percent), and more than half of respondents provided residential treatment (54.8 percent).<sup>61</sup>

The following exhibit describes some of the types of services provided by NAPHS members that are outside the scope of the traditional inpatient and outpatient services and generally considered key in the system of care philosophy.<sup>62</sup>

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<sup>61</sup> Trends in Behavioral Healthcare Systems: A Benchmarking Report. The National Association of Psychiatric Health Systems. 1998 Annual Survey Report.

<sup>62</sup> NAPHS Interviews and Kutash, K. Rivera, V.R. "What Works in Children's Mental Health Services?" Uncovering Answers to Critical Questions. 1996.

**Exhibit 10**  
**Examples of NAPHS Services**

<b>Type of Service</b>	<b>Program Characteristics</b>
Day Treatment	<ul style="list-style-type: none"> <li>• Falls in the middle of continuum of care, between inpatient and outpatient</li> <li>• Setting varies from hospital-based to school-based</li> <li>• Considered most intensive of long-term, non-residential MH services available to children</li> <li>• Can include special education, counseling, vocational, crisis intervention, recreational, etc.</li> </ul>
Day Treatment Models in Schools	<ul style="list-style-type: none"> <li>• Educational assessment and planning</li> <li>• Special schools that provide full-day educational programs</li> <li>• On-site mental health services linked to in-home services for families, and full-time residential schools</li> </ul>
Therapeutic Foster Care	<ul style="list-style-type: none"> <li>• Least restrictive form of care among residential services</li> <li>• Provides treatment for troubled children within private homes of trained families</li> <li>• Combines family-based care with specialized treatment</li> <li>• Relatively new form of treatment</li> <li>• Highly individualized</li> <li>• Generally a low number of children in the home</li> </ul>
Youth Corrections	<ul style="list-style-type: none"> <li>• Designed for youth on probation for minor offenses or youth who have been adjudicated through the courts</li> <li>• Some corrections programs take form of wilderness-type programs, while others are secured residential programs</li> </ul>
Home-Based Services	<ul style="list-style-type: none"> <li>• Delivered primarily in family's home</li> <li>• Committed to family preservation and reunification</li> <li>• "Ecological" perspective and involve working with the community</li> <li>• Service delivery hours are flexible to meet needs of families</li> <li>• Multifaceted services; education, counseling, skill training, etc.</li> <li>• Relationship between home-based worker and family is uniquely close</li> </ul>
Respite Services	<ul style="list-style-type: none"> <li>• Provided both in child's home and in out-of-home settings by trained respite providers</li> </ul>
Group Homes for Specific Populations	<ul style="list-style-type: none"> <li>• Created for children and adolescents who cannot function in the family setting, but do not require institutional or residential care</li> <li>• Child is maintained in the community and continues to be involved in community life up to his/her best ability</li> <li>• Typically limited to eight or fewer residents</li> </ul>
Independent Living	<ul style="list-style-type: none"> <li>• Residential programs helping young adults ages 18 to 25 successfully achieve independence</li> <li>• Assist youth in planning for education and career; and working to resolve personal and family problems</li> </ul>

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## VII. Key Problems Still Remain in Addressing Behavioral Health Needs of Youth

From this overview, it is clear that much has been learned about what types of services and programs are effective in meeting the needs of children and youth. A wide variety of agencies and resources are available. Nevertheless, some key problems remain that frustrate efforts to address children's behavioral health needs. This section reviews some of the most important of these problems, reported from the vantage point of NAPHS service providers' daily experience.

### Lack of Needed Services

The effort to control costs in both public programs and private health insurance has created enormous pressures to constrain funding. While these pressures have increased the emphasis on providing services efficiently and cost-effectively, they also have in many instances led to **under-funding** of important services and **denial of needed care**.

Several members of the NAPHS Youth Service Committee report that a number of their treatment facilities for children - be it an inpatient facility or a "wilderness program," consistently maintain full occupancy. They report that they are often forced to place children on long waiting lists for services. A recent *Los Angeles Times* article profiled a parent in desperate need of a 24-hour supervised care and treatment facility for her child, who had been diagnosed with autism and attention deficit hyperactivity disorders.

*The Ventura county woman (Tina) in the article reported that by age 6 her 10-year old son was "totally out of control, hitting people frequently, banging his head against the wall and screaming continuously. He couldn't function and I couldn't get him into a hospital."*

Approximately 1,800 children with emotional, mental and behavioral disorders are being served by the Ventura County mental health department, according to the article. The county, however, only has one residential treatment facility and one state hospital in California that will accept emotionally disturbed youths on a long-term basis. The Ventura county mother reported that her son is currently living at home because there are no facilities that have an opening.

*"While Tina (mother) and other parents support the county's policy of keeping mentally and emotionally troubled youths at home and out of mental hospitals if possible, they contend that the county lacks sufficient inpatient facilities with 24-hour supervised care and treatment. Without these support services they fear their children could ultimately land in another sort of institution - Juvenile Hall."*

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## Fragmented Systems of Care

According to many studies, children and adolescents with serious mental, emotional or behavioral health disorders are poorly served by the various public agencies that provide their care.<sup>63</sup> Given the array of diverse settings in which children's mental health problems are treated and prevention is attempted, it is not surprising that agencies and providers of care continue to struggle with fragmentation in service delivery.

Several NAPHS members report that the majority of the children and adolescents they are providing care to lack access to coordinated behavioral health services as they need them. Many children are forced to remain in an inappropriate treatment setting because the multiple payers of services do not agree on the appropriate treatment for the child at a given point in time.

For example, a child welfare agency may identify a child that is being abused and determine the child needs to be placed in a residential treatment facility. Medicaid or a public sector managed care entity, however, may disagree with child welfare and refuse to pay for the service either because the entity does not believe the care is necessary or appropriate, or the entity is not allowed to reimburse for a particular service. In the meantime, the child in need of a particular type of service is either not receiving any sort of care, or is inappropriately directed to receive care from a treatment setting because one of the payers has agreed to cover it.

*"The services should fit the needs of the child and family, and instead, kids are frequently caught in the crossfire of the multiple agencies disagreeing over what qualifies as appropriate care," said one NAPHS member. Another member stated, "In some situations, it is impossible to place a child in the best program to meet their needs because the decision must be based on whether or not a particular payer is willing to reimburse a particular service."*

This typical scenario places the providers of services in a very difficult situation. NAPHS members report that they typically invest significant staff resources in working with agencies to receive portions of funding that pieced together, will cover a range of services for one child. Specifically, one member said that of \$25 million in facility operating costs, \$1 million is dedicated to pursuing payment approval for appropriate services for children. NAPHS members stress that the more straightforward the administrative mechanisms that pay for the services are, the easier the provision of services will be.

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<sup>63</sup> Stroul, B. Children's Mental Health. Creating Systems of Care in a Changing Society. 1996. Community-Based Mental Health Service for Children in the Child Welfare System, Macro International Inc. June 30, 1992.

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Over the past decade, more and more states have made efforts to meet the needs of children through comprehensive, multi-agency systems of care and agreements that provide individualized services in a child-centered and family-sensitive manner. Members reported that interagency agreements could be helpful if the agencies reflected their commitment to providing coordinated care through the following mechanisms: 1) resource allocations, 2) operational policies and regulations, 3) budget priorities, 4) financing policies, and 5) administrative mechanisms.

One NAPHS member reported that while interagency agreements and collaboration would be useful in addressing this problem, it is often difficult to persuade child-serving agencies to participate in such agreements. He said that although all of the agencies have a vested interest in the well being of children, they find it difficult to work collaboratively because of different philosophical approaches to providing care and fears of forfeiting control over how dollars are spent.

### **Inflexible Funding Streams**

Allocations for child serving agencies are governed by a host of federal mandates, regulations, reimbursement rules, and categorical funding restrictions. NAPHS members report that these restrictions often create difficulties in providing appropriate care to children and their families.

Because many local and state mental health programs are not required to cover all children that are living with serious mental health problems, children are often placed on long waiting lists for services from mental health agencies. A recent article in the *Chicago Tribune* reports that an unpublished study by the Bazelon Center for Mental Health Law suggests that parents of mentally ill youth are turning their children over to child welfare agencies to secure mental health services.

This emerging trend, coupled with comments from NAPHS members, indicate that Title IV-E dollars are a critical source of funding for children's mental health services, but limitations on the use of these funds often conflict with evolving "systems of care" and "wrap-around" models. For example, while there is much evidence that parents who place children in state custody are often dealing with some level of dysfunction themselves, (i.e., alcohol or other substance abuse problems), Title IV-E funds restrict the use of dollars to provide counseling and treatment to parents.



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## Recruitment and Retention of Front-Line Staff

NAPHS members report serious concerns regarding a number of issues related to the recruitment and retention of front-line staff (i.e., case managers, social workers, child psychiatrists<sup>64</sup>) in their child/adolescent treatment facilities and programs across the country. Members consider qualified front-line staff to be one of the most valuable resources they have in implementing effective treatment programs for children and adolescents.

*“The front-line staff members are the individuals that are dealing with the every day emergencies – from a child physically attacking another child to a teenager refusing to take his medications. These individuals are also the ones that can make the most significant changes in a child’s life,” said one NAPHS member.*

NAPHS members said that it is extremely difficult to maintain highly qualified staff for several key reasons:

- Inadequate salaries;
- Unmanageable caseloads leading to persistent stress;
- Staff frustration with the various public and private sector bureaucracies; and
- Staff dissatisfaction with the lack of resources necessary to make a difference in the outcomes of the lives of children.

## Conclusions

Based on this review, the following conclusions suggest some avenues for future efforts to improve services for children and youth with behavioral health disorders.

- Highly publicized acts of school violence—while rare—do present an opportunity to bring issues surrounding youth’s mental health needs to the forefront of public and policy-makers’ attention. However, the far more common instances of children and youth whose problems lead them to do poorly in school or simply drop out may be difficult to highlight without stigmatizing them as “potentially violent.”

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<sup>64</sup> Several reports have focused on the number of child and adolescent psychiatrists in the United States (American Academy of Child Psychiatry, 1983; Council on Graduate Medical Education, 1990; Graduate Medical Education National Advisory Council/GMENAC, 1980). While estimates vary on the magnitude of need, the studies are in agreement that there is and will continue to be a serious shortage of child and adolescent psychiatrists. The 1980 GMENAC estimated there would be only 45 percent of the needed child psychiatrists in 1990. Anticipating a much larger need, the Council on Graduate Medical Education in 1990 calculated the number of child psychiatrists met only a tenth of the demand and that the shortage would continue into the foreseeable future.

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- The high prevalence of youth with behavioral health problems in the juvenile justice system presents both opportunities and risks for increasing attention and funding for needed services. The high visibility and concern about juvenile behavior provides an opening for information about the relationship of mental disorders with the types of behavior that result in children and youth entering the juvenile justice system. However, current punitive attitudes toward youthful offenders may instead serve to identify all youth with “behavioral health disorders” as offenders or potential offenders who deserve punishment rather than treatment. Several key pieces of pending legislation include both positive and negative provisions that could substantively impact the lives of these children. Such provisions range from weakening the language requiring separation of adults and children in confinement to providing state block grants to develop and implement effective screening and assessment of juveniles entering the system.
  - A lack of knowledge and understanding about behavioral health and disorders—among the general public as well as among policy-makers at various levels—together with the lack of a strong political constituency for disadvantaged children, makes securing resources for services and supports for this population a difficult challenge. Traditionally, children’s mental health and substance abuse services have been a junior partner in broader behavioral health coalitions. However, the current public focus on children in a variety of areas such as education, healthcare and support for families, provides an opportunity to expand the universe of advocates for children’s behavioral health services.
  - A key requirement for improving policy and resources available for children’s behavioral health will be the establishment of baseline and trend data on prevalence and costs of conditions and services specific to children and youth. The data available on all mental health and substance abuse services raises significant concerns about timeliness, completeness, and consistency with other data involving health and human services. However, the current lack of ability to identify and follow children and youth concerns even within these limitations serves to perpetuate their low priority in funding programs.
  - Finally, children and youth services depend on multiple funding streams involving systems (such as education and juvenile justice) *in addition to* those involved in mental health and substance abuse funding (such as Medicaid and state and local behavioral health agencies). The system of care philosophy and the spectrum of care it envisaged were keyed to the coordination of public sector funding agencies. The rapid deployment of managed care in both public and private sector behavioral health creates special challenges, as some of these sources remain “unmanaged” while others create multiple managed care contracts with different entities, giving each an incentive to shift costs to the others. An updated model for the system of care would include the range of public and private resources (both financial and service) needed to address the spectrum of child and adolescent disorders, together with options to fit the variety of service and financing structures that are emerging in the field.

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## ACKNOWLEDGMENTS

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NAPHS Youth Services Committee:

The purpose of this committee is to promote the need for behavioral health treatment, education, and rehabilitation services for troubled youth; to obtain more visibility for youth services; and to raise youth services on the national agenda. The Committee addresses public policy issues related to youth services and makes recommendations to the Board of Trustees.

Chair:

**Elliot Sainer**, Aspen Youth Services, CA

Members:

**Alan Axelson, M.D.**, InterCare Behavioral Health, Ltd., PA

**David Beardsley**, Health Management Associates, FL

**Neil Campbell**, Children's Comprehensive Services, Inc., TN

**James Cole**, Devereux Cleo Wallace, CO

**Edward Irby**, Alternative Behavioral Services, VA

**Jewel Norman**, Charter Behavioral Health Systems of Atlanta at Laurel Heights, GA

**Kevin Sheehan**, Youth and Family Centered Services, TX

**Walter Grono**, Devereux Foundation, PA

## APPENDIX

### How Programs Work for Children and Youth

This section provides some representative stories of real children or case examples of youth served in programs operated by NAPHS members. These stories are provided to give a realistic sense of who the children are, and then to show the range of approaches and some of the difficulties encountered in serving them.

In addition to NAPHS' anecdotal examples of effective programs, members report that they typically use the following indicators to determine whether or not children are improving in their treatment programs.

- Reductions in recidivism rates
- Reductions in inpatient length of stays
- Improved functioning on specific behaviors or dimensions
- Improved school attendance and/or performance
- Reduction in incarceration and recidivism rates for juvenile offenders
- Increased parent participation and/or support
- Increased youth and/or parent satisfaction with services

#### Program A: "Joe"

Joe, a 16-year-old from Billings, Montana, entered the mental health system at age 11 due to school behavior and truancy issues. Since the age of nine, Joe has received child protective services because of neglect and physical abuse; his father was incarcerated and his mother was heavily dependent on alcohol and drugs. By age 16, Joe had received a misdemeanor charge for criminal mischief, including shoplifting, "joy riding," and marijuana possession with intent to sell. Joe was referred to Program A after he was tried for "joy riding" and possession of marijuana.

During orientation, Joe made two run-away attempts. He was uncooperative and belligerent, and denied having any problems. On the back-country expedition he ran away during the first week. Program staff followed Joe and, after several days, he reluctantly returned to the group. The program requires that the children move together during the expedition, but this proved to be difficult for Joe, who resisted becoming a part of the group. Joe, however, excelled at some of the more difficult tasks and soon emerged as a leader. Joe was a survivor and quickly adapted to situations that arose in the backcountry. He graduated from the expedition as one of the more progressive children.

When Joe moved into the residential component of the program, however, he began to show some of the same behavior patterns he had exhibited in the beginning. Once he began some of the community service work programs, however, he was able to control many of these behaviors. He enjoyed activities more than sitting down and talking, and the concept of contributing to society resonated with him. After leaving the residential component of the program he decided to go to Job Corps, which he completed in six months with training in plumbing. Thus far, he has stayed out of the juvenile justice system and child protective services.

### **Background on Program A:**

Program A is a residential wilderness program in Montana that has been in operation for four and a half years. This program serves 110 adolescents a year from ages 13 to 18. The majority of the children served (70 to 80 percent) are alcohol and/or drug abusers. Seventy-five percent are referred to the program through the juvenile justice system, while 20 percent receive referrals through the child welfare system. Although the program is designed for high-risk youth, it does not serve children diagnosed with severe psychiatric disorders or a history of physical assault.

The program has four key components:

#### **I. Orientation**

- Orientation comprises the first month of the program and includes stabilization, family and individual assessments, diagnostic work-ups, individual and group counseling, structured education (provided through an on-site, accredited education facility), and basic behavioral health care.

#### **II. Back-Country Expedition**

- The back-country expedition is a two-month trek into the wilderness of Montana, designed to become more difficult over time. By the end of the expedition the children will be able to navigate on their own, read compasses and make solo hiking trips.

#### **III. Residential Care**

- Upon returning from the expedition, the children enter the residential component. This portion of the wilderness program is designed to help the children make the transition back into society. This component lasts two months and includes structured education and community service work projects.

#### **IV. After Care**

- This last phase can last from 35 days to two months. Included in After Care are outpatient family and individual therapy sessions, mentoring, and a case manager who coordinates services in the community.

### **Goals of Program A:**

Program A is designed to provide youth with an opportunity to develop positive behaviors during a challenging and unusual life experience. Administrators hope to expose children to a humane experience that will teach the children discipline, positive involvement, accountability and useful daily living habits.

The provider attributes this program's effectiveness to its origins; administrators of the program reported that a need existed for a short-term intervention program as an alternative to a lock-down inpatient or long-term residential facility. Key areas for intervention were identified and integrated into the structure of the program from the beginning. The After Care services are considered a key component of the design because they facilitate successful re-entry into society.

### **Program B: "Sam" and "Susan"**

Currently Program B is treating Sam, a four-year-old boy who is in the custody of the Department of Children and Families. In his four years, he has been in 17 foster homes. He was born addicted to cocaine and removed from the home due to neglect and suspicion of abuse. Since that time, he has had no contact with family members. He has shown behavior that is extremely hyperactive and aggressive toward other children. His treatment includes behavioral therapy, medication and a highly structured educational setting. The treatment objective is to prepare him for foster care placement (therapeutic or regular placement, depending on progress) and participation in the day program if he is from the area. He has been in residence for four months and has shown improvement.

Program B, is also currently treating "Susan," a 12-year-old, deaf girl, who was referred to the program by her family. She has a history of sexual abuse by family members. Her diagnoses include thought disorder and borderline intelligence, i.e., she does not qualify as mentally retarded, but her IQ is on the borderline of mental retardation. Due to aggressive behavior, she has a history with the juvenile justice system. Since she has been in residence at Program B, she has been arrested twice for assaulting staff members. After her first arrest, she served 18 days in detention. On the day of her return, she struck a staff member. After her second arrest, she was returned to a highly structured behavioral health program, coupled with family intervention, to control antagonistic behavior exhibited by her family. The treatment goal for this child is to teach her safe behaviors so that she can be returned to her home and the support services in her area. After six months in the program she has shown signs of improvement.

## **Background on Program B:**

Program B is a residential treatment center (RTC) and outpatient day program in Florida that has been in operation since 1988. The program serves boys and girls from ages 4 to 18 with 200 per year served by the RTC and 80 per year served by the outpatient day program.

All of the children served have an Axis I DSM-IV diagnosis accompanied by long-standing behavioral disorders that prohibit safe living. Eighty percent of the children over age 11 have some level of co-occurring substance abuse problems, though the program does not serve children with substance abuse problems exclusively. The child welfare system refers 60 percent and the juvenile justice system refers 15 to 20 percent of the children in the program. Virtually all of the children have violent behavior problems.

The day program is a chartered alternative school system, separate from the RTC, that provides education for the severely emotionally disturbed. The RTC provides the following services to youth: individual and group therapy, nursing, psychiatric services, medication management, education through an accredited school, eating disorders therapy, sexual abuse therapy, substance abuse therapy, parental separation and loss therapy, recreational therapy, outdoor therapeutic activity, equestrian programs, and specialized services for deaf children.

On average, children are in the program from six months to one year, with a range of one month to three years. If children lived with family prior to treatment they are generally returned to family after treatment. Foster children are either returned to foster care or discharged to therapeutic foster homes if available. Local children are referred to the day program after treatment in the RTC. However, most of the children in the program are not from the immediate area, and are therefore referred back to their home physician. Staff members at Program B work closely with caseworkers from the home district to identify programs that will provide youth with follow-up care.

Children in Program B receive treatment for psychiatric problems, as well as the manifestations of those problems, such as violent behavior. Ninety percent of the care at the behavioral level is focused on safety; younger children are taught how to recognize unsafe behavior in themselves and others, how to identify safe people and to enforce warning signs. For the older children, the program teaches the difference between consent and coercion, helps them examine the impact of their behavior on others, and teaches them to accept increased accountability for their actions and recovery.

### **Goals of Program B:**

In the short-term, Program B's goals are: 1) to provide a nurturing and safe environment for children, 2) to utilize available resources to meet the individual needs of children, and 3) to show children that they are capable of identifying their own needs. In the long term, Program B is striving to affect the successful development of individualization and independence in children. The most effective component of the program thus far has been the ability of administrators to individualize children's programs and treatment plans.

### **Program C: "Ted"**

Seventeen-year-old Ted is currently housed by Program C, a residential treatment center (RTC) for juvenile sex offenders. He came to the RTC eight months ago after it was revealed that, while in several foster homes, he sexually assaulted or made attempts to sexually assault female members of the household. Before entering foster care, Ted's family-life was tenuous; his mother died shortly after his birth and his father has been in and out of prison. Through the years, however, Ted has received support from a sister, who is 15 years older than Ted, and from a frail grandmother. For economic and health-related reasons, Ted's family placed him in foster care and with the help of the juvenile justice system, referred Ted to Program C.

During his time at Program C's RTC, Ted has participated in the weekly counseling sessions and his sister and brother-in-law have taken on the role of parents in the family therapy and parental support groups. In addition to the sex-offending behaviors, Ted was diagnosed with depression and obsessive-compulsive disorder during one of the weekly psychiatric visits. With the help of the in-house nursing staff, Ted has adhered to his schedule of medications and has shown improvement. Ted has also shown marked improvement in school and has had regular attendance. He hopes to leave the program at the end of the year and move in with his sister and her husband. After returning to a home environment, Ted will continue to receive day treatment services.

### **Background on Program C:**

Program C is a residential treatment center and day program for juvenile sex offenders that has been in operation since January 1996. The program has 30 beds in the RTC and 15 day treatment slots. It serves boys ages nine to 17. Both service delivery units operate at full capacity. All boys in the program have molested someone at some point in their lives. Seventy-five percent of the boys in the program are referred by the juvenile justice system, while others are either self or family-referred or referred by the Department of Children and Families. The primary problem in all cases is the sex-offending behavior. Some of the children also have problems with substance abuse.



For the residential treatment program, children receive 23 hours of group therapy per week, ten hours of which must address sex-specific issues. Also included in group therapy are strategies for anger management, self-esteem building and activity therapy. Weekly treatment includes one hour each of family therapy, individual therapy and parental support, two hours of family group therapy, structured free time, and public schooling with certified teachers. In addition, children receive a medical and psychiatric visit every week and there is 24-hour nursing care provided by a registered nurse. The day treatment program provides the same treatment services. These services, however, are less intensive, because the children are only there six hours a day; e.g., children in the day program only receive 10 hours of group therapy per week.

The average length of stay for this program is one year. Children in the RTC are stepped down to the day treatment program after completing the residential program. Program C also makes referrals to other outpatient services after treatment in the RTC. Those who are 17 and without a family are usually stepped down to a pre-independent living home. Children of all ages discharged to their families receive in-home consultation by a behavioral analyst.

### **Goals of Program C:**

Overall, Program C addresses three problems: 1) the child's Axis I diagnosis, 2) the sex-offending behavior and 3) family dysfunction. These problems are treated concurrently within the program.

At a minimum, the goals of Program C are to prevent the children from becoming repeat sexual offenders, to increase the safety of the community, and to improve their children's ability to function safely in society as a whole. Thus far, the program has been relatively successful at attaining these goals. Although outcomes for this population cannot be accurately measured until four years after discharge, Program C is currently at a 50 percent success rate, which is the national average for juvenile sex offending programs.

Program C has found several key components of their program to be particularly effective. In their sex-specific group therapy sessions, they spend a great deal of time focused on victim role-playing. This exercise highlights the effects of sex offending on the victim and helps the children understand the victim's perspective. The program also teaches the children about appropriate sexual fantasies and sexual relationships. They teach that sexual relationships should have "CERTS" - consent, equality, respect, trust, and safety.

## **Program D: "Juan"**

Program D is serving Juan a 9-year-old, Spanish-speaking boy, exhibiting behavioral problems in the classroom. His teacher referred him to the school psychologist who concluded that he needs a mental health assessment. Consequently, he was referred to one of Program D's programs, where he was assessed and assigned to a bilingual therapist and a caseworker. The caseworker will collaborate with the boy, his teacher and the boy's single mother. The therapist will provide an in class consultation to help the child's teacher manage his behavioral problems and he will also work with both the mother and child until the mother is comfortable managing his behavioral problems. The program, in the case of a single mother, will also provide a male mentor to spend time with the child and serve as a positive male role model.

### **Background on Program D:**

Program D is a multi-site program providing treatment services at 18 sites in California and Nevada. The services are provided through community-based outpatient care facilities emphasizing three treatment components - education, mental health treatment, and rehabilitation. The youth in the program are at-risk of or have been diagnosed with serious emotional disturbance, or have conduct disorders that may lead to involvement with the juvenile justice system. The following description will focus on the mental health component of the program.

The mental health component has been in operation since 1987. Each of the 18 sites may serve, on average, 60 to 200 clients ages five to 21 at any given time. Children may be referred to the program through several entities including the school district, family, the juvenile justice system, Medicaid agencies, and the social service department. Program D also receives children through their emergency shelter where police take children when the home environment is no longer safe.

This program provides services for children with a number of various problems from violent behavior to dual diagnoses of mental health and substance abuse problems. Treatment focuses on everything from an initial screening/assessment to managing psychosis. Particular services provided include community-based counseling, family treatment, medication support and administration, school based mental health services, school mental health consultation, substance abuse treatment, job training, therapeutic camping, residential rehabilitative services for adjudicated youth, psychological and psychiatric evaluation and testing, case management, crisis intervention and wrap around services.

For services that are not provided directly by Program D, they participate in several collaborative and interagency arrangements. These arrangements include relationships with the following:

- Child care agencies,
- Emergency service organization such as the Red Cross,
- Social service organizations such as the Boys and Girls Club,
- Parenting groups,
- Advocacy groups, such as the Alliance for the Mentally Ill,
- Psychiatric hospitals and
- Specialty groups, such as the Latino Psychological Organization and the Asian American Psychological Organization.

### **Goals of Program D:**

Program D's goals are: 1) to prevent out-of-home placements of children, 2) increase academic improvement and 3) prevent children from becoming involved or further involved with the juvenile justice system. Thus far, program administrators have received positive feedback regarding these goals. They are currently putting in place an outcomes measurement system to further monitor the effects of their treatment programs.

Several innovative aspects of Program D are reported by administrators to be particularly effective. Adolescents on probation are often not welcome or treated well by the mental health system. In response to this, Program D has developed a treatment program and a team of staff members specifically for this population. They also have developed a day treatment program for small children who suffer from Post-Traumatic Stress Disorder due to familial abuse. Additionally, they have developed state-of-the-art school programs and services to prevent out-of-home placement or hospitalization.

Because Program D works with impoverished communities, one of the primary challenges faced by this program is reaching their target population. These communities do not have the resources for transportation or childcare services so they have difficulty connecting with services. Another challenge is working cooperatively within a fractured social service system. This program tries to establish a relationship between the child, the family and the counselor. Facilitating this relationship, however, may require contacting two or three uncoordinated entities within the social service system.

### **Program E: "Jimmy"**

Program E is currently treating eight-year-old Jimmy who has been in multiple foster homes and is now in a group home. He has never known his father and was removed from his home because of maternal neglect. He was referred to the program through the department of child welfare. Initially, he could not participate in club activities because he was aggressive, easily provoked and paranoid. He was placed in a behavioral management program where he was rewarded for controlling his behavior. Jimmy responded immediately to this program, because he had never received any positive reinforcement before. He is now interacting well with the members of the club. He has joined the club basketball team and the child welfare department is looking for a more permanent foster care home for him. Jimmy is still behind in school academically, but they feel that now that his behavioral problems are under control his academic performance in school will improve.

### **Background on Program E:**

Program E is an outpatient day rehabilitation program with components emphasizing intensive-community service and home social skills for parents. It has been in operation since December 1998 and is currently serving 35 children ages five to 18 in Las Vegas, Nevada. There is a separate program for adolescents and pre-adolescents as well as adolescent girls referred to the program through the courts.

The children served by this program have severe emotional problems, impaired socialization skills and behavioral problems that interfere with their progress in school and their ability to interact with peers and family members. These children have a variety of diagnoses, but the most common are Attention Deficit Disorder, Conduct Disorder, and depression. They usually have disruptive family environments and/or a history of foster care or group home care. Many of the adolescents in the program have secondary problems with drugs or alcohol, particularly those who are referred to the program through the juvenile justice system. Ten percent of the children in the program are referred through the juvenile justice system; the remaining 90 percent are referred through the child welfare system.

The major strategy of the program is to provide two components of treatment: 1) intensive therapy and 2) structured socialization with intensive supervision. To ensure the provision of both of these components, Program E entered into a partnership with the Boys and Girls Club, where the program is conducted. This arrangement allows the program to provide traditional group therapy, including strengthening social skills and self-esteem, cognitive behavioral therapy, behavioral reinforcement, supervised socialization and opportunities for improved social relationships within the Club. This provides an opportunity for Program E's children to interact with the 300 other children who attend the club. For the older children, this is particularly effective because they are given the opportunity to have mentoring relationships with a coach and self-esteem building responsibilities.

During the six hours at the club after school, the children are given the opportunity to participate in a number of therapeutic activities that would not otherwise be covered by Medicaid (their primary funding source). Recreational therapy, computer centers, libraries, tutoring and homework assistance are all treatment-enhancing resources provided for free by club staff.. This arrangement allows for the provision of services that Program E could not offer otherwise.

The home social skills program works in the homes of program children to improve communication and social interaction within the child's family. A caseworker provides an in-home assessment and works with other family members (particularly other household children, who are not in the program) to enhance the overall social skills of the home. The program also assists parents with parenting skills.

In the intensive community service component of the program, staff works closely with the drug court and the mental health department to provide services for children in this system. This program provides group psychotherapy, drug monitoring, and coordinates job training with vocational providers.

Although medical services are not provided on site, Program E coordinates with a child's primary care doctors or pediatricians to provide medical care when necessary. Also, Program E coordinates with the schools to provide in-school behavioral consultation when needed.

### **Goals of Program E:**

Program E has three goals: 1) to stabilize placement so children are not moving from home to home, 2) to improve children's socialization skills (this outcome is measured by school performance and a child's ability to interact with other children in the club.), and 3) to improve self-esteem. Lack of self-esteem is a significant problem with children in this program. Program E measures improved self-esteem by a child's ability to interact well with other children in group therapy.

### **Program F: "Beth"**

Beth entered Program F as a mid-ninth grader. Before entering the program, Beth had extensive absences from her home school and extensive incidences of violent behavior and destruction of property. Her first day in the program, in an attempt to get suspended, she spilled paint all over the school. Her assaulting and destructive behavior continued for the next three to six months. Beth was assigned a counselor, whom she could contact anytime. Also, she was placed in a special learning center for students who cannot be with their peers. This center was a non-traditional classroom setting in that there were no desks and no structured time frame for the curriculum.

In this setting, Beth was given individual goals and would earn points for achieving those goals. These goals could be academic, e.g., completing a chapter, behavioral, e.g., not cursing at the teacher, or social/interactive, e.g., sitting within three feet of another student all the while respecting their property and personal space. With each achievement, the scope of the goals increased. Academically, this setting was structured such that she would work on one subject for weeks at a time to prevent over-stimulation. As time passed and with each achievement, Beth began to master additional subjects.

Beth also was given the opportunity to engage with younger, handicapped students to gain insight into how those less fortunate or with greater obstacles to overcome could behave positively and be successful. Also, she was given the opportunity to engage in more physical outdoor activities than she would have at a more traditional school. Eventually, Beth was given the opportunity to leave the school environs and enter the community at large. By the time she graduated, Beth was in a more typical learning environment and demonstrating improvement; she had bonded with the staff and her counselor, her attendance had improved, and she became a leader on the student council. After graduation, Beth went on to attend junior college.

#### **Background on Program F:**

Program F is a specialized school in Los Angeles, serving children ages five to 21 with special education needs. It has been in operation for six years and serves 111 students. Currently 60 percent of the students are at the junior high and high school level and 40 percent are at the elementary school level. This program serves as an extension of the children's local school district working in conjunction with 38 school districts in Orange and Los Angeles counties. This school is part of a category of schools in California known as non-public schools, which are part of a continuum of care for children with special needs.

All children who attend this school and others of its type must meet certain eligibility requirements, such as a diagnosis of severe emotional disturbance. However, children have other problems, such as autism, severe delay of language, learning disabilities, developmental delays, health impairment and traumatic brain injury. All children in this program are referred by their home school district.

The school provides the following services: speech and language development, adaptive physical education, counseling, health and nursing, and transportation services. Children may enter the school at any point during the academic year and stay, on average, for one to one and a half years. Children are reviewed at least once a year to determine how much they have progressed toward their goal. The ultimate goal is to return the child to their home school.

Although confidentiality laws prohibit aftercare once the child has left the school, Program F does provide a number of aftercare services. If a child is returning to his/her home school (as opposed to graduating), the program will work with him/her on the necessary skills for success at their home school. Toward the end of his/her stay in the program, the child may spend a half of day at the home school and a half of day at a Program F school. For those students who will be graduating, the program helps them find a job or continued schooling, open a bank account, find an apartment, etc. They provide transportation to their jobs and check with their supervisors to measure their progress on the job.

This program cannot contract out for services they do not provide on site. They must be able to provide all services listed on a child's Individualized Education Program (IEP). The services this school and other non-public schools provide allow the school district to decide what school is most appropriate for a child's IEP.

### **Goals of Program F:**

Program F aims to create positive memories of school life and have their students experience success at school. Most of the children who enter this program have many unpleasant school memories. Few have success stories.

Many of the challenges this program faces stem from the disparate communities and school districts from which the children are drawn. The program seeks to have a personal relationship with each school district and to tailor each student's education to meet the home school district's requirements. Program F also coordinates several intramural activities with other schools so that the children interact with other children from their home school and neighborhoods.