EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, ON JUNE 6, 1985

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EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS

THURSDAY, JUNE 6, 1985

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in room 2257, Rayburn House Office Building, Hon. George Miller presiding.

Members present: Representatives Miller, Coats, Sikorski, Wheat, McHugh, Boggs, Wolf, Boxer, Johnson, and McKernan.

Staff present: Alan J. Stone, staff director and counsel; Ann Rosewater, deputy staff director; Marcia Mabee, professional staff; Mark E. Souder, minority staff director; Carol Statuto, minority professional staff member; and Linda Belachew, secretary/correspondent.

Chairman MILLER. The Select Committee will come to order.

The purpose of this morning's hearing is to take a look at the emerging trends in mental health care for adolescents, especially those youngsters struggling with psychological or emotional problems, or with drug and alcohol dependencies.

This year, the Select Committee has already held two hearings addressing the problems of alcoholism and its implications for families. Today, we will explore some of the emerging trends, and the methods available to treat youngsters with emotional and substance abuse problems.

Significant changes in insurance coverage seem to be quickly expanding certain services for adolescents, especially in-patient psychiatric and drug-related hospitalization. At the same time, public mental health resources, especially community-based treatment alternatives, are becoming more and more scarce.

I'm concerned by this trend, because all families in crisis deserve access to appropriate care, not just those who have private insurance coverage. I'm also concerned that, if such a trend is indeed taking place, it be for appropriate care and not just some kind of incarceration. Generally, I believe, increased mental health coverage is a positive development, but we must be cautious to avoid the possible negative consequences.

We are here today to learn more; are there increased admissions for youth in hospitalization in psychiatric or in chemical-dependency units? If so, what forces are driving this increase, and is such care appropriate?

Do these new trends give any more hope for the millions of children already without needed mental health services, or, as the GAO report which I requested and which will be available in a few weeks will show, will there continue to be more minority youth in public facilities and white youth in private hospitals or clinics?

As always, we will hear today from clinicians, researchers, providers, patients, and children in our effort to educate ourselves. I look forward, as I'm sure the other members of this committee do, to gaining insights from the record we will create today.

[Opening statement of Congressman George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Young people and their families, especially those youngsters stuggling with psychological or emotional problems, or with drug and alcohol dependencies, are the subject of today's hearing. This year, the Select Committee has already held two hearings addressing the problem of alcoholism and its implications for families. Today we will explore some of the emerging trends in the methods available to treat youngsters with emotional and substance abuse problems.

Significant changes in insurance coverage seem to be quickly expanding certain services for adolescents—especially inpatient psychiatric and drug-related hospitalization. At the same time, public mental health resources—especially community-based treatment alternatives—are becoming more amd more scarce.

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Generally, I believe increased mental health coverage is a positive development, but that we must be cautious to avoid possible negative consequences.

We are here today to learn more.

Are there increased admissions of youth for hospitalization in psychiatric and chemical dependency units?

If so, what forces are driving this increase and is the care appropriate?

Do these new trends give any hope for the millions of children already without needed mental health services? Or, as a GAO report I requested and which will be available in a few weeks shows, will there continue to be more minority youth in public facilities, and white youth in private hospitals or clinics?

As always, we will hear today from clinicians, researchers, providers, parents, and children, in our effort to educate ourselves.

I look forward, as I'm sure all members of Congress do, to gaining insight from the record we will create today.

Chairman MILLER. Mr. Sikorski, do you have a statement you would like to make?

Mr. SIKORSKI. Thank you, Mr. Chairman. I commend you for holding this hearing. I'd like to welcome the witnesses here today, especially my fellow Minnesotans.

In Minnesota, we take the protection of our most precious resource, our children, very seriously. In fact, I chaired the Select Committee on Juvenile Justice while a member of the Minnesota Senate, and headed our Health, Welfare and Corrections efforts on behalf of children.

I serve on the Board of the Minnesota Mental Health Advocates Coalition, and while in the Senate, I had the opportunity to work closely with Ira Schwartz on health issues. He's dedicated and determined and I commend him for spurring national interest in the problems we're examining today.

I'd also like to thank my constituents, Barbara and Marissa DeFoe, for their courage and willingness to share with the committee their traumatic experiences.

All of us have to be deeply troubled by the question of over-institutionalization of teenagers with psychiatric and chemical dependency problems, and some who have none of these problems, but are institutionalized, nonetheless. Today, we intend to examine the numbers; why there is such an apparent increase, the effect of this institutionalization on adolescents, and any remedial steps we need to take.

Clearly, we have to develop a range of appropriate alternatives for adolescents, educate the public on the value of quality out-patient care, and encourage insurance laws that provide greater balance between treatment programs and alternatives.

Our children must not be used as pawns in a game of emotions and economics between parents, providers and insurance companies.

Once, again, Mr. Chairman, thank you for having the hearing.

[Opening statement of Congressman Gerry Sikorski follows:]

OPENING STATEMENT OF HON. GERRY SIKORSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

I'd like to welcome the witnesses here today—especially my fellow Minnesotans. In Minnesota we take protecting the rights of our most precious resource—our children—very seriously. In fact, I chaired the Select Committee on Juvenile Justice while a member of the Minnesota Senate, and headed our health, welfare and corrections' efforts on behalf of childen.

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All of us have to be deeply troubled by the question of over-institutionalization of teenagers with psychiatric and chemical dependency problems. Today we intend to examine the numbers; why there is such an apparent increase; the effects of this institutionalization on adolescents and any remedial steps we need to take.

Clearly, we must develop a range of appropriate alternatives for adolescents, educate the public on the value of better outpatient care and encourage insurance laws that provide greater balance between treatment programs.

Our children must not be used as pawns in a game of emotions and economics between parents, providers and insurance companies.

Chairman MILLER. Thank you. Without objection, I would like to include in the record, after the opening statements, a fact sheet prepared by the staff on the emerging trends in mental health coverage for adolescents.

I'd like to recognize Congressman Coats, the ranking minority member of the Select Committee.

Mr. COATS. Thank you, Mr. Chairman. I apologize for being late. I've been late for everything so far today.

Chairman MILLER. Sounds like one of those days.

Mr. COATS. It really has been one of those days.

This hearing, on the emerging trends of mental health care for adolescents, raises some very serious issues. I look forward to all the testimony that we're going to be hearing today.

The first issue that is of major concern to me, is the apparent trend toward increasing use of inpatient hospitalization. It seems that there are several ways to interpret this, and all the interpretations rest on a clear understanding of the diagnostic criteria used to recommend hospitalization of a teen.

Are these criteria so vague and ambiguous as to allow abuse, such as the unnecessary confinement of troubled teens for profit, or are the diagnostic criteria well-defined, and widely accepted? If so, one could conclude that perhaps this confinement increase is due to a rise in the number and severity of severely emotionally disturbed teens. Or, alternatively, is the increase due to heightened sensitivity by parents of the benefits of early intervention?

Frankly, I don't know these answers, but I'm hoping that in this hearing we can clarify these issues. Whether children are placed in detention centers, inpatient psychiatric units, or substance abuse treatment facilities, clearly rests on who decides on where and when to place these teens, the reasons for the placements and the alternatives that exist to institutionalization.

I'm looking forward to testimony that will bring this information out.

It is equally important that our committee really understand what the factors are that lead teens to be increasingly troubled, and subject to these kinds of alternatives. In other words, what is the underlying cause of this apparent crisis in the mental health of our children? Where do their troubles begin, and how can effective intervention and prevention strategies be developed to help these families cope, and to help children lead productive and satisfying lives?

Mr. Chairman, I regret that I won't be able to be present for the entire hearing, to hear all the testimony of each of the witnesses. Unfortunately, another one of my committees is meeting right now on the subject of the proposed sale of Conrail, an issue of extreme importance to my district.

I have, however, read the testimony of each of the witnesses. I will attempt to be present for as much of their testimony as possible. I also ask unanimous consent that we leave the record open for the customary time so that we can submit additional views and comments.

Thank you, Mr. Chairman.

[Opening statement of Congressman Dan Coats follows:]

OPENING STATEMENT OF HON. DAN COATS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA, AND RANKING MINORITY MEMBER, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

Mr. Chairman: This hearing on the "Emerging Trends in Mental Health Care for Adolescents" raises some very serious issues. I look forward to all of the testimony that will be presented here today.

The first issue that is of major concern to me is the apparent trend toward increasing use of in-patient hospitalization. It seems that there are several ways to interpret this—all of the interpretations rest on a clear understanding of the diagnostic criteria used to recommend hospitalization of a teen. Are these criteria so vague and ambiguous as to allow abuse such as the "unnecessary" confinement of troubled teens "for-profit?" Or, are the diagnostic criteria well defined and widely accepted? If so, one could conclude that, perhaps, the confinement increase is due to a rise in the number and severity of severely emotionally disturbed teens? Or, perhaps, the increase is due to heightened sensitivity by parents of the known benefits of early intervention? Frankly, I don't know, but I am hoping that this hearing will clarify the issue.

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Mr. Chairman, I regret that I cannot be personally present to hear the testimony of all the witnesses. Unfortunately, another of my Committees is meeting on the proposed sale of Conrail, an issue of extreme importance to my district. I have, however, read the testimony of the witnesses.

Chairman MILLER. Without objection. Thank you.

[Fact sheet referred to follows:]

EMERGING TRENDS IN MENTAL HEALTH CARE FOR ADOLESCENTS—A FACT SHEET

ADMISSIONS OF ADOLESCENTS TO INPATIENT PSYCHIATRIC FACILITIES ARE INCREASING

Between 1980 and 1984, admissions of adolescents to private psychiatric hospitals increased an estimated 450%—rising from 10,764 to 48,375. (NAPPH, 1985)

Nationwide, the number of children and youth in facilities caring for dependent and neglected children declined 59% between 1966 and 1981—from 60,459 to 24,712—while the number of children and youth in facilities caring for mentally ill and emotionally disturbed children increased 57%—from 21,904 to 34,495. (GAO, 1985)

In Minnesota, the rate of psychiatric admissions for juveniles has increased from 91 per 100,000 admissions in 1976 to 184 per 100,000 in 1983. The proportion of juveniles receiving inpatient treatment for chemical dependency increased from 17% in 1978 to 23% in 1982. (Ira Schwartz, Marilyn Jackson-Beeck, Roger Anderson, "Crime and Delinquency," July, 1984)

MANY PSYCHIATRIC ADMISSIONS FOR ADOLESCENTS MAY BE UNNECESSARY WHILE THE MAJORITY OF SERIOUSLY ILL CHILDREN GO UNTREATED

Of the estimated 3 million seriously disturbed children and youth in this country, two-thirds are not getting the services they need. Many others receive inappropriate care—studies suggest at least 40% of the hospital placements of children and youth are unnecessary, or the children remain much too long. (Children's Defense Fund, 1982; L. B. Silver, paper presented at the American Psychiatric Association/Society of Professors of Child Psychiatry Conference, 1983)

In 1982, Blue Shield of Minnesota found that 25% of juveniles' inpatient days in Minnesota psychiatric and chemical dependency facilities were medically unnecessary. (Schwartz, Jackson-Beeck, Anderson, 1984)

The top five diagnoses for juveniles admitted to Minnesota psychiatric facilities in 1982 were very broad and not clearly indicative of serious mental illness: (1) disturbance of emotion specific to childhood and adolescence; (2) neurotic disorder; (3) disturbance of conduct; (4) unspecified adjustment reaction; (5) depression. (Schwartz, Jackson-Beeck, Anderson, 1984)

According to a recent GAO survey of three states, of the youth that continue to be placed in juvenile justice facilities, the majority are non-white, while over 70% of children and youth placed in health facilities are white. (GAO, 1985)

ONCE LARGELY PUBLIC, MENTAL HEALTH CARE IS INCREASINGLY A PRIVATE SERVICE

Services for children and adolescents

In 1966, 7.6% of the 145 psychiatric facilities for children and youth in the U.S. were operated for profit; by 1981, 17.1% of 369 facilities were operated for profit—a 125% increase. (OJJDP, 1983)

Services for the general population

In the mid-1950's, 97% of psychiatric beds were in specialized public hospitals; by 1982, 76.5% of beds were under public auspices—16.4% were in private non-profit general medical hospitals, and 7.1% were in for-profit facilities. (Mark Schlesinger and Robert Dorwart, *New England Journal of Medicine,* October 11, 1984)

While representing only 7.1% of the total, for-profit psychiatric beds increased 150% between 1969 and 1982. By 1982, 85% of all for-profit psychiatric facilities were controlled by multifacility corporations—nearly two-thirds by the five largest chains. (Schlesinger and Dorwart, 1984)

A 1973 NIMH survey of halfway houses and community residences for the mentally ill revealed that 10% of responding facilities were operated for profit; by 1977, 50% of all such facilities were operated by for-profit multifacility chains. (Schlesinger and Dorwart, 1984)

FACTORS THAT MAY BE FUELING INPATIENT PSYCHIATRIC ADMISSIONS OF ADOLESCENTS

States are deinstitutionalizing troubled youth in juvenile justice facilities

In 1979, 199,341 non-delinquent youth were held in secure facilities; by 1981, 22,833 non-delinquent youth were in such facilities. (OJJDP, 1984)

Nationwide, the number of children and youth in residential care decreased between 1966 and 1981—from 155,905 to 131,419.

Community-based alternatives are not keeping pace with the needs of troubled youth

In 1981, the Community Mental Health Centers Act was repealed. Funding for community mental health centers was folded into the Alcohol Drug Abuse and Mental Health block grant and has been reduced by more than one-third—from $306 million in FY 1981 to $227 million in FY 1984. (NIMH, 1984)

While many states have instituted successful programs to prevent institutionalization of troubled youth, development of necessary services has been hampered by state budgetary constraints and reductions in federal support. Long-range planning has also been severely hampered by uncertainty over the future of the Juvenile Justice Delinquency and Prevention Act. (Testimony, State Juvenile Justice Advisory Groups, House Subcommittee on Human Resources, March 7, 1984)

Many states currently mandate mental health coverage; inpatient care more extensively covered than outpatient care

Currently, 13 states have passed laws mandating insurance coverage for psychiatric care (APA, 1985), 21 states mandate coverage for treatment of alcoholism, and 11 states mandate coverage for treatment of drug addiction (NASADAD, 1985).

On June 3, 1985, in a unanimous decision, the U.S. Supreme Court in *Metropolitan Life Insurance Company* v. *Commonwealth of Massachusetts* upheld a state's right to mandate coverage of specific conditions and illnesses by private insurers. It is expected many more states will enact laws mandating insurance coverage of psychiatric and chemical dependency treatment. (National Mental Health Association, 1985)

58% of employees in medium and large size establishments have insurance policies which provide the same coverage for inpatient care for mental illness as they do for other illness, but only 10% of employees receive comparable benefits for outpatient mental health care. 54% have outpatient care subject to a 50% copayment, and 62% have separate dollar limits, often $1,000 (APA, 1984).

Chairman MILLER. The first panel the committee will hear from will be made up of Ira Schwartz, who is a Senior Fellow at the Hubert Humphrey Institute of Public Affairs, University of Minnesota; Barbara DeFoe, who will be accompanied by her daughter Marissa DeFoe, of Coon Rapids, MI; and Dr. James Egan, who's the Chairman of the Department of Psychiatry, Children's Hospital National Medical Center, Washington, DC.

If you'll come forward, please, and take a seat at the——

Mr. SIKORSKI. It's Coon Rapids.

Chairman MILLER. Coon Rapids.

Mr. SIKORSKI. I know these Minnesota names are tough.

Chairman MILLER. Welcome to the committee. We appreciate you taking your time to come down and to share your expertise and your thoughts with us.

Ira, we'll begin with you. Feel free to proceed in the manner with which you're most comfortable. Your written statement, if you have one, will be entered into the record in its entirety.

STATEMENT OF IRA M. SCHWARTZ, SENIOR FELLOW AND DIRECTOR, CENTER FOR THE STUDY OF YOUTH POLICY, HUBERT H. HUMPHREY INSTITUTE OF PUBLIC AFFAIRS, UNIVERSITY OF MINNESOTA

Mr. SCHWARTZ. Mr. Chairman, members of the committee, I want to thank you for inviting me to testify here today. I do have a copy of my written testimony, which I will leave to have entered into the record.

I also want to commend the committee for holding this hearing on the issue of the growing numbers of juveniles being placed in inpatient psychiatric and chemical dependency programs in private hospitals and also in free-standing residential units.

I think, as we begin to dig into this, we'll find that it's a very very complex issue, and also one that I think is beginning to show up in a number of other States, and eventually, I think, will unfold as a problem of national significance.

Although I'm the director of the Center for the Study of Youth Policy at the Humphrey Institute at the university, the views that I'll be expressing today are my own, and not those of the institute or the university. Neither of those institutions take positions on the public policy.

However, I will be talking a little bit about some of the findings of our research at the center.

Very briefly, Mr. Chairman, and members of the committee, I'm sure you're all aware of a recent CBS evening news broadcast which documented the fact that admissions to inpatient psychiatric units in private psychiatric hospitals jumped dramatically from 1980 to 1984. In fact, the admissions represented an increase of nearly 350 percent.

However, our research indicates that really these figures probably only tell a very small picture. We found, for example, based on our research in Minnesota, that the number of juvenile psychiatric admissions to hospitals in the Minneapolis-St. Paul area virtually tripled between 1976 and 1984. There was a doubling of the inpatient days of care and the rate per 100,000 of admissions more than tripled. And we expect that those numbers will continue to go up, because, as recently, I think, as 2 weeks ago, another hospital, general hospital, 73-year-old Eitel Hospital, announced that it was closing and would be reopening as a juvenile psychiatric program.

All of these admissions were in general hospitals; none were in the one private psychiatric hospital which is located in the State of Minnesota. And my contacts with executives in the insurance industry, with child welfare advocates, mental health advocates, juvenile justice professionals, indicate that, in those States where this is expanding, it appears to be occurring largely in the private general hospitals throughout the United States.

And so, I think, that, as we begin to look into this, we'll find that probably that is where the greatest increase is taking place.

I'd like to share with you a few issues that were raised as a result of our research. First of all, we found that the vast majority of the placements in these inpatient psychiatric and chemical dependency units in the State of Minnesota were largely voluntary placements, and largely paid for by third-party health care reim-

bursement. The third-party health care reimbursement came into play because of Minnesota's mandatory mental health insurance laws. Those laws were passed in the early 1970's out of a real recognition of problems related to mental health and substance abuse in our State.

The problem was that when the laws were passed they simply said that, at the time if you, Blue Cross and Blue Shield, want to sell insurance in the State of Minnesota, you had to provide coverage for mental health and chemical dependency treatment.

The law went on to say that you have to pay or provide only 80 percent of the first $600 for outpatient care and full cost for up to 28 days for inpatient care. And nothing more than that. Consequently, with the laws being written as vague as they were, with declining admissions to hospitals because of improved physical care in the community, and because of shortened average lengths of stay, this created enormous potential for the growth of these programs as well as the potential for abuse.

Many other States have replicated Minnesota's law in various forms.

The other thing that we found is that many young people are being admitted to the units in the State of Minnesota for such things as conduct disorder, adolescent adjustment reaction, attention deficit disorder, and in the chemical dependency units for being chemically dependent. These terms are very vague and quite broad, and consequently, they really represent almost an open-door policy in terms of admissions.

And this is one of the serious problems. In fact, I think Congressman Coats, when he talked about the issue of the criteria for admissions, really touched his finger on a very important aspect of this.

There are also some significant legal and procedural safeguard issues. A colleague of mine in California, Barbara Lourie, who I talked with and who's a mental health advocate, basically said that most young people in these programs are sort of in a legal twilight zone. And the reason she says that, and I think she's correct, is that these admissions are voluntary but in effect, most young people are being coerced into the programs, and when they're there, they're in locked units primarily, particularly in the hospitals.

Now, they're not really voluntary patients because they can't leave on their own. And, on the other hand, they're really not involuntary patients, and they don't have the benefits of appropriate due process and legal and procedural safeguards. So they're basically admitted as a result of decisions by their parents, usually supported by a physician, and locked into these units.

I think some of the questions that are raised by this are: Should parents have the absolute right to admit a child to an inpatient psychiatric or chemical dependency program against the child's will, particularly when parents and young people are arguing or are at each other's throats?

Second, should placement in a locked psychiatric or chemical dependency program be left almost entirely in the hands of psychiatrists; and, also, should juveniles be afforded some due process and procedural safeguards?

Another issue that's raised, and one that I'm particularly sensitive to because I had some direct involvement in this at one time, is that it appears that a sizable number of young people who are showing up in these programs are status offenders. The juveniles who we've literally come off of 15 years of attempts throughout the United States, and particularly at the Federal level, to remove from the detention centers and training schools and jails in this country.

Now it appears that a number of these young people who are showing up in these units are runaways and truants and juveniles who are incorrigible and having serious problems with relationships with their parents. Also, a number of these young people are girls, and they're being admitted for promiscuity. And again, this is another one of the issues that we confronted at the Federal level with respect to the institutionalization of young people in detention centers and training schools in the United States.

I'm concerned about this because I do not think it was the intent of the Juvenile Justice and Delinquency Prevention Act to remove status offenders from the juvenile justice system only to have them incarcerated in another system. And also, we're beginning to see the deferential handling of young women in these facilities, which is very much the same issue that we saw in the juvenile justice system.

While it appears that there's some youth that are being placed in these programs unnecessarily, and I think our research documented that, I think that new data from Blue Cross and Blue Shield of Minnesota documents an increased volume of patient care that has been denied because it has been determined to be medically unnecessary. But while there's many youths that are getting unnecessary care, there are also others who are being denied appropriate service. For example, the overwhelming majority of young people in these units, at least in our State, are white middle-class youth, and generally youth that come from families that have insurance or whose families can afford to pay for the cost of care.

In contrast, youths from low-income families, particularly minority families, more often than not end up being defined as being delinquent, and end up in the justice system. In fact, our current research nationally on juvenile justice shows that now, for the first time in history, over 50 percent of all the juveniles incarcerated in our Nation's detention centers and training schools are children of color.

Another disturbing factor is that there are allegations of abuse and questionable practices. For example, there are reports of arbitrary and capricious use of solitary confinement; things going on in these facilities that you couldn't get away with in a public institution or you'd end up in Federal court. Verbal abuse on the part of staff; little or no work with families; inadequate amounts of time spent by psychiatrists; and the incarceration of children as young as 2 and 3 years old.

I'm also concerned about the potential long-term adverse consequences of some of these practices. I recently heard of a case in Connecticut of a young man who's 21 years old, married, working, wife working, doing well, and they wanted to buy a home. They applied for a mortgage, and were denied the mortgage, even though

they had the downpayment and had adequate finances, because he was declared to be a risk, because when he was 17 years old, he spent 4½ months in an in-patient chemical dependency unit, and was declared to be an alcoholic.

I don't know how common this practice might be; and I hope this is certainly an isolated incident. But it certainly raises the question of what are the long-term implications and aspects of being incarcerated or admitted to these inpatient units.

Mr. Chairman, our research has lead us to conclude that a hidden system of juvenile control is developing in the State of Minnesota, and in a number of other States. It is of extreme concern to policymakers in our State right now, and they're beginning to look at potential remedies.

It is also a system that we found to be largely unmonitored, unregulated, and driven by the availability of third-party health care reimbursement. And I think, clearly, that this is an issue that demands attention on the part of policymakers, health care professionals, juvenile justice and child welfare professionals, public interest groups and child advocates.

It is also, I might add, an issue that is very difficult to get a handle on. Because we're talking about third-party health care reimbursements, private hospitals, and voluntary admissions. There are usually no records. There are no incentives for information to be published, to appear in public circles, and consequently, it requires a lot of digging to really even find out what the extent and nature and scope of the problem really is.

With that, Mr. Chairman, I want to thank you for inviting me, and I appreciate the opportunity to testify before this committee, and would be happy to answer any questions that you might have.

[Prepared statement of Ira M. Schwartz follows:]

PREPARED STATEMENT OF IRA M. SCHWARTZ, SENIOR FELLOW AND DIRECTOR, CENTER FOR THE STUDY OF YOUTH POLICY, HUBERT H. HUMPHREY INSTITUTE OF PUBLIC AFFAIRS, UNIVERSITY OF MINNESOTA

Mr. Chairman, members of the committee, I want to thank you for inviting me to testify today. The issue of growing numbers of juveniles being placed in inpatient psychiatric and chemical dependency (drug and alcohol) treatment programs in private hospitals and free-standing residential facilities, largely fueled by the availability of third party health care reimbursement is one that demands our immediate attention.

Currently, very little is known about this development. Undoubtedly, the interest and involvement of the committee will help to shed light on what may prove to be a complex problem and one of national significance.

At present, I am serving as senior fellow and director of the Center for the Study of Youth Policy at the Hubert H. Humphrey Institute of Public Affairs at the University of Minnesota. While some of my comments will reflect the findings of research activities undertaken at the center, the views and opinions I am expressing on this topic are my own and not those of the Humphrey Institute or the University of Minnesota.

Although the House Select Committee on Children, Youth and Families has been in existence for a relatively short period of time, the committee is already recognized as a key source of data and policy information of the general condition and problems confronting children, youth and families in America. Also, the committee has developed a solid reputation amongst policy makers, practitioners, public interest groups and child advocates at the national, State and local levels.

I know that the committee is deeply concerned about the problems young people are having with respect to chemical dependency. Also, I know that the committee is alarmed by the extremely high rate of teenage suicide and the high incidence of

emotional problems and other stresses that impact the lives of our children and youth.

However, while the problems confronting families and services that are responsive is great, there is mounting evidence that some of the approaches used in meeting the needs of troubled youth and families are inappropriate and costly. In particular, I am referring to the alarming trend of institutionalizing juveniles in private hospitals and free standing residential facilities for chemical dependency and psychiatric treatment, largely fueled by the availability of third party health care reimbursement.

For example, it was recently reported on the CBS Evening News that juvenile admissions to private psychiatric hospitals jumped from 10,764 in 1980 to 48,375 in 1984. This represents an increase in admissions of more than 350 percent. However, these figures may be the tip of the iceberg because they only pertain to admissions to the 230 hospitals that are members of the National Association of Private Psychiatric Hospitals.

Our research suggests that the largest number of admissions may be in private general hospitals that have developed inpatient psychiatric and chemical dependency programs. For example, the following table depicts the admissions trends and patient days of care for juveniles admitted to Minneapolis/St. Paul area hospitals for psychiatric care between 1976 and 1984.

TABLE I—JUVENILE PSYCHIATRIC ADMISSIONS

Year	Number	Rate per 1,000	Patient days
1976	1,123	91	46,718
1977	1,062	88	53,730
1978	1,268	107	60,660
1979	1,623	142	68,949
1980	1,775	158	74,201
1981	1,745	159	72,381
1982	1,813	165	71,267
1983	2,031	184	76,899
1984	3,047	299	83,015

All of these admissions were in general hospitals. None was in the one hospital in Minnesota that is a member of the National Association of Private Psychiatric Hospitals.

Also, I would like to point out that the vast majority of these admissions were "voluntary" placements. In other words, they were not ordered by the courts. They occurred as a result of parents consenting to admit their child, often upon the recommendation of a physician.

Comparable data on admissions to inpatient chemical dependency programs for juveniles is not available. However, the indications are that the number of juveniles admitted to these programs in Minnesota increased significantly during the late 1970's and early 1980's and have leveled off in the past few years. Also, it appears that a significant number of youth in these programs come from other States.

While our formal research on the issue has been limited to the State of Minnesota, we suspect that juveniles are being propelled into these programs elsewhere. Informal contacts with representatives from the health insurance industry, specialists in health care, juvenile justice and child welfare professionals, academics and members of the media suggest that juveniles are being confined in hospitals in many other States.

The psychiatric and chemical dependency treatment industries targeted toward children and youth in Minnesota raise some important issues and policy considerations. These include:

1. The majority of inpatient psychiatric and chemical dependency placements are paid for by third party health care reimbursement. In the early 1970's, the Minnesota Legislature enacted laws that mandated insurance companies to include coverage for mental health and chemical dependency as a condition for selling health insurance in the State. Minnesota's laws were among the first of their kind and have been used as a model for the enactment of similar legislation in many other States.

Minnesota's mandatory mental health and chemical dependency health insurance laws are clinically vague and provide financial incentives favoring inpatient as compared to outpatient care. This, coupled with a need for services on the part of fami-

lies, and an excess of hospital beds, has created ideal conditions for the development of inpatient psychiatric and chemical dependency programs as well as the potential for abuse.

2. There is a need to develop more specific criteria for admission to inpatient psychiatric and chemical dependency treatment. Currently, juveniles are largely being admitted to facilities for such things as emotional disturbance, conduct disorder, adolescent adjustment reaction and attention deficit disorder. These categories imply a level of diagnostic precision that has yet to be proven empirically and allow for the exercising of virtually unbridled discretion on the part of mental health professionals.

3. There are significant legal and procedural safeguard questions that need to be explored. The overwhelming majority of the youths admitted to inpatient psychiatric and chemical dependency programs are admitted on a "voluntary" basis (not ordered by the court). More often than not, these youths are referred by their parents. However, our research, as well as examples cited by legal aid attorneys and mental health advocates, suggests that many youth are coerced into these programs. For many, it means deprivation of liberty without benefit of due process.

Some of the questions that must be addressed are: "Should parents have the absolute right to admit a child to an inpatient psychiatric or chemical dependency program against the child's will?" "Should placement in a locked psychiatric or chemical dependency program be left almost entirely in the hands of psychiatrists?" "Should juveniles be afforded due process and procedural protections?"

4. One of the principal objectives of the Federal Juvenile Justice and Delinquency Act of 1974 is the deinstitutionalization of status offenders from such secure facilities as detention centers, training schools, and adult jails. However, on-site visits to facilities, discussions and interviews with psychiatrists, nurses, and social workers, and reviews of records suggest that some of the youths being incarcerated in private psychiatric and chemical dependency programs are status offenders. Instead of truancy, running away, incorrigibility, or inability to get along with parents, these youths are admitted for such things as conduct disorders or chemical dependency. Also, there is evidence that females are being admitted to psychiatric units for promiscuity.

The intent of the Juvenile Justice and Delinquency Prevention Act was not to have status offenders removed from institutions in the justice system only to have them incarcerated elsewhere.

5. While it appears that many youths are being placed in inpatient programs unnecessarily, there are others who are being denied access to appropriate services. For example, the overwhelming majority of youth in inpatient psychiatric and chemical dependency programs are from white, middle and upper class families which have insurance coverage or are able to pay for the cost of care. In contrast, youths from poor or low income families who are in need of mental health services tend to be defined as delinquent and end up in the public child welfare or juvenile justice systems. This is particularly the case for minority youth.

6. Another disturbing factor is that allegations of abuse and questionable practices are mounting. For example, there are reports of arbitrary and capricious use of solitary confinement, verbal abuse on the part of staff, little or no work with families, inadequate amounts of time spent with patients by psychiatrists, and the incarceration of children as young as 2, 3 and 4 years old.

Mr. Chairman, our research has led us to conclude that a "hidden" system of juvenile control is developing in Minnesota and in a number of other States. It is a system that is largely unmonitored, unregulated and driven by the availability of third party health care reimbursement. Clearly, this is an issue that demands immediate attention on the part of policy makers, health care professionals, juvenile justice and child welfare specialists, public interest groups and child advocates.

Chairman MILLER. Thank you. Barbara.

Ms. DEFOE. I also want to thank you for inviting us. We really hadn't counted on this opportunity to tell our story, but, now we're here, so we'll do the best that we can.

STATEMENT OF BARBARA DeFOE, PARENT, COON RAPIDS, MINNESOTA, ACCOMPANIED BY MARISSA DeFOE [AGE 15], HER DAUGHTER

Ms. DEFOE. Our experience was rather dramatic, but I'll just tell you, as briefly as I can, what happened.

In 1984, when school was out for the summer for my daughter Marissa, she was preparing for a national bible quizzing competition in Ames, IA, that was to be held the last week in June.

Marissa is an identical twin, an A student, honor student, gymnast, concert band member, track team member, and she's classified as a gifted child. She and her twin sister had been taking all high-potential classes in school, and they were very active in the church. So she probably was under a lot of stress and pressure, because she always has a real full schedule.

On June 10, 1984, Marissa had attended a powerful antiabortion rally at church in Coon Rapids, and the next day she and her sister picketed an abortion clinic in Minneapolis, along with members of the church. She really didn't want to go, but her sister made posters, and her sister wanted her to come along. This was very upsetting for her, and she couldn't sleep.

Marissa's a very conscientious girl and it bothered her, and she began to read her bible and lost a lot of sleep.

I became concerned over her lack of sleep and I called a pediatrician that had only seen her once before for a physical. We had changed pediatricians because our other one lived so far away. I wanted a sedative to help her sleep and possibly some counseling, if she needed that to help her with these problems.

I was at work and I phoned her grandmother to come over and check on her, and her grandma came over, and Marissa decided to walk her dog. And my mother kind of overreacts to things, and she was really worried about Marissa. So——

Chairman MILLER. All of our mothers do.

Ms. DEFOE. Yes, she gets really excited.

VOICE. Let's hear it for mothers.

Ms. DEFOE. Well, she's a good grandma but she worries a lot.

So, Marissa went to the park to walk the dog, anyway, and the dog came back. Well, Marissa didn't, so grandma thought, well, maybe she's going to run away. She's all upset and she called the police. Well, I came home from work and discovered that she wasn't home, and I went over to the park and I saw her walking, so I thought, well, I'll go get her.

And, in the meantime, a police car had come along and we got to Marissa. And the policeman talked to her, and he thought she was upset, but he didn't think, you know, that she was that bad or anything.

And he gave us a ride home. When we got home, grandma came out and she said, well, the doctor's office called and they said take her to the emergency room of the hospital. The doctor'll meet you over there. So I thought, well, she's in the car and maybe this would be easier to just take her over there, so we could talk to the doctor.

Well, that's not what happened. We got to the hospital and there was a lot of confusion, but we waited for the doctor, and the doctor sent over a social worker. We have PHP insurance, and have to go through the Metropolitan Clinic of Counseling, so she sent a young girl over.

And this lady talked to Marissa for a few minutes, and she came back and said to me, I think she's preanorexic, and I disagreed with her because Marissa's always been a good eater and she was

never underweight, and I thought, well, that's just off the wall. But she was convinced that that was the problem.

Well, then a resident doctor saw her and he said that she should be admitted but he confessed that he didn't really know much about mental health and emotional problems or illness. He assured me that Marissa would get a room, be given a sedative, and receive any necessary counseling.

Well, instead, she was put in a locked adolescent psychiatric ward, along with other youths who were there for alcohol and drug abuse, and probably behavior problems. It was June 12, 1984, and Marissa was about to experience the worst nightmare of her life. She was terrified and refused oral drugs. Marissa had been taught not to take drugs and she was afraid of them.

They held her down that first night and gave her injections of Haldol. When she fought back, they placed her in solitary confinement. And that was without my permission. She still hadn't slept or seen a psychiatrist.

The next day I called the hospital and asked to talk to the psychiatrist. He still hadn't seen Marissa. Later, he called me back and said Marissa was very psychotic and that I should take a vacation and not worry and to trust him. Marissa was not allowed any visitors except myself, and then I could only see her at specific times on visiting days. It wasn't every day.

Well, I insisted on meeting the psychiatrist, and he was very arrogant and he really didn't want to see me. It was really a problem to get to see him. He told me that Marissa was so psychotic that she may never come back. He wanted to increase the drugs that she was on. I asked about the side effects, but he wouldn't tell me.

I wanted a second opinion and was told to trust him. He said to me, I'm divorced; I'm a single parent with three teenagers, and he told me that, according to the history I'd given, I had had—I'd never had any competent men in my life; therefore I didn't trust men, and would I please trust him. And I thought that was really wonderful.

This ward was set up by him, and he would never admit that it wasn't the right place for her. This program was his baby.

Marissa's condition, physical and mental, worsened daily; she became dehydrated, drool poured out of her mouth, and her mucous membranes dried up, causing her nose to bleed. She had stiff muscles, Parkinsonian shakes, no control of bladder, and she couldn't eat. Marissa had lost about 10 pounds. She could hardly function or speak and she looked as if she had suffered a stroke.

Marissa was told that if she took her drugs, she would be given a room with a bathroom and a roommate. On June 20, 1984, I made up my mind to take her out and get her off all those drugs and see for myself what I had, and then get a second opinion. I contacted Bill Johnson, a mental health advocate and told him the story, and asked him about her legal rights.

Bill wanted to see her. He and I went to the hospital armed with release papers that Bill had brought. The hospital refused to let either one of us see her, and denied us access to her medical records. They wanted 12 hours notice to release her. I refused and they brought in more staff to try and talk me out of taking her home. Well, Bill convinced them that they had better release her

to us. Then they wanted 3 hours, and he said no, we'll give you an hour.

She couldn't walk and she had to be taken in a wheelchair. Her lips and tongue were swollen and she could hardly talk or swallow. I talked to a private psychiatrist that night, and he advised us that I sit up with her all night and give her lots of fluids and high potency vitamin B pills. And to bring her into his office the next morning.

He gave her medicine to counteract the side effects of Haldol. He said he would love to work with her, but that I probably couldn't afford the $100 an hour that he charged. My insurance is an HMO physician's health plan, and they have their own clinic that we have to go to. So, then I took Marissa on June 25, to see one of their psychiatrists, and he talked to her, and he told us that, well, she probably shouldn't have been in the hospital.

He recommended seeing a child psychologist. On July 18 I took her to see a psychologist at the Metropolitan Clinic of Counseling. He thought that Marissa shouldn't have been hospitalized and said that every one overreacted and everything snowballed. This same doctor had seen Marissa and her twin sister one year before, and at that time, he said not to worry about them because they were normal, healthy teenagers, that behaved like most twins.

I thought, well, the twins do their own thing, and I thought, well, maybe they need some counseling, you know, they get kind of hyper and I thought, maybe they should see a counselor. Kind of behavior things, but, he said, "No, don't try to be a supermom; they're just fine. Don't worry about them."

So this same doctor I took her to said she shouldn't have been there.

Well, after going through all of this, and getting my daughter off of all the drugs that had been pumped into her, she was appropriately angry about the whole experience. Marissa was embarrassed and humiliated. However, she's a fighter and a strong-willed girl. She's now 15, still an A student, active in track, band, volleyball, gymnastics, cheerleading, and Bible quizzing. And Marissa has total recall of everything that happened to her.

The hospital said that she wouldn't remember any of it. I took her to see her pediatrician, and he said, thank God that I got her out when I did. And I felt that the hospital would have kept her until the insurance ran out, and this pediatrician agreed.

Last February, Marissa and her twin, Grandma, and myself, were interviewed by England's Yorkshire Television and by Australia's "Sixty Minutes." They were very interested in what is happening to our children in American adolescent psychiatric hospitals.

So I guess we're not alone. And it was an experience I would never want any other child to go through or any other parent. And I just, I can't tell you how devastating it was for us, not only in heartache, but in money, and I worried about what long-range effects this would have on Marissa. I was told by the child psychiatrist that she was fine and he really didn't think she'd have a problem.

But that was kind of a tough thing for a 14-year-old to go through.

Thank you.

[Prepared statement of Barbara DeFoe follows:]

PREPARED STATEMENT OF BARBARA DEFOE

School was out for the summer and my daughter Marissa was preparing for a National Bible competition in Ames, Iowa held on the last week in June.

Marissa is an identical twin, an "A" student, honor student, gymnast, concert band member, track team member and classified as a "gifted child." She and her twin sister had been taking all high potential classes in school and were very active in church.

On June 10, 1984, Marissa had attended a powerful anti-abortion rally at church (Coon Rapids Evangelical Free). The next day she and her sister picketed an abortion clinic in Minneapolis along with other members of the church. This was very upsetting for her and she couldn't sleep. Marissa is a conscientious girl and she began reading her Bible searching for answers.

I became concerned over her lack of sleep and called a pediatrician that had seen her only once before for a physical. I wanted a sedative to help her sleep and some counseling if it was needed. I was at work and phoned her grandma to go over and check on her. Meanwhile, Marissa had decided to walk our dog in the park. When the dog came home without her, Grandma panicked and called the police, thinking maybe she had run away. I drove home and found Marissa walking from the park. The police came by and talked to me, then they offered us a ride home. In the meantime, the pediatrician's office called and said that we should go to the hospital emergency room which was next door to her office building and she would meet us there. Instead the pediatrician sent a clinical social worker.

She talked to Marissa for a couple of minutes and said, "I think she is pre-anorexic and we should get her a room." I disagreed as Marissa has always been a good eater and was never underweight.

The resident doctor saw her and said she should be admitted but confessed he didn't know much about mental or emotional illness. He assured me that Marissa would get a room, be given a sedative and receive any necessary counseling.

Instead she was put in a locked adolescent psychiatric ward along with other youths who were there for alcohol and drug abuse.

It was June 12, 1984, and Marissa was about to experience the worst nightmare of her life. She was terrified and refused oral drugs. Marissa had been taught not to take drugs and she was afraid of them. They held her down that first night and gave her injections of Haldol. When she fought back, they placed her in solitary confinement. She still hadn't slept or seen a psychiatrist.

The next day I called the hospital and asked to talk to the psychiatrist. He still hadn't seen Marissa. Later he called me back and said Marissa was very psychotic and that I should take a vacation and not worry and to trust him.

Marissa was not allowed any visitors, except myself, and I could only see her at specific times on visiting days.

I insisted on meeting the psychiatrist. He was very arrogant and didn't really act like he wanted to meet with me. He told me that Marissa was so psychotic that she may never come back. He wanted to increase the drugs that she was on. I asked about the side effects but he wouldn't tell me. I wanted a second opinion and was told to trust him. This ward was set up by him and he would never admit that it wasn't the right place for her.

Marissa's condition, physical and mental, worsened daily. She became dehydrated, drool poured out of her mouth, and her mucous membranes dried out, causing her nose to bleed. She had stiff muscles, Parkinsonian shakes, no control of her bladder, and she couldn't eat. Marissa had lost about ten pounds. She could hardly function or speak and she looked as if she had suffered a stroke. Marissa was told that if she took her drugs, she would be given a room with a bathroom and a room-mate.

On June 20, 1984, I made up my mind to take her out and get her off all those drugs and see for myself what I had and then get a second opinion.

I contacted Bill Johnson, a mental health advocate, and told him the story and asked him about our legal rights. Bill wanted to see her. He and I went to the hospital armed with release papers that Bill had brought. The hospital refused to let either one of us see her and denied us access to her medical records. They wanted twelve hours notice to release her. I refused and they brought in more staff to try and talk me out of taking her home. Bill convinced them that they had better release her to us.

She couldn't walk and had to be taken in a wheelchair. Her lips and tongue were swollen and she could hardly talk or swallow.

I talked to a private psychiatrist and he advised that I sit up all night and give her lots of fluids and high potency Vitamin B pills and to bring her in to his office the next morning. He gave her medicine to counteract the side effects of Haldol. He said he would love to work with her but that I probably couldn't afford the hundred dollars an hour that he charged. My insurance is an HMO-Physician's Health Plan and they have their own clinic (MCC) that we have to go to.

I took Marissa on June 25 to see one of their psychiatrists. He talked to her and told us that she shouldn't have even been in the hospital. He recommended seeing a child psychologist.

On July 18, I took her to see a psychologist at the Metropolitan Clinic of Counseling (MCC). He thought that Marissa shouldn't have been hospitalized and said that everyone overreacted and everything snow-balled. This same doctor had seen Marissa and her twin sister the year before and said not to worry about them because they were healthy normal teenagers that behaved like most twins.

After going through all of this and getting my daughter off all of the drugs that had been pumped into her—she was appropriately angry about the whole experience. Marissa was embarrassed and humiliated. However, she is a fighter and a strong-willed girl. Marissa is now fifteen, still an "A" student, active in track, band, volleyball, gymnastics, cheerleading, and Bible Quizzing. Marissa has total recall of everything that happened to her. The hospital said she wouldn't remember any of it.

I took her to see her pediatrician and he said to thank God that I got her out when I did. I felt that the hospital would have kept her until the insurance ran out and this pediatrician agreed.

Last February, Marissa, her twin, Grandma, and myself were interviewed by England's Yorkshire Television and by Australia's Sixty Minutes. They were very interested in what is happening to our children in American adolescent psychiatric hospitals.

Chairman MILLER. Thank you very much. Marissa, did you desire to testify?

MARISSA DEFOE. Umm hmm.

Chairman MILLER. OK. Go ahead.

STATEMENT OF MARISSA DeFOE [AGE 15], DAUGHTER OF BARBARA DeFOE

MARISSA DEFOE. Mr. Chairman, members of the committee, I want to thank you for this opportunity to be here and testify and I hope that my testimony will benefit many other kids that might be placed in a psychiatric ward.

On June 12, 1984, I was taken to the hospital emergency room in a police car. I agreed to be taken there, but I was a little bit nervous. I didn't think I needed a physical since I was in pretty good shape from track.

While waiting at the hospital, a volunteer worker talked to me. There was a nurses strike going on and other nurses and volunteers filled in for the regular staff.

About after an hour, I was anxious to go home and I was very hungry, because I had had no breakfast or lunch that day. Then, a social worker wanted to talk to me. I was very upset and I tend to talk fast when I'm excited. This lady misunderstood my fast talking for slurred speech. I could see our discussion was getting nowhere, and I never mentioned anything to her about my weight or eating, so I don't know why that she thought I was preanorexic.

They said that I needed a room, and that I would be given lunch. A social worker took us upstairs and asked me and my mom a lot of questions. She kept asking me if I had ever been on drugs or smoked. I hadn't. She didn't seem to believe me.

I didn't know that I was on the psychiatric ward. My mom seemed a little bit shocked at the whole thing. They told my mom

to leave, and bring back some clothes for me. I was given an orange folder telling me of the hospital policies and the rules of the ward. They had a code in which you earned certain privileges if you did what they said, like taking your medicine, and you could, like, call people on the telephone if you did what they told you.

The first thing they wanted to do was to strip search me. And I refused. And that made them very angry. The people there were afraid of any sharp objects, like metal clothes hangers or string ties in sweat pants or sweat shirts. They were afraid someone would try to commit suicide.

I met some of the other kids there, that were about my age. They were smoking and one told me later that the nurses had warned them not to talk to me. One boy, named Eric, looked like a zombie. He was very heavily drugged, and I was told by the other kids that he was very intelligent, and that he had resisted their methods, so they had drugged him.

I cooperated with them until they insisted that I take oral medication. The nurse said that I was sick, but I refused it. So, later that night, five or six people came into my room, and held me down on my bed, and took all my clothes off, and put me in a hospital gown. I stiffened up so they couldn't give me a shot, and so they carried me screaming into a cold white room, and locked me in. I prayed to get out. They came back and pinned me to the floor and gave me an injection. I let them, this time, hoping that they would leave me alone.

In a few minutes, they came back with another injection, and then they left. I started to pound on the door and chant "Let me out." I tried to pick the lock with the wire on my retainer. I was really scared. About 4 or 5 in the morning, the nurse finally let me go to my room. I was very tired.

The next day, I was threatened with the drug, and I was told that if I didn't take them, I would get shots. I got lots of shots. I tried to drink lots of water to flush the medication out of my system. I overheard the nurses and therapists talking about me, and telling each other what the drugs were doing to me.

One lady didn't believe that I was psychotic, so she took me into a room and asked me a lot of questions about my family, school, and hobbies. I heard her tell the nurse that she thought I was quite normal, but the nurse reassured her that I was not.

That afternoon, I met with a doctor. I had no idea that he was a psychiatrist. He got mad at me and told me to phone my mother. The phone wouldn't work because I didn't realize that I was supposed to dial "9". Then he didn't really talk to me at all. He just took me back to my room. I didn't like him at all, when I first saw him. He was very impatient with me, and he made me feel uncomfortable. I didn't like his eyes.

I was made to go to school in groups with the other kids, and all the while, they were giving me shots. I grew more and more tired. I lost my appetite and I could hardly swallow. I asked one nurse to feed me. One night, I could barely move, must less talk or eat. A staff member threw my clothes on the floor and was angry because I didn't eat my dinner that night. I had wet my pants; I couldn't stop drooling, and my nose was clogged with dried blood.

I couldn't hardly focus my eyes to read the letter that I'd received. The nurses called up a doctor to look at me. He took one look at me and decided to take me off the drugs for a few days. So they told me to run up and down the halls and not to go to sleep. I was so sleepy that I could barely walk, much less run.

No one gave me a bath or washed my hair; there was no bathroom in my room. And I had trouble dressing myself. I couldn't take a shower because you had to keep pushing on a lever to make the water come out, and I was too weak and miserable. My mother visited me when she could. And I wanted to go home.

I couldn't believe it when the social worker said that I could go. She was angry and tried to clean up my room, and comb my tangled hair. All my clothes were wet and bloody, and she threw them in my suitcase.

My mom had a man, Bill Johnson, help to take me home. I was so happy to see my sister and brother and dog.

I went to see a psychiatrist the next day. He gave me some pills to counteract the drugs. I started to feel a little better but I was still tired, and I almost fell asleep on his couch. I had lost a lot of weight.

Later, I saw a psychiatrist in Minneapolis. He had trouble believing my story, but said that I probably shouldn't have been there. I went to see my orthodontist. He said that I was lucky that no permanent damage was done to my mouth from the drugs. He said I could have undone 2 years of wearing braces.

About 2 weeks later, I saw a counselor whom I like very much. He also said the whole thing was a big mistake, and that I had a good reason to be angry about it. He said I was fine, and I didn't have to come back.

Later, when I read my medical records, I was shocked to see the lies in it about me and about my mom. The medical records were stamped all over in red ink, and said that the patient should never be allowed to read this because it might upset them. I don't know.

My closest friends are the only ones who know about this experience. I've always been really embarrassed to tell people about it. Sometimes I have nightmares, and I will never forget the pain.

But now, at least, I know it wasn't my fault.

Thank you.

[Prepared statement of Marissa DeFoe follows:]

PREPARED STATEMENT OF MARISSA DEFOE

On June 12, 1984, I was taken to the Hospital Emergency Room in a police car. I agreed to be taken there, but I was a bit nervous. I didn't think I needed a physical, since I was in pretty good shape from track.

While waiting there, a volunteer worker talked to me. There was a nurses strike going on and other nurses and volunteers filled in for the regular staff.

After about an hour I was anxious to go home and very hungry, having had no breakfast or lunch. Then the Social Worker wanted to talk with me. I was upset and when I'm excited I tend to talk quite fast. This lady misunderstood that for slurred speech. Our discussion was getting nowhere. I never mentioned anything about my weight or eating, so I don't know why she thought I was pre-anorexic.

They said that I needed a room and that I would be given lunch. A social worker took us upstairs and asked me and my Mom a lot of questions. She kept asking if I had taken any drugs or smoked. I hadn't. She didn't seem to believe me. I didn't know that I was in a Psychiatric Ward. My Mom seemed a bit shocked by the whole thing.

They told my Mom to leave and bring back some clothes. I was given an orange folder telling me of the Hospital Policies and rules of the ward. They had a code in which you earned privileges if you did what they said.

The first thing they wanted to do was strip search me. I refused and that made them angry.

The people there were afraid of sharp objects: metal clothes hangers or string ties in sweat pants or sweat shirts. They feared someone would commit suicide.

I met some of the other kids. They were smoking and one told me later that the nurses had warned them not to talk to me.

One boy, Eric, looked like a Zombie. He was heavily drugged and I was told by the other kids that he was very intelligent and had resisted their methods.

I cooperated with them until they insisted I take oral drugs. The nurse said I was sick, but I refused. Five or six people came into my room and held me down and took all my clothes off and put me in a hospital gown. I stiffened up and they carried me screaming to a cold white room and locked me in. I prayed to get out. They came back and pinned me to the floor and gave me an injection. I let them this time, hoping that they would leave me alone. In a few minutes they came back with another injection and left.

I started to pound on the door and chant "let me out." I tried to pick the lock with my retainer. I was scared. About four or five in the morning the nurse finally let me go to my room. I was very tired.

The next day I was threatened with the drugs and told I would get shots if I didn't take the medicine. I got lots of shots. I tried to drink lots of water to flush the medicine out of my system. I overheard the nurses and therapists talk about what the drugs were doing to me. One lady didn't believe that I was psychotic and took me into a room and asked me questions about my family, school and hobbies. I heard her tell the nurse that she thought that I was normal—but the nurse reassured her that I was not.

That afternoon I met with a doctor. I had no idea that he was a psychiatrist. He was mad at me and told me to phone my Mother. The phone wouldn't work because I didn't realize that I was supposed to dial "9" first. I didn't like him from the very first. He was impatient and made me feel uncomfortable. I didn't like his eyes.

I was made to go to school and groups and all the while they were giving me shots. I grew more and more tired. I lost my appetite and could hardly swallow. I asked a nurse to feed me.

One night I could barely move, much less talk or eat. A staff member threw my clothes on the floor and was angry because I didn't eat my dinner.

I had wet my pants. I couldn't stop drooling and my nose was clogged with dried blood. I couldn't focus my eyes to read a letter that I had received.

The nurses called a doctor up to look at me. They told me to run up and down the halls and not to go to sleep. I was so sleepy I could barely walk, much less run.

No one gave me a bath or washed my hair. There was no bathroom in my room. I had trouble dressing myself. I couldn't take a shower because you had to keep pushing on a lever to make the water come out. I was too weak and miserable. My Mother visited me when she could. I wanted to go home. I couldn't believe it when the Social Worker said I could go home. She was angry and tried to clean up my room and comb my tangled hair. All my clothes were wet and bloody. She threw them in my suitcase.

My Mom had a man, Bill Johnson, help her take me home. I was so happy to see my sister and brother and dog.

I went to see a psychiatrist the next day. He gave me pills to counteract the drugs. I started to feel better but I was so tired that I almost fell asleep on his couch. I had lost a lot of weight.

I also saw a psychiatrist in Minneapolis. He had trouble believing my story but said that I probably shouldn't have been there. I went to see my Orthodontist. He said I was lucky that no permanent damage was done to my mouth from the drugs. He said it could have undone two years of wearing braces.

About two weeks later I saw a counselor whom I liked very much. He also said the whole thing was a mistake and that I had good reason to be angry about it. He said I was fine and didn't have to come back.

My closest friends know about my experience at the hospital. I've never been too embarrassed to tell anyone about it. Sometimes I have nightmares and I will never forget the pain. Now, at least I know it wasn't my fault.

Chairman MILLER. Thank you very much, Marissa.

We have a vote on over in the House Chambers, so we're going to recess for a couple of minutes. We'll come back, Dr. Egan, and hear your testimony.

[Brief recess is taken.]

Chairman MILLER. The committee will reconvene. And at this time, we will hear from Dr. James Egan, who is the chairman of the Department of Psychiatry at Children's Hospital National Medical Center, Washington.

Dr. Egan, welcome to the committee.

Dr. EGAN. Thank you. It's a pleasure to be here. And I, too, am delighted to have been asked.

STATEMENT OF DR. JAMES EGAN, CHAIRMAN, DEPARTMENT OF PSYCHIATRY, CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER, WASHINGTON, DC

Dr. EGAN. I have some very brief prepared remarks. Perhaps too brief. But I'll be happy to expand upon them, and to entertain any questions.

Considerable attention has been paid in the media and elsewhere to a number of alarming trends in the lives of our Nation's children. Among these are the increased rates of suicide, substance abuse, out-of-wedlock pregnancy, delinquency, accidental deaths, declining academic standards, school dropouts, physical and sexual abuse, to name just a very few.

Paralleling these phenomena are corresponding increased rates of admission to psychiatric hospitals, and juvenile justice facilities. In spite of these increased utilization rates, the Children's Defense Fund estimates that, and I quote,

> At least two-thirds of the three million seriously disturbed children and adolescents in this country who need mental health services, do not get them.

From some of the preceding testimony, it seems clear that confusion exists everywhere, regarding the scope of the problem and its nature. Let me attempt to try and set a few of the confused areas straight.

One. Rates of admission to adolescent psychiatric in-patient treatment units are up because there are more impaired adolescents. In addition—and this is, perhaps, the most important thing I will say—the percentage of adolescents with significant problems can be expected to continue to rise sharply in the future.

Two. It is well established that antisocial children and delinquent adolescents are frequently served by both the mental health and juvenile justice systems, and that factors that affect entrance into or egress from one system, will correspondingly impact upon the other.

Three. Decisions for admission of children and adolescents for inpatient psychiatric treatment, are based upon severity of functional impairments, rather than upon diagnoses, since diagnoses are poorly correlated with the degree of impairment, or the need for, or length of, inpatient treatment.

I would parenthetically state that merely having an anemia does not justify admission to a medical unit; on the other hand, if you have a profound anemia, it does. Ditto hepatitis, ditto pneumonia, ditto a variety of other disorders. It's not the diagnosis that drives

the admission, but the severity of impairment that's subsumed under that diagnosis.

In addition, inpatient treatment is recommended only when a lesser level of care will not be effective, or is not available. To that end, a full range of psychiatric services would include inpatient and partial hospitalization programs, day and evening hospitalization, as well as residential treatment centers, and long term—meaning 6 months to 2 years—of psychiatric hospitalization for those few who need them and are likely to benefit from them.

In addition, some children and adolescents will need therapeutic foster care, group homes or halfway houses. When a lower level of care is not available, frequently a more intensive and costly level of care will be employed.

Four. There are many levels of review of the appropriateness of such admissions to facilities, including the quality assurance programs at those institutions, which are mandated by the Joint Commission on the Accreditation of Hospitals. In addition, there are peer review programs run by the American Psychiatric Association that are currently used by more than 25 fiscal intermediaries, including CHAMPUS, that review, retrospectively, or concurrently, the appropriateness of quality of care.

Plans are currently underway, and guidelines have been established by the American Psychiatric Association—which I was not at liberty to include in the packet, for the moment—for the preadmission certification process. Which is to say that physicians will have to justify, prior to admission, or within 24 hours of admission in the case of an emergency, the appropriateness of that admission.

Finally, some abuses do exist; and the previously mentioned efforts are aimed at reducing abuses of inpatient treatment.

I would offer one, not well documented, but I think, informed, speculation, that a disproportionate number of such abuses—not unlike some that we've heard today—I think occur at other than psychiatric facilities. I think they occur disproportionately at free standing, special substance abuse treatment facilities, for example.

Thank you, Mr. Chairman.

[Prepared statement of Dr. James Egan follows:]

PREPARED STATEMENT OF JAMES EGAN, M.D., CHAIRMAN, DEPARTMENT OF PSYCHIATRY, CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER AND PROFESSOR OF PSYCHIATRY AND BEHAVIORAL SCIENCES AND OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON SCHOOL OF MEDICINE

Considerable attention has been paid in the media and elsewhere to a number of alarming trends in the lives of our nation's children. Among these are the increased rates of suicide, substance abuse, out-of-wedlock teenage pregnancy, delinquency, accidental deaths, declining academic standards, school drop-outs, physical and sexual abuse, to name a few.

Paralleling these phenomena are corresponding increased rates of admission to psychiatric hospitals, and juvenile justice facilities. In spite of these increased utilization rates, the Children's Defense Fund estimates that "At least two-thirds of the three million seriously disturbed children and adolescents in this country who need mental health services do not get them."

It seems clear that confusion exists everywhere regarding the scope of the problem and its nature. Let me quickly try and set the record straight.

1. Rates are up for admission to adolescent inpatient psychiatric treatment units because there are more impaired adolescents. In addition, the percentage of adolescents with significant problems can be expected to continue to rise sharply in the future.

2. It is well established that antisocial children and delinquent adolescents are frequently served by both the mental health and juvenile justice systems, and that factors that affect entrance into or egress from one system will impact upon the other.

3. Decisions for admission of children and adolescents for inpatient treatment are based upon severity of functional impairments rather than diagnoses, since diagnoses are poorly correlated with the degree of impairment, or need for or length of inpatient treatment. In addition, inpatient treatment is recommended only when a lesser level of care will not be effective or is not available. To that end a full range of psychiatric services would include acute inpatient and partial hospitalization programs (Day and Evening) as well as residential treatment centers and long-term (six months to two years) psychiatric hospitalization for those few who need them, and are likely to benefit from them. In addition, some will need therapeutic foster care, group homes, or halfway houses. When a lower level of care is not available, a more intensive and costly level of care will frequently be employed.

4. There are many levels of review of the appropriateness of such admissions including quality assurance programs at the institutions which are mandated by the JCAAH. In addition, there are Peer Review programs run by the American Psychiatric Association that are currently utilized by the fiscal intermediaries for concurrent or retrospective review of the appropriateness of and quality of care. Currently more than 25 insurance companies in addition to CHAMPUS have contracts with the APA for such Peer Review.

5. Plans are underway for the American Psychiatric Association to provide Pre-Admission Review for the appropriateness of admission to psychiatric units.

6. Some abuses do exist and the previously mentioned efforts are aimed at reducing abuses of inpatient treatment.

COMMITTEE PEER REVIEW OF THE AMERICAN ACADEMY OF CHILD PSYCHIATRY

CRITERIA FOR UTILIZATION REVIEW OF CHILD/ADOLESCENT PSYCHIATRIC TREATMENT

I. Short-term—Less than 30 days:

II. Inpatient setting:

III. Pre-admission criteria—criteria appropriate to justify admission to an acute short-term hospital (less than 30 days) for comprehensive psychiatric evaluation and/or treatment. There must be present two or more of criteria A–G.

A. Acute disabling symptoms, such as: impaired reality testing, disordered or bizarre behavior, psychotic organic brain syndromes, depression, anxiety, hysteria, conversion, disassociation, depersonalization, somatization, phobia(s), compulsion(s), hypochondrias, insomnia, over/underactivity, eating disorder.

B. Acute danger to self to others or to property (attributable to primary psychiatric disease, based on preadmission evaluation).

C. Failure of other treatment program.

D. Medical necessity for diagnostic procedures available only in a hospital, such as: special drug therapy, continuous skill psychiatric observation or treatment, etc.

E. Medical necessity for structured environment or critical intervention available or possible only in an inpatient hospital setting.

F. Psychiatric disorder significantly complicating evaluation and treatment of physiological illness.

G. Severely impaired social or family, educational or vocational, or developmental functioning.

IV. Concurrent review criteria—Specific justification required if:

A. Absence of physician's note within 24 hours of admission documenting reasons for admission and initial problem formulation, treatment goals, and treatment plan.

B. Absence of physician's progress note more than every third day.

C. Absence of daily nursing care note by RN.

D. Absence of individual or group medical psychotherapy five times a week. (Defined in the 1980 edition of the AMA current procedural terminology).

E. After seven days, absence of assessment of family or meaningful adults or community agencies resulting in problem formulation, treatment goals and treatment plan.

F. After seven days, absence of appropriate educational or vocational evaluation resulting in problem formulation, treatment goals and treatment plan.

G. After fourteen days, absence of appropriate educational or vocational program.

H. After fourteen days, absence of comprehensive psychiatric evaluation resulting in comprehensive summary of patient's strengths and developmental needs, problem formulation, treatment goals, and treatment plans such as:

1. Impairment of interpersonal, familial, occupational or academic functioning and/or normal developmental progress.

2. Comprehensive evaluation including, but not limited to:

a. History of present illness and previous psychiatric treatment;

b. Relevant family history;

c. History of physiological health, illness, and treatment;

d. Assessment of current physiological functioning, including physical exam;

e. Developmental history;

f. Psychosocial assessment of family or family surrogates and related community resources;

g. Psychoeducational assessment;

h. Appropriate psychological testing;

i. Description of assets as well as problems in functioning in various roles and settings;

j. Mental status exam.

3. Diagnosis on DSM-III, Axis I or II.

I. Absence of age-appropriate daily recreational/activity therapies.

J. Absence of neuroleptic medication in patients who have exhibited significant psychotic symptoms (see letter Q), for a period greater than 10 days, except in the presence of significant uncontrollable side-effects with multiple drugs.

K. Absence of psychostimulant medication and attention deficit disorder with hyperactivity, except in the presence of significant side-effects with multiple drugs.

L. Use of more than two psychotropic medications at one time.

M. Change of psychotropic medications (not dose) more than twice in a seven day period.

N. Use of sedatives or hypnotics more than seven days at a time or in the presence of significant side-effects.

O. Use of ECT or adversive behavior modification, or use of restraints or seclusion for more than 6 hours.

P. Use of neuroleptic medication (major tranquilizers) by any route:

1. In absence of target symptoms, i.e., thought disorder, positive psychotic symptoms, such as bizarre behavior, aggressiveness, sleep disorder, or hyperactivity; or

2. In the presence of significant side-effects or;

3. When target symptoms have not improved after a ten day trial at adequate dose level of a particular drug.

Q. Use of IM psychotropics (except long-acting):

1. For more than seven continuous days or;

2. In the presence of significant uncontrollable side-effects.

R. Use of anti-depressant medication:

1. In absence of target symptoms such as: school phobia, enuresis, night terrors, major depression, or complex compulsive or phobic symptoms or;

2. In the presence of significant side-effects or;

3. When target symptoms have not improved after a 21 day trial at adequate dose level of a particular drug.

S. More than 60 minutes of individual medical psychotherapy or 120 minutes of group or family medical psychotherapy in one day.

T. Use of psychostimulant medication, (except in an attention deficit disorder or narcolepsy):

1. In the presence of significant side-effects;

2. When target symptoms have not improved after a ten day trial at an adequate dose level of a particular drug.

U. Concurrent use of three or more medications with anti-cholinergic effects.

V. Death from any cause.

W. Suicide attempt.

X. Elopement or leaving against medical advice.

Y. Readmission within 30 days, except as a planned transfer between treatment facilities.

V. Defined time frames for diagnostic evaluations and therapeutic interventions—(Contained in Concurrent Review Criteria):

VI. Program/facility standards—(Contained in Concurrent Review Criteria):

VII. Qualifications of provider—Must be Board eligible or Board certified psychiatrist with Child Training or experience during residency training period.

National Association of Private Psychiatric Hospitals

CHILD PSYCHIATRIC HOSPITALIZATION

The treatment of children in a psychiatric in-patient program is a significant and essential component of comprehensive mental health services to children and adolescents. However, the contributions of this essential program to the treatment of seriously mentally ill children is often poorly understood by non-psychiatric health care providers who do not differentiate it from residential treatment programs.

The absence of appropriate child psychiatric hospital settings does not allow effective and intensive treatment of seriously disturbed youth in a safe environment increasing the morbidity and risk of harm to the patient.

In the following brief report, we highlight the differences in the setting, characteristics of the patient population served and the role of child psychiatrist in four different types of the facility:

A.—Acute care, short-term in-patient unit program.
B.—Intermediate-term in-patient units.
C.—Long-term in-patient units.
D.—Psychiatric residential treatment programs.

A—SHORT TERM IN-PATIENT PROGRAM

1. *The setting.*—The short-term in-patient programs provide for systematic observation, evaluation and treatment planning for acutely disturbed youths who are responding to an extreme crisis situation by personality disintegration, functional deterioration, self-destructive behavior or other forms of disturbed behavior. The dedicated short term in-patient units provide comprehensive and intensive treatment for the child and his family, utilizing multiple treatment modalities. When the care for the acute psychiatric disorders is provided in beds scattered throughout a general hospital, the program is more diagnostically oriented and lacks the capability to intervene therapeutically with highly disturbed and self-destructive youths.

2. *Patient characteristics.*—The patients treated in a short term in-patient unit suffer from extreme response to a crisis situation by functional deterioration in their adaptive capacity. However, the recent origin of the disorder will allow the child and his family to reconstitute their capacities sufficiently within 60 days to continue their psychiatric treatment in a lower level care facility. A relatively stable family and social situation is necessary for treatment to be successful.

3. *The role of child psychiatrist.*—The role of the child psychiatrist in a short term hospital setting is one of a primary care physician, leader of the treatment team and responsible for the functioning of the mental health team. As a primary care physician, he provides the patient with intensive diagnostic and therapeutic care including individual and family therapy, pharmacotherapy and often group therapy. When acute care is provided in beds scattered throughout a general hospital, the role of the child psychiatrist is limited to a diagnostician, treatment planner and primary care provider while guiding the hospital staff with the psychiatric care of the patient.

B—INTERMEDIATE TERM IN-PATIENT UNITS

1. *Setting.*—The intermediate term units provide evaluation and treatment of sub acute emotional disorders which require an extended intensive psychiatric treatment for a period exceeding 60 days but less than two years in duration. The setting is similar to short term in-patient units with a higher level of educational and recreational capabilities.

2. *Patient characteristics.*—The disorders of the patients is subacute and of long enough duration to compromise their adaptive and functional capacities to the point requiring a relatively long period of hospitalization before they can regain their capacities sufficiently to continue treatment in a lower level care facility. Often the family and social setting requires substantial modification to accommodate the needs of the patient after discharge.

3. *The role of child psychiatrist.*—The role of a child psychiatrist is provision of intensive primary care, continued treatment planning, leadership and supervision of the mental health team in a manner similar to the short term in-patient units although the psychiatric treatment is usually less intensive in an intermediate care unit.

C—LONG TERM HOSPITALS

1. *Setting.*—The setting and staffing is similar to the intermediate care units.

2. *Patient characteristics.*—The population is very heterogeneous representing a broad range of chronic psychiatric and neurobiological disorders which has interfered with the patient's emotional development and object relation capacity. Therefore, the patient can only relate to highly trained and specialized treatment staff under the supervision of a child psychiatrist. Furthermore, the peer relationship in the hospital can only be achieved with the assistance of psychiatric treatment staff. Because of the limitations in the child's functional capacities, family and social supports are not sufficient to manage this patient at a lower level of psychiatric treatment (out patient or partial hospitalization).

D—RESIDENTIAL TREATMENT CENTERS

1. *Setting.*—The residential treatment centers treat a homogeneous population of disturbed children. Although the patient population is sufficiently disturbed to require a total treatment program, their homogeneity facilitates peer group relationship, requiring a less intensive therapeutic intervention by a less specialized mental health team.

2. *Patient characteristics.*—The capacity for object relation is sufficiently present to allow peer relationship as well as the capacity to form alliance with trained mental health professionals. Often there are limitations in the family and social support system that have not been responsive to intervention. The needs of the child exceed the capabilities of available family system and lower level support services.

3. *The role of child psychiatrist.*—The role of a child psychiatrist is one of leadership of the mental health team for treatment planning and multi-modal psychotherapy. The daily psychotherapy is necessary but can be carried out by trained mental health professionals under psychiatric supervision.

[FROM INTRACORP]

THE ADMISSION CERTIFICATION

Now there's an inexpensive way to reduce admissions to acute-care hospitals.

What is it?

Pre-Admission Certification is the process in which an Intracorp Medical Review Specialist evaluates the treating physician's request for a non-emergency, inpatient admission to an acute-care hospital against established medical criteria, to determine the medical necessity and appropriateness of inpatient stay and proposed treatment plan.

This evaluation assures that only patients with medical need for hospitalization are approved for admission; that proposed treatment is customary for the diagnosis and that opportunities for treatment to be received in more cost-effective settings will be identified—settings that neither sacrifice quality of treatment or anticipated result.

If the criteria for inpatient hospitalization are not met, a local Intracorp Physician Advisor with the appropriate medical specialty will review the case and make a recommendation for approval or denial. Our Medical Review Specialist then communicates the findings to the treating physician, patient, hospital and customer.

How it works—Here's how Pre-Admission Certification works, step by step:

Attending physician contacts Intracorp—When the attending physician recommends admission to the hospital for non-emergency elective procedures, the patient or family informs the physician that Pre-Admission Certification by Intracorp is required.

The attending physician completes the Medical Review Request form and mails it to Intracorp, or calls Intracorp with the required medical information and then submits the form. In case of emergency admissions, it is the responsibility of the physician, patient, or patient's family to contact Intracorp by telephone within 24 hours, or by the next working day if admission occurs over a weekend.

Intracorp evaluates the data—Next step, an Intracorp Medical Review Specialist reviews the medical information on the Medical Review Request form and evaluates it against established medical criteria, to determine the medical necessity and appropriateness of inpatient admission and the proposed treatment plan.

Is the proposed treatment customary for the diagnosis? Is it necessary for the patient to be admitted to an acute-care hospital to receive the treatment? Or could the proposed treatment be delivered in a more cost-effective setting without any sacrifice in quality of treatment or anticipated result? For instance, in an outpatient clinic, doctor's office or ambulatory surgical center.

If criteria are met—If the information available meets medical criteria, Pre-Admission Certification is granted, and Intracorp so notifies the attending physician, patient or family, hospital and customer.

If criteria are not met—If medical criteria are not met, the Intracorp Medical Review Specialist refers the case to an Intracorp Physician Advisor of the appropriate medical specialty.

Physician Advisor reviews the case—If after reviewing all of the available medical information the Intracorp Physician Advisor determines the admission is medically justified, the Pre-Admission Certification is granted. This determination is communicated by Intracorp to the attending physician and all concerned.

But if the Physician Advisor questions the medical necessity of the admission, the attending physician is contacted to discuss the case.

If Physician Advisor recommends against admission—After talking with the attending physician, if the Physician Advisor determines the admission is still not medically justified, a recommendation is made for denial of admission. This is then communicated to the attending physician, who may agree with the evaluation and alter the plan of treatment, in which event a decision against admission is made and all parties are notified.

What if attending physician disagrees?—Then the case must be referred to a second Physician Advisor of the appropriate medical specialty.

Second Physician Advisor consults—After reviewing the same medical information available to the original Physician Advisor, the second Physician Advisor may contact the attending physician, and will then make a determination as to the medical necessity of the admission to the acute-care facility.

A decision is made—If the second Physician Advisor agrees with the attending physician, the recommendation is made to approve the admission. But if both Physician Advisors disagree with the attending physician, the recommendation will be for denial. Whatever the decision, it is made quickly and all parties are notified by Intracorp. If there is a recommendation for denial of hospitalization the patient may still decide to enter the acute-care hospital, realizing that benefits may be reduced depending upon the employer's plan design.

When conducted by phone, Pre-Admission Certification can be granted on the same day the request is received. An additional day is required for each Physician Advisor review, if necessary.

As an insurer, you benefit from Pre-Admission Certification in the savings that result from reduced admissions to acute-care hospitals.

As an employer, you benefit from the overall cost reduction in your company's medical utilization and associated expenditures resulting from fewer acute-care hospital admissions. You know that the dollars available for your company's benefit programs are being spent wisely and efficiently without sacrificing quality of care.

Most important of all, employees are spared unnecessary pain and anxiety of needless medical procedures and hospital stays.

For maximum savings, include Continued Stay Review in the package. Intracorp offers Pre-Admission Certification with Continued Stay Review as a combination package that evaluates both the appropriateness of the admission and length of stay.

Contact your nearest Intracorp Office or call toll-free 800-345-1075. In Pennsylvania, Alaska or Hawaii, call collect 215-687-9450. Or write: Intracorp, 985 Old Eagle School Road, Wayne, PA 19087.

CONTINUED STAY REVIEW

Now there's a way to shorten costly hospital stays without compromising quality of treatment or results.

What is it?

Continued Stay Review—is an off-site medical review process conducted by telephone with the treating physician at designated intervals until discharge occurs. Using established medical criteria and length of stay norms, Intracorp determines the medical necessity and appropriateness of both the treatment plan and inpatient stay.

The purpose of Continued Stay Review is to assure that only patients with a medical need for hospitalization are certified to remain as inpatients; and that the treatment plan is customary for the diagnosis.

How it works—Here's how Continued Stay Review works, step by step, after the attending physician admits the patient to the hospital:

Intracorp notified of admission—Continued Stay Review begins when Intracorp is notified by phone that the patient has been admitted to the hospital. This notifica-

tion comes from either the patient, the patient's family or the attending physician within 24 hours or on the first business day following weekend admissions.

Intracorp contacts treating physician—Immediately on learning of the admission, an Intracorp Medical Review Specialist informs the treating physician that Intracorp has an agreement to perform a Continued Stay Review on the case and request comprehensive medical information on the patient's objective clinical status and the physician's treatment plan.

Medical information evaluated—After careful evaluation of the patient's medical situation and the physician's treatment plan against established medical criteria, the Intracorp Medical Review Specialist makes a determination on the medical necessity of inpatient hospitalization.

If continued stay is certified—If medical criteria are met, the Intracorp Medical Review Specialist certifies continued stay and establishes the date on which the next contact should be made with the treating physician for subsequent review.

A precise formula is used to establish the date of the next contact based on the patient's clinical situation and length of stay norms for the geographic area in which the patient is receiving treatment.

Additional stay certified—On the date established for the next Contined Stay Review, Intracorp's Medical Review Specialist once more contacts the treating physician for an update on the patient's progress, treatment and discharge plans. If medical criteria continue to be met, additional days of continued stay appropriate for the individual patient's needs are certified and the date for the next review is established with the treating physician.

If criteria are not met—If after carefully reviewing the information from the treating physician medical criteria for continued stay are not met, the case is referred to an Intracorp Physician Advisor of the appropriate medical specialty. This can occur during the initial or any subsequent reviews of the admission.

Physician Advisor decides case quickly—After reviewing all available information, the Physician Advisor can recommend approval of continued stay, in which case the treating physician is immediately notified and advised of the date for the next review by Intracorp.

If the Physician Advisor questions the medical necessity for continued stay, and feels that denial should be recommended, the treating physician is contacted and the case discussed. The treating physician may agree with the recommended denial and arrange for discharge of the patient.

If treating physician disagrees—In a situation where the treating physician disagrees with the Physician Advisor's recommended denial of continued stay, a second Physician Advisor of the same medical specialty will be called in to decide the case, either agreeing with the treating physician or the first Physician Advisor's recommendation for denial.

Prompt notifications are made both in writing and by phone to the patient, treating physician, hospital and customer if there is a recommendation of denial.

Basic review process continues until discharge—And so the basic review process is repeated at designated intervals until the patient is discharged or until criteria are no longer met.

Time frame—Conducted by phone, Continued Stay Review is usually determined the same day the Intracorp Medical Review Specialist talks with the treating physician. If Physician Advisors are consulted, their opinions are usually given the same day or within 24 hours. Intracorp makes every effort to expedite the process to achieve maximum savings for the customer.

How you benefit—As an insurer, you benefit from Continued Stay Review in the savings realized from fewer "bed days" in acute-care hospitals.

As an employer, you benefit from fewer lost working days caused by unnecessary extra time in the hospital.

The patient benefits by getting to come home promptly, something few will object to.

For maximum savings, include Pre-Admission Certification in the package. Intracorp offers Pre-Admission Certification with Continued Stay Review as a combination package that evaluates both the appropriateness of the admission and length of stay.

For more information—Contact your nearest Intracorp Office or call toll-free 800-345-1075. In Pennsylvania, Alaska or Hawaii, call collect 215-687-9450. Or write: Intracorp, 985 Old Eagle School Road, Wayne, PA 19087.

Chairman MILLER. Thank you. Gerry, you have questions?

Mr. SIKORSKI. Yes, please. Thank you, Mr. Chairman, Ira. It seems to me that the focus of attention at CBS and the others has

been on inappropriate admissions, such as that described in Marissa's testimony this morning—people that just made it through any screening process that exists. What are the numbers? What percentage of those that are admitted would you say are inappropriate?

Mr. SCHWARTZ. I'll give you a conservative estimate that came from representatives of the insurance industry in the State of Minnesota. At least 50 percent of the admissions in this inpatient psych and CD programs for juveniles were inappropriate.

Mr. SIKORSKI. Fifty percent?

Mr. SCHWARTZ. At least 50 percent. Now, that's what the insurance company people tell me. I suspect it's probably higher. Based on the research that we've done, the medical records that we've reviewed, and also looking at the rate of denial of reimbursement that Blue Cross and Blue Shield for example, which I think has really assumed some leadership in trying to look at those cases very carefully.

Mr. SIKORSKI. That's an incredible number.

Mr. SCHWARTZ. That's correct. And I think it's based on——

Mr. SIKORSKI. Many millions of dollars, and nationwide that probably stretches into the hundreds of millions of dollars.

Mr. SCHWARTZ. Well, I'm looking at the estimates, at least in the State of Minnesota. I don't know what the scope of the problem is, for example, in California or Texas or other States, but my contacts indicate that this is growing elsewhere.

When we've looked at individual cases, what we have found—and I think the doctor really put his finger on a very critical element, here—and that is, has there been appropriate other community based or lesser levels of care provided or made available. And what often happens is that, first of all, many parents are not advised to seek a second opinion, so prudent kind of practices that we'd exercise if we had a serious physical problem are not always utilized, or consumers are not really informed of what options they have.

Second of all, many community-based alternatives are not fully utilized. That certainly is the case in the State of Minnesota. And, in looking at the records, what we have found is that many cases appear in the units and they may have had some counseling or some community-based programming, but there are lots of other options that could have been available that are much less intrusive that are not utilized.

I had a meeting with the Minnesota Association of Child Psychiatrists to talk about this issue, and one of the things that came up was the fact that juveniles were spending twice as long in these units as were adults. And I'm not really aware of much clinical evidence showing that the juveniles are twice as sick as adults or that it takes twice as long to cure them.

So, I asked what, you know, what was the issue here. And one of the problems that came up was that they said that many of these young people could not go home because they felt the home situation was detrimental. While that may in fact be the case, we're still spending $250 or $300 a day to house these young people in a hospital when in fact they could have been with a relative or in a foster home, or a shelter care facility at much less cost.

So I think there's a lot of dimensions to this that raise some serious issues.

Mr. SIKORSKI. How about the numbers? You said 2, 3 and 4-year olds were placed in institutionalized care?

Mr. SCHWARTZ. That's correct.

Mr. SIKORSKI. Emotional?

Mr. SCHWARTZ. Yes.

Mr. SIKORSKI. What are the numbers there?

Mr. SCHWARTZ. Every year, for the last 5 or 6 years—and this is just the figures from Blue Cross and Blue Shield, that we worked with very closely and have been very helpful—there have been anywhere from 20 to 25 people under the age of 5 years of age that have shown up in inpatient psychiatric units, that they have paid out reimbursement for.

Blue Cross and Blue Shield of Minnesota only insures 25 percent of the population in the State of Minnesota. They're the largest insurance carrier, but, you know, there are still others that are available in the State. And so that is happening.

We were stunned to find out about that, but nonetheless, it is going on.

Mr. SIKORSKI. I'd like to thank Marissa and her mother for coming. The chairman and I just took Marissa over and showed her another institution, the House of Representatives, during the vote. Some have said there's no adult supervision here.

The concern I have is that Barbara acted as a concerned mother and parent, and I've been in this situation before with family members and friends. It's a tough issue; the denial system surrounding chemical dependency and emotional difficulty is strong. A pathology exists within the family, within the community, and within our neighborhoods to deny that a problem exists, or a problem of the magnitude warranting some outside assistance, exists.

It's the nature of the disease or the illnesses with which we're dealing. And I'm sympathetic to the parents who, faced with this tough situation, need assistance, and when they reach out we're saying that the nature of the care, the delivery system, or the structure of that delivery system is such that there's almost a great push for institutionalization, instead of something that's more appropriate.

Mr. SCHWARTZ. I think that's true. And, also, many parents were frustrated, don't know what is available in the community. And I think that, you know, frankly, hospitals with declining admissions and shortened lengths of stay, are looking around for business. And that's why you turn on TV in Minneapolis and there's advertisements all over for hospitals advertising chemical dependency treatment.

And some of the ads, by the way, I think are really designed to seduce parents to turn their children over to the hospitals. There's one—just a 10-second ad—by Compcare that I think is particularly effective. It starts out as an infant, and this infant becomes a teenager over a series of photographs, and the last two photographs are mug shots.

And it says, if your child is having problems with drugs or alcohol, call the care unit.

Well, you know, I mean, here's an out for a family who suspects or they know that their child may be having problems. And unfortunately, it's a very drastic form of care, and these ads are very appealing. And parents don't always know what other options they have available.

Chairman MILLER. What extent do we—and Dr. Egan, I'd be interested in your considering it—make almost a self-diagnosis, as a family unit. There's a diagnosis by, it appears in a number of these cases, by a parent or the parents, or maybe parents and children. It occurs when one of the members of the family is acting out in such a fashion that they can't be controlled. The instinctive response is to sign up for what has been broadcast as the answer to your problems.

And it seems to me that, from what little I know at this point, and as it appears on the TV screen, that the message is to bring your child in and we'll take him. It's sort of like getting your car repaired. No fuss, no muss. Show up at the care unit if you have insurance or means to pay. It's almost as if the only diagnosis you need is that the parent says, I want my child placed here.

Is that as simple as I make it out to be?

Mr. SCHWARTZ. I think that's part of it, but it's also even a bit more subtle. For example, one of the hospital facilities has a staff member that goes out and meets with teachers in the schools to talk about their services. And they offer a free diagnosis.

Sometimes they take teachers out to lunch. Well, nobody takes teachers out to lunch. And so, you know, they talk about their services and what they have available and if a child is falling behind in school, for reading or their attention span is short, or they're hyperactive, this is a service that's available.

And so, as one might expect, a lot of the referrals happen through parents who—because of contacts with teachers who've had access to some of these outreach folks, end up making referrals. And it's paid for free, in effect, because it's paid for by your private health care insurance. There's a lot of ways that this happens. And we're finding that, curiously, too, as I said, the vast majority of the young people who enter these facilities are white middle class youth.

Chairman MILLER. Let's see if we can separate the issue. I assume that you're not stating that the coverage, in and of itself, is improper?

Mr. SCHWARTZ. No, I——

Chairman MILLER. That the Minnesota law, in this case, or other State laws that require mental health services, is improper?

Mr. SCHWARTZ. I think our law in the State of Minnesota is deficient, and I think there is some recognition that the law is wide open and does allow for fiscal incentives that largely favor inpatient——

Chairman MILLER. I understand the issue is inpatient versus outpatient. But the coverage is quite proper. The question remains, though, whether that coverage allows for proper diagnosis or protection of the patient.

Excuse me. Dr. Egan?

Dr. EGAN. It seems to me, Mr. Schwartz, you confuse several issues. And, I presume, unintentionally. One is chemical dependen-

cy facilities versus psychiatric facilities; and inappropriate admissions for chemical dependency versus psychiatric.

In your testimony, I read nowhere near 50 percent Blue Cross disallowal. I read 20 percent. I mean that's an almost threefold distinction from your written and oral testimony.

Second, I think to make an inference from disallowal to the notion that it's inappropriate admission, is naive. Very candidly, the people paying the bills would like to reduce their costs. And traditionally what they do is they say, let me see your last 10 Blue Cross patients, if it's a Blue Cross audit, and diligently look to see that a doctor's signature has not accompanied a note, or some faulty technical documentation.

And then say, aha, 2 of the 10 charts failed to meet adequate technical documentation standards; therefore, we will disallow 20 percent of the claims of that institution. That's rather standard procedure. I certainly think that the records ought to be technically excellent, and I certainly wouldn't in any way defend poor records, but I think to go from the notion that necessarily a disavowal means that the treatment was inappropriate, is a leap that you've so far not demonstrated the evidence for.

Mr. SCHWARTZ. Could I make a comment on that?

Dr. EGAN. Sure.

Mr. SCHWARTZ. I didn't mean to make the two connections. I think the question I responded to was what proportion of the cases might be inappropriate. And the estimates from the Blue Cross and Blue Shield people in the insurance industry, as well as some others, have estimated that perhaps at least 50 percent of the current admissions are unnecessary and could benefit from other forms of outpatient care.

The growing amount of denial of reimbursement was another indicator of the fact that there are cases that are entering that are medically unnecessary. I'm glad you pointed that out.

Dr. EGAN. Let me, if I could, just say one other thing. The American Psychiatric Association and the Academy of Child Psychiatry are terribly concerned about this. The American Psychiatric Association has the most finely tuned and well developed peer review system of any medical specialty.

Currently, as I say, 25 separate major carriers, Aetna, Prudential, Money, CHAMPUS, a number of the Blues, because they go by States, utilize those services precisely to get some professional support in disallowal or evaluation of those kinds of abuses, when, and if they occur.

Needless to say, that's something of a political dilemma for the profession, since here we have very strong policing action within the profession which, when it's effective, in fact does hit the pocketbook of the profession; and notwithstanding that, we have rather forcefully pushed that through. I am one of the two child psychiatrists that up until 3 weeks ago, when my term was up, was on the peer review committee of the American Psychiatric Association.

So, we're working very hard to try and correct some of these abuses. And I think they do occur; but, if you'll permit, I think your estimates are grossly exaggerated, at least for psychiatric units.

Chairman MILLER. Barbara and Marissa, let me ask you a question. Since you've gone through this experience, and you are obviously familiar with it, to what extent did you determine that either there are other young children being placed in these facilities or other families? Have you come across it with respect to your neighbors, your friends, or schoolmates?

MARISSA DEFOE. Yes. There's a girl that lives in back of me, and she was in at the same time I was. And there's another boy that I met, and he's been there several times. You know, and they've told me like some of their experiences that happened to them, where they locked them up or put them in straitjackets, and gave them drugs.

Dr. EGAN. Could I ask if that's a psychiatric hospital?

MARISSA DEFOE. Yeah, well——

Chairman MILLER. I believe it's a general hospital.

Dr. EGAN. It's a general hospital with a——

MARISSA DEFOE. With a psychiatric ward.

Ms. DEFOE. But they also have a——

Dr. EGAN. Chemical dependency program.

Mr. SIKORSKI. It's an adolescent program for both, and that's why it's a little difficult to make the distinction that you made, because many of these units, as I understand it, function for both psychiatric and chemical dependence.

Dr. EGAN. Does it have full-time psychiatric 24-hour round the clock psychiatric services?

MARISSA DEFOE. Umm hmm. It does.

Chairman MILLER. Dr. Egan, let me ask you this question. We see these units that spring up and they appear to be part of a general hospital, private hospital, public hospital, what-have-you. In the case of the San Francisco Bay area, it appears that hospitals built somewhat aggressively a few years ago, and now find out that they have a wing or a floor that they simply don't use because of the changes in the way we now deliver care.

Are we talking about a freestanding unit that contracts for that space and is left to their own? Because, obviously, in their television advertising, they're utilizing the name of a well-respected, well-known community based facility where their unit is.

Dr. EGAN. Yes.

Chairman MILLER. But what is being suggested here, and I think the distinction you might be drawing, Doctor, is that this is a separate service, than you might find in a general hospital where psychiatric services are one of the services of that hospital. This is a freestanding clinic within that hospital that is contracting for space, or renting under some other financial arrangement, but which may not provide the same kind of screening process or care or peer review that you say we should expect. Is this the case?

Dr. EGAN. You've stated it perfectly. You've stated it perfectly. There are a number of programs that, in fact, do just as you say. Hire space, use the name for merchandising. No question about it. Some of them are very good. Merely because they have that fiscal relationship, it does not automatically indict them. Some are not so good.

Chairman MILLER. What's the practice of a hospital that allows their name to be used? Obviously the consumer believes that this is

a function of hospital A or hospital B, which has a reputation of some sort in that community, and in fact what you really have is a freestanding operation under the roof of that hospital?

Dr. EGAN. I think you raise a very important question. I have no defense for that. What I would like to say, though, if I could, just two quick points, one on the substance abuse, and one on the under four psychiatric hospitalization. Under the current guidelines, and I regret I can't give them to you, for preadmission certification for substance abuse, you must meet a number of criteria. Among them, things like you must show not only a consumption of a certain amount, you must show evidence of impairment from that consumption or taking that drug. You must show things like tolerance, you know, your two martinis no longer do the job, and so you now need four in order to achieve the same job.

A whole variety of impairments must be met to justify it; not just that you say I think I drink too much. That no longer will suffice, at least for programs that are going to be under the peer review system there.

Let me suggest that, what falls on many inpatient psychiatric units for children under 5, are really very severely developmentally impaired children. Children with, for example, severe autism that are also self-abusers—chewing their lips or something of that sort, banging their heads, self-destructive in a variety of ways. Severely retarded children with serious self-abusing potentials. Those kinds are the kinds of children, not just a little unhappy or "more neurotic" children, but severely developmentally impaired. They're not frequent but they are real; and they do in fact need hospitalization. To imply or to get the inference that merely because there are children under 4 that are psychiatrically hospitalized, that that's somehow a shocking thing, you ought not to be shocked, assuming it's an appropriate admission. It's an appropriate thing to do.

Mr. SCHWARTZ. I think that those cases that the doctor described are certainly the kind of cases that warrant hospitalization. Sadly, the cases, though, that I was referring to when we had a chance to look at the medical records and consult with others, were not those kinds of cases. And that was the thing that we found to be, I think, most disturbing.

The other thing I wanted to mention is that even though there is a distinction between the inpatient units in private hospitals—private general hospitals—and separate private psychiatric hospitals that are members of the National Association of Private Psychiatric Hospitals, I think we also—even though they've made tremendous efforts to tighten the criteria and I think the practices are probably of a much higher standard—there are also room for abuse, I think, in those facilities.

To give you an example, we only have one such facility in the State of Minnesota. And one case that was described in an article that we published, was the case of a young girl named Sarah who was brought to Minnesota for 3 days of educational testing. She and her parents came to Minnesota and the issue was that she and her parents were at odds; they were fighting with each other. She was not a girl who was involved with drugs or had problems with

delinquency, but serious family disputes and really violent arguments.

She was brought to Minnesota by her parents, her father's the president of a large, prestigious university in another State. They got off the plane, rented a car and drove to this facility. And, as soon as they drove up, Sarah knew that this was not a school. And she refused to go into the facility.

Her parents were in there for about 2 hours, and then finally six men came out and surrounded the car and she voluntarily admitted herself to the facility, where she was held for 9 months until an attorney, who she contacted through the Civil Liberties Union, threatened to file a suit against the facility and her parents.

I realize that this might be an extreme case, but it certainly, I think, is an indication that we ought to not just focus at just general hospitals that are setting up these units. It could be a problem that may affect other places, as well.

Mr. SIKORSKI. Mr. Chairman?

Chairman MILLER. Yes?

Mr. SIKORSKI. I've been an attorney for people who were being committed involuntarily, and have been an attorney in commitment proceedings. I have also been personally involved in interventions, both psychiatric and chemical dependency, where you go in and try to convince people to seek out help and/or get the help, and some of these involved institutionalized programs.

There are mostly gray areas in these situations, and inappropriate is a difficult term to define. It's a tough thing, and for parents, especially. We focus on the kids, but the parents go through a process—what made me think of it is these parents that were with this daughter named Sarah.

And Barbara's here to talk about it. It's not a clear-cut black and white situation. It's a tough thing whether you let your kid in this situation go on, or let this individual go on. The analogy is, if they're bleeding to death, you seek out emergency help; but if they're dying from alcoholism or a chemical dependency, you have the same responsibility, but it's not easy to make the black and white distinction.

Mr. SCHWARTZ. That's correct, except that in these cases, what we're finding is that juveniles are really sort of in a legal twilight zone. Even though they're voluntary admissions, they're basically there against their will and they're incarcerated. And they don't have the benefits of a voluntary patient because they can't leave on their own.

On the other hand, because they're not involuntary patients, there's no due process at all. And in the case of Sarah, she was in effect confined because she had violent arguments with her parents, and she dressed punk. And it seems to me, having her confined in a psychiatric hospital because of that, is unnecessary and inappropriate.

Also, I think, it raises some interesting and very complex civil rights issues. I mean, I, as a parent, if my child has an immediate medical problem, and requires an operation, or whatever, and I take my child to the emergency room, and he says, no, I don't want the doctor to do it, well, I'm going to damn well see that it happens.

But what about the situation where, if my son, is running away from home, and my wife and I are fighting with him, and we're arguing and so should I take my son down to X hospital and have him admitted for psychiatric care when, in fact, it's really a different kind of an issue; a family problem.

Which raises another question. We find that very little work is really done with the families. That's probably one of the most troubling aspects of this. Many of these issues are rooted in family difficulties of various types, and yet, parents are often excluded from the process.

Mr. SIKORSKI. That's strange. Even though the rationalization for double average time in institutionalization is that the family is the problem, yet, there's not as much family work as——

Dr. EGAN. If I could just—since we've used a number of individual anecdotes, let me suggest that we, at Children's Hospital here, require the parents to be in treatment three times a week in family sessions under direct supervision of a supervisor through a two-way mirror in order to gain an admission. That's one of the prime requirements.

Chairman MILLER. Congresswoman Boggs.

Mrs. BOGGS. Thank you, Mr. Chairman. And thank all of you. Thank you, especially, Marissa, for being with us and for your testimony. I was wondering how large Coon Rapids is? Your hometown? What is the population of Coon Rapids?

Ms. DEFOE. Mr. Sikorski, what's the population of Coon Rapids?

Mrs. BOGGS. Well, I was just wondering how large——

Mr. SIKORSKI. It's 40,000.

Ms. DEFOE. 40,000.

Mrs. BOGGS. 40,000. Because the reason I was asking that is——

Mr. SIKORSKI. Is this for revenue sharing moneys?

Mrs. BOGGS. Yeah; what do you want and how do you want to know it.

But I was just wondering about the size of the city because that would in some way indicate what size institution the city could support, and what type of psychiatric or other medical care could be provided within a hospital setting or an outpatient facility setting within such a population size.

And I assume that, because of the comparatively small size of the city, that it could support only one hospital medical facility, or are there several medical hospitals in the city?

Ms. DEFOE. Well, I don't really know. I know that this particular psychiatrist also was affiliated with other hospitals, and possibly you know sees patients in other hospitals. So, I think that they have.

Mrs. BOGGS. In addition to of course the insurance coverage now of mental difficulties, you also have the problems of smaller hospitals unable to afford the drug dependency units and psychiatric units, and so it opens the way for national organizations to come in and to set up a freestanding clinic within the hospital itself, and they do perform the service that apparently is not in place at all before they come.

So that that's a needed service and what we're really saying is that it should be better monitored; that peer review should extend

to these facilities, as well as to the psychiatric hospitals, themselves.

And, of course, are there in place in Coon Rapids, for instance, halfway houses, or other kinds of community facilities where the young people could go in lieu of being hospitalized?

Ms. DEFOE. I don't really know that.

Mrs. BOGGS. Marissa, do you know about any of those?

Ms. DEFOE. The one thing that really concerns us and upsets us is the fact that once you have a child that's in a facility like this, you have no control over what is written, what the records say. These people will justify what they're doing, and they can write anything they please, whether it's an out and out lie, to justify what they're doing. They can omit whatever they want to omit, which this hospital did, and there you are. And then try to prove that what was done was wrong. Hey, it's in the records. And those records are supposed to be truthful, and in fact, they are not, and there you have it.

Mrs. BOGGS. Well, the Freedom of Information Act, I think, has taken care of that. I sympathize with you very much and I think what happened to Marissa and to you and to your mother and to your whole family is a despicable situation. But, as Dr. Egan has suggested, oftentimes young people need—and I quote the doctor—therapeutic foster care, group homes, or halfway houses, that are simply not available.

All of us, I believe, as a Nation, should try to foster the building and the housing, the treatment, and the care of young people.

Mr. SIKORSKI. Will the gentlewoman please yield?

Mrs. BOGGS. Certainly.

Mr. SIKORSKI. Your point is absolutely excellent. Coon Rapids is in a county of a quarter of a million people, but not a single halfway house for mental health people. And we're now involved in a struggle in the community, my wife and my mother-in-law, are all involved in locating a halfway house in this county of a quarter of a million people.

And you hit the nail on the head. But the other alternative, perhaps more appropriate levels of care, just aren't available to the extent that they should be.

Thank you.

Mrs. BOGGS. Dr. Egan, we've been very interested in this committee and in other committees that we have served on, about the problems of physicians and other health care personnel not recognizing the effects of one drug upon another, or the effects of certain kinds of medication upon the patient himself or herself.

Apparently, there was no one who consulted Marissa's pediatrician to find out if she had any reactions to certain kinds of drugs, or any kind of allergies, or if she was taking any other kind of medication with which the drugs they were giving her would interplay. Is there any kind of protection against this type of activity?

Dr. EGAN. I think you put your finger on a very difficult problem. What I would say is, it's getting increasingly difficult because in fact there are more medications, to understand their interactions. I think those of us who are developing more and more gray hair are getting more and more conservative in the use of medication, as we go along.

What I would say is, just for your information, that the vast majority, the overwhelming majority of psychoactive medications in this country, are not in fact prescribed by psychiatrists. And so that we have the unfortunate experience in some ways of those with less training in psychopharmacology being the primary ones ordering the medications and I don't know what to do about that.

Mrs. BOGGS. But with regard to the severity of reaction that Marissa experienced from taking them, is there no hesitation on the part of the institutions in administering them? Should there be a release from the parents before a youngster is subjected to this type of medication?

Dr. EGAN. You raise a number of interesting questions. I would think that, except in emergency situations, virtually all treatments are approved by the parents. It gets to another interesting legal question. Virtually everyone, when they come into a hospital, signs a relatively broadly worded blanket umbrella permission.

Increasingly, I think, wise practitioners are not using that, but are using a rather more delineated specific treatment release, also including a time of ending of that, and then requesting another, not unlike what we do for release of information. We used to just get more blanket releases, but now we really require a release of information for each person, the principal of a school, or pediatrician, and so forth.

Well, moving in those directions, it adds to the paperwork, but——

Mrs. BOGGS. But what can we do to facilitate that speed?

Chairman MILLER. Barbara, did you?

Dr. EGAN. I don't know.

Chairman MILLER. Barbara, did you want to comment on that?

Ms. DEFOE. I'd just like to make one comment. When my daughter was in the hospital, she was only given one blood test. She was given high dosages of drugs, she had terrible side effects, and that they gave one blood test to monitor what was happening to her.

And no real physical beforehand to see if she had any physical problems. And I just find that, you know, appalling.

Mrs. BOGGS. I find it appalling, too, and that was the question I was asking. Thank you very much.

Dr. EGAN. And so do I. And I can assure you that it does not represent standard care.

Chairman MILLER. Congressman Wolf?

Mr. WOLF. Thank you very much, Mr. Chairman. I want to thank all the members of the panel. Both sides have made good points, but it does seem that there is a little bit of one side versus the other.

Mr. Schwartz, in your statement on page 8, you say some of the questions that must be addressed are should parents have the absolute right to admit a child to an inpatient psychiatric or chemical dependency program against the child's will? Well, when you have a 14-year-old child, or a 15-year-old child who's on drugs—and the reason I comment on this is, I just had the opportunity to be at the Straight Program.

Are you familiar with Straight?

Mr. SCHWARTZ. I've only heard of it.

Mr. WOLF. I think they do an outstanding job. Returning to my point, you really are going to have a very difficult time having a 14-year-old child commit himself to a program. And so I think you have to be careful that you don't take children's rights to the point that you have a 14-year-old child getting a lawyer from the American Civil Liberties Union.

The thing is, as Congressman Sikorski said, it's a gray area; and we really have to be careful. Because you may take this position, along with another great civil libertarian, but in the process, maybe that 14-year-old child is being ruined; and as a result of that, may end up dying. We're losing, we're missing 1 million kids a year, who are just leaving.

So I think we've got to be careful that we strike a balance. Even though a lot of what you say has a good point.

The other comment I wanted to make, and I hope the chairman will be very sensitive to this, I have been one that has pushed Blue Cross and Blue Shield to make this reimbursement available and hope the committee record doesn't give Blue Cross and Blue Shield, Money, and the other carriers, the hope that maybe they can get out of this. In the Federal Government, they've been cutting back these services; and I've been one whose been pushing, with Mrs. Oakar and others, to expand the services.

So I think there's a real potential here that this hearing, unless there's some clarification at the end, doesn't say, OK, health carriers, we're not interested in your carrying this, and we're going to be very willing to allow you to drop these services.

Does that trouble you a little bit?

Mr. SCHWARTZ. Two comments. One, this past Tuesday morning, I had breakfast with the president of Blue Cross and Blue Shield on these issues, and they are not interested in getting out of payment. Well, let me just comment on the comments of the president of Blue Cross and Blue Shield.

They are interested in paying for appropriate care. And I think that's really what the issue is here, I think, there's questions about whether or not there are high numbers of inappropriate admissions to these units.

Now, the other thing is that these are locked units, particularly the psychiatric units. Now, if we deprive people of their liberty, they should have the benefit of due process. The problem here is that the young people who are put in these programs are sort of in a legal twilight zone, and I don't know what the answer is, either. But they're not voluntary patients, even though they're put in voluntarily because they can't leave on their own.

And, on the other hand, they don't have any due process protections because they're not involuntary commitments, either. And so, I mean, to show you how easy it is, to get a child admitted to one of these programs, the CBS news documented a case example of a young person would have been admitted, was not actually put in the locked unit because they backed out at the last minute to make sure she wasn't put in because he or she might—other things might happen, but they were going to admit this girl, accept her for admission because of the following criteria:

She was threatening to run away from home but had not run away. Her parents, or the man who acted as her father, said that

they found evidence of marijuana in her bedroom, and suspected that she was smoking marijuana; she was dating an older boy or an older man 4 or 5 years older than she was, and that her grades were falling in school.

Based on that, the Golden Valley Health Center was going to admit her to their locked psychiatric unit. Now, that's not the kind of case that you were describing of a case that is really, you know, in crisis and in danger and needs some immediate attention and has to be hospitalized for care.

Mr. WOLF. Well, let me make a comment.

Dr. EGAN. Could I respond to that, please? Mr. Schwartz, you left out the fact that the first four hospitals that were approached declined to admit her. And they proceeded until they finally got five, and the fifth one said yes.

But I must state that repeatedly, you have left out all the data so that it has the appearance—I'm sure it's not intended—but at least lends itself to the appearance that you're not being fully forthright on these issues.

Mr. SCHWARTZ. Well, the first one declined her because she didn't meet the criteria. The other two, because their beds were full. They didn't have any empty beds.

Dr. EGAN. In terms of civil liberties issues for patients, it seems to me I'm always on the forefront of this issue; and I was fighting it in the sixties, when civil libertarians felt that chronic psychiatric patients were really being deprived of their civil liberties, and really engineered a mass exodus of patients.

They are now the very same people, rather shamelessly, I must say, decrying the fact that they're sitting on grates. And that they've become the homeless bag people. There is a limit to the amount of civil liberty protection that you can afford certain people.

I'll give you one other vignette. I had a patient that was absolutely incorrigible, seriously delinquent, no parental control whatsoever, and it was at a time when, in the District of Columbia, we provided an adversary system and a judicial review before a patient could be admitted to a hospital. A patient under 14 years of age had to have a judicial review.

Legal Aid Society provided the child with a lawyer. The parents, of course, got pro bono lawyers. The tilt was definitely on the child's side. In the meantime, the mother couldn't get the child to the hearing, because he was so incorrigible. At the same time, Child Protective Services accused this poor woman of neglect. She was sandbagged from both sides, accused of neglect because she couldn't get the child under control; and, yet legally, was being opposed by a very capable attorney, from getting her child the help that it needed.

I think it's a bag of worms. I would be far more cautious than you've been; and I suspect you're being as incautious as you are, only to get this thing on the table.

Mr. WOLF. Let me make one last comment, and then ask a question.

I think the committee should be very sensitive. Both sides have very good points, but in the process, while we argue this on an intellectual basis, there are going to be kids destroyed. There's an as-

sumption, a rebuttable assumption, that when someone is a juvenile, they're really not ready to—unless they're 16 years old, for example—drive; unless they're 18, and hopefully we're moving now to 21, 21 to drink. We're not talking about a 21–22-year-old Marine Corps sergeant stationed at Quantico, VA. We're talking about a 13-, 14-, 15-year-old child. In our system of government, the parent has the responsibility and I think in most cases, there's a deep abiding love on the part of that parent, they want the best for their child.

And I think you make some good points. For instance, a person will go around and think he is going to get ripped off, and these parents get confused, and the psychiatrists and the hospital can give them advice? By this point they are looking for any voice of authority to say something to guide them. And I think we have to be careful in influencing parents. It's a balance but it is very grey area. I wouldn't want to be part of a process whereby we lead parents to believe it is the wrong thing to ever seek out help.

I guess my last comment is, Dr. Egan, why do you think there has been an increase in admissions?

Dr. EGAN. Complicated, to be certain. But let me give you a couple of the issues. What we're seeing is, in many ways, the lag time. The figures are, for example, the threefold increase in suicide in the last 20 years; and if you plot that out with an account for the age gap, it corresponds almost exactly to the divorce rate.

And at least one of our universities—Minnesota, may I add—has conducted a very good study that suggested there's undeniable connection between the increased suicide rate and the rate of divorce.

In a more generic term, what I would say is I think we're seeing the dissolution of the family in many of its conventional forms, not the least of which is increased erosion of parental rights, some of which are even encouraged to be more so today. And I think we're finding that the statistics are, for example, only 40 percent that American children can anticipate a mother and a father for the first 7 years of life.

So that fully 60 percent will have lost one important relationship before they are 7. I think we're just now beginning to see the results of some of these experiences. Many childhood experiences that we thought were more benign, like divorce, we're finding are far from benign. The prospective studies that are carefully controlled and well done by people like Mavis Heatherington, in Virginia, at the University, or Wallerstein and Kelly in California, are really showing that it's not as benign as we once thought.

So, if I had to look at one large area to account for a large percentage of the variance (but by no means only), I would look to really very unstable family relationships, dissolution of family relationships; inadequate parenting from either absent or nonexistent parents, or overwhelmed parents.

Mr. WOLF. Thank you very much.

Chairman MILLER. Congresswoman Johnson?

Mrs. JOHNSON. I have no questions. But my prime concern, and the point of view from which I'll be reviewing the testimony, is the lack of alternatives and a variety of treatment centers for teens. I am also interested in how we may rectify our inability to intervene appropriately and early. And I just wondered if, from your experi-

ence, Dr. Egan, there were particular kinds of programs that you've seen succeed or, particular deployments of Federal grant dollars, that have been more effective than others?

Dr. EGAN. You will now embarrass me by that question. Up to now, I've not been embarrassed. I'm a bit embarrassed. Unfortunately, when it comes to good empiric data of efficacy of one treatment versus another, we are unfortunately in our infancy. And if I could encourage the Congress to do one thing, in terms of mental health, it would be to fund studies that were aimed at clearly determining what in fact are the effective treatments as definitively as we can at this stage in time.

Are some of our conditions perhaps not treatable? Are they like Alzheimer's? And, if that were the case, then we ought to know that. And then make whatever other provisions are needed. If, in fact, you have conditions that cannot respond even to several years of hospitalization and a half a million dollars of expenditure; and the outcome is no better than chance, I think that would be important information for us in terms of how to husband our meagre resources.

Merely, I think we must move beyond, as a profession and as a field, from saying I know it works, I feel it works, or my aunt had it work, you know, that kind of thing, so that we have empiric good studies. That has not been done.

Mrs. JOHNSON. Is it your opinion that we've had enough experience, that there is enough out there for these studies?

Dr. EGAN. No, I think; we have some data to say some things really do work; and that has to be popularized better. And that's really information distribution, but in fact, there have not been enough good studies, no.

Mrs. JOHNSON. Thank you.

Dr. EGAN. Let me just say, you can take a child with a variety of disorders, and quite legitimately get people that will say only family therapy, only individual therapy, only cognitive therapy, only pharmacotherapy, only institutionalization, when it would seem unlikely that they're all equally effective. Or worse yet, equally ineffective. I think we need that data. And I think really it's only Congress that can begin to get it to us somewhat in a tidy and timely way.

Chairman MILLER. Thank you. Let me just say a couple of things. Part of this topic that we're covering here, in particular the question of appropriate care, which I think is a more generic issue here, is one I feel like I've seen before in the foster care issue. Ten years ago, when we saw huge numbers of children who were being locked up in locked facilities, and were being heavily drugged so the caseloads could be increased by proprietary care units, finally the civil libertarians did go in and say that those children had to be brought home; they had to have their rights assured, because they had committed no crime; they had done nothing wrong.

And I'm a little concerned that part of this is déjà vu. I fully agree with Congressman Wolf, that the inclusion of mental health services within insurance plans is absolutely essential and should be expanded, given the stress and related problems that people live under today.

But I'm concerned about what seems to be emerging is maybe the only or the fast accelerating track for treatment of these problems which is the suggestion of these freestanding clinics within hospitals or freely associated with hospitals. As I look at Blue Cross and Blue Shield, as they list the top five diagnoses for adolescents that were admitted to these psychiatric units, it looks far different than the criteria that was part of your testimony, Dr. Egan.

This list is far more abstract in terms of "unspecified adjustment reaction"; as abstract as bizarre behavior is, it doesn't seem to go as far as that one, and that's what my concern is. The question is whether or not we're paying for inappropriate care, or whether, by not providing other kinds of care, we've now moved to this extreme, an intensified locked fully-paid-for facility for 30 days or 60 days, and then that's it.

And there is also the question of followup. One of the things we found out about children in foster care was 80 percent of the families before their children were taken away from them had received no infamily services, and in 80 percent of the families, nobody came back to see if they could reunify that family once a child was taken.

What I'm afraid of, is somebody may utilize 30 days of treatment covered by insurance, and then the child is dismissed and the parent moves on to maybe a whole new set of problems that occurred as a result of what may be inappropriate or improper treatment. And that's not to place a blanket indictment. But I'm a little worried that there's a funneling operation moving here in terms of where dollars are, whether they're from private insurance or public insurance, where we're moving in terms of what is considered to be appropriate care.

Dr. EGAN. Well, I think you raise some legitimate issues. Not the least of which are followup and follow after care, and, as you know, outpatient services are increasingly being rather severely curtailed in terms of the number of visits, for example. I'm currently working with a family, that the entire family has for its prepayment insurance program, 20 visits per year.

Well, it's a multiproblemed family, including one person that needs psychiatric hospitalization. When that person comes out, there in fact is no money and no funding for continued outpatient services. And here we then have somebody that is basically above the working poor, stable job with insurance, although going for the least expensive insurance policy, in the hope that they won't need other services, and now cannot afford the ongoing outpatient psychiatric care and then, either has to go to the public sector, or get none.

The public sector—I don't need to remind you is not a cornucopia.

Chairman MILLER. I look at my home county, and it's larger than my district, but it's 650,000 people. And my wife's on the mental health board there, and they're struggling to find 22 placements for adolescents.

Dr. EGAN. Yes.

Chairman MILLER. It's a high income county, but you don't have to drive around very long to understand there's a lot of potential placements on the streets among the adolescents. But it is nearly

impossible to find publicly supported placements. The goal this year will be 22 or 23 new placements.

And, as you point out in your testimony, apparently we can expect to have an increasing number of children with severe problems appearing on the horizon.

Dr. EGAN. Yes; and, if I could just tell you where I think you could potentially intervene to reduce one of the unfortunate consequences that Mr. Schwartz alluded to, namely, a really two-track system of health care.

That, if public moneys are not in fact available for the poor, then the mental health issues, then you really will in fact have a two-track system much more in place than we currently do have.

Chairman MILLER. Thank you, very much. And Barbara and Marissa, thank you. I want to thank you very much. I think that the issues that you've raised allow us to begin a much larger and broader issue, in terms of mental health services for adolescents, than we'd anticipated. That's the nature of this committee.

Thank you very very much.

Next, the committee will hear from a panel made up of Mark Schlesinger, who is a research coordinator for the Center of Health Policy and Management, the John F. Kennedy School of Government, Harvard University;

Kevin Concannon, who is the commissioner, department of mental health and mental retardation in the State of Maine; and

Albert Richard, Jr., who is the chief juvenile probation officer from Dallas County, TX.

Gentlemen, welcome to the committee. We will hear from you in the order in which I called your names. Your written statement will be placed in the record in its entirety, so to the extent that you want to summarize or perhaps comment from what you heard during the first panel, it would obviously be very beneficial to us.

We're still doing all right in time, so proceed in the manner you're most comfortable.

Mr. SCHLESINGER. Thank you, Mr. Chairman. I appreciate the chance to address the committee.

STATEMENT OF MARK SCHLESINGER, PH.D., RESEARCH COORDINATOR, CENTER FOR HEALTH POLICY AND MANAGEMENT, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY

Mr. SCHLESINGER. What I would like to do today is place some of the issues we've already heard in the context of the broader commercialization of the American health care and mental health care system. Although we've to some extent focused on the clinical criteria and the incentives created by insurance, it may be equally important to try to understand the incentives and motivations that providers and providing institutions are operating under to really understand the policy issues in this problem.

The American health care system has experienced a number of episodes of commercialization in the past, and each of them have a similar format, involving three stages:

In the first phase, the demand for care vastly outstrips the capability of traditional providers to supply services, usually because government's begun to subsidize care in one way or another.

In the second phase, there is a large influx of profitmaking institutions in the health care system. Those profitmaking institutions differ from traditional providers in several important ways. First, they tend to be more organizationally autonomous, that is, have fewer formal and informal connections with the community in which they operate.

Second, they tend to deliver different packages of services in different ways. The package of services tends to be more narrow, less innovative and to some extent more standardized than the services traditionally provided by nonprofit public sectors.

By way of analogy, the entry of for-profit providers is, to the American health care system, often like McDonalds is to the American hamburger, and similar issues about whether this kind of standardization in fact leaves us better off or worse off, occur in both cases.

The third, and I think perhaps the most important phase for the committee to think about, occurs when existing nonprofit and public providers respond to the influx of for-profit providers. They respond to the competitive threat that they see them representing, becoming more and more over time like those for-profit providers. Nonprofit and public institutions adapt the way they operate and the kinds of services they provide, so that over time, ownership based distinctions become less and less.

Now, it's my sense and the sense of others that the American mental health care system is currently between the second and third phases that I just described.

Over the past decade, there's been a significant increase in the role of profitmaking organizations supplying mental health care. Depending on how you measure it and what services you look at, the role of for-profit providers has somewhere between doubled and quadrupled over that period.

Similarly, those for-profit mental health care providers tend to offer services in a somewhat different way than do preexistng providers. They're more sensitive to economic incentives. Our evidence suggests that for-profit organizations are less than half as likely to admit patients for reduced charges, they're less than one-fifth to one-quarter as likely to supply services which are considered unprofitable.

Similarly, for-profit providers tend to offer a different package of services, a package of services that tends to be more standardized, tends to orient care more to an inpatient basis—because it can be more readily administered—tends to be less innovative, and finally, tends to omit services that have broadly diffused community benefits. These latter services include education and vocational rehabilitation, services that affect the well-being of the client once they've been discharged back into the community, rather than staying within the facility.

Finally, it's my sense that we are beginning to enter the third phase of the commercialization of mental health care. Let me quote, briefly, an observation made by Dr. Leon Eisenberg of Har-

vard Medical School at the annual meeting of the American Psychiatric Association, held last month: He stated:

> The worst of it is that voluntaries, unable to cross-subsidize expensive but essential clinical services because of cost-competition, are becoming ever less distinguishable from the proprietaries, as they 'market,' and worse, 'demarket', diversify, 'unbundle', 'spin-off' for-profit subsidiaries, develop 'convenience-oriented feeder systems', attempt to adjust case mix and triage admissions by their ability to pay.

Hence, it's my sense that those initial differences that are represented by profitmaking organizations are now spreading to the mental health care system more generally. I believe that this spread has important implications both for the health care system, and particularly for the mentally ill.

Let me here hazard three predictions: First, that the spread of proprietary and more commercial nonprofit mental health care will lead to an inevitable focus on inpatient care, whatever the incentives provided by insurance. Because inpatient care tends to be more manageable, involves less innovation, and is more readily standardized, it seems clear that the standard mode of operating for such providers will be to foster that sort of care, rather than outpatient services.

Second, judging from past experience of episodes of commercialization of the health care system, it's very likely that we'll soon see a rapid influx of for-profit facilities into the substance abuse area for adolescents. This will have several impacts. One, it will tend to cause competition among providers as they struggle more and more to fill their capacities with an adequate number of patients, will cause them to be more and more aggressive, in terms of marketing their services, whether to schools or otherwise; and will intensify the narrowing of services as they try to become as cost-efficient as possible.

Also, I think it's inevitable whenever there's an influx of new providers into an area, that there will be some who are in it, simply seeking short-term profits, the quick buck. And one would expect, it's very likely we'll see episodes where, in the quest of that quick profit, providers tend to cut quality of services, engage in fraudulent practices, and other unethical practices.

Third, and lastly, I think it's important to recognize that, as the commercialization of mental health care progresses beyond the for-profit sector, it's going to be very important for us not to simply blame profitmaking as the source of the problems that are likely to emerge with commercialization. That's not to say that the profit motive won't be linked to some of these problems, but simply that they are also linked to the kinds of incentives we give these institutions, which are very sensitive to economic incentives.

Moreover, if we focus exclusively on the profitmaking organizations, we'll tend to lose sight of the fact that the same behavior is spreading to other types of providers, as well.

That concludes my testimony. I thank you for your time.

[Prepared statement of Mark Schlesinger follows:]

PREPARED STATEMENT OF MARK SCHLESINGER, PH.D., RESEARCH COORDINATOR, CENTER FOR HEALTH POLICY AND MANAGEMENT, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY

Mr. Chairman and members of the Committee: My name is Mark Schlesinger. I am research coordinator of the Center for Health Policy and Management, John F. Kennedy School of Government at Harvard University. It is my intent to place the issue of profit-making in the treatment of substance abuse in the context of the broader commercialization of the American health and mental health care system.

Many observers have noted that, over the past ten to fifteen years, health care in this country has increasingly been viewed as an appropriate and profitable area for commercial ventures. This is not the first episode of "commercialization" in American health care. It is my belief that a review of past and current patterns of commercialization will provide important insights into the issues raised in today's hearing.

THE RECORD OF COMMERCIALIZATION IN HEALTH CARE

Commercialization in American health care has occurred several times over the past hundred years. At the turn of the century, medical education became largely the province of businesses which trained doctors for a profit, much in the way trade schools now teach auto mechanics or computer programming. During the 1940s, large commercial insurance companies began to offer health insurance, a product which had previously been available largely through private nonprofit organizations or cooperative agencies.

From the late 1950s through the 1960s, the nursing home sector was converted from an aggregation of small, often family-run, operations to a booming industry. In the 1970s, renal dialysis centers—previously limited to large teaching hospitals—were increasingly established as profit-making enterprises, many franchised in the model of fast food emporiums.

Each of these episodes of commercialization followed a common pattern, and can be separated into three stages. In the initial phases of this transition, it becomes widely recognized that traditional providers are not supplying sufficient services to meet the demands of clients. Often this results from new government initiatives subsidizing treatment. The demand for nursing home care, for example, burgeoned after the passage of Medicare and Medicaid. The number of patients treated for end-stage renal disease grew exponentially in the decade after it was covered under Medicare.

The second stage of commercialization takes the form of an influx of profit-making enterprises. A large and growing body of research has documented that these new entrants differ on average from traditional nonprofit providers in several important ways:

"Proprietary providers tend to be more sensitive to financial incentives, offering fewer services and treating fewer clients who do not generate a profit.

"Investor-owned enterprises, particularly when initially entering an industry, tend to offer a more standardized package of services than do traditional private nonprofit providers. Thus, new entrants appear more like "franchises", compared to pre-existing providers which follow a more "skilled craftsman" model. The services offered in proprietary settings tend to be relatively non-innovative.

"Organizationally, for-profit providers tend to be more "self-contained". Compared to private nonproft providers, their boards of directors are smaller and more representative of staff than the community at large. By increasing organizational autonomy in this manner, for-profit institutions increase their ability to respond more quickly than can nonprofit institutions to changing conditions."

The third, and in many ways most important, stage of commercialization occurs largely in response to the influx of for-profit providers. Existing institutions, both public and private nonprofit, begin to behave increasingly like their investor-owned counterparts. As competition from proprietary facilities threatens to draw away profitable patients/clients, nonprofit organizations more aggressively strive to attract and hold such clients. In addition, the entry of profit-making organizations to some extent changes the perceptions of all providers' about their role in the community and their fiduciary relationship to patient and the general public.

THE CONTEMPORARY COMMERCIALIZATION OF MENTAL HEALTH CARE

Mental health care is undergoing commercialization similar to that observed previously in other sectors of the American health care system. In my assessment, we are now in the second—and about to begin the third—stage of this transition.

The first stage of commercialization, the expansion of demand for care, was initiated by state regulation and reinforced by the federal government's adoption of prospective payment. Throughout the 1970s and 1980s, states have mandated coverage of mental health care by private insurers. As of 1984, more than half the states required coverage for the treatment of alcoholism, 40 percent for mental illness and a third for the treatment of drug abuse. The growth of prospective payment, including Medicare's DRG system, has made mental health care appear even more attractive to health care providers. In the short-run, psychiatric specialty hospitals have been exempted from prospective payment under DRGs and continue to be paid on the basis of costs. In the long-run, professional standards for treatment are sufficiently ambiguous that treatment of the mentally ill can be readily adapted to be made "profitable" under virtually any form of reimbursement. It is thus not surprising that over 1000 short-term general hospitals are anticipated to establish psychiatric units over the next five to ten years.

These same incentives have encouraged the growth of proprietary mental health care. A recently issued report by a major Wall Street investment firm concluded that:

"The psychiatric hospital industry is an attractive subsegment of the hospital industry for investors. Inpatient psychiatric care is widely insured, occurs with predictable and increasing incidence and is complex enough to render cost control efforts difficult."

The influx of proprietary providers is already well advanced. In the past fifteen years the number of beds in psychiatric hospitals under proprietary auspices has increased over 150 percent. Investor-owned general hospitals are growing at an equal rate and are increasingly providing care for the mentally ill. For-profit ownership has become even more pronounced in residential facilities and institutions specializing in the treatment of substance abuse. When last surveyed, between one quarter and one third of these facilities were investor-owned. Many of these investor-owned facilities are a part of a multi-facility system: as of 1982, two-thirds of the for-profit psychiatric hospital beds in this country were controlled by the five largest multi-hospital "chains".

As in other episodes of commercialization, the newly entering for-profit providers appear to offer care different from pre-existing providers. Survey data reveal that proprietary facilities are half as likely to offer to treat patients at reduced charge and less than one quarter as likely to offer services which are inadequately reimbursed. Staffing ratios are on average lower in for-profit than nonprofit facilities. The former tend to offer a narrower range of services; in particular, they are less likely to provide educational and rehabilitative services. Anecdotal reports suggest that investor-owned facilities are concentrating to a greater extent on inpatient treatment than are private nonprofit institutions.

Neither this evidence, nor experience with past episodes of commercialization of health services, indicate that the proprietary facilities cannot supply adequate—and in some cases quite high—quality mental health care. In fact, by specializing in the type of care they provide, profit-making agencies may supply services more efficiently than do their nonproprietary counterparts.

Nonetheless, prior experience with commercialization, particularly in the nursing home industry, suggests that with any rapid influx of new providers, some will seek quick profits, through either low quality care or fraudulent practices. In addition, existing evidence indicates that investor-owned mental health care facilities place greater emphasis on obtaining profitable patients and selecting those services which are profitable and readily managed by administrators.

Although current differences between for-profit and other institutions are fairly pronounced, as the mental health care sector enters the third phase of commercialization, some of these distinctions will be narrowed or eliminated. There is evidence that this is currently occurring. Journals for (nonprofit) hospital administrators are replete with articles discussing "adapting to the age of competition". At the 1985 annual meeting of the American Psychiatric Association, held last month, Dr. Leon Eisenberg of Harvard Medical School reported that:

"The worst of it is that voluntaries, unable to cross-subsidize expensive but essential clinical services because of cost-competition, are becoming ever less distinguishable from the proprietaries, as they 'market,' and worse, 'demarket', diversify, 'unbundle', 'spin-off' for-profit subsidiaries, develop 'convenience-oriented feeder systems', attempt to adjust case mix and triage admissions by their ability to pay."

COMMERCIALIZATION AND THE TREATMENT OF SUBSTANCE ABUSE

These broad patterns of commercialization hold implications for state and federal officials concerned with the treatment of substance abuse. Continuing commercialization of these services, along with mental health care in general, is likely to have several important consequences.

"Providers will focus on inpatient services. This will occur for several reasons. First, inpatient care is more readily manageable, and thus amenable to the administrative approaches found in many for-profit institutions. Second, professional protocols for inpatient care are in many cases better developed than for outpatient treatment; outpatient care calls for a level of innovation that is unlikely to be found in many of the programs initially established to provide treatment.

"There will be a rapid influx of proprietary providers. This offers some real advantages, by assuring that programs offering services will be rapidly and widely available. At the same time, it presents some potentially serious risks. An influx of providers increases competition, forcing facilities to become increasingly aggressive at generating utilization. This may lead to placements of clients in programs inappropriate to their needs. In addition, any rapidly expanding program will prove hard to control and therefore more readily subject to fraudulent practices.

"The problems associated with the service system will not be exclusively those produced by the profit motive. The pursuit of profits is neither the sole nor even the most important source of problems associated with commercialization. Proprietary institutions do appear more sensitive to financial incentives, and this may lead them, in response to such incentives to treat or not treat patients in a manner which is socially undesirable. Commercialization, however, represents a broader change, a reduced sense of community responsibility. This may have far more pervasive effects than the profit motive per se, extending to effect the performance of private nonprofit and public facilities. The problems associated with commercialization must therefore be dealt with, not by blaming profit-making, but by more explicit statements of the responsibilities of health care facilities to the communities in which they operate and by more careful understanding of the types of financial incentives created by the ways in which we pay for and regulate the treatment of substance abuse."

These predictions point to issues and problems which will not be readily solved. Nonetheless, our experience with past episodes of commercialization in health care suggests that such problems will likely occur in programs for the treatment of substance abuse. Both clients and the general public will be best served if they are addressed expediently.

Chairman MILLER. Thank you. Mr. Concannon.

Mr. CONCANNON. Thank you.

STATEMENT OF KEVIN W. CONCANNON, COMMISSIONER, MAINE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, AUGUSTA, ME

Mr. CONCANNON. Chairman Miller, members of the committee, my name is Kevin Concannon, and I'm the commissioner of the department of mental health in the State of Maine. I very much appreciate the opportunity to appear here today.

I wish to speak particularly in support of the efficacy, if you will, of State level strategies, which avoid the overuse of restrictive and institutional settings for children and adolescents, and which optimally facilitate and support the development of an array of suitable alternatives. I'd like to highlight some of the points in my written testimony.

First of all, I think, Maine has created an exemplary approach to many of the issues that I've heard discussed, both by Members of the Congress here today, as well as the panelists that have preceded me. And that is, it seems to me, that at the State level, one of the key predictors of the general mix of services available to disturbed children and family, is a factor that is heavily influenced, or should be heavily influenced by leadership at the State level.

The State of Maine, I think, took a very effective step about 10 years ago, in the creation of a cabinet-level interagency planning effort, which oversees the development of such services for children, the licensing, their planning, their funding, and most importantly, their oversight.

Maine, as a State, does not leave, and much of the testimony I've heard here today has tended to describe, it seems to me, the system or aspects of the system of care of juveniles or young persons, either seeking psychiatric or substance abuse care, as though these were free-market forces operating in a laissez faire environment. That certainly isn't the case in my part of the country, generally, that is, in the New England States, and I can speak specifically for Maine, and I'm generally familiar with New Hampshire, Vermont, and Rhode Island, as states that directly intervene at the State level, in terms of impacting persons who would, be they proprietary or nonprofit, provide an array of services.

I think a coherent coordinated mechanism at the State level enjoys a number of advantages and I'd like to highlight those from the experience of the State of Maine. First of all, it creates a predictable controlled and overseen development of proprietary as well as nonprofit services for children, and in the case of Maine, I'd point out the mix is overwhelmingly nonprofit agencies.

There is but one proprietary psychiatric substance abuse hospital in our State. Joint planning and funding has allowed States like Maine, a relatively poor State, to optimize the use of funds, be they Federal or State funds, to support programs that are both least restrictive, and we believe, efficacious for children.

In the State of Maine, contrary to some of the testimony you've heard earlier today, we have witnessed a reduction over a 5-year period, a conscious reduction, in the number of residential treatment center beds for children, be they for psychiatric purposes or for substance abuse. And I would attribute that reduction to a number of factors that I'm going to comment on, but most importantly, I think it is the planned full, affirmed bypartisan support of Governors and legislature, as well as agency heads that have overseen the system in the State.

We have, in our State, effectively promoted new and additional home-based treatment intervention services for emotionally disturbed children, and adolescents and for children entering the juvenile justice system. I regret that Mrs. Johnson is not here, in that one very effective—she asked the question of efficacy, or are there programs that we can point to that seem to respond to the needs of seriously disturbed children and their families, without necessitating hospitalization or institutionalization.

In the case of Maine, we have nine such programs funded, licensed, and overseen by the four principle State-level agencies that are modeled to a large degree on a program or set of programs out of the Tacoma, WA, area known as "homebuilders." These are home-based approaches to children and their families, and the entrance criteria for these programs are, the child must be referred by the juvenile court, mental health professionals, by schools, by child welfare officials as needing residential treatment, so we're not talking about the creaming process here of dealing with the kids whose pathology or problems are easily resolved.

And, in the case of Maine, we're doing 6-month and 1-year followups on these children to look at the broad criteria of is the child still in the home, and are the parents or the child collectively reporting a reduction in symptomatology.

These are very effective: These are cost-effective, they are humane, and they are directly reflected in the reduction in the number of residential or more costly treatment center beds in the State. Maine has, as a State, in statute, and in practice, a certificate of need process enacted into law by the legislature, again strongly supported on a bipartisan basis. The certificate of need process contains some of the free-market forces that would take place otherwise, from a proprietary or a nonprofit agency.

When agencies have turned to Maine, for example, I reviewed the data before coming down here, and over the past 3 years, 53 proprietary or nonprofit agencies have turned to us to suggest, we want to provide more inpatient substance abuse beds for adolescents, for example.

We have currently a moratorium in our State, affirmed by the 4 State agencies, opposing in effect at this time, any further development of inpatient adolescent beds. And we have effectively dissuaded—if I can use that word—those who would offer unneeded, unnecessary beds to respond to the needs of these young citizens and their families.

So there are effective strategies, I want to point out.

The State of Maine is one of eight States that has applied to the National Institute of Mental Health effectively, I guess, or successfully, I should say, applied for program funding under the so-called CAASP, or Child and Adolescent Services Program grants. You might be interested to know that of 54 States and territories, when the Congress authorized the CAASP at the National Institute of Mental Health, 43 of the 54 States and territories applied for these moneys that are targeted, not for additional services, but that are targeted at system improvement at the State level, to enable States to better manage the array of services for children requiring everything from in-home services to the most restrictive, if you will, out of home placement.

There is tremendous, I take that as, direct evidence that there's a lot of interest and realization at the State level that system improvements can be made. We're one of the States that have received these relatively modest grants in Federal terms, I would say, but important for States like Maine, and long-term, I think many of the kinds of issues that I've heard here today, are likely to be addressed by programs like CAASP, effectively supported by the Congress at the State level.

I would point out, as well, that in Maine we have effectively leveraged, if you will, and supported a variety of public funds from the Federal level, the block grant funds and social services, the alcohol, drug abuse and mental health funds, those funds that are available through Public Law 94-142, with State funds so that we can collectively between these four principal State level agencies, support the placement and services of children in those settings that are least restrictive of their freedom but that are most appropriate.

We have a mandatory insurance law, just by way of reference, in Maine, mandatory mental health and alcohol insurance law, but that mandatory law mandates, as well, a variety of out-patient interventions for persons, so I think there are various subdivisions even within the mandation issue around the insurance benefits, and we're relatively a recent State in that respect.

Finally, I would point out that we have, I believe, a very important and identifiable and visible locus of policymaking and planning for children's health, children's mental health, in substance abuse services in our State. I think that's an extremely important element, and an absent one in many States at the local level.

About a month or so ago, I was at a meeting in Texas of a number of children's mental health principally child psychiatrists, and from the podium, about 400 child psychiatrists were asked if they could identify the person or the locus—that is, the office in their State—that sets mental health policy for children and adolescents.

And fewer than a dozen so-identified that.

I take that as a problem with State government on failing to effectively convey to practitioners, family, and others, the utility of a locus at the State level, as well as the manner in which the American Mental Health Care System has evolved wherein practitioners dealing with families on a day-to-day basis are unable to influence the policymakers and planners at the State level.

Thank you, sir.

[Prepared statement of Kevin W. Concannon follows:]

PREPARED STATEMENT OF KEVIN W. CONCANNON, COMMISSIONER, MAINE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, AUGUSTA, ME

Mr. Chairman, members of the committee. My name is Kevin W. Concannon and I am the commissioner of the Maine Department of Mental Health and Mental Retardation. Since February of 1980, I have served as commissioner of Mental Health and Mental Retardation and for several years had responsibility, as well, for corrections and juvenile justice. I appear to speak in support of State level strategies which avoid overuse of restrictive and institutional settings for children and adolescents and, which optimally facilitate and support, the development of an array of suitable treatment options for disturbed children, adolescents and their families.

As a State, Maine has taken effective steps at the State level to provide more adequately for the mental health treatment needs of children and adolescents requiring special intervention through the development of a predictable and visible interagency planning office for children's services at the State level. This interagency planning effort for children, originally supported by Federal funds from the Law Enforcement Assistance Administration, has for 10 years been the instrument through which State level policy, planning and funding for the treatment needs of children and adolescents have been addressed. Specifically, in Maine, the four major child serving agencies—Mental Health and Mental Retardation; Corrections; Education; and Human Services—jointly coordinate the planning and needs assessment efforts, licensing of these facilities, funding, and oversight of the range of residential treatment centers operating in Maine serving disturbed children and adolescents. These commitments to interagency planning and a coherent, legislatively affirmed, policy for funding, licensing and overseeing the range of treatment centers in our State have resulted in a number of benefits:

1. A more predictable, controlled, and overseen development of proprietary and non-profit children's residential, psychiatric and treatment services in the state;

2. Among the four State agencies with differing individual legislative responsibilities, the joint planning and funding has allowed State agencies to make the optimum use of their respective funds, that is, mental health funds are used as an adjunct to support special education monies available through P.L. 94 and 42 for services not funded by special education;

3. The number of residential treatment center beds in our State over a 5 year period has been reduced, at the same time that a variety of less restrictive treatment options has been encouraged and financially supported by the major State agencies to serve children and adolescents;

4. Particularly over the past 3 years Maine has effectively promoted new and additional home-based treatment intervention services for emotionally disturbed children and adolescents and for children entering the juvenile justice system. So-called "homebuilders" or home-based services based upon the model from the State of Washington have effectively diverted hundreds of Maine children who had been recommended for more intensive, more restrictive residential treatment either in psychiatric inpatient units or residential treatment centers by social workers, physicians, mental health agencies, schools or juvenile justice intake workers. In short, Maine's experience has affirmed the cost-effectiveness and humaneness of being substantially committed to intensive, home-based services with mental health professionals as an effective strategy to deflect the majority of children referred for residential treatment.

5. Maine has moved from being reactive as a State agency to being proactive through the development of a "certificate of need" process enacted into law by the Maine Legislature. The certificate of need legislation in Maine requires that proposed vendors of residential treatment to our youth anticipating application for Medicare, Medicaid or private insurance reimbursements must submit proposed projects to the certificate of need process. This includes public hearings, feasibility data and review by the affected State agencies. The C.O.N. process has been extremely helpful in guiding the collective efforts of individual State agencies, as well as appropriately dissuading individual entrepreneurs or agencies who have proposed expansions or major developments in Maine that are, in the judgment of State and local officials unnecessary.

6. Through the interdepartmental children's process in Maine, agencies seeking to provide new or expanded programs are encouraged to seek direct technical assistance and advice from the interdepartmental children's staff. These staff, incidentally, take their direction from the four cabinet level officers, commissioners of the respective agencies, and the deputy commissioners, hence assuring that the interagency efforts reflect the current direction and policy of agency heads.

7. Maine, through the interdepartmental planning, funding and licensing process for children's treatment centers, has maximized its use of Federal as well as State funds, and in the case of Federal funds has utilized funds from the social services block grant, the alcohol, drug and mental health block grant, and education funds available through public law 94 and 42.

8. Maine is one of the initial eight States funded by the CASSP (Child and Adolescent Service System Program) through the National Institute of Mental Health and I believe the Congress is to be congratulated from the mental health community's viewpoint for your authorization and funding of the CASSP program. You may not be aware that of 54 States and territories, in 43 of the States the highest level of the executive branch agencies applied to receive these system improvement funds, and I am confident that this program, while relatively modest by Federal standards, will pay long-term dividends in enhancing the ability to State systems to serve better the needs of children of emotionally and behaviorally disturbed children whose needs transcend any one public or private agency system at the State level. Finally, I would point out that it has been my observation that States that have an identifiable locus of policy making and planning for children's mental health or corrections related services for children beyond the State institutions are organizationally better able to oversee and plan for the range of needs of children and adolescents without being so overly dependent upon pure "market forces" and this locus of planning helps to directly facilitate appropriate, less restrictive treatment and habilitation settings for children and adolescents at the state level. The absence of an identifiable locus continues to be of concern to me and others in the field. Anecdotally, at a meeting I attended a month or so ago in Texas with approximately 400 child and adolescent psychiatrists from across the U.S., fewer than a dozen of those in attendance were able to identify the specific locus or individual within their respective states who set and oversaw children's mental health policy. This, regrettably, contributes to unresolved problems in certain states and areas of the country.

Thank you for this opportunity.

Chairman MILLER. Thank you. Mr. Richard?

Mr. RICHARD. Mr. Chairman, thank you for the opportunity to testify.

STATEMENT OF ALBERT RICHARD, JR., CHIEF JUVENILE PROBATION OFFICER, DALLAS COUNTY, TX

Mr. RICHARD. It's my understanding that what this committee would like to hear is a perspective from the Dallas and Texas areas regarding their perceptions of this problem.

This is not an issue that's come to the fore either in Texas, or in Dallas. It's not one that's talked about publicly. However, in recent discussions with a number of professionals in the Dallas community, I was surprised to find a great deal of concern and interest, and a great deal of pessimism about future developments relating to the provision of residential programs for children.

I have two examples in my written testimony which are intended to illustrate the extent of the power, and the potential abuse of that power that can be exercised in these psychiatric and chemical dependency programs. These examples were gleaned from conversations with attorneys and others in the Dallas community, again, expressing their concern that this will become an increasing option for many parents, particularly due to some revisions of State insurance laws.

In one case, a young man was totally immobilized and strapped to his bed; he was visited by his attorney who was representing him because it was an involuntary commitment to a private psychiatric facility. When she questioned the nurse about why he had to be totally immobilized in such a manner, the nurse said he violated his treatment plan because he went to the bathroom across the hall without permission.

In the other example, the immediate use of drugs on a child assuming that he had a depression or some other kind of disorder and I guess some type of medical protocol that says as soon as you walk in the door, you get drugged, we had that young boy in detention for months, he never exhibited any depression, he never exhibited any psychotic behavior, he was never even a behavior problem. I was somewhat surprised to learn that medication was such a big part of his treatment, since he seemed so lucid and so able to understand the ramifications of his behavior and the possible therapy that he would have to undergo.

The contrast to the detention center these programs present is quite striking. In the Dallas County Detention Center, for example, no child is ever handcuffed, no child is ever put in a straitjacket or any other type of restraint. A child may be separated, put in a separate room, or watched closely, and even then systematically, every effort is made to take a child off of even that much restriction.

We have a locked environment, but we don't find it necessary to have a repressive environment, and in fact, we try to enrich it as much as possible.

There is a continuous, continual, and a persistent effort on the part of parents, school officials, and I think health care officials, to categorize the misbehavior by children as some form of illness. It was my experience, as a probation officer, that parents repeatedly and persistently requested that some type of label be given their child's misbehavior. If they then had an opportunity for the child to be locked away in some facility, that was even better.

Parents have a tendency, somewhat in a state of panic and sometimes maybe simply because they're incompetent parents, to relieve themselves of the responsibility for their children's misbehavior. It is often quite easy for psychiatric health care providers to pursuade parents that the alternative that they offer, which is medically approved and medically supervised, is the appropriate and caring alternative that they should provide their child.

In Texas, basically what has happened is that this has not been a widely available alternative, although it certainly has been there, there have not been any of the mandatory provisions that you've discussed, regarding Minnesota, and there has not been a proportionate number of beds.

Recently, the Texas Legislature passed two provisions that will increase the number of chemical dependency beds. One is that there is no longer a requirement that a certificate of need be issued for alcoholism treatment programs. And second, that insurance companies cannot refuse to pay for alcoholism treatment.

Those two provisions were passed very benignly, or because of some very benign pressure by some public officials who had been unable to obtain alcoholism treatment in their State, and felt that it was a tragedy and it probably was, that people were not able to get the help that they needed.

It is the opinion of some health care providers and attorneys in the Dallas area, that because of those two provisions, the number of chemical dependency beds in the Dallas area could double in 6 months, or more than that over a period of a year or two.

There are a number of attorneys who are concerned about the fact that it's too easy, already, for parents to get children into these facilities, and they are quite distraught by these developments, primarily because the number of beds will probably lead to a number of questionable admissions, again, as you've discussed earlier.

I admit as the committee has discussed, that the whole issue relating to this type of care is very difficult to assess objectively. However, I would point out that the effort to identify a need is probably the most difficult part of this issue to assess because the need in a real sense is created by the existence of the program.

There is not available and again, as has been discussed earlier, neither in terms of the private providers, for-profit providers, a wide range of alternatives and options. None of the chemical dependency programs offer a halfway house, for example, nor foster homes or some type of intermediate care, other than outpatient.

One of the persons with whom I spoke recently suggested that she did want to develop a new program that would offer a halfway house as an alternative. If she does, it will be the first in the Dallas area to be offered. She also indicated that if she did provide this type of service, she would not be able to make a profit. It would be a break-even at best. So you can see that the financial motivation to establish that type of alternative is not there.

The public sector, as well, in terms of strictly chemical dependency, has not been able to offer parents a wide variety of alternatives, either. The mental health, mental retardation services in Dallas County, for example, have very minimal provision for community based care, for either alcoholism or chemical dependency.

For the most part, these alternatives are either not well-known and in almost every case, they are very inadequately funded. So you see, that a number of parents do face a real crunch, a real issue. They're looking for an alternative; they are looking for help. Even those who are balanced in their motives. Parents who are truly nurturing, who want some help, have difficulty.

The parents who are not quite so benign in their motives are less restrictive. They have little restraint in using the extreme alternatives that the lockups offer, and therefore, what happens is, essentially the children are in a position of having no power, no say, and they essentially are shuffled off to the most convenient alternative available.

It's an unfortunate combination of factors that makes that possible, and I think what you're dealing with is perhaps, as a grey area, you're not able to give a definitive answer to it, but I think you would at least need to address the issue of whether or not unrestrained growth of these programs is beneficial, as well.

Thank you, Mr. Chairman.

[Prepared statement of Albert Richard follows:]

PREPARED STATEMENT OF ALBERT RICHARD, JR., CHIEF JUVENILE PROBATION OFFICER, DALLAS COUNTY, TX

An attorney has been appointed to defend the application for involuntary commitment of an adolescent to a private hospital. The attorney goes to visit the young man in his room. He is strapped to his bed, totally immobilized. The attorney asks the nurse what the problem might be. The nurse explains that the patient violated his "treatment" plan by going to the bathroom across the hall without permission and being strapped down is the consequence he must suffer. This is evidently an intensive and restrictive treatment protocol which is supposed to improve mental health.

Another young man has committed a very violent offense. He is detained for many weeks. His high powered attorney seeks the best possible treatment for him since the family can afford to pay. While in detention he is a model inmate. Boyish and somewhat befuddled by his predicament, he is nevertheless controlled and well oriented to his incarceration.

The Court allows that he be committed to a private psychiatric facility as the disposition of his case.

Days after entering care, he rapidly deteriorates. The drugs he was automatically administered upon admission are increased in dosage to deal with his deepening depression. Ironic that a juvenile detention center can be more stabilizing and less depressing than a hospital. But not surprising.

Detention centers have a well established set of legal and professional standards and restraints. Psychiatric facilities have much more latitude and access to invade your body and restrain your behavior. Even with well developed mental health codes the prerogatives of the staff of a psychiatric facility far surpass the scope and intensity of the powers of criminal or juvenile justice facilities. Once a child is identified as a patient, there is great potential for intrusive and destructive interventions.

Immediately after employment in juvenile justice, I found myself besieged by parents eager to identify the cause of their children's behavior as lying in some form of psychiatric disorder. Requests for brain scans were commonplace and for a full battery of psychiatric evaluation. The implication was that if some form of illness were found the parent would be relieved of at least some of the responsibility for the child's misbehavior.

This desperation on the part of parents is not lost on health service providers. In the last two (2) years at least three (3) large corporations have considered, or have actually implemented programs and beds in the Dallas/Fort Worth area to meet the demand for an alternate for parents facing adolescent behavior problems including drug abuse. At least 115 new beds have been opened in the Dallas area during this time, and a much higher number is either being planned or considered.

Concern about the growth of programs, both public and private, for substance abuse treatment especially, has caused a local group of child-care providers in

Dallas to plan a local forum to examine the need and appropriateness of such an expansion. Both for profit and non-profit providers will participate.

There is every indication in Texas that there is significant motivation for hospitals to provide adolescent psychiatric and chemical dependency programs. Attorneys and child-care providers are concerned about this growth. The monetary motivators are obviously primary in causing such an increased corporate participation. Success of such programs requires marketing and recruitment energy which may not be restrained or checked by the accountability which the public sector faces. There is great potential to overuse the more profitable option of residential instead of non-residential services. There is an obvious inclination to diagnose and identify problems which require such care. Unlike the public sector. there isn't a sentiment or even a pretext that the business sector is attempting to work its way out of a job. Business is there to stay as long as the money is there. Not necessarily a laudable goal in the context of human services.

Recently, the Texas Legislature passed two (2) laws which will increase the number of adolescent care beds in the State. No longer is it necessary to obtain a Certificate of Need to open an alcohol treatment facility. Also, insurance carriers can no longer refuse to pay for treatment of alcoholism. But of these factors are expected to significantly increase the number of alcohol treatment beds in the Dallas/Fort Worth area. This is especially true since many hospitals are experiencing low censuses and since they can be reimbursed at actual cost by Medicare and Medicaid.

The number of available beds is the key to the real potential for abuse. The more beds the more pressure to fill them. Given that the juvenile system has increasingly made it difficult for problematic children to be dumped on itself, parents may easily turn to the private sector. Despite some legal safeguards in Texas, parents can essentially place their children in chemical dependency programs as easily as they can admit them into a hospital for appendicitis.

The whole issue of adolescent psychiatric and chemical dependency treatment is very difficult to assess objectively. Hospitals can, in most cities, easily fill existing beds and experience a waiting list at that. It is almost impossible to conclude that this means a true need is being met. The "need" may have been in a real sense created by the availability of the beds.

Therefore, some form of regulation and control needs to restrict not only the admission process, but the scope of treatment itself. There also needs to be some form of incentive for providing less restrictive forms of treatment and control. It should never be assumed that parents and health care professionals will automatically provide reasonable, balanced and appropriate interventions. Their motivations are too complicated and frequently self-serving to trust implicitly.

Finally, there is no question that many children and families are experiencing difficulties which desperately need to be addressed. Intensive hospital programs can be helpful and effective. As long as there are adequate safeguards, restraints, and cost controls, the benefits which can be provided will assist everyone involved, including the patient. Lacking a balance, we will see repeated the abuses which had been exhibited by juvenile justice when it was virtually unrestrained. Respect for children and caution in their care will result in the type of nurturance and interventions appropriate to the problem. A lack of wisdom could easily increase and aggravate what are usually only typical childhood and adolescent problems.

Chairman MILLER. Thank you, Mr. Richard.

Once again, we have a vote, and if you don't mind, I would like to go over and vote, and I'll come right back for the questions.

[Brief recess is taken.]

Chairman MILLER. Thank you very much for sticking with us. I'm sorry about the interruptions.

Dr. Schlesinger, your testimony is rather forceful about what we might expect in terms of the increased utilization of the for-profit mechanisms. And when I think sometimes that you're overstating the case, I listen to Mr. Richard, whose concern is that the chemical dependency units can circumvent the certificate of need requirement, I assume under the guise that it's an alcoholism treatment program. Mr. Richard, are you using alcohol treatment program and programs for chemical dependency. One sounds broader than the other. Is it the same facility interchangeably?

Mr. RICHARD. In fact, at the last minute, a provision for chemical dependency was taken out of that law, and I raised that point with the person I was speaking to, and said, oh, no, they took out drug abuse. And she said, "what's the difference if they're using chemicals or—any kid with a drug problem's going to use alcohol. And so they will be brought in; they will qualify."

Chairman MILLER. Do you see that as a pretext by which the case load can be maintained?

Mr. RICHARD. This is a person in the industry, who said it's not going to be a problem.

Chairman MILLER. It's not a problem.

Mr. RICHARD. They're going to get them in.

Chairman MILLER. Well, that's one view of it.

Mr. Concannon, I'm encouraged by what you're saying. It appears, should the State desire it, and I don't have any way to measure at this point in our hearings, what Maine does as opposed to what California and other States do, but if the State should desire, you seem rather confident that they can maintain control over both public and the private facilities, operating together. This seems to be the nub of your case.

Mr. CONCANNON. Correct. And I think there are a number of reinforcing elements, and one is the reference here to the certificate of need, the kinds of laws and policies. Maine has a fairly stringent certificate of need, encompassing certificate of need law. But as well, at the policymaking level, cabinet level officers who by agreement have said any children's residential center coming into the State under any degree of intensity, whether it's just a group home or whether it's a residential treatment center, by policy, the proponents must come and deal with all four agencies in one matrix, one locus of operation.

And that has helped, I think, actually helped those who would provide the service, and it's certainly helped the State. Because, previously, and I've been around State government for about 10 years, people would come in serial fashion, and what they didn't get from the mental health agency, they would go to the alcohol agency or social service agency or somewhere else, and the right hand did not know what the left hand was doing.

I think if you get a policy that is affirmed at that level, and then what has helped overall in all of this is that we have strong legislative and, obviously, gubernatorial support to support the idea that we didn't want to encourage just pure market forces. There ought to be a relationship between persons opening the door for some type of service, and what the judged needs are of the State. They are unavoidably impacted, if you will, in the broader area of children's services by what the mix of services are.

If there are no group homes, for example, for children of various categories, then you're going to get a lot of pressure on more restrictive hospital based beds, and so we have to look at the whole system as our view as well, and that's where it helps to have this kind of planning vehicle at the State level. It helps all of us.

Chairman MILLER. Let me ask you this. Maine has their share of low income families, if I remember correctly.

Mr. CONCANNON. Very definitely. I think we're 41st in the country in terms of per capita income so it's a relatively poor State.

Chairman MILLER. Right. I recall this because your Governor did the report on children's accidents?

Mr. CONCANNON. Correct.

Chairman MILLER. Which compared and found poverty to be significant and also a predictor of accidents. In this health care system that you're talking about, you said you have a mandatory insurance coverage?

Mr. CONCANNON. Yes; we have mandatory mental health and mandatory substance and drug abuse coverage for outpatient services. It was available previously for inpatients, but the legislature mandated outpatient services. This is where there was a previous tendency for persons, even Medicaid, for example, to reimburse more intensive inpatient services, and over the past several years, the outpatient aspects of both Medicaid, as well as private insurance, have been mandated by the legislature.

Chairman MILLER. Do those individuals who are covered by private insurance, do they use public facilities?

Mr. CONCANNON. Yes. Definitely.

Chairman MILLER. So you would have a mix of clientele of working poor, unemployed people, middle-class people?

Mr. CONCANNON. Absolutely. We operate, my department operates the State hospitals, for example, fully JCAH accredited. There are other factors, I think, should be brought out too. If one maintains accredited state of the art public facilities, then people tend to retain their confidence in them, but if they are neglected, like the classic State hospitals of old, then people are going to go elsewhere.

Well, we maintain accredited staff, and we get a wide variety of income levels in our hospitals.

Chairman MILLER. Let me ask you this, and Dr. Schlesinger, you may want to comment. It seems to me that if I was sitting out there as a consumer, and I was having trouble with one of the adolescents in my family, or concerned about them, or suspected something, it seems to me the message I would be receiving is that the public facilities are being cut back, or they're not working or they're less available, and all of a sudden in the middle of a Sunday night program, comes on an advertisement which says bring your child to us. I just wonder how, if the State desires to keep these two tracks from spreading apart, how do you integrate those programs?

Is there any attempt to have a requirement, either in Dallas or Massachusetts, or Maine, that these private facilities take children of unemployed parents or people who can't pay the rate. Or is this really the beginning of a separate system starting of adolescent health care being launched?

Mr. CONCANNON. Well, I can't speak for the other States, but that general concern about creating or encouraging a two-track system was very much in our mind in Maine, when we had a major proprietary hospital come in and open up for business, more recently. And during the certificate of need process, we testified; we have working protocols with that hospital, and in fact, anticipating proprietary hospitals coming in, the Maine Legislature enacted legislation that says, by statute, a person cannot be transferred from a

private hospital to a State hospital for other than medical reasons, and I must approve that.

That is, that recommendation is made to the commissioner of mental health, and the purpose of that legislation was to preclude the possibility of persons using up their insurance benefits after 30 days or whatever the limits might be, and then being transferred into the public system. So I think we've anticipated that in our case. And I haven't seen any evidence of that, of dumping or——

Chairman MILLER. Let me ask you this. There's a fair amount of concern, again in the area that I come from, in medical cases, of "dumping" people without insurance. I've had a number of tragic cases right in my own district, where people have been transferred and pushed from hospital to hospital, and finally have died before they were provided surgery or care.

The allegation is being made that the hospital's determinations are being made because these people have no insurance. That seems to be the direction they're going. You're suggesting you've been able to stop such "dumping" in Maine?

Mr. CONCANNON. We have been able—Maine is a system principally of community based nonprofit hospitals. And between their obligations to provide a certain amount of free unreimbursed care, as well as the Maine Medicaid system is another factor. We're a State in which an overwhelmingly high percentage of physicians and hospitals participate in Medicaid, as compared with some numbers I've seen in some States, the numbers of physicians who agree to accept or serve Medicaid. We haven't had problems along that line, so I haven't seen evidence of that. I'm not aware of that as an issue in the State of Maine.

Chairman MILLER. Would that certificate also require a facility such as we're talking about, a chemical dependency facility, a psychiatric facility, to have criteria for admissions?

Mr. CONCANNON. Yes.

Chairman MILLER. That's one of the things it has?

Mr. CONCANNON. Yes.

Mr. SCHLESINGER. Could I comment on this question?

Chairman MILLER. Yes.

Mr. SCHLESINGER. It seems we're in a peculiar kind of double bind, here. On the one hand, we're concerned, and rightfully so, with creating a two-track system for hospital care. There are some States, by creating indigent care pools for hospitalization, which address that concern directly. However, by creating indigent care pools for hospital care, we've now created the opposite problem: We're hospitalizing everyone again, which is exactly the problem we wanted to avoid.

Chairman MILLER. In the mental health area?

Mr. SCHLESINGER. In mental health side. And unless we come up with some way, it seems to me, of providing a balanced system of payment for people without insurance, not just for hospitalization, it seems to me that our efforts to avoid two-tracking will inevitably lead to more hospitalization of the mentally ill.

Chairman MILLER. Let me ask you this. Assuming good faith and a strong public interest desire, does the system that Mr. Concannon outlines work toward the prevention of such a two tracking system?

Mr. SCHLESINGER. I think it does. I think Maine's been very progressive in that sense. At the same time, I think we have to recognize that the trend nationwide is in the opposite direction. The States are dropping their certificate of need programs and are pulling back from the direct provision of mental health care, going to contracting with private providers, with relatively little control over that system.

And so, although I think Maine represents very nice example, I'm not sure it's one we can place a lot of faith in for the country as a whole.

Chairman MILLER. Again, as politicians, we're products of our own environment, but I've seen two of my public hospitals convert to private hospitals in the last month. This seems to again follow what you're suggesting, Dr. Schlesinger. In moving to a more competitive mode, like the private providers, they're moving to position themselves so that they can compete.

So I would assume that I will then see a greater emphasis being placed on receiving this kind of reimbursement?

Mr. SCHLESINGER. I would suspect.

Chairman MILLER. Congressman McKernan?

Mr. MCKERNAN. Thank you, Mr. Chairman. I apologize for arriving at the 11th hour. I want to welcome the Commissioner from my State, and say that——

Chairman MILLER. He brought the little ray of hope we've had in this committee all day. Welcome him warmly.

Mr. MCKERNAN. Well, I think you'll find that if you look at the number of the programs that have been implemented in the State of Maine, that there is a lot of hope for what States can do in a creative and progressive way.

But to the Commissioner, I'd just say that I've been testifying in another hearing, which I thought was going to take half an hour, and it was 3 hours, but hopefully that will mean more jobs in Maine in the lumber industry which will give us more funds to implement important programs such as his.

Speaking of certificate of need, in my real life, before I became a Member of Congress, I was very involved, as you remember, Kevin, in the institution of that law.

Mr. CONCANNON. Yes.

Mr. MCKERNAN. Has there been any problem with regard to private hospitals with the skimming concern that many people had? Obviously, it was finally determined that in Maine, at least in the one private psychiatric care hospital, that was not going to happen; what has the experience been?

Mr. CONCANNON. I think, really, the Maine law, the certificate of need law, put that proposal through vigorous review and the legislature, on a bipartisan basis, considered the potential of it, and we have not seen any evidence at this point, of the skimming, and we have been quite sensitive to that, obviously.

I think, as I mentioned to an earlier question, the historic commitment of the legislature to maintaining the State hospital system and the community mental health center system at an accredited and decently financed level has played a major factor, too, in retaining public confidence in the system in our state.

Mr. MCKERNAN. Let me ask you a more philosophical question, Kevin, about the future, if this trend continues and more and more for-profit hospitals started to develop. I guess you mentioned to the chairman that in Maine, we don't really have a history of that; I mean, this is the first facility of this type that ever came in, so that we were just a little concerned and we did have the foresight to make sure that they would be subjected to rigorous testing before they were approved. But do you see, under the certificate of need process, whether or not we are adequately protected, if we get more and more of these applications, even if they can demonstrate a need? Will they be changing the way services are related, so that one group of people are going to these private hospitals, and another group of people will go into the other not-for-profits?

Mr. CONCANNON. I would hate to see that happen. I clearly would. And, at this point, I don't see evidence of that in Maine because the system, the community-based hospitals, as well as the tertiary hospitals, there's a very well integrated system of care across the State. We're one of the States that has all graduate, so-called graduate level community mental health centers.

That's again a tribute to the legislature over the years, we still have holes in our system. I'd have to say that but we have the basic rudiments of a basic health care system that at this point, unless something just cataclysmic happened, I don't see us going the route of what apparently is happening in some parts of the country.

Mr. MCKERNAN. If you could just give the committee, a cursory in nature, and if you have any other more thought out explanations after, if you could furnish it in some kind of written testimony, some of the growing pains you may have had in your inter agency approach. Because you talked about in your testimony the great successes, especially in the deinstitutionalization and a very different focus on how we're delivering services, which I think is very important and I guess I'm not as pessimistic as our other experts and witnesses here, but I think we're doing great things in Maine, and that we're on the right track, but there may be some learning curve issues that you might be able to share with us as to how other States could get into it.

Mr. CONCANNON. Well, certainly, the inner agency effort in Maine has had to overcome some traditional turf boundaries, if you will, of persons, all agencies, for example, guarding the respect of Federal streams. If I'm the mental health agency, I'm going to be careful about, for example, mental health block funds, right now. I don't really want to spend them on child welfare, and conversely, the child welfare agency doesn't want to expend title 20 moneys on children's mental health, and then you get alcohol, drug abuse, and other factors like that.

So we've had to kind of overcome some understandable uneasiness about, are you trying to reach into my back pocket, even for good purposes, and expend limited resources. So, it's been a process that has grown over I'd say the 10-year period, and it was rather cumbersome and complicated initially where we had a lot of people in the middle levels of State government negotiating things back and forth, and it became I think terribly bureaucratized at one

point, and got out of control. The cure was almost as bad as the illness.

A couple of years ago, we streamlined that down, and took the department heads, and said, let's limit it to the department heads and their deputies; allow real people to do the staff work for you, but limit the decisionmaking to the four department heads.

And we've seen the advantage with limited State and Federal resources of our kind of throwing our oar in together and that's been advantageous, you know, really to all of us to keep people out of our hospitals and institutions. I was reminded of the fact that, for example, in public psychiatric hospitals, it follows an earlier question about public-private, across the country in the early 1960's, there were 500,000 people, more or less, in public psychiatric hospitals, and about a quarter of that number were children and adolescents.

If you look at that numbers now, there are under 150,000 people in the United States in public psychiatric hospitals, and considerably less than a quarter of them are school-aged children or younger, and that's the case in Maine. We have 600 State operated beds, and we have about 40 young persons, aged 18 and younger, in those beds. So we have definitely considerably reduced the utilization of hospitals for this group of persons. We learned it over time and I think it's trust; I think the legislature has been important. In Maine, as you know, the legislature tends to stay close to the executive branch, and if they sense our going in a direction they don't want to affirm, then they can very appropriately call us before them, and they have tended to stay along with this and have been supportive of co-mixing, if you will, State moneys for agreed-upon policy directions.

The numbers of children in foster care in our State have gone down from a high of 2,500 and now are around 1,900, and again, that's been with legislative support for home-based care.

Mr. McKERNAN. Thank you, Mr. Chairman. I just want to again welcome my Commissioner. Thank you, Kevin.

Chairman MILLER. Thank you, John, for coming to the hearing.

Mr. Richard, how long have you been in probation work?

Mr. RICHARD. Fifteen years.

Chairman MILLER. You've obviously had a great deal of contact with a substantial number of young people in your area.

With the growth of the new beds for chemical dependency psychiatric treatment, have you had any representatives of these operations come to you and suggest that you ought to be bringing people, or people in your department ought to be bringing the families of young people to them for services?

Mr. RICHARD. The recruitment efforts are quite aggressive. Each of these corporations or hospitals that set up these programs need to fill the beds. And we have been approached, and, in fact, we studied carefully and we have even contracted with some of these facilities on occasion. Probably no more than, in the past 2 years, no more than five children, where we paid part of the cost.

But when we had a child that we thought it was appropriate and needed that type of care, we'd make an effort to pay for it, and in some cases, we shared the cost either with the parents directly, or their insurance company.

Chairman MILLER. Have you established your own guidelines in terms of the probation department on when you would use those facilities, and when you wouldn't?

Mr. RICHARD. Right. We make a careful assessment of the case, and of course, it has to be approved by the juvenile court.

Chairman MILLER. Is it your impression that the representatives of these corporations and these programs would like you to use them more than perhaps you are?

Mr. RICHARD. Well, I'll tell you one conversation I had with one of the recruiters. I said——

Chairman MILLER. When you say recruiter, what are we talking about?

Mr. RICHARD. Well, a person from the treatment program whose job it is to fill the beds. And they've used the term recruiter to me, and/or marketer.

Chairman MILLER. That's what I was afraid of, but go ahead.

Mr. RICHARD. Both terms have been used by these individuals.

Chairman MILLER. Marketer and recruiters.

Mr. RICHARD. Marketing and recruiting. In fact, I think that's the job title, if I'm not mistaken. One of them was in danger of being fired because her beds were not full. I had a conversation with one of the marketers, and I said, "What kind of pressure are you under to fill these beds."

And she said, "Well, I had a conversation with the boss the other day, and he just said, "Well, I know you think that you're trying to provide care, and you're trying to make sure that it's appropriate and meaningful. But I'll tell you this: the beds better be full."

Chairman MILLER. That's a pretty heavy indictment.

Let me ask you this. To the extent you can, this recruiter or this person that was engaged in marketing that you had this conversation with, or others that your familiar with, what is their professional background?

Mr. RICHARD. Usually some kind of background in counseling or working with children. Education, probation. I know of one who came directly from juvenile probation, not my department. Another who came from school counseling background.

Some, I know of one or two others who had no background necessarily, in that field. There is a certain professionalization among these people, now, let me emphasize. Most of them very much want to do a good and appropriate job. And, in fact, they take some pride in saying I'll refuse to recommend hospitalization unless I really think it's necessary, but that is up to them, as individuals, for the most part, because they will apparently get no flack back at the home office, if they recommend hospitalization and it's not really necessary.

Chairman MILLER. So you don't really—and again, I'm just asking for your impressions—but you don't see a real peer review operation in effect here, in terms of whether or not that initial recommendation or acceptance is appropriate or not appropriate?

Mr. RICHARD. No. I asked the question, just before I came, of one of these persons. I said, now I'm a little confused—and I am confused somewhat on the law, itself—as it relates to both involuntary mental health commitments and chemical dependency commitments.

I said, I'm a parent and I come in and say, this is my kid, I found some marijuana. I want him hospitalized because I'm afraid of what's happening to him. And I said, can I force that kid to go into that unit?

No, because we have to do an assessment.

I said, no, I'm not asking that. I'm asking can I, as a parent, force the kid in. And when I finally got through all the professionalism and "we don't do that," and all that stuff—and, I might add, the statement was made—"A good program wouldn't do that," but I said, "A bad program could do it, couldn't they?"

I was told yes, the kid would have no alternative since she would be locked up.

Chairman MILLER. Do you have any experience where these lockup programs are desired by parents who are seeking to avoid an adjudication by the court with respect to behavior or actions by their children?

Mr. RICHARD. By the very nature of that dynamic, that means we would never see them, so it's hard for me to answer that.

Chairman MILLER. Well, I mean in cases where there's been an arrest; there's been an arrest and you might not see them because they're not officially on probation.

Mr. RICHARD. Right.

Chairman MILLER. In cases where there has been an arrest and the parent desires not to have their child subject to an arrest, or subject to punishment, for whatever reasons, is there any effort to use these facilities to plea-bargain?

We'll put our son or daughter into one of these programs, and we'll see how that goes. Sort of an informal diversion program?

Mr. RICHARD. Yes. There is an effort, and in some cases, it's even an alternative that we, as the juvenile system, can hardly pass up. If we think it's an appropriate, if we think the parents are being responsible for the most part, we'll go along with it.

I think the probation officers in the department would be very reluctant to agree to something like that if they felt like a child was simply being railroaded, but here again, the dynamic is built in. It's an alternative that we would have to seek if we had that child. So, if it's—and especially if it's somewhat voluntary on the child's part, we're going to say, let's pursue that.

Chairman MILLER. What other alternatives would normally be available to you if you didn't have this one, in the community? Would they be limited or extensive?

Mr. RICHARD. They would be limited. We have one mental State hospital that we do refer to, as does a large part of the State, that would provide inpatient care, and we have very limited public community based counseling or family programs, very limited.

Chairman MILLER. Without passing judgment on this kind of program or facility, somebody in your position, or people who work with you, or people who work in the juvenile justice system, would clearly have to eye these progams as a resource?

Mr. RICHARD. Yes. And we have, from the beginning. Actually, this development, as I mentioned in my written testimony, is somewhat new in terms of this number of beds being available.

And the only thing that I was cautious about from the beginning was the involuntary placement of children in these programs—and

the pressure to fill the beds. But, as far as we were concerned as the juvenile system, yes, if it can be worked out through the insurance, through the parents, or through our partial payment, this is a resource we probably will be able to use on occasion.

Chairman MILLER. Are you talking about such care as a formal condition of probation?

Mr. RICHARD. Either. Either an informal agreement or a formal condition. Typically, our involvement would be——

Chairman MILLER. I talked earlier about a funneling operation it appears that there's a number of different avenues that can lead a family to this kind of facility.

It can either be an almost casual mistake in diagnosis, as in the case of Marissa, or a more formal condition of probation or sentencing or diversion within the juvenile justice system, but the result is one of these facilities is used.

Mr. RICHARD. Right. Ironically, however, I think, in the juvenile system, because it goes before the court, because the attorney has a mandate to represent the child's best interest, because the probation officer has a mandate to represent the best interests of the child, what will generally emerge is an appropriate admission.

Chairman MILLER. All right. But this raises a question Mr. Schwartz raised earlier. The children who end up in this facility may be there under completely different circumstances. You may have a young person who's placed there under court's direction with an identified case plan as to what's to be done during that 30 days, or 60 days. You may have another child that may be there for almost identical reasons, but really has no benefit of an attorney, or the supervision to see whether or not proper care is being carried out.

So we have numerous ways to get into the system, and we have numerous dualities in the system in terms of the treatment or the protections that exist for young people.

And the good news is that you're telling us that the number of beds in these units is growing in the Dallas County area? And it appears to be growing across the country?

Mr. RICHARD. Right. Did I say that was good news?

Chairman MILLER. No. Well, this committee always starts out with a little subject for a hearing, and we find out we're up to the top of our waders in water.

I don't want to prolong this point. However, Dr. Schlesinger, I would appreciate your further comments. What you describe as a trend and something we ought to be looking for concerns me because at last in Dallas County and San Francisco Bay area and maybe in Minnesota, it's arrived. It's here. I mean these 30-second spots are run all of the time, and we listen to Dr. Egan and Mr. Richard and see a growing number of young people with severe problems on the horizon.

Mr. SCHLESINGER. I think that's quite right. I tended to cast things in the future tense, more than in the present tense, principally because I see this not as being confined to the for-profit providers. It is spreading to providers in other forms of ownership, as well, as they compete with the for-profits. So, to some extent, we're seeing the tip of the iceberg labeled for-profit now. It may very well foreshadow a direction in which the mental health care system as

a whole is going to be moving, where everyone will become more aggressive at marketing, recruiting and other euphemisms for getting people into their facilities.

Mr. McKERNAN. Will the gentleman yield?

Chairman MILLER. Wish I was from Maine. What?

Mr. McKERNAN. I don't blame you, especially this time of year, Mr. Chairman. He said he wished he was from Maine.

What can State governments do to try to restrict this trend that you've identified? In other words, what can State governments do to try to put a different focus on the delivery of services and try to get more to the way Maine has gone about it?

Mr. SCHLESINGER. Well, let me begin by noting one thing that State governments shouldn't do. It seems to be not a wise course to simply say, we don't like what the profit motive does; let's make the for-profits illegal. Because, very often, what that simply does is drive the same people into creating subterfuges of not-for-profit organizations.

A classic case was California in the early 1970's, when they set up their pre-paid HMO's for Medi-Cal patients and forbade for-profit HMO's. And sure enough, they got for-profit behavior in ostensibly nonprofit HMO's.

So that doesn't seem to be the right route to go. It strikes me as being more useful to take all non-profit and for-profit facilities, as private facilities, and attempt to define with them, much as I think Mr. Concannon described, a contract for what their responsibility is to the community.

Very often, for-profit providers are very good at providing in-patient care. I think nothing I said earlier should be used to denigrate the quality of care they deliver on an in-patient basis. It's just that very often, they do less well at delivering the kinds of services at broader community ramifications, often involving outpatient care. That's in part because we have never clearly in the history of our health care system, told institutions, what their responsibility was, as private facilities, to the community in which they operate.

In the absence of that sort of statement, it's very easy for a private enterprise to think internally, not to think of the broader community. We rely on the altruism of private, nonprofit providers to take care of those broader community interests. And I think that altruism is very rapidly being eroded.

Mr. McKERNAN. I guess one of the problems I have, and I guess I would accept your wisdom on the subject, of not trying to ban for-profit hospitals.

But my general theory of corporations and corporate law is that you ought not to expect them to do anything other than what is in their own self-interest and is going to provide a reasonable return to their stockholders. That is why we have government agencies that put restrictions around them.

Fortunately, there are some corporations which have a social conscience and do try to do things. But I think that just because of the nature of the beast, that you just ought to understand that. We ought not to say that's bad or that's good, that's just a fact of life, and therefore, I think there is a greater need for an awareness on

the part of the health planners, especially in the health care field, to take a good hard look at that.

That not-for-profits don't have quite the same demands for money for turnaround investments, so that they don't have the same needs. Probably, there's a different atmosphere there than there is in a for-profit.

Mr. SCHLESINGER. I think that's true. And I certainly didn't mean to say that there are no differences related to ownership. Simply that those may diminish over time. One other approach which I think may prove quite successful is to build on a strength of for-profit facilities: rapidly and widely supplying services once the general state of the art is fairly well-known.

One of the problems with the out-patient side of mental health care is that the state of the art is not terribly well-established. One approach, I think, therefore, would be to try to develop an out-patient system, perhaps in the public hospitals, perhaps in private, nonprofit, that could be used as a model that the for-profits could emulate.

I would predict that if you develop one that works, that as long as it's reimbursed by insurance, it'll be very quickly emulated.

Mr. MCKERNAN. It seems to me that the for-profits have a greater marketing mechanism because of the incentive to do that well, so that perhaps, you're right. They're not big on research and spending the money for new ways of delivering services, but, rather, maximizing the return, once somebody else has developed that particular system.

Again, that's just another fact of life; not an indictment.

Mr. CONCANNON. Just to add to something that Congressman McKernan raised a question about for-profits. Even in instances, it's been our experience, the Maine way, that for-profits give, let's say, community services where a percentage of patients are admitted without means. All that means in a proprietary organization, is those costs are shifted to the patients who do pay.

So there are some limits to that, too, in the sense that if you admit one out of five patients for free, then you just charge the other 80 percent of the persons coming in a premium, to offset that. So, it's kind of an informal taxing system.

Chairman MILLER. If I can just interrupt. One of the concerns would be that you try to keep some integration of the system, some cross-pollinization there, if you will, of not only the clientele, but of the delivery systems, so that you don't end up with two entirely segregated systems.

Mr. CONCANNON. Exactly.

Chairman MILLER. And there's nothing wrong with a public system being reimbursed by private insurance. Looking at the issues of chemical dependency and drug abuse and our 20-year effort to deal with it, one of the lessons we've learned is that it's sort of different strokes for different folks.

There's things that work for one group of people, and dont't work for another, and there's people who can deliver services to a group, and can't reach another group. It's a kind of a quilt of services that are necessary, if we're going to reach the general population. And I just hate to see, whether you call it creaming or dumping or segregation, or whatever, where one system takes off in one

direction and leaves some without proper diagnoses and care. That's why I'm encouraged by the way you've set it up in Maine.

Mr. CONCANNON. I certainly agree. What's been going through my mind during this exchange back and forth, is that perhaps one of the most effective things States can do, or counties, in the States where county government is a very controlling force, is to make sure that their own publicly shaped so to speak public and nonprofit, as well as proprietary systems, don't fall below a certain threshhold that people vote with their feet, and start going to these proprietary, I mean, in disproportionate numbers. And I think some States have been too driven by their ideology in the whole mental health field to say, let's pay attention to whether this is a State-operated facility or not, more than what kind of care is provided to people.

And we're seeing that right across the country, I think, right now. States like Maine, fortunately, with good Yankee values, resisted some of these more trendy approaches, in other parts of the country, to closing their hospitals and so severely limiting the ability of the public agency to do the job.

And, fortunately, now the trend is coming back the other way. People are recognizing that it was all not a halcyon kind of world out there, and the proprietary those new hospitals built. And I think one of the strongest things people can do is, at the State level, expect better services and demand it of the people that they appoint or elect.

Mr. MCKERNAN. Let's not get too radical in your recommendations. [Laughter.]

Chairman MILLER. Let me ask just one final question of Dr. Schlesinger. In terms of the structuring of the payment system, how do we design outpatient reimbursement, or payment, to try to avoid this segregation and breakdown between the public and private systems?

Mr. SCHLESINGER. Well, that's tricky, because part of the segregation has to do with who pays for care, and so when you're talking about tampering, you're talking tampering with the private insurance system, tampering with the Medicaid system and tampering with the Medicare system.

Its difficult to "fine-tune" a system this complicated. It is obvious, though, that the minimal and shrinking outpatient coverage under many States, created such a large incentive, that in some cases it's hard to understand why a profit-oriented facility would have any outpatient service. In fact, many of them don't. So, clearly, there's these broad changes by which you can try to better balance incentives.

On the other hand, it's very hard to know how you can fine tune things enough to get the right balance of outpatients and inpatients in all cases, because it clearly won't be the same for all patients. Some diagnoses and some conditions will make sense to institutionalize someone, whereas, in another slightly different clinical setting, and slightly different family support setting, you wouldn't want to institutionalize them.

It's hard to imagine tinkering with reimbursement systems at that level to try to deal with subtle incentives for or against institutionalization.

Chairman MILLER. Thank you. And thank you to all three panelists, for taking your time and sharing your thoughts with us.

The committee stands adjourned.

[Whereupon, at 12:45 p.m., the hearing was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM THE STATE OF MINNESOTA

The information that has been generated on the rise in the institutionalization of adolescents is startling. As Chairman of the Senate Finance Committee's Subcommittee on Health I am concerned both about the quality of care being provided to these kids and the needless costs to the total health care system.

Although the issue revolves around state insurance laws and state mandated coverage policies, I think we all agree that inappropriate placement and poor quality care are subjects that must be addressed by all levels of government.

A recent ruling by the U.S. Supreme Court confirmed the states' role in this area, upholding a Massachusetts law which requires insurance companies to cover mental health services in employer-based plans. Currently some 26 states have mandated coverage laws. Although well meaning, these laws have contributed to the rise in the numbers of children, placed in psychiatric treatment hospitals. The logic is simple: If the insurance company will pay, the incentives are for hospitals and treatment facitilites to admit.

And in fact, inpatient treatment is increasing at an alarming rate with no controls on quality, appropriate diagnosis, and appropriate placement. Over the last four years, institutional placement of adolescents has increased by 350%.

There are promising signs, however. Blue Cross/Blue Shield of Minnesota has taken the initiative in trying to prevent the needless institutionalization of adolescents. They have tightened their admission criteria and they have instituted a preadmission screening program for admissions to psychiatric treatment facilties. These initiatives led to payment denials for 20% of the cases filed last year.
I am hopeful that as other insurance companies are faced with increasing costs, they too will begin to look more closely at their admission criteria and the quality of treatment provided.

In the meantime, we should note that this issue also has an important federal facet. I think it is high time we examine our federal insurance policies and their mental health and alcoholism treatment benefits. Medicare and Medicaid have generally utilized inpatient, medically-based treatment facilities. Questions have been raised not only on the comparative effectiveness of inpatient care but also on its relative costs. I plan to further explore the feasibility of coverage for outpatient and freestanding treatment facilities. In addition, I intend to examine more closely Medicare's admission criteria for inpatient mental health and alcoholism treatment.

Congress should also direct its attention to federal laws governing employee-benefit plans. Under current law, employee-based insurance is under the jursidiction of the states and state mandated insurance laws. The self-insured, on the other hand, come under federal employee-benefit laws that do not mandate special treatment coverage. Justice Blackmun encouraged the Congress to explore the different treatment of employee benefit plans and I would concur with his advice.

I thank, Representative Miller for the opportunity to include my Statement in the Select Committee's Hearing Record. I commend the Committee for its work in this area and I look forward to hearing from my Minnesota constituents.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS, WASHINGTON, DC

Dear Mr. Chairman:

The National Association of Private Psychiatric Hospitals (NAPPH) appreciates the opportunity to present testimony for the record on the important issue of "Hospitalization of Children and Adolescents in Psychiatric Hospitals."

NAPPH is a trade organization representing the nation's freestanding, not-for-profit and for-profit, nongovernmental psychiatric hospitals. Our member hospitals offer programs for the care of children, adolescents, adults, the elderly, and alcohol and substance abusers with psychiatric disorders. Our members are all accredited by the Joint Commission on Accreditation of Hospitals (JCAH). NAPPH hospitals offer only active treatment programs for all types of mental disorders. Our membership accounts for more than 90 percent of the nation's private psychiatric hospitals which meet our standards for membership.

State licensing requirements for psychiatric hospitals vary considerably from state to state, and the term psychiatric hospital is used to describe a multitude of different types of facilities. NAPPH maintains strict requirements for membership. There are many facilities providing mental illness and substance abuse services to children and adolescents that do not meet these rigorous membership requirements.

The "Minimum Requirements" for NAPPH membership, which are appended to this statement, provide that all member hospitals must:

"* Provide medically directed inpatient services for the diagnosis, treatment, care, protection and rehabilitation of individuals admitted with psychiatric disorders;

"* Be accredited by the Joint Commission on Accreditation of Hospitals;

"* Have at least 50 percent of all hospital beds designated psychiatric beds, not inclusive of alcohol or substance abuse beds, or other medical care beds;

"* Be licensed as a hospital by the appropriate state agency or by an agency of equivalent jurisdiction;

"* Have an organized medical/professional staff;

"* Have a Board-eligible or Board-certified psychiatrist assume the medical direction of all patients with the primary diagnosis of a psychiatric disorder;

"* Psychiatric hospitals that are part of a university hospital system must demonstrate that the organization and function of the medical staff is independent from elected public officials and that the principle source of patient care funds are from private or indemnification sources.

"* Be a freestanding hospital facility and not a unit of a general hospital.

"In addition to these minimum requirements, a potential member must meet NAPPH standards and complete successfully an on-site survey by NAPPH. The standards for membership have been

approved by the Board of Trustees and are required of every membership category.

"I. **The Medical/Professonal Staff**

A. There must be a formal system of review of the credentials of the staff and the process of granting clinical privileges. All members of the medical/professional staff shall be granted clinical privileges based on their training, experience, and current competence in that clinical area.

B. Review of medical/professional credentials and clinical privileges shall be conducted at least biannually.

"II. **The Rights of Patients**

A. The hospital shall have written policies and/or procedures regarding patients' rights that address privacy; the use of high-risk or restrictive procedures, including seclusion, restraint, and behavior modification that employs noxious stimulation or deprivation of nourishment; and means to resolve complaints of patients or families.

B. Written hospital documentation must reflect implementation of these policies and procedures.

"III. **The Written Plan of Treatment**

A. Each patient shall have a plan of treatment which shall be written and revised periodically in accordance with time frames established by the hospital and related to the patient's progress.

B. The written plan must document the reason for hospitalization; state identifiable goals and measurable objectives with treatment interventions; demonstrate

participation by a psychiatrist in direction and supervision on an ongoing basis; and be reviewed and revised according to the patient's needs. Progress notes in the medical record relate to the plan of treatment.

"IV. **The Medical Record**

A. A medical record shall be maintained for each patient and shall demonstrate a consistent level of documentation of participation by a psychiatrist member of the medical staff and professional nursing care in the treatment of the patient.

B. The record shall show progress notes that reflect the participation by all professionals involved in the treatment of the patient.

C. The medical record shall reflect an assessment of discharge planning needs at the time of admission as well as ongoing review and coordination of discharge services throughout hospitalization.

"V. The Quality Assurance Program

A. The hospital must have a written, hospital-wide quality assurance program supported by the governing body and defining authority, responsibility, integration, and communication.

B. Quality assurance activities must include, but are not limited to: patient care monitoring activities; utilization review; credentials review and clinical privileging; facility and program evaluation; and staff growth and development.

C. The program shall demonstrate problem identification, assessment, correction, and monitoring.

D. Ongoing quality assurance activities shall be integrated into all major clinical services, including psychiatry, psychology, nursing, social service, activity service, and dietary.

E. The hospital quality assurance plan shall be reviewed annually.

"VI. **A Demonstrated Quality Environment**

The hospital must demonstrate a quality environment to meet the needs of the patients, with identifiable and adequate space and resources available to provide activity, rehabilitation, social and other indicated therapeutic services, including appropriate patient privacy.

"Before any hospital can be made a full member, a physician from a member hospital, the NAPPH Director of Patient Care Services, or a surveyor trained by the NAPPH Director of Patient Care Services must complete an on-site survey. The survey report is given to the NAPPH Committee on Membership and the Board of Trustees for consideration. Each membership application is reviewed separately.

"The surveyor reviews hospital documents including the state license. JCAH accreditation and any contingencies, the medical staff by-laws, the minutes of the governing body, medical staff and clinical committees of the medical staff, and the rules and regulations of the medical staff are reviewed. This is to

ensure that all such rules as written by the hospital are being followed and that there is appropriate monitoring of clinical practice."

"The survey must show that the hospital provides active treatment, that is, treatment that can be expected to result in improvement of the condition. Care from admission to discharge must be under the supervision of a psychiatrist. The surveyor looks for sufficient professional staff to carry out the plan of treatment as recommended by the physician. A registered nurse must provide coverage around the clock, and a physician must be available at any hour, every day of the week.

"The surveyor does a concurrent and retrospective random chart review to assure that all treatment procedures as ordered by the physician are administered, and that the patient's response to those treatments is recorded along with the patient's overall progress. There is a review of incident reports to assure that the hospital is providing appropriate assessment, review, and follow-up. The surveyor looks for fully implemented quality assurance and utilization review programs."

Child and adolescent admissions to psychiatric facilities are increasing because more of them are severely psychologically disturbed. The most recent President's Commission on Mental Health Report (1979), estimated that 1.4 to 2.0 million adolescents have severe psychological problems. More current objective studies confirm these figures. Tragically, these severe

psychological problems often manifest themselves in suicide. An American teenager takes his or her own life once every 90 minutes, and this year an estimated two million young people between 15 and 19 will attempt suicide. Suicide is now the third leading cause of death among young Americans.

Fortunately, the American public is becoming increasingly aware of the problem and increasingly accepting of the need for appropriate treatment. Public education campaigns have contributed to this heightened awareness of the growing numbers of troubled youths. Mrs. Reagan's efforts are but one example of the work being done to draw public attention to this problem. Increased health insurance coverage for treatment of mental illness is a reflection of a more enlightened public attitude. The psychiatric community has responded to this demand for psychiatric services by initiating new programs and expanding facilities.

NAPPH knows that the hospitalization of a child or adolescent is a very serious matter, and an often traumatic event for the patient and the family. To help ensure that admissions are medically necessary, NAPPH's member hospitals must, as a condition of membership and JCAH accreditation, establish and adhere to specific admission criteria, carry out thorough psychiatric and medical evaluation, and employ extensive treatment and discharge planning. Only a psychiatrist can admit a patient to a NAPPH hospital, cutting down dramatically on the number of inappropriate admissions to NAPPH hospitals. However,

it is important to understand that diagnosis alone cannot determine the need for admission; the need for admission can be determined only by the degree of psychopathology presented by a given patient at a given time. Diagnoses are poorly correlated with the degree of psychopathology, impairment or need for inpatient care.

In addition, inpatient care is recommended by a psychiatrist only when a lesser level of care will not be effective or is not available. NAPPH supports the availability of a full range of psychiatric services.

The Association has published model guidelines for admission and discharge of children and adolescents. These guidelines were developed, at the request of the Board of Trustees, by psychiatrists who specialize in the care of children and teenagers. Attached is a copy of these guidelines which we request be printed in its entirety in the hearing record.

NAPPH's guidelines note that "only a small percentage of children and adolescent patients need acute-care hospitalization. Hospitalization is indicated under the following circumstances:

"* Outpatient treatment is not feasible due to:

1. Failure of outpatient treatment.
2. The patient is too acutely ill for outpatient treatment.
3. Treatment in a less restricted environment is not feasible because of the patient's response to his/her total life situation.

"* The patient's clincial picture includes the expression of conscious or unconscious conflicts through the use of surface behavior which is dangerous to the patient, to other, and/or to property. Such surface behavior may include overt suicidal or homicidal acts, but also may include behavior which, although not an immediate threat to anyone's life, is clearly so self-defeating and/or self-destructive that immediate acute-care hospitalization is the only reasonable intervention. Examples of such behavior include instances of fire-setting, sexual promiscuity, running away, and drug abuse.

"* The patient's demonstrated inability to function in one or more of the three major areas of life:

1. The family.
2. Vocational pursuits (which for most children and adolescents are educational in nature).
3. The choice of cummunity resources. The basic question in this area should be whether the patient uses community resources which are constructive to his/her current life situation or does he/she select resources which are predominantly destructive in nature. (Community resources include but are not limited to vocational interests in school, church activities, scouting activities, the expression of hobbies and/or special interest in the community, as well as the individual's choice of peers for nonstructured community activities).

"* The patient's symptomatology is worsened by the absence or collapse of his/her support systems--especially the family--to

the degree that intervention at the level of acute-care hospitalization is warranted."

"It is important to understand that admission can only be determined by consideration of the degree of psychopathology presented by a given patient at a given time. Attempting to determine criteria for admission by other means, such as diagnosis, simply does not work with child and adolescent patients.

"The following are examples of reasons which may justify the need for acute care psychiatric hospitalization of a child or adolescent. A physician may use such a checklist to identify for the hospital staff the immediate reason for a patient's admission.

* Patient presents danger/potential danger to self.
* Patient presents danger/potential danger to others.
* Patient presents antisystems/bizarre bahavior that is destructive to the community.
* Patient is unable to attend to age-appropriate responsibilities.
* Patient demonstrates significantly impaired reality testing.
* Patient exhibits impaired judgement/logical thinking.
* Patient is unable to function in native environment (family, school, community).
* Patient's pathological behavior has persisted or escalated in spite of outpatient psychotherapy.
* Patient exhibits pronounced affective behavior disturbances.

* Patient demonstrates impending loss of control.
* Patient is in need of high-dose, unusual medication or somatic and psychological treatment with potentially serious side effects.
* The patient's support system is so disturbed by his/her behavior that treatment is jeopardized.
* A noxious native environment exists which jeopardizes the patient's outpatient treatment and a lesser level of care is not appropriate or available.
* The patient in his/her present state cannot function without extensive coordinated help from others.
* The patient needs 24-hour skilled comprehensive and intensive observation.
* There is a clinical need for an intensive inpatient evaluation.

"This list of specific indicators can never replace sound clinical judgment by a psychiatrist at the time of evaluation or consultation to consider admission to an acute-care hospital. They are only examples of clinical dysfunction."

NAPPH believes that its members have responded responsibly to the increase in the number of severely psychologically troubled youths by developing new programs and more and better facilities. NAPPH continues to support the development of appropriate alternative settings for psychiatric care, especially partial hospitalization programs. NAPPH offers the Committee its Guidelines For Psychiatric Hospital Programs for Children and Adolescents as its contribution to help assure that all admissions are medically necessary.

GUIDELINES FOR PSYCHIATRIC HOSPITAL PROGRAMS

CHILDREN & ADOLESCENTS

PUBLISHED BY
THE NATIONAL ASSOCIATION
OF PRIVATE
PSYCHIATRIC HOSPITALS

INTRODUCTION

The admission of a child or teenager to a private psychiatric hospital for mental illness is a serious matter. Family life is disrupted and parents are often distraught.

Hospitalization is also expensive. Although any hospital stay is expensive, mentally ill children and adolescents require more than just treatment for their illness. They require extraordinary resources to care for them, to educate them, and to help them cope with the implications of their illness.

The National Association of Private Psychiatric Hospitals, as the leader of the nation's nongovernmental hospitals, offers these guidelines as a model program for the psychiatric care of chlidren and adolescents. Criteria for admission and discharge are included. Our purpose is to help those involved in the creation of such programs and those involved in the reimbursement of patient care—insurance carriers, benefit managers and employers—understand the treatment needs of children and adolescents whose illnesses are severe enough to warrant hospitalization.

This model program was developed by the NAPPH Children and Adolescent Care Committee at the request of the Board of Trustees. The committee members are all psychiatrists in hospital and private practice who specialize in the care of children and teenagers.

This model program will be reviewed and revised periodically as new treatment methods and clinical advances in psychiatry change the nature of inpatient care.

Representing only the highest quality programs has been the mission of NAPPH since its creation in 1933. This model program with admission and discharge criteria for psychiatric care for children and adolescents is another indicator of our aim for excellence.

NAPPH Board of Trustees
March, 1984

1

MISSION STATEMENT

Every private psychiatric hospital has a focused mission for its clinical programs. However, a common thread should be woven into any mission statement: The inpatient treatment program for children and adolescents is to provide the *highest quality* of care possible to patients and their families. Such a mission is to be accomplished by creating a treatment environment which maximizes the opportunity for the patient and his/her family to resolve psychopathology and to resume a relatively sound, age-appropriate pursuit of developmental tasks.

2

PHILOSOPHY

The philosophy of a model child-adolescent model program should have as its basic ingredient the achievement of its mission statement, that is, to create a treatment environment which maximizes the opportunity for the patient and his/her family to resolve psychopathology and to resume a reasonably age-appropriate pursuit of developmental tasks. This environment must include therapeutic attention to the following areas:

- Skills of daily living.
- Psychoeducational and/or vocational remediation and development.
- Opportunities to develop interpersonal skills within a group setting.
- Restoration of family functioning.
- Enhanced utilization of community support systems.
- Any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family.

The major role of the psychiatrist in this process is to supervise and coordinate clinical findings into a comprehensive diagnostic formulation and treatment plan.

Underlying this philosophy is the premise that child and adolescent psychiatric patients, inevitably and by definition, vary in the successful achievement of age-appropriate developmental tasks. Patients will have had different degrees of success in mastering age-appropriate skills. Therefore, the clinical signs, symptoms, and needs of child and adolescent patients also vary greatly. The goal is to enhance the delivery of psychiatric care in settings which can provide the most age-appropriate specialized services for the recognition, evaluation, elaboration, and treatment of the physical, psychological, developmental, social, educational and/or vocational, avocational, family, and spiritual needs of child and adolescent patients.

We firmly support the use of these services on the basis of careful, individualized prescription of treatment after sufficient evaluation. We do not advocate a "shotgun" treatment approach which makes use of all services for all patients.

3

CRITERIA FOR ADMISSION

Only a small percentage of child and adolescent patients need acute-care hospitalization. Hospitalization is indicated under the following circumstances:

- Outpatient treatment is not feasible due to:
  1. Failure of outpatient treatment.
  2. The patient is too acutely ill for outpatient treatment.
  3. Treatment in a less restricted environment is not feasible because of the patient's response to his/her total life situation.
- The patient's clinical picture includes the expression of conscious or unconscious conflicts through the use of surface behavior which is dangerous to the patient, to other, and/or to property. Such surface behavior may include overt suicidal or homicidal acts, but also may include behavior which, although not an imme-

diate threat to anyone's life, is clearly so self-defeating and/or so self-destructive that immediate acute-care hospitalization is the only reasonable intervention. Examples of such behavior include instances of fire-setting, sexual promiscuity, running away, and drug abuse.

- The patient's demonstrated inability to function in one or more of the three major areas of life:
  1. The family.
  2. Vocational pursuits (which for most children and adolescents are educational in nature).
  3. The choice of community resources (including but not limited to avocational interests in school, church activities, scouting activities, the expression of hobbies and/or special interest in the community, as well as the individual's choice of peers for nonstructured community activities). The basic question in this area should be whether the patient uses community resources which are constructive to his/her current life situation or does he/she select resources which are predominantly destructive in nature.
- The patient's symptomatology is worsened by the absence or collapse of his/her support systems—especially the family—to the degree that intervention at the level of acute-care hospitalization is warranted.

It is important to understand that admission can only be determined by consideration of the *degree of psychopathology* presented by a given patient at a given time. Attempting to determine criteria for admission by other means, such as diagnosis, simply does not work with child and adolescent patients.

The following are examples of reasons which may justify the need for acute care psychiatric hospitalization of a child or adolescent. A physician may use such a checklist to identify for the hospital staff the immediate reason for a patient's admission.

- ☐ Patient presents danger/potential danger to self.
- ☐ Patient presents danger/potential danger to others.
- ☐ Patient presents antisystems/bizarre behavior that is destructive to the community.
- ☐ Patient is unable to attend to age-appropriate responsibilities.

- ☐ Patient demonstrates significantly impaired reality testing.
- ☐ Patient exhibits impaired judgment/logical thinking.
- ☐ Patient is unable to function in native environment (family, school, community).
- ☐ Patient's pathological behavior has persisted or escalated in spite of outpatient psychotherapy.
- ☐ Patient exhibits pronounced affective behavior disturbance.
- ☐ Patient demonstrates impending loss of control.
- ☐ Patient is in need of high-dose, unusual medication or somatic and psychological treatment with potentially serious side effects.
- ☐ The patient's support system is so disturbed by his/her behavior that treatment is jeopardized.
- ☐ A noxious native environment exists which jeopardizes the patient's outpatient treatment and a lesser level of care is not appropriate or available.
- ☐ The patient in his/her present state cannot function without extensive coordinated help from others.
- ☐ The patient needs 24-hour skilled comprehensive and intensive observation.
- ☐ There is a clinical need for an intensive inpatient evaluation.

This list of specific indicators can never replace sound clinical judgment by a psychiatrist at the time of evaluation or consultation to consider admission to an acute-care hospital. They are only examples of clinical dysfunction.

4

CRITERIA FOR DISCHARGE

It should be understood that individualized discharge planning is an ongoing process that starts with the patient's admission and initial evaluation. Discharge should be considered only when the following criteria have been met:

- Identification of the underlying issues and conflicts represented by the maladaptive surface behavior which necessitated admission. There is at this point in treatment a reasonable expectation that the surface behavior can be managed safely in a less restrictive environment.
- The youngster has an increased potential to function in a more reasonably age-appropriate way within his family, educational/vocational pursuits, and in the community at large.
- A smooth transition from the hospital phase of treatment to the post-hospital phase of treatment can be anticipated and thus further the therapeutic efforts made in the hospital. In the vast majority of cases, the hospital phase of treatment will be much shorter than the total treatment program. The post-hospital phase of treatment is often the most delicate. Not only must the patient integrate back into the family and community, he/she and the family must continue in treatment to continue to resolve underlying conflicts and to enhance further growth in the youngster's capacity to function in an age-appropriate way.

It is the responsibility of the hospital treatment team to identify the various areas in which the patient will need support following discharge. This is an essential part of post-hospital treatment and planning. These areas include planning for individual therapy, family therapy, educational and/or vocational therapy, Alcoholics Anonymous, Narcotics Anonymous, church, and/or any other such family or community support systems which may be appropriate for a specific patient. The inpatient treatment team must choose and prepare these potential resources and support groups for each individual patient's after-care program.

5

CRITERIA FOR LENGTH OF STAY

The criteria for the length of stay for the psychiatrically disturbed child or adolescent patient must be determined by the degree of incapacitation that the patient is experiencing in the three major areas of life—the family, vocation (for these patients, this is primarily school), and the community in general. Examples of the patient's functioning in the community includes (but is not limited to) his/her use (or lack of use) of such community resources as structured peer groups (scouts, extracurricular school activities, church, etc.), the individual's choice of peers, and obeying the law.

6

HOW PATIENTS OBTAIN PRIVILEGES

There are many methods by which the patient's capacity to assume increased responsibility within the treatment program can be measured and acknowledged by the treatment team. Some form of patient privileging is essential as one means of measuring the patient's progress in treatment. However, the specific form the privileging takes depends on the particulars of the program in which the patient is being treated. Often, the degree to which the privileging/disciplining system is a dynamic process is an accurate indicator of the degree of dynamics present throughout the program. The following criteria should be met in any privileging system:

- Patient privileges should be based on a dynamic process and not on a process of "automatic privileging." Privileges should be earned, not granted because a patient has been in a program for a given period of time, because a certain length of time has passed since the patient sustained a loss of privileges, etc.

- Whenever possible, the discipline inherent in a loss of privileges should be tied to the area of the patient's expressed irresponsibility. For example, if an adolescent patient smokes at a time or place in which smoking is prohibited, the loss of privilege should be tied to the smoking; if a child creates a particular disturbance at bedtime, the loss of privileges should be tied to bedtime.
- Privileges should be determined by the patient's individual level of responsibility as expressed in both the verbal and nonverbal messages given by the patient.
- The patient should have a gradual increase in responsibility or level of privileges while in the hospital so that discharge is at a time when the patient is used to assuming increased responsibility.
- Privileges and responsibilities should be related to specific treatment goals of the individual patient and his/her family.
- Patient privileges are distinct from patient rights. Privileges are a clinical treatment method. As such, when a patient's privileges are restricted, the clinical reason for such restriction must be documented in the medical record.
- Privileging should be a process in which the patient takes an active role whenever possible. In fact, oftentimes in dynamic programs the patient group participates in many of the privileging and disciplinary decisions and processes.

7

TREATMENT APPROACHES

There is a strong consensus that the multidisciplinary treatment team approach is the most useful in the inpatient treatment of children and adolescents. In fact, given the current state of clinical knowledge, we see no other option in treatment approaches to these patients. However, the composition of the treatment team may vary according to the needs of a particular patient and according to the particular treatment program being considered. What is not optional is the need for active communication among all members of a multidisciplinary treatment team. Good communication assures that all members of the team are aware of and pursuing the goals for the individual patient and his/her family.

The multidisciplinary treatment team approach is currently mandated by the Joint Commission on the Accreditation of Hospitals.

8

STAFF-PATIENT RATIO

Most programs treating children and adolescents require a higher staff-to-patient ratio than found in adult programs. It is essential that all staff be given direct, on-site supervision by professionals specially trained and experienced in dealing with emotionally disturbed children and adolescents.

Clearly, a specific staff-to-patient ratio is dependent upon the nature of the program being considered and the type of patient any given program accepts for treatment.

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9

OPEN VS. CLOSED STAFFING

Effective child and/or adolescent programs can be established with an open or a closed medical staff. The important variable is the degree to which the working cooperation between the physician and the total treatment team is developed and put into use. Without such close working cooperation, treatment is often fragmented, confusing, and inconsistent.

It is essential that the hospital administrator share with the medical director the responsibility to assure that a working cooperation exists between the open staff physician and the total treatment team, as well as among members of the open medical staff. Unquestionably, an open medical staff system requires much more administrative time than is necessary in a closed staff system.

10

CREDENTIAL REVIEW AND PRIVILEGING OF STAFF

We recommend the medical model for the private psychiatric hospital providing services for emotionally disturbed children and adolescents. This model dictates that there be a formally organized, traditional medical staff. Part of the medical staff's responsibility is to oversee the delivery of psychiatric care at all levels in the hospital. The medical staff by-laws should clearly identify the process by which privileges are granted and periodically reviewed. This responsibility should not only encompass the privileging of physicians but also of other professionals to whom the delivery of patient care is delegated in the treatment program.

11

OUTCOME STUDIES

It is essential for each program to evaluate the effectiveness of what they do both concurrently and retrospectively. However, the lack of standardization in outcome studies currently makes comparison of data from program to program quite difficult. What is needed is a multi-hospital outcome study. Such a study would provide hard data which is presently not available in the area of outcome studies of the inpatient treatment of children and adolescents.

12

PROGRAM EVALUATION

We approve of the present efforts being made to standardize program evaluation through program planning and by setting programmatic goals and objectives. An example of such efforts is the JCAH standard on program evaluation.

13

QUALITY ASSURANCE

A quality assurance program is essential in any private psychiatric hospital treating children and/or adolescents. A comprehensive quality assurance program helps to ensure the delivery of high quality psychiatric care and increases staff efficiency through objective patient care evaluation. Such a program should be a hospital-wide endeavor to improve patient care through the assessment of care rendered and the correction of identified problems. The five essential components of a quality assurance program are:

- Problem identification
- Problem assessment.
- Problem correction.
- Problem correction monitoring.

- Program monitoring.

In addition, the following areas must be integrated into the overall quality assurance program in order to accomplish meaningful assessment and in order to make appropriate responses on reported real or suspected problems:

- Utilization review.
- Audit.
- Infection control.
- Patient care monitoring.
- Facility evaluation.
- Program evaluation.
- Safety.
- Credentials.
- Staff growth and development.
- Policy and procedure development.

14

RESEARCH DATA

There are vital psychiatric issues that require research data that are not currently available. It is not reasonable to expect that each hospital should be able to develop its own research program. However, at a very minimum, each hospital should be expected to address any critical research areas identified through the hospital's quality assurance program. This is in no way meant to discourage those hospitals who have progressed to the point that they can do more refined research independently.

15

CONCLUSION

These basic criteria are essentials to any private psychiatric hospital program treating emotionally disturbed children and adolescents. Programs will and rightfully should take on different forms related to, among other things, the basic philosophy of the founding and/or key treatment staff, and the nature of the population being served. However, these guidelines are essential ingredients in the delivery of quality patient care in a safe and expeditious manner no matter what form a particular treatment program may take.

REQUIREMENTS FOR NAPPH MEMBERSHIP

PUBLISHED BY
THE NATIONAL ASSOCIATION
OF PRIVATE
PSYCHIATRIC HOSPITALS

INTRODUCTION

The National Association of Private Psychiatric Hospitals was created in 1933 to represent the interests of the nation's private, freestanding psychiatric hospitals and the patients they serve. The Association works at both the local and national level to promote high-quality care and treatment for the psychiatrically ill and to foster the cost-effective and efficient operation of the nongovernment hospitals that provide those services. NAPPH also assists member hospitals to achieve a level of clinical and managerial effectiveness consistent with the goals of high-quality care and efficient operation.

Currently, the Association has 224 member hospitals located in all regions of the country and ranging in size from less than 50 beds to more than 300. Member hospitals provide active treatment programs for the care of children, adolescents, adults, the elderly, and alcohol and substance abuse patients. NAPPH hospitals maintain active treatment programs, and treatment includes both inpatient and after-care services. Before consideration of its application for admission to the Association, each hospital receives a comprehensive survey of its facility, treatment programs, and staff.

These membership requirements will be reviewed regularly and revised as necessary to reflect new advances in inpatient psychiatric care.

NAPPH Board of Trustees
May, 1985

1

MINIMUM REQUIREMENTS

All member hospitals of the National Association of Private Psychiatric Hospitals (NAPPH) must:

- Provide medically directed inpatient services for the diagnosis, treatment, care, protection and rehabilitation of individuals admitted with psychiatric disorders;
- Be accredited by the Joint Commission on Accreditation of Hospitals;
- Have at least 50 percent of all hospital beds designated psychiatric beds, not inclusive of alcohol or substance abuse beds, or other medical care beds;
- Be licensed as a hospital by the appropriate state agency or by an agency of equivalent jurisdiction;
- Have an organized medical/professional staff;
- Have a Board-eligible or Board-certified psychiatrist assume the medical direction of all patients with the primary diagnosis of a psychiatric disorder;
- Psychiatric hospitals that are part of a university hospital system must demonstrate that the organization and function of the medical staff is independent from elected public officials and that the principle source of patient care funds are from private or indemnification sources.
- Be a freestanding hospital facility and not a unit of a general hospital.

The Association offers provisional membership to those hospitals that have been operational for less than one year, and associate membership to hospitals applying for membership for the first time. This two-year Association membership period gives the hospital the time necessary to receive a JCAH survey. NAPPH also offers a corresponding membership category to private psychiatric hospitals in other countries, for the purpose of exchange of clinical and administrative information.

2

STANDARDS FOR MEMBERSHIP

In addition to the minimum requirements for membership, a potential member must meet NAPPH standards and complete successfully an on-site survey done by NAPPH. The standards for membership have been approved by the Board of Trustees and are required of every membership category.

I. The Medical/Professional Staff

A. There must be a formal system of review of the credentials of the staff and the process of granting clinical privileges. All members of the medical/professional staff shall be granted clinical privileges based on their training, experience and current competence in that clinical area.

B. Review of medical/professional credentials and clinical privileges shall be conducted at least biannually.

II. The Rights of Patients

A. The hospital shall have written policies and/or procedures regarding patients' rights that address privacy; the use of high-risk or restrictive procedures, including seclusion, restraint, and behavior modification that employs noxious stimulation or deprivation of nourishment; and means to resolve complaints of patients or families.

B. Written hospital documentation must reflect implementation of these policies and procedures.

III. The Written Plan of Treatment

A. Each patient shall have a plan of treatment which shall be written and revised periodically in accordance with time frames established by the hospital and related to the patient's progress.

B. The written plan must document the reason for hospitalization; state identifiable goals and measurable objectives with treatment interventions; demonstrate participation by a psychiatrist in direction and supervision on an ongoing basis; and be reviewed and revised according to the patient's needs. Progress notes in the medical record relate to the plan of treatment.

IV. The Medical Record

A. A medical record shall be maintained for each patient and shall demonstrate a consistent level of documentation of participation by a psychiatrist member of the medical staff and profes-

sional nursing care in the treatment of the patient.

B. The record shall show progress notes that reflect the participation by all professionals involved in the treatment of the patient.

C. The medical record shall reflect an assessment of discharge planning needs at the time of admission as well as ongoing review and coordination of discharge services throughout hospitalization.

V. The Quality Assurance Program

A. The hospital must have a written, hospital-wide quality assurance program supported by the governing body and defining authority, responsibility, integration, and communication.

B. Quality assurance activities must include, but are not limited to: patient care monitoring activities; utilization review; credentials review and clinical privileging; facility and program evaluation; and staff growth and development.

C. The program shall demonstrate problem identification, assessment, correction, and monitoring.

D. Ongoing quality assurance activities shall be integrated into all major clinical services, including psychiatry, psychology, nursing, social service, activity service, and dietary.

E. The hospital quality assurance plan shall be reviewed annually.

VI. A Demonstrated Quality Environment

The hospital must demonstrate a quality environment to meet the needs of the patients, with identifiable and adequate space and resources available to provide activity, rehabilitation, social, and other indicated therapeutic services, including appropriate patient privacy.

3

THE NAPPH SURVEY FOR MEMBERSHIP

Before any hospital can be made a full member, a physician from a member hospital, the NAPPH Director of Patient Care Services, or a surveyor trained by the NAPPH Director of Patient Care Services must complete an on-site survey. The survey report is given to the NAPPH Committee on Membership and the Board of Trustees for consideration. Each membership application is reviewed separately.

The surveyor reviews hospital documents including the state license, JCAH accreditation and any contingencies, the medical staff by-laws, the minutes of the governing body, medical staff and clinical committees of the medical staff, and the rules and regulations of the medical staff. This is to ensure that all such rules as written by the hospital are being followed and that there is appropriate monitoring of clinical practice.

The prospective member hospital must either provide for or demonstrate that appropriate contracts are in place for such services as radiology, laboratory services, pharmaceutical services, medical-surgical procedures, electroencephalograms (EEG), and electrocardiograms (EKG).

The survey must show that the hospital provides active treatment, that is, treatment that can be expected to result in improvement of the condition. Care from admission to discharge must be under the supervision of a psychiatrist. The surveyor looks for sufficient professional staff to carry out the plan of treatment as recommended by the physician. A registered nurse must provide coverage around the clock, and a physician must be available at any hour, every day of the week.

The surveyor does a concurrent and retrospective random chart review to assure that all treatment procedures as ordered by the physician are administered, and that the patient's response to those treatments is recorded along with the patient's overall progress. There is a review of incident reports to assure that the hospital is providing appropriate assessment, review, and follow-up. The surveyor looks for fully implemented quality assurance and utilization review programs.

The prospective member hospital must show a well-organized and fully implemented mechanism for credential review and privilege delineation. The surveyor may interview department heads or chiefs of service to assure appropriate ongoing clinical supervision and monitoring of practice. The surveyor will also assess all full-time equivalent professional staff by discipline.

NATIONAL ASSOCIATION OF
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June 18, 1985

Honorable George Miller
Chairman
Select Committee on Children,
Youth and Families
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The American Psychiatric Association (APA), a medical specialty society representing more than 30,000 psychiatrists nationwide, who are concerned with the treatment of mentally ill patients, appreciates the Committee's interest in our best professional judgement as to the appropriate clinical criteria governing admission of minors into inpatient psychiatric treatment facilities.

The Association supports legislation which ensures that children in need of mental health care and treatment receive appropriate care and treatment; recognizes parents' authority to make medical decisions for their children; protects children against needless hospitalization and deprivation of liberty; and enables medical decisions to be made in response to clinical needs and in accordance with sound psychiatric judgment.

To achieve these goals and objectives we submit for your consideration and inclusion in the Committee hearing record the APA's "Guidelines for the Psychiatric Hospitalization of Minors". The complexity of this mental health treatment policy and the development of public policy relating thereto are well known to you and reflected in the "Four Alternatives to the Guidelines for the Psychiatric Hospitalization of Minors: Clinical and Legal Considerations", an integral part of the above cited guidelines. For example the document discusses and provides alternative approaches to who should be considered a "parent" for the purposes of admitting children to mental health facilities without judicial review and to what age to draw the line between parental autonomy and a teenager's autonomy for purposes of psychiatric hospitalization.

We also bring to your attention a model state statute regarding civil commitment of the mentally ill. This model law makes the provision of treatment the indispensable element justifying commitment and addresses the critical issues of a patient's

"rights to treatment" and "rights to refuse treatment" - issues that appeared in the Minnesota cases cited at your June 6 hearing.

We stand ready to serve as a resource to this Committee should you decide to explore the development of a model law governing commitment and subsequent treatment of mentally ill minors.

Cordially,

Jay B. Cutler
Special Counsel and Director,
Division of Government Relations

JBC:ff:mg

cc: Members, Select Committee on Children, Youth and Families

Am J Psychiatry 139:7, July 1982

OFFICIAL ACTIONS

Guidelines for the Psychiatric Hospitalization of Minors

This document was approved by the Assembly at its May 8–10, 1981, meeting and by the Board of Trustees at its Dec. 11–12, 1981, meeting. It was prepared by the Task Force on the Commitment of Minors[1] under the Council on Children, Adolescents, and Their Families.

Preamble: Legislative Purpose

It is the purpose of this legislation to ensure that children in need of mental health care and treatment will receive appropriate care and treatment, to recognize parents' authority to make medical decisions for their children, to protect children against needless hospitalization and deprivations of liberty, and to enable medical decisions to be made in response to clinical needs and in accordance with sound psychiatric judgment.

Section 1: Definitions

For purposes of this Act, the following definitions shall apply:

(a) "Child" means any person under the age of 18 years.

(b) "Days" means every day other than Saturdays, Sundays, and legal holidays, except where otherwise expressly noted.

(c) "Parent" means (i) a biological or adoptive parent who has legal custody of the child, including either parent if custody is shared under a joint custody agreement, (ii) a person or agency judicially appointed as legal guardian of the child, or (iii) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law.

(d) "Court" means that court within a given jurisdiction which deals most frequently with family, juvenile, or civil commitment matters.

(e) "Commissioner" means the state commissioner or director of the responsible department.

(f) "Hospital" means any facility or unit that is licensed and accredited for the provision of inpatient diagnosis and treatment services for mental and emotional disorders of children.

(g) "Mental disorder" means a substantial disorder of the child's cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior; mental retardation is sufficient neither to justify nor exclude a finding of a "mental disorder" within the meaning of this section.

(h) "Certification" refers to a judicial determination made after a hearing that a child satisfies the criteria for psychiatric hospitalization.

(i) "Treatment plan" means an individualized plan for treatment designed for a particular patient and appropriate to his or her specific needs.

(j) "Ward of the state" means a child whose legal guardian is the state or a state agency or official in an official capacity, including a child in foster care.

(k) "Accreditation" refers to the successful achievement of certification by an acceptable accrediting body.

Section 2: Voluntary Admission of a Child

(a) *Admission of children under 16.* When, in the judgment of a treating or admitting physician, a child under 16 is in need of hospitalization because of a mental disorder, the parent of the child may place him or her in an accredited hospital for diagnosis, evaluation, and/or treatment.

(b) *Parental admission of children 16 and older.*

(i) The parent of a child 16 years of age or over may, with the written consent of the child and with the concurrence of the treating or admitting physician, voluntarily admit the child to an accredited hospital for diagnosis, evaluation, and/or treatment.

(ii) In order to assure that a child's consent to such hospitalization is voluntary, the child shall be advised at or before the time of admission of his or her right pursuant to section 4 of this Act to contest the admission and of the provisions of subsection (d) of this section. If the child wishes to consult an attorney, the hospital shall not proceed with admission under this section until such time as the child has an opportunity to consult with an attorney.

(c) *Self-admission by children 16 and older.* A child 16 years of age or over may, with the concurrence of the treating or admitting physician, admit himself or herself to an accredited hospital for diagnosis, evaluation, and/or treatment provided, however, that notice is given by the hospital to the child's parents of the rights protected under section 3 of this Act.

Any child admitted pursuant to this section shall be advised at the time of admission of the provisions of subsection (d) of this section and of the requirements of section 3 of this Act. At the time of admission, the hospital shall obtain the child's written consent to hospitalization and treatment. A child admitted pursuant to this section who is a ward of the state may designate a friend or relative over the age of majority to receive notification of the child's hospitalization.

(d) *Notice of intent to leave.*

(i) Form of notice. Any child admitted pursuant to subsection 2(b) or (c) of this Act may give notice of intent to leave at any time. The notice need not follow any specific form so long as it is written and the intent of the child can be discerned. The notice may be written by a person other than the child, provided that it reflects the stated wishes of the child. The staff members receiving the notice shall immediately date it, record its existence on the child's medical chart, and send copies of it to a) the child's attorney, if any, b) the court, and c) the parents or other legal guardian of the child.

(ii) Discharge or notice of contest. The director of the hospital shall discharge the child from the hospital within 5 days after receipt of the child's notice, unless either the hospital, the parent, or other legal guardian files a Notice of Contest with the court within the 5-day period. Copies of the Notice of Contest must be delivered to a) the child or his or her attorney, b) the child's parents or other legal guardian, and c) the hospital. If no petition for certification has been previously filed under section 4 of this Act, the proponent of continued hospitalization shall do so with the filing of the Notice of Contest.

(iii) Custody pending hearing. If a valid Notice of Contest has been received, the director of the hospital may continue hospitalization on an involuntary basis until a hearing has been held and the court orders otherwise. In no case may the child be held more than

[1]The Task Force on the Commitment of Minors included Michael G. Kalogerakis, M.D., chairperson; Rosalyn Innis, M.D.; Carl P. Malmquist, M.D.; Harold Boverman, M.D.; and David Zinn, M.D. Vicky C. Jackson, Esq., served as legal consultant, and James Asam, M.D., was APA/NIMH Minority Fellow.

Reprints of the Guidelines/Alternatives are available from the Publications Sales Department, American Psychiatric Association, 1700 18th St. N.W., Washington, DC 20009. The cost is $2.50 for a single copy; discounts are available for quantity orders. *Orders must specify publication #P149-A and be accompanied by prepayment.*

15 days beyond the expiration of the 5-day notice unless a hospitalization or rehospitalization hearing has been held within 7 days of the court's receipt of the notice of contest.

(iv) Hearing. A hearing to determine the necessity for continued hospitalization shall be held within 7 days of the court's receipt of the notice of the contest. The hearing will conform to the requirements of subsection (e) of section 4. After such a hearing, the court shall order the child discharged if it concludes that hospitalization is no longer justified under the criteria of subsection (e)(iii) of section 4.

(e) *Authority to adopt regulations.* The commissioner is hereby authorized to promulgate detailed regulations to implement the preceding provisions of this section.

Section 3: Parental Rights and Responsibilities

(a) *Notification of admission pursuant to subsection 2(c).* In the event that a child is voluntarily admitted pursuant to subsection 2(c), the child's parents shall be notified immediately. The notice shall be in the form most likely to reach the parents and shall advise the parents of the admission and of the parents' right to participate in any proceeding under this Act. In the case of a ward of the state, the notice required by this section shall be sent to the appropriate state official.

(b) *Notification of petitions to certify or admit pursuant to sections 4 and 5.* Any parent of a child shall be notified immediately in the event of the filing of a petition to certify that child pursuant to section 4 or of a petition for emergency admission pursuant to section 5. The notice shall be in the form most likely to reach the parents and shall advise the parents of the admission or certification and of the parents' right to participate in any proceeding under this Act.

(c) *Parental participation in treatment.* Any parent of a child admitted to a hospital under this Act shall be entitled to confer at regular intervals with the treating or admitting physician concerning the child's condition, treatment, or diagnosis. The hospital or other proponent of certification may request that the parent of any child hospitalized under this Act be available for consultation and cooperation in connection with the treatment process and may seek a court order to require such parental cooperation.

(d) *Notice to withdraw.* Any parent whose child has been admitted to a hospital pursuant to section 2 of this Act may at any time file a Notice to Withdraw the child from the hospital. Upon receipt of such notice, the hospital may (i) discharge the child immediately to the custody of his or her parent, or (ii) if, in the opinion of the treating physician, release would be seriously detrimental to the child's health, a) discharge the child to the custody of his or her parents after advising the parents of the physician's advice against discharge and seeking written parental acknowledgment that they have been so advised, or b) refuse to discharge the child for a period of no more than 3 days after receipt of the Notice to Withdraw, provided that the hospital or the physician files a petition for certification pursuant to section 4 of this Act.

If the petition is filed within 3 days of the parent's Notice to Withdraw, the hospital may continue to hold the child for treatment until such time as a hearing is held pursuant to the requirements of section 4.

(e) *Right of child 16 or older to remain.* If a child 16 years of age or older admitted pursuant to subsection 2(b) or (c) of this Act objects in writing to a proposed discharge requested by his or her parent and states in writing his or her desire to remain as a patient pursuant to subsection 2(c) of this Act and if the child otherwise meets the requirements of 2(c), the hospital shall within 3 days so notify the parents and may continue to hold and treat the child. The parents shall be advised in the notice of their right to initiate judicial proceedings to procure the discharge of their child by filing a Petition to Discharge with the court. Such a petition shall set forth the basis for the parents' belief that the child is no longer in need of hospitalization, with specific reference to the criteria set forth in subsection 4(b) of this Act. Upon filing of the petition, the procedures set forth in subsection 4(e) of this Act shall apply, except that the burden shall be upon the parents to demonstrate that the criteria for hospitalization are not met.

(f) *Appointment of counsel.* In the event that a parent opposes a certified admission or discharge which the child or the child's representative seeks, in any judicial proceeding held under any section of this Act the court may, in its discretion, appoint separate counsel to represent the parent in the event that the parent cannot afford to retain counsel.

Section 4: Judicial Certification

(a) *Applicability.* Any parent of a child, any other person having physical custody of a child, including a hospital to which the child has been admitted under section 2 or section 5 of this Act, or the state, acting through its commissioner, may seek to have a child hospitalized for diagnosis, evaluation, and/or treatment pursuant to this section. Except as provided in sections 2 and 5 of this Act, a child may be admitted to a hospital only pursuant to the procedures prescribed in this section.

(b) *The petition.* A petition for certification of a child under this section shall be filed by the proponent of certification with the court. The petition shall state (i) that the child has a mental disorder, (ii) that the child is in need of treatment or care available only at the institution or type of institution for which certification is sought, (iii) that no less structured means will be as effective in providing such treatment or care, (iv) the factual bases for the above allegations, and (v) the name of the hospital for which the child would be certified.

(c) *Appointment of counsel; waiver of hearing.* Upon receipt of such petition, the court shall appoint counsel to represent the child. Within 7 days of the appointment, counsel shall advise the court in writing whether or not the child wishes to contest the petition. If counsel notifies the court that the child does not wish to contest the petition, the court may thereupon issue an order authorizing hospitalization for an initial period not to exceed 45 days. If the attorney notifies the court that the child wishes to contest the petition, then the matter shall be set down for a hearing within 7 days of receiving such notice.

(d) *Custody pending hearing.* Pending the certification hearing, the child's custodial status shall remain unchanged except as otherwise provided by law, provided further that, on motion and in compliance with any other constitutional or statutory requirements, the court may order a temporary change in the child's custodial status if it finds that such a change of custody would promote the best interests of the child.

(e) *The certification hearing.*

(i) All hearings held under this section shall be held in camera. Any disclosure made by the child during the course of evaluation or treatment under this Act shall be admissible in the certification hearing; however, no disclosure made by the child in connection with the proceedings under this Act shall be admissible in any delinquency or criminal proceeding unless the child introduces evidence concerning his or her mental condition in such a proceeding.

(ii) The child shall be represented by counsel and, further, shall have the right to be present at the hearing unless a) both the child and his or her attorney waive the child's right to be present for all or part of the hearing or b) on motion of any interested participant or party or the court, the court determines that it would be seriously detrimental to the child's medical condition and/or treatment for him or her to be present for all or part of the hearing.

(iii) The burden shall be on the proponent of certification to demonstrate, by clear and convincing evidence, that a) the child has a mental disorder and that b) the child is in need of treatment or care available at the institution for which certification is sought and that no less structured means are likely to be as effective in providing such treatment or care. Medical testimony shall be presented and such lay testimony as the court in its discretion deems appropriate.

(iv) The child shall have the right through his or her attorney to cross-examine those witnesses favoring certification and to present testimony and evidence (including the child's own unsworn statement) in opposition to certification and/or in favor of less structured alternatives.

(v) The child's parents shall have a right to participate in the hearing.

(vi) The court may, on its own motion, subpoena and question relevant witnesses.

(f) *Findings; verdict; appeal.* At the conclusion of the hearing or within 3 days thereafter, the court shall enter an order either denying or granting the petition and shall state the factual basis for its

findings regarding the criteria specified in subsection (e)(iii) of this section. If the petition is denied, the court may enter such other order or referral as may be otherwise authorized by law to secure proper care for the child. If the petition is granted, the court shall specify the period for which certification is authorized, which shall in no event exceed 45 days, and the hospital for which certification is authorized.

(g) *Renewal petition.* If the hospital staff or the person who sought the original hospitalization desires to extend the hospitalization beyond the period authorized by the court, a petition for rehospitalization must be filed with the court before the expiration of the hospitalization period. The continued necessity for and conditions of hospitalization of every child hospitalized under this section for a consecutive period of more than 45 days shall be reviewed in accordance with this paragraph. Such review is a matter of right and may not be waived. The procedures set forth above in subsections (b)–(f) shall be applicable in the recertification proceeding except that

(i) if an attorney has previously been appointed or undertaken to represent the child, such representation shall be continued unless the court for good cause determines otherwise,

(ii) if the child's appearance was waived for the immediately prior certification or review proceeding, the court shall require that, at the least, the child be physically brought before the court unless the child's physical condition would thereby be threatened, and

(iii) in evaluating the criteria set forth in subsection 4(e)(iii), the court, in any rehospitalization hearing, must consider the child's prior treatment, the ability of the hospital to provide effective treatment, and the likelihood of future cure or improvement through treatment.

(h) *Authorized period of hospitalization.* The initial hospitalization period under any certification order shall be no longer than 45 days; the next consecutive hospitalization period shall be no longer than 90 days; and all subsequent consecutive hospitalization periods shall be no longer than 6 months, except as otherwise set forth in this Act.

For purposes of calculating the authorized certification period under this paragraph, the word "day" shall include every day, except that where the last day of a statutory period described in these sections falls on a Saturday, Sunday, or legal holiday the period shall be deemed to expire on the next following business day.

Section 5: Emergency Admission

The provisions of section 4 shall not apply to emergency admissions authorized by this section.

(a) *Procedures for emergency admission.*

(i) By taking the child to a hospital. When, as a result of a mental disorder, any child appears in need of immediate hospitalization for evaluation or treatment of a mental disorder, any concerned person may take the child to a mental hospital. On the basis of an examination of the child and any other available information, the examining physician shall make a determination as to the need for emergency hospitalization. If the physician determines that the child, as a result of a mental disorder, appears to be in need of immediate hospitalization, the child shall be admitted for emergency hospitalization and treatment.

(ii) By petition.

a) Any concerned person may file a petition for emergency hospitalization of a child. Such petition shall state that the petitioner believes that the child appears to be in need of immediate hospitalization for evaluation or treatment of a mental disorder and state the facts on which this belief is based. The petition shall be filed with the court, which shall cause an appropriate evaluation to be made of the facts alleged in the petition. Within 48 hours of the filing of the petition, the court shall either deny the application or issue an order authorizing a peace officer to bring the child to a designated hospital for evaluation for emergency hospitalization.

b) Upon the child's arrival at the hospital, the admitting or treating physician shall examine the child to make a determination as to the need for emergency hospitalization. If the physician determines that the child, as a result of a mental disorder, appears to be in need of immediate hospitalization for evaluation or treatment, the child shall be admitted for emergency hospitalization and treatment.

(b) *Acceptance.* Whenever a child is brought to the hospital for emergency admission, the hospital may accept physical custody of the child and may request the person who brought the child to the facility to remain on the premises until a decision concerning the child's admission has been made. The hospital shall then evaluate the child's condition and admit or release him or her in accordance with the requirements of this Act.

(c) *Prompt examination.* Each child accepted by a hospital shall promptly be examined and evaluated as to his or her mental and physical condition.

(d) *Ensuring appropriate medical care.* A hospital accepting any child pursuant to this section whose physical condition reveals the need for immediate medical attention shall take reasonable steps to ensure that appropriate medical care and treatment for such physical condition is made available.

(e) *Recommendations for further treatment.* If a child is not approved for admission for emergency hospitalization by the hospital, the hospital shall make such recommendations for further care and treatment of the child as it may deem necessary.

(f) *Notification of parents or guardian.* In any case where the proponent of the emergency admission is not the child's legal custodian, the child's parents or other guardian, including, where applicable, the appropriate state official, shall be immediately notified of the hospitalization.

(g) *Communication; attorneys; parental notification.* During the period of emergency admission, the child has a right to initiate or receive communications from his parents or others, unless the treating physician concludes that it would be seriously detrimental to the child's condition or treatment, so indicates in the child's medical record, and notifies the parents of this determination. In no event, however, may the child be denied the opportunity to consult an attorney.

(h) *Seven-day limit on emergency admission; exception.* If a hospital admits a child pursuant to this section, it may hold him or her for evaluation and treatment for a period not exceeding 7 days provided that, if an application for hospitalization under section 2 is filed, provisions of that section will govern and, further, if a petition for certification under section 4 is duly filed, the provisions of that section will govern and the hospital may continue to hold and treat the child pending the action of the court on the said petition.

Section 6: Medical Services Review

(a) *Necessary and appropriate care.* Every child admitted to a hospital under this Act is entitled to receive necessary and appropriate medical care or treatment, as is more specifically provided below.

(b) *Commissioner's authority; internal medical review.* The commissioner shall adopt regulations to ensure that necessary and appropriate care and treatment, and internal medical review thereof, is afforded to all children admitted or certified to any hospital under this Act.

(i) Such regulations shall provide reasonable time periods within which a written treatment plan must be developed for every child and following which the treatment plan must be carefully reviewed and updated in accordance with the child's ongoing progress and needs.

(ii) Such regulations shall also provide procedures for assuring that the child's treatment is in accordance with the treatment plan then in effect for such child.

(c) *Opportunity for independent medical review.* Any child hospitalized under this Act, the child's parent, or, if the child is a ward of the state, the appropriate state official is entitled to an independent medical review of the appropriateness of decisions made either to discharge or to continue hospitalization of the child. The commissioner shall adopt appropriate regulations concerning the procedures for conducting such review.

Section 7: Discharge

(a) *Duty to discharge.* At any time that the child no longer suffers from a mental disorder or no longer is in need of hospitalization, it shall be the duty of the treating physician to secure the expeditious and appropriate discharge of the child.

(b) *Petition for alternative discharge plan.* A hospital may discharge a child admitted under the provisions of this Act at any time

prior to the expiration of the authorized period of hospitalization when, in the medical judgment of the treating physician, continued hospitalization is inappropriate (except when otherwise mandated by law.)

(c) *Petition for alternative custodian.* In the event that a child's parent refuses to accept a child released or discharged under this Act, the hospital may petition the court to designate an alternative party into whose custody the child should be released.

Four Alternatives to the Guidelines for the Psychiatric Hospitalization of Minors: Clinical and Legal Considerations

This document was approved by the Assembly at its May 8–10, 1981, meeting and by the Board of Trustees at its Dec. 11–12, 1981, meeting. It was prepared and subsequently revised (Feb. 9, 1982) by Alan A. Stone, M.D., chairperson, and Richard Bonnie, J.D., consultant, Council on Governmental Policy and Law.

1. *Who should be considered a "parent" for the purposes of admitting children to mental health facilities without judicial review?*

As written, the guidelines contain an extremely broad definition of the term "parent." Psychiatrists whose primary objectives are to facilitate hospitalization of children in need of inpatient services and to minimize judicial intervention prefer the definition of "parent" to be as broad as possible, including even public agencies responsible for the care of children who are wards of the state.

Other psychiatrists find this approach unsatisfactory because it takes insufficient account of the problem of unnecessary hospitalization and of the special needs and situations of children who are wards of the state and are typically relegated to the least effective treatment settings. Psychiatrists giving greater weight to these concerns would distinguish between parents (including individuals who act, personally, as parents) and persons who make decisions about children in their official capacities as agents of the state. Parental decisions about hospitalization of children are well within the traditional legal deference given to family autonomy and therefore should not ordinarily be subject to judicial review. However, agents of the state acting in loco parentis are not part of that legal tradition and are often inclined to act because of general administrative considerations rather than the actual psychiatric needs of the children. Therefore, it is argued, the decisions of such agencies to confine such children should not be insulated from judicial review. Judicial review in such cases does not subject a family to the adversarial process and therefore cannot be objected to on the basis of that clinical consideration. Proponents of this view would define parent so as to exclude state agencies and would substitute the following language for the definition of parent in subsection 1(c):

Alternative 1

(c) "Parent" means (i) a biological or adoptive parent who has legal custody of the child, including either parent if custody is shared under a joint custody agreement, (ii) a person judicially appointed as legal guardian of the child, or (iii) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. However, the term "parent" does not include [the state or the Department of Welfare] when it has assumed the status of legal guardian of a child; nor does it include persons or agencies, including foster parents or others, who exercise custodial responsibilities upon delegation by [the state].

Although other crucial policy concerns are implicated in these two options, the major clinical choice is between an approach that imposes the fewest obstacles to admission of children to psychiatric hospitals at one which places some measure of restraint on state agencies, whose decision may be responsive to pressures other than the best interests of the child. The danger of an approach that facilitates admission in all cases is the possibility of unnecessary institutionalization. The danger of subjecting state agencies to judicial scrutiny is that they may deprive a child of needed hospital services to avoid what may seem to them red tape and interference. The costs of unnecessary institutionalization are of course mitigated when the hospital facilities are such as to guarantee very high quality care, treatment, and psychiatric participation.

2. *At what age should the line between parental autonomy and a teenager's autonomy be drawn for purposes of psychiatric hospitalization?*

Because the guidelines establish separate procedures concerning psychiatric hospitalization of "minors," it is obviously necessary to designate, for a variety of purposes, the age at which a teenager's preferences will have any legal effect. All of the psychiatrists involved in the formulation of the proposed guidelines agree that a person 18 or older should be regarded as an adult for present purposes; accordingly, this means that the hospitalization of persons older than 18 would be governed entirely by the adult civil commitment procedures rather than by the proposed guidelines, which, by their terms, apply only to "children"—i.e., persons younger than 18 years old.

Also, all of the psychiatrists involved in the development of these guidelines agree that children have "rights" and that older adolescents should be entitled to some degree of legal independence concerning their psychiatric treatment. The disagreement arises in connection with the designation of the ages at which the adolescent's preferences should have legal effect. In general, opinion is divided on whether the designated age should be 14 or 16. It is not possible, however, to evaluate this issue in the abstract; instead, the matter should be considered in the three contexts in which the age of the minor has operational significance under the guidelines:

A. At what age, 14 or 16, should a parental decision to hospitalize a minor in a psychiatric facility be subject, at the outset, to judicial review through a certification procedure?

B. At what age, 14 or 16, should a child who has been admitted to a psychiatric facility upon parental request be entitled to initiate a legal proceeding to contest continued hospitalization?

C. At what age, 14 or 16, should a child be entitled to seek psychiatric treatment, including hospitalization, without parental consent?

Each of these questions will be discussed briefly.

A. At what age, 14 or 16, should a parental decision to hospitalize a minor in a psychiatric facility be subject, at the outset, to judicial review through a certification procedure?

The parental admission procedure in subsection 2(a) of the guidelines is designed to give parents the authority to admit children (assuming consent of a psychiatrist) without subjecting the family to an adversarial process in which the child, represented by counsel, is permitted to oppose the decision of the parents and the psychiatrists. Psychiatrists whose primary concern is the integrity of the family and the authority of the parents would set the limit of

childhood for this purpose at least as high as 16. This position is reflected in the guidelines: under subsection 2(a) a minor 16 or older could not be voluntarily hospitalized unless in need of emergency treatment or certified by a court; however, a person 15 or younger would have no right at the outset to judicial review or to adversarial process encroaching on a parental-psychiatric decision concerning hospital admission. Although there was considerable debate in favor of both higher and lower ages (e.g., 18 and 14), the eventual consensus emphasizing clinical considerations was 16. (This was the vote of the Assembly. It appears that this issue, rather than any of the others here described, was the central focus of the Assembly's debate.)

B. At what age, 14 or 16, should a child who has been admitted to a psychiatric facility upon parental request be entitled to initiate a legal proceeding to contest continued hospitalization?

Given that parents are not entitled to hospitalize children aged 16–18 without judicial review, it follows that a child older than this who is admitted without protest and then decides that he or she does not wish to remain is entitled to be discharged unless he or she meets the criteria for involuntary certification by a court. The guidelines so provide in subsection 2(d).

It is not clear, however, that the age chosen for subsection 2(d) should be 16 even though that is the designated age for purposes of parental admission under subsection 2(a). Although there is agreement on clinical grounds that a 14-year-old or 15-year-old child is not entitled, at the outset, to judicial review of parental-psychiatric decisions to hospitalize him or her, some psychiatrists believe that such a child should nonetheless be entitled, at some point, to initiate a legal proceeding to contest continued hospitalization. Those who take this approach argue that even if the law should facilitate admission, crisis intervention, hospital evaluation, and an initial period of treatment, it is both legally and clinically desirable to respect the younger teenager's autonomy at some point thereafter if he or she resists continued confinement. Obviously, those psychiatrists who stress parental authority (when the decision to admit is approved by a psychiatrist) prefer to insulate this authority from judicial review and would not permit the 14- or 15-year-old child to contest continued hospitalization in an adversarial manner. They also believe that adolescent resistance to treatment is a crucial clinical reality and that the legal right to contest hospitalization would feed that resistance. Thus they would, on treatment grounds, oppose giving legal weight to the adolescent's autonomy.

As now written, the proposed guidelines reflect the view that adolescents younger than 16 should not have a legal right to resist hospitalization and that 16 should be the operative age in both subsections 2(a) and 2(b). Under the opposing view, the first sentence of subsection 2(d)(i) would be modified as follows in order to make 14, rather than 16, the operative age:

Alternative 2

(d) *Notice of intent to leave.*

(i) Form of notice. Any child 14 years or older admitted under this section may give notice of intent to leave at any time.

C. At what age, 14 or 16, should a child be entitled to seek psychiatric treatment, including hospitalization, without parental consent?

As a result of developments in the law governing drug abuse treatment, birth control, and abortion, teenagers are entitled to have access to such services without parental request or consent. The guidelines follow this same trend in subsection 2(c) by permitting older teenagers (16 and older) to admit themselves to psychiatric facilities; under this provision, parents would be notified and would be entitled to initiate a hearing to remove the child, but they could not automatically prevent the admission.

The question, as before, is the age below which the parents should have a veto power over the child's autonomy—here, when the child opts for hospital treatment. As written, the guidelines set the age for self-admission at 16, thus allowing a parental veto of decisions by 14- or 15-year-olds, even when a psychiatrist responding to the child's request specifically recommends admission. This approach reflects the view that the law should vindicate parental authority in such situations. Other psychiatrists would permit self-admission at 14 even if a 14- or 15-year-old child had no right to resist parental decisions to admit him or her or to continue hospitalization. Those who favor this option believe that even young teenagers should be encouraged and have the opportunity to seek treatment on their own. They believe there are obvious clinical situations in which this alternative may be particularly important. Without such a provision, they argue, disturbed and exploitative parents could prevent a young teenager who needs hospital treatment from getting it. Under this approach, the first sentence of subsection 2(c) would be revised as follows to make 14, rather than 16, the operative age:

Alternative 3

(c) *Self-admission by children 14 and older.* A child 14 years of age or older may, with the concurrence of the treating or admitting physician, admit himself or herself. . . .

3. *Should there be additional legal safeguards as the length of confinement to a mental health facility increases?*

Psychiatrists whose major concern is treatment naturally prefer guidelines that facilitate such treatment. Some psychiatrists believe that children and adolescents with certain psychiatric disorders require long-term treatment and that no particular legal obstacles should be raised when long-term treatment is regarded as clinically desirable. Under this view, which is reflected in the guidelines as now written, long-term hospitalization of children hospitalized by their parents under subsection 2(a) would not be subject to judicial review and would be subject only to the periodic medical review required by section 6. Again, this approach is based on the clinical consideration that adolescent resistance to treatment would be intensified by judicial review. (It should be emphasized, however, that under subsections 4(g) and (h) older teenagers who are judicially certified would have to be recertified after 45 days, 90 days, and every 6 months thereafter.)

Other psychiatrists believe that, despite the best therapeutic intentions, long-term confinement of young children and teenagers involves consequential risks. Such confinement is also a more substantial deprivation of the child's legal rights. Even in the case of minors the loss of liberty entailed by indefinite confinement should not be based on a purely medical decision. The assumption of this responsibility by well-meaning psychiatrists in the past has been tragic for children and damaging to the image of the psychiatric profession. Therefore, these psychiatrists believe there should be additional legal safeguards in all cases involving significant periods of hospitalization, whatever the child's age and without regard to whether the initial admission was by parental or judicial decision. However, proponents of this view would insist that the criteria for continued hospitalization be based on psychiatric treatment considerations. Implementing this alternative would require that section 2 of the guidelines be amended by inserting the following language after subsection 2(d):

Alternative 4

(e) *Certification for long-term hospitalization.* No child admitted to a facility under section 2 of this Act may be hospitalized for a consecutive period of more than 6 months unless a petition for certification has been filed in accordance with the procedures specified in section 4. Any petition for certification filed under this subsection shall state, with supporting reasons and facts, that

(i) the child has a mental disorder that requires long-term care,

(ii) the child has not been, and is not likely to be, harmed by continued hospitalization,

(iii) treatment is available and is being provided and a plan of continued treatment has been formulated,

(iv) continued hospitalization is the most effective and beneficial treatment available, and

(v) the recommendation for continued hospitalization has been reviewed and approved in accordance with the procedures for independent review specified by [the commissioner] under subsection 6(e).

At a hearing for certification under this subsection, the burden shall be on the proponent of certification to prove, by clear and convincing evidence, that continued hospitalization is in the best interests of the child. Any certification order issued under this subsection shall be valid for 6 months.

"*Authority to adopt regulations*" would become subsection (f).

Keeping Troubled Teens at Home

by Bonita K. Lantz

Like many other public child welfare agencies, Valley West Social Services in Kearns, Utah, was confronted in the early 1980s with increasing requests for out-of-home placements while service expenditures and staffing commitments remained the same or were decreased. There was a cry to "work smart"—to do more with less. The Child Welfare Act of 1980, P.L. 96-272, included an expectation that beginning October 1, 1983, "reasonable effort will be made in *each* case to prevent or eliminate the need for placement . . ."

In reviewing programs to determine intervention effectiveness, concerns were raised regarding the use of out-of-home placement – foster homes, group homes and psychiatric facilities—to treat minor delinquents and status offenders. Such cases required extensive staff time with little evidence of success. Typically, while these adolescents moved unsuccessfully through several programs and positive change became more remote, the goal of return home was abandoned by the agency worker, child, parent and family members. Then, when they were released from care at age 18 with nowhere else to go, they went home.

These concerns, coupled with recent training in a family systems behavioral method, led the agency to develop a strategy to serve status-offending adolescents more efficiently through intensive family therapy and tracking.

The treatment model used was Func-

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tional Family Therapy, (FFT), a method developed by Dr. James F. Alexander and Dr. Bruce V. Parsons and first tested with adolescent status offenders in Salt Lake City in 1971 and 1977. These studies found that the incidence of court referrals for delinquency of the identified adolescent and the incidence of sibling delinquency was 30 to 50 percent less in families receiving Functional Family Therapy, in contrast to families receiving other forms of treatment.[1]

While Valley West Social Services was interested in replicating these results, we were even more concerned about determining whether increasing the skills of family members would have an impact on the family's ability to remain together. Another desired result was that placement resources would be reserved for those children and families for whom temporary separation was the best alternative.

To supplement the therapy component, a paraprofessional "youth advocate" worked with each adolescent, serving as an objective friend to listen to the child's concerns and to make suggestions or discuss strategies for behavioral change. The advocate assisted the adolescent with job hunting or school placement, tracked his or her progress in school, at work and at home and acted as a role model. The advocate met daily with the therapist to discuss each case.

When the experimental program first began, two social workers provided regular, court-ordered protective services for 25 to 30 families and also offered Functional Family Therapy at least once a week to six to 12 families whose members included an acting-out or status-offending adolescent. Although the adolescents had received counseling or probation services, they had failed to benefit from these services and a juvenile court screening committee had determined they were in need of out-of-home placement.

While this method succeeded in increasing family members' skills and keeping the family intact, the agency believed that more intensive services would enhance success rates in 70 percent of the cases. Additional staff would also be needed, for the therapists—who had carried double caseloads for over a year—were exhausted!

Based on the experience of the experimental program, the agency received a grant in FY 1983 from the Children's Bureau, ACYF, to conduct a pilot project staffed by one Functional Family Therapist, two paraprofessional advocates and one half-time supervisor. Families were expected to receive therapy for 60 to 90 days, with a caseload size of 12 families for the therapist and six adolescents for each advocate. Families received therapy twice a week for the first month and then once a week for the remainder of treatment. Advocates met daily with the adolescent at first, then decreased intervention over the span of treatment. Therapy sessions were held in the office or at home and each family was seen at home at least once. The advocate's contact with the adolescent was frequently in the field—at school, home or work.

Treatment included assessment, therapy and education. All behavior within the family was seen as a reflection of a relationship payoff: a family member was using closeness, distance or "midpointing"—a blend of distance and closeness.[2] One example of a relationship payoff of closeness might be a child who runs away, then calls home crying that she's been hurt and asks to go home. She arrives home to her mother's open arms—and receives her total attention. Essentially, when the "dust settles" the child achieves closeness.

Once the therapist assessed the function of the family members' behavior, then therapy and education phases "fit" skill building and technical aids to these functions to allow the person to maintain the same relationship in more efficient ways.[3] Cases were terminated

"Since a number of the youths had to pay fines imposed by the juvenile court, the team coordinated with the court to allow the adolescents to work off the fines, under the supervision of the advocates, by performing a variety of tasks around the office. . ."

when family members were able to freely engage in problem-solving without the therapist's assistance.

In order to provide adolescents in the program with peer group support, as well as reward desired behavior, a Youth Council organized a variety of group activities—trips to movies and an arts festival, a visit to the local juvenile detention center and talk sessions to share feelings and concerns. To maintain the program's focus on the total family and to dispel parental concern over one child receiving attention for "bad" behavior, siblings were also encouraged to participate.

Since a number of the youths had to pay fines imposed by the juvenile court, the team coordinated with the court to allow the adolescents to work off the fines, under the supervision of the advocates, by performing a variety of tasks around the office—shoveling snow, pulling weeds, picking up litter, cleaning and painting. In cooperation with the agency's adult service unit, we also arranged work for youths who had been required to make restitution. The young people helped prepare sandbags for an expected flood and provided a variety of services for older and handicapped members of the community, with whom they worked exceptionally well.

Program Operation

The case of 16-year-old Larry White and his family illustrates how the program operates.

Larry lives with his younger sister and mother, June Green, who had remarried about four years ago after being head of the household for five years. Two older married sisters live in the Salt Lake area. Mr. Green works as an auto mechanic and Mrs. Green works two jobs as a waitress. Larry's natural father, Harry White, is in prison in Illinois and has had no contact with Larry in the last nine years. In school, Larry reads on the 4th-grade level and is a behavior problem. Larry had been placed in several special programs, but the school reports frustration with his non-attendance and poor attitudes. He also is seen as easily led by friends. The family has received counseling previously but feels it has not helped.

At the time of his referral to the program, Larry had stolen $300 worth of food stamps from a neighbor. On earlier court referrals he was found guilty of truancy and possession of alcohol and tobacco. Both the court intake officer and Larry's parents felt that he needed to be out of the home; in fact, Larry's mother refused to take him home, saying "Someone else can take him and straighten him up." The juvenile court screening committee identified Larry as a child requiring placement.

Before the court date to adjudicate custody, the intensive family therapist met with the family to discuss alternatives to placement. The therapist listened to the family's concerns, explained the costs and realities of foster care and discussed the FFT program. By this time Larry had been out of the home a few days, and after the program was explained to Mrs. Green and she realized there would be follow-up, she was less insistent on her son's need for placement.

The therapist then identified and assessed the function of the family members' behavior and regular therapy sessions were arranged in the home. Larry returned home after the first session.

The advocate attended the first session and made an appointment to see Larry the next day. Over a period of three weeks, the advocate met daily with Larry. Larry stated that he hated school and wanted to work. He had a girlfriend who lived some distance away, which made regular contact with her impossible. Larry told the advocate that he wished he could do some of the fun things his stepfather did. Since Larry slept in an unfinished basement with no walls or privacy, his nieces and nephews got into his things and damaged them when they visited. Larry said he felt his family didn't care about him.

The advocate, therapist, parents and school counselor arranged for Larry to have work release status and attend classes to develop employment skills. Larry and the advocate went job hunting and Larry obtained employment washing dishes. The advocate also worked with Larry on communication skills and encouraged him to talk about his feelings and build relationships. Larry's sister and brother-in-law began taking a greater interest in him and he spent several weekends in their home. The brother-in-law, a milkman, took Larry with him on early morning runs. After five weeks, however, Larry lost his job because he had made cash overdraws that exceeded his wages. He and the advocate went job hunting again and Larry found another dishwashing job. Following the FFT model, each difficulty was reframed as an opportunity to develop alternative behavior and learn new skills. In school, Larry regularly attended his swimming and industrial foods classes but neglected math and English.

The family continued to meet weekly with the therapist for 10 weeks, during which time communication, negotiation skills and fair fight rules were taught. Larry's parents agreed to pay half the cost of a foot locker to protect his possessions and he reported that this gesture made him feel that his parents cared about him. A message center was established to improve communication within the family. The parents set aside one night a week to go out together, which improved their ability to communicate and work as a team.

Intensive therapy was terminated at this point, but since Larry had not fully paid his fines and restitution, his case was transferred to a case manager. Six months after termination Larry was working full time and had not been involved in any further delinquency.

"Emphasis is placed on the importance of the individual."

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Protzel, M. S. Nursing behind bars. *American Journal of Nursing*, March 1972, *27*(3), 505-508.

Report to the congress by the comptroller of the United States. A federal strategy is needed to help improve medical and dental care in prisons and jails. December 22, 1978.

Ris, H. W. Comprehensive medical care in a state institute for youth in Wisconsin. In R. Bodine & R. Brown (Comps. & Eds.), *Guidelines for Health Care in Juvenile Court Institutions*. American Academy of Pediatrics, Chapter One, Northern California, n.d., 225-231.

Ris, H. W., & Dodge, R. W. Gonorrhea in adolescent girls in a closed population. *American Journal of the Diseases of Children*, 1972, *123*, 206-209.

Smielek, J. E. & Spitz, W. U. Death behind bars. *Journal of the American Medical Association*, December 1978, *23*, 240.

U.S. Department of Justice, Law Enforcement Assistance Administration, National Criminal Justice Information and Statistics Service. *The nation's jails: A report on the census of jails from the 1972 survey of inmates of local jails.* Washington, DC: U.S. Government Printing Office, May 1975.

THE ABUSE OF STATUS OFFENDERS IN PRIVATE HOSPITALS

Michael Robin

ABSTRACT. On the basis of 3 years of experience as a psychiatric assistant in a Twin Cities hospital, the author argues that placement in a psychiatric ward is essentially abusive to status offenders. He points out that many of these young people have been abused, but that they are treated on the ward not as abused children, but as problem children. Being locked up, having to follow treatment plans, being threatened with isolation and medication, and being treated by insecure staff with insufficient training are all, this author argues, abusive.

Because the Juvenile Justice and Delinquency Prevention Act of 1974 placed restrictions on the use of public facilities for the treatment of status offenders, many states are now placing status offenders in private psychiatric hospitals, circumventing the deinstitutionalization law. Unfortunately, we have no national statistics on the extent of hospitalizations of status offenders, and if we did, they would likely be gross underestimates, as most status offenders are not admitted to hospitals under a court order but under the threat of one, usually by a parent or social worker.

As a matter of definition, status offenses are those noncriminal behaviors such as incorrigibility, running away, and truancy that are considered illegal because of a child's age. Status offenders are by definition "out-of-control," and treatment in the hospitals tends to focus on modifying or changing those behaviors that are deemed unacceptable to adult society. The problem is that by focusing on behavior as such, and by defining children as out-of-control, the complex reasons why childen act out are missed. Definition is crucial; for as Mark Twain said, "If the only tool you have is a hammer, then you tend to treat every problem as if it were a nail." How children's problems are defined will have major implications for the course and content of their treatment and is at the root of what I

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see as the considerable emotional and physical abuse that adolescent patients endure in psychiatric hospitals.

This paper is based on my 3 years of experience as a psychiatric assistant in a Twin Cities hospital. I will try to stay away from horror stories of gross abuse, for that is not my point. Rather I intend to show how the system itself, when working properly, is abusive to children. My initial reaction to this program was quite positive. I was caught up, like many others, in the power I had over children. However, as I gained more experience and my knowledge of child development increased through my education, I came to reject the system.

Status Offenses and Child Abuse

Status offenders are often children who have been abused, yet in this hospital they are treated as offenders. Only occasionally is a child placed on the unit with a specific clinical disorder such as schizophrenia, depression, or anorexia nervosa; instead, most patients are diagnosed as having behavior or conduct disorders, like status offenses. A number of investigators have pointed out that many children in institutions have suffered earlier abuse and neglect within their own families, foster families, or other institutions. Douglas Kline, an educator at Utah State University, testified before Congress in 1979 that "the children who come into conflict with the law and ultimately populate our institutions are for the most part victims of physical abuse, neglect, abandonment, and/or sexual molestation *before* they came into conflict with juvenile authorities and *before* they are committed to institutional environments." The New York Select Committee on Child Abuse found in a 1978 study that nearly 50% of the families who had been reported for child abuse and neglect eventually had at least one child taken to court for delinquency and ungovernability. The summary of the report cautioned, however, that child maltreatment cannot be used as an indicator or predicator of future juvenile misbehavior. The two are strongly associated, but other factors affect whether or not a child becomes delinquent or ungovernable.

Such facts are consistent with my own experience as a psychiatric assistant. Many of the patients had indeed suffered abuse, both physical and sexual, or had been neglected. While most staff knew that the children had suffered serious maltreatment, they generally believed that these children's behavior had elicited abuse, rather than that the behavior disturbances were symptoms of abuse and neglect. As in most child care institutions, the psychiatric staff were largely untrained and ignorant of the special

needs of abused children, and they frequently responded to the children in a manner similar to that of the children's abusive parents.

Dynamics of Child Abuse and Neglect

The major psychological dynamic in abused children is identification with their aggressors (Martin & Rodeheffer, 1980). That is, children respond to their maltreatment by assuming their own "badness"; for why would their parents, who are so wonderful, abuse them unless they were bad? Abused children typically have great difficulty directing their rage toward their aggressors, for they assume that if they did, their parents or caretakers would go away. Consequently, they develop what might be called a shame-based personality (Bach, 1980). They are bad; they are responsible for the abuse, as they deserve the abuse that comes to them. In fact, abused children are particularly adept in provoking punishment or rejection from others, for when they get it, it confirms who they are, that they are indeed shameful and unworthy.

Abused children learn to survive by accommodating their needs to the needs of the aggressors within their environments. They have a hypervigilant attitude, constantly fearful of assault or invasion, with little ability to take for granted the care and nurture of their caregivers. They become "watchers," acutely aware of mood changes in the adults around them, and they develop a rather "chameleon nature," learning to shift their behavior according to what is expected of them and denying their own impulses. The children learn to avoid punishment by becoming experts at "passive resistance," by feigning acceptance of what others demand. On the surface, then, abused children try to control and manipulate everyone and everything; however, this behavior is less willful than assumed and is based on fear of rejection or punishment.

Additionally, abused children are valued most when they are meeting the needs and expectations of their parents. This is especially apparent when children are obeying or simply staying out of their parents' way. They are not valued in their own right for their own needs, values, and interests. Furthermore, their efforts at being competent or independent frequently result in verbal or physical abuse. Abused children are thus more apt to feel that they lack control over their environments and that external factors, rather than their own efforts, determine the outcome of events. Abused children are essentially joyless, lonely creatures who have a poor sense of themselves, lack initiative and confidence, and find relationships with others quite stressful.

The process whereby children learn self-control is also disrupted in abusive families. They identify with a parent who is a model of aggressive behavior but who denies expressions of aggression from the children. The children, lacking effective self-control, alternate between extreme inhibition and sudden volatile outbursts. Their lack of self-control is also seen in their tendency to lie and steal when not monitored. Their efforts, through misbehavior, at establishing a separate identity and independence from their parents tend to be more symbolic than real. Acting out serves to deny children's dependency needs and repeats the earlier traumatic experiences of punishment, abandonment, or ridicule. Misbehaving then becomes a means to control the environment and make it predictable, but it covers up the underlying shame and fear of not being loved.

Daily Regimen

Many child-rearing practices that would be considered abusive if done in the family are legally and socially condoned by our society in the name of discipline and treatment. It is in the normal course of treatment that many children are abused. When children enter the hospital, they are quickly oriented to its rules and regimen, and great effort is made to establish the authority of the staff over the children. The locked door is the most obvious and salient symbol of the children's powerlessness in their new environment. The children are not allowed to be outside the unit until the staff considers them trustworthy enough not to run away and until they are working on their treatment goals, which routinely takes 2 to 3 weeks and sometimes longer. Thus, to maintain control within the institution, an artificially restricted environment is set up, so that children are forced to comply with authority to regain the privileges they have hitherto taken for granted. Many children report feelings of shame and humiliation at being locked up and resent the implication that they are somehow dangerous or crazy. Incest victims and other victims of abuse are routinely placed on this unit, along with children who have committed serious crimes; this tends to reinforce their idea that they are bad and they have done something wrong. The problem is that this hospital makes no distinction between those patients who need and those who do not need to be locked up, so that many who do not need to be locked up suffer the consequences of inappropriate placement.

The daily regimen is designed primarily for the convenience of the staff in maintaining control over the children and has little to do with the developmental needs of the individual child. The design of the unit allows

for constant observation, so that the only opportunity children have to be unmonitored is when they are in their own rooms, and even here privacy is violated by frequent room checks. Moreover, the staff can, at will, search children's rooms or persons, further violating their personal and bodily integrity. This is clearly not a relaxed, secure atmosphere free from constant scrutiny, something Konpka considers vital to healthy group life in residential treatment (1972, p. 172). The tension is enhanced further because the unit has no gym or outdoor play area. Many children, lacking an outlet for their pent-up energy and emotions, respond by chain smoking, overeating, general irritability, or occasional violent outbursts. Very few staff appreciate how the environment of the institution itself—its restrictions, its boredom, its close living quarters—may encourage children to act out. In their view, the children's behavior is the problem.

Hospitalized children are expected to follow a plethora of depersonalized rules and regulations which teach them compliance more than they teach them responsible behavior. In many messages given by the staff, explicit communications, for instance that children should be responsible for themselves, are contradicted by implicit ones. Children on the ward are never allowed to decide for themselves what they wish to do and to do it unmonitored. They are given care plans with a variety of target behaviors that are part of their treatment plan. In most cases, the children do not understand the language or the purpose of the care plan, nor are they consulted on its content. Nonetheless, they are expected to use it and receive feedback each hour on how well they are fulfilling their behavioral goals. Bettleheim and Sylvester have argued that compliance with stereotyped rules may constitute adequate adjustment to the institution but allows the child little opportunity for spontaneity and responsible decision making. "Complete determination by external rules prevents the development of inner controls. Emotional conflicts cannot be utilized toward personality growth because they are not intrapsychic conflicts, but only occasional clashes between instinctive tendencies and impersonal external rules" (1972, p. 71).

Children are always expected to accept the feedback given them by the staff, which tends to be negative and critical. Many disturbed children become easily discouraged by negative criticism, as it affirms their already low self-concept. Generally, the staff does not understand the importance of positive reinforcement as a more effective influence on behavioral change. All too often, staff are insensitive to the children's intellectual and developmental level and use abstract, complicated language or speak in a harsh degrading tone. Children are not allowed to disagree with staff, and

because accepting feedback is tied to earning privileges, most children learn that it is not worthwhile to argue with staff. In addition, they are not encouraged to think for themselves and to learn how to evaluate what they hear about themselves, to decide what sounds plausible and what does not. In effect, what the children really learn is to manipulate adults by giving them the compliance they demand. In this role reversal, the needs and views of the children are discounted by the adults around them.

In the ward, children are denied the right to decide whom they will trust and in whom they will confide or even if they will trust anyone at all. For example, each day children have a "one-to-one" where they talk over their problems with a staff member. Because the staff person changes frequently, children are actively discouraged from talking with only a few people and are expected to talk openly with any staff member. Should they refuse to talk with someone, they might be punished for allegedly not working on their problems. Because talking about their problems is tied to earning privileges, many children survive by learning how to speak about themselves with psychological terms that they do not understand. As Piaget points out, adolescents are capable of abstract thought, of reflecting on their own behavior and motives; but the development of abstract thought depends on the maturational level of the child, not only on the chronological (1975). To expect children who have been abused or who have learning difficulties to verbalize their feelings is abusive in itself, for it expects more than the behavior of which the children are capable. Furthermore, by discouraging primary relationships, the hospital is denying the children what they need most, a consistent caretaker who offers unconditional nurturance. The ever changing caretaker is, according to Rutter, one of the great failures of institutions in providing therapeutic intervention, for it continues and reinforces the lack of consistent care from which abused children have already suffered (Rutter, 1979, pp. 147-154).

Discipline and Punishment

Discipline in the psychiatric ward relies heavily on isolation and seclusion. For rule violations or for not working satisfactorily on their treatment goals, children are routinely placed on room restriction. As a matter of course, when children are placed in their rooms, the rooms are stripped of all personal or leisure items such as books, games, or radios. The length of time children are kept in seclusion varies from a short period for minor infractions to 24-hour periods or longer for more serious violations. For

example, if staff judge that a particular child is not working hard enough on resolving problems, that child will be placed on room restriction until his or her attitude changes, which in some cases has been up to a week or more. In one extreme case, a 13-year-old hyperactive boy was kept on room restriction for 6 weeks, until he acknowledged the pain of his family situation. During this time, this child was not allowed any communication with his family or his fellow patients, nor was he allowed any recreational activities or to go to school. This practice is torture, the principle of which is that with sufficient pain, people will change their behavior.

The "time-out" room is a small, bare room of concrete walls and screened windows, used when children are out of control. It can also be used when room seclusion has not produced the desired behavior change. Seclusion in the time-out room tends to produce initial affective responses of rage and terror, then helplessness, and eventually resignation and compliance. Wadeson has suggested that seclusion may encourage paranoid reactions in disturbed patients (1980, pp. 163-170). They fear being overpowered, "looked at," and controlled. Expressions of bitterness and humiliation are frequently reported weeks and months after the isolation incident. Furthermore, many abused and disturbed children harbor deep anxiety about being abandoned, unwanted, and unloved, which tends to be reinforced by their time-out room experiences. Miller, drawing on the work of D. Winnicott, argues that anxious adolescents, like infants, need to be able to project their anxiety onto their care givers, who then absorb it and return back to the children a sense of security (1978, pp. 434-447). Holding out-of-control children rather than isolating them can give anxious adolescents the equivalent of the cuddling mothers give their infants. Emotional development occurs when children are allowed to express their feelings without the fear of punishment or abandonment. This institution, instead of hiring adequate numbers of skilled staff, resorts to isolation or to drugs like Thorazine or Haldol for the management of disruptive behavior, which is another example of abuse.

Needs of Staff

The attitude of the staff toward these children is markedly ambivalent; they claim to be nurturant and child centered, but they are also hostile and demand disciplined and controlled behavior. The concern for order and obedience leads to denial of the children's needs and often to abuse. The techniques of control and the forms of communication that staff use with patients are generally not those they would use with their own chil-

dren. These children are said to be "different," to suffer primarily from a lack of consistent limit setting rather than from a lack of love. Miller notes that the shaming, disparaging, and controlling seem to have a "particularly disruptive and sadistic element to them" (1978, p. 440), one that tends to assume an exaggerated willfulness on the part of the misbehaving child. These inappropriate techniques may arise because the staff are inadequately trained and supervised for the work they do. They lack an appreciation and understanding of the behavioral dynamics of child abuse, so they often overreact to the children's oppositional behavior. Such instances tend to heighten the staff's sense of helplessness and lack of control over the children. Staff will thus act to restore their authority, and, in the process, they often disregard the meaning of the children's behavior. Staff need children to be compliant, as it gives them a sense of power that is otherwise lacking in their lives. They tend to exaggerate their own importance in the children's lives, and they do not appreciate the effect of their own feelings and insecurities on the therapeutic relationship. Staff powerlessness is reinforced by their status within the hospital structure, where they receive low pay, have little room for advancement, and are expected to be compliant within the hierarchical structure defined by the medical model of treatment. The staff are unable to direct their frustrations within the system, so they turn to the child for a sense of power. Just as the staff have little understanding of how their own work environment may affect their feelings, they are unappreciative of how they stifle the initiative and autonomy of children by imposing too many restrictions on their behavior.

Conclusion

Abused children have a remarkable ability to provoke further punishment and mistreatment from their caretakers. In this study, I have attempted to show that by defining delinquent children as ungovernable rather than as abused, hospital psychiatric wards reinforce character traits that are rooted in earlier abuse. More than limits and discipline, what abused children need are consistent care and nurture, or simply love. As Ashley Montagu wrote, "no child adequately loved ever became a delinquent or murderer" (1971, p. 174). If we are to provide treatment to delinquent children, we need to reject their efforts to push us away or provoke us to punish them. We need to offer more than rules and regimentation, for they need more than simply to be controlled. We need to provide environments that are safe and predictable, but most of all loving.

REFERENCES

Bach, J. *An ideological framework for understanding the emotional layers of the shame-based personality*. Unpublished paper, 1980.

Bettleheim, B., & Sylvester, E. A therapeutic milieu. In J. Whittaker & A. Treschman (Eds.), *Children away from home*. Chicago: Aldine Publishing Company, 1972.

Kline, D. Testimony before subcommittee on child and human development, January 24, 1979.

Konopka, G. The role of the group in residential treatment. In J. Whittaker & A. Treschman (Eds.), *Children away from home*. Chicago: Aldine Publishing Company, 1972.

Martin, H. & Rodeheffer, M. The psychological impact of abuse on children. In G. Williams & J. Money, *Traumatic abuse and neglect of children at home*. Baltimore: John Hopkins Press, 1980, pp. 254-62.

Miller, D. Early adolescence: Its psychology, psychopathalogy, and implications for therapy. In S. Feinstein & P. Giovacchini (Eds.), *Adolescent psychiatry*, Vol. VI. 1978, pp. 434-447.

Montagu, A. *Touching: The human significance of the skin*. Columbia University Press, 1971.

Piaget, J. Intellectual development of the adolescent. In A. H. Esman (Ed.), *The psychology of adolescence*. New York: International Universities Press, 1975.

Rutter, M. Separation experiences. Journal of Pediatrics, July 1979, *95*(1), 147-154.

Summary report of the relationship between child abuse and neglect and later socially deviant behavior. New York Select Committee on Child Abuse, March 1978.

Wadison, H. *Art psychotherapy*. New York: Wiley Press, 1980, 163-170.

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Mental Health: the Hidden System of Adolescent Social Control*

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Following the deinstitutionalization movement of the past two decades, we see in the 1980's the emergence of a "hidden system" of social control of juveniles. Prior to deinstitutionalization, that part of the child welfare system that dealt with the control of misbehaving children could be described, quite roughly, as centered on the juvenile justice system, and involving publicly funded control institutions. Today, while the juvenile justice system and its public systems still exist, the "hidden system" that has evolved alongside it is characterized by a mental health emphasis, and by privatization.

This system of social control developed in response not only to deinstitututionalization, but also to a more pervasive and long-term process of the medicalization of deviance. For at least the past century, behaviors which were once seen as instances of immorality or evil--including delinquency--have become reinterpreted as symptoms of sickness or disease (Conrad and Schneider, 1980; Spector, 1981). Furthermore, increasing numbers and types of deviant have been treated in those institutions designed for the ill--hospitals and clinics--and with the sorts of psychological and somatic therapies deemed suitable to those who are seen as in trouble, rather than as causing trouble.

Several trends in the 1960s and 1970s were superimposed upon the general process of medicalization to produce the

hidden system of controlling juveniles. One was the sequence of legislation that mandated coverage of psychiatric treatment (particularly inpatient treatment) by both public insurance providers such as Medicare, and by private providers such as Blue Cross and Blue Shield. Insurance coverage made mental hospitals accessible to many non-indigent individuals who would otherwise not have been able to utilize inpatient psychiatric services either for themselves or for their offspring.

The deinstitutionalization movement of the late 1960s and early 1970s was directed toward two populations which are relevant to the hidden system: juvenile status offenders (and to some extent delinquents) and the mentally ill. Both Federal and State level policy during this era was directed at the diversion of juvenile status offenders from juvenile justice system processing and institutions, and the removal of mentally ill persons from the state hospitals into the community, through the community mental health movement.

There are three theories of the historical factors which led to the deinstitutionalization movement: one based on ideology, one based on economics, and one based on technology. These theories--at least the first two--may be taken either as competing or as complementary explanations.

The ideological impetus to the deinstitutionalization movement was labeling theory's insistence that

institutionalizaton was deleterious, rather than restorative, in its effect on offenders and mental patients. The work of sociologists such as Scheff (1966) and Goffman (1961) were cited extensively during the policy debates that preceded deinstitutional legislation.

The political-economy theory rests on the notion of the "fiscal crisis of the state" (O'Conner, 1973), and indicates that deinstitutionalizaton was prompted not so much by social theory as by imminent bankruptcy. The states sought to empty their mental hospitals and curtail their juvenile hall populations becuase they could no longer afford to maintain the expensive institutions which had flourished during earlier and more solvent days of the welfare state (Rose, 1979; Scull, 1980).

A final theory of the impetus to deinstitutionalization is technological, and pertains to mental patients rather than to juveniles. It asserts that the advent of psychoactive drugs enabled the states to release patients who could then be properly maintained in the community with regular dosages of these drugs. Scull (1980), however, demonstrates that the beginning of the deinstitutionalization movement in England and the United States preceded the introduction of psychoactive drugs by a decade or so.

What is clear from later developments in the hidden system is that economic factors, as well as new ideas in

psychiatry and social science, are significant in shaping the ways in which social policies are developed and implemented. For during the period after deinstitutionalization, the private sector, especially the for-profit private sector, came forward to fill the gap left by the withdrawal of the public sector from responsibility for some of its mentally ill and juvenile dependents.

Lerman (1982) and Guttridge and Warren (1984) have outlined this process of privatization. The deinstitutionalization policies of the 1960s-1970s with respect to juveniles encouraged the states, using fiscal incentives, to deinstitutionalize status offenders from public corrrectional facilities. As earlier work on this movement indicates, this left the states still able to utilize private correctional as well as public mental health and private mental health inpatient facilities for "deinstitutionalized" juveniles. (Lerman, 1982; Warren, 1981; Guttridge and Warren, 1984).

Within the private mental health sector, the hidden system involves at least the following types of residential facility for juveniles: private psychiatric hospitals or wings of general hospitals for those under 18, residential treatment centers (RTC's), and, most recently, chemical dependency inpatient facilities (CDU's). Our purpose here is to collect together the rather sketchy but still valuable evidence concerning the scope and growth of this hidden

system during the past 15 years. What is certain is that the private sector is more significant than the public sector in providing inpatient psychiatric care to minors. As Zenoff and Zients (1983:192) note

> The assumption that youngsters receiving inpatient mental health services are in state or county facilities is incorrect. Of more than 95,000 children admitted to impatient facilities in 1975, for example, only approximately 25,000 were placed in county or state hospitals.

ADOLESCENT PSYCHIATRIC HOSPITALIZATON

The psychiatric hospitalization of troubled children is legitimated by the progressive medicalization of childhood and other deviance, and facilitated by fairly recent changes in insurance provisions. However, the gatekeepers to both public and private mental hospitals, and the insurance providers, require a diagnosis of psychiatric disorder taken from the Diagnostic and Statistical Manual of the American Psychiatric Association (popularly known as DSM III). While on the face of it this diagnostic requirement would hamper the admission of non-schizophrenic or non-psychotic youth to psychiatric hospitals, in fact there are a number of diagnoses which could fit wayward or delinquent youth. For example, the DSM III category Conduct Disorder is defined as a:

> ... repetitive and persistent pattern of aggressive conduct by either physical

> violence against persons, or thefts outside the home involving confrontation with a victim....The nonaggressive types are characterized by the absence of physical violence...However, there is a persistent pattern of conduct in conflict with norms for their age, which may take the form of....persistent truancy and substance abuse; running away from home over night ...persistent serious lying ...vandalism or fire setting; or stealing (DSM III, pp 45 - 46).

National data indicate the increasing use of private psychiatric hospitalization as a means of controlling misbehaved youth, while national and local data specify some of the dimensions of this increasing privatization. National data show that juvenile inpatient hospitalization more than doubled between 1970 and 1975, with an increase from 6,452 to 15,462. The increase leveled off between 1975 and 1980 rising to 16,735 inpatients. Overall these changes represent a a 159% increase for the decade (NIMH, 1985 unpublished preliminary report).

The rates of private psychiatric hospitalization for all age groups show an increase from 1970, which is interesting in the light of deinstitutionalization policy and the decline in the state hosptial population. For the general population, the rate per 100,000 was 43.3 in 1970, rising to 62.6 in 1980. The rate of increase for the under-18 population was even more dramatic. In 1970 it was 9.3, in 1975 23.3, and by 1980 it was 26.3--more than doubling in a decade (NIMH, 1985).

If we cross classify these national statistics by gender they provide a comparison between the open system of juvenile

justice and the hidden mental health system as loci of social control. Those juveniles who are incarcerated in justice facilities are overwhelmingly male, with the pre-deinstitutionalization exception of status offenders, who tended to be predominantly female. One dimension of the privatized hidden system is that it does not parallel the other system's wide disparity between male and female incarceration. In 1980, 9,386 of the private psychiatric inpatients were male, while 7,849 were female. In previous years, the female rate actually exeeded the male: 8.4 males to 10.2 females per 100,000 in 1970, and 22.5 to 24.1 in 1975 (NIMH, 1985).

A California study of four juvenile psychiatric hospitals in Los Angeles also showed a relatively balanced sex ratio Guttridge, 1981). In addition, this study provides an overview of some of the other characteristics of the hidden system, and a comparison between a public facility and three different private facilites (Guttridge, 1981; Guttridge and Warren,1984). In general, the hidden system (at least for this location during the late 1970s) tends to be less minority-oriented as well as less predominantly male, and includes middle class as well as lower SES youngsters (Guttridge, 1981; Guttridge and Warren, 1984). The California study also indicates that less psychiatric care is provided where there is more need, and more care where there is less need, in a system which permits privatized health care. Of

the four psychiatric hospitals or wings studied, the public hospital sample experienced shorter stays and higher levels of pathology, while the private hospital demonstrated the reverse relationship: longer stays and lower levels of pathology. The mean stay in the county hospital was 13 days; the private hospital means ranged from 25 to 106 days. The schizophrenic or psychotic diagnosis rate was 29.5% in the public hospital, and ranged from 12.4 to 19.5% in the private hospitals. The private hospital clientele was made up primarily of juveniles with DSM II antisocial, personality disorder, depressive, drug abuse or runaway reaction types of diagnosis (Guttridge, 1981; Guttridge and Warren, 1984).

The private hospitals were also more likely to have voluntary juvenile inpatients and the public hospital to have involuntary commitments. In California--as in most other states--incarceration in a psychiatric hospital may occur, for adults, on a voluntary or involuntary basis. While juveniles may be involuntarily committed to psychiatric institutions under the same legislation as adults (the Lanterman-Petris-Short Act in California), for juveniles, "voluntary" refers to being volunteered by parents or guardian;it is only very rarely that juveniles either do, or are permitted by law to, sign themselves in to a psychiatric institituion.

In the California study, 15.7% of the juvenile patients

in the public hospital were voluntary commitments, while the proportion of voluntary placements for the three private hospitals ranged from 49.5 to 90.4% (Guttridge, 1981; Guttridge and Warren, 1984). This high rate of voluntary placements at the private hospitals indicates a demand from parents, as well as from official juvenile control representives, for the psychiatric hospitalization of youth. This demand appears to be as likely in middle-class as in lower class households (although no direct measures of parental SES were possible in the California study), and may be related to the increased incidence of divorce, single-parent families, and step-parents (Guttridge and Warren, 1984).

State-level data indicate the significant contribution of insurance coverage to the increase and expansion of adolescent psychiatric commitment. The cost of treatment in these institutions is very high, ranging from $200 to over $1000 per patient per day; a cost borne primarily by private insurance carriers. Insurance data from Minneapolis indicate that in 1976 there were 1123 admissions to private psychiatric hospitals in the local area which were reimbursed by either Blue Cross or Blue Shield, accounting for 46,718 patient days, while in only the first six months of 1983 the figures were 1124 and 43,855 respectively. The rate per 100,000 population was 187 in 1976 and by 1983 it had risen

to 412 (Schwartz, et al., 1984).

The fact that the rate of hospitalization in Minneapolis exceeds the rate per 100,000 nationwide serves to underscore our previous point concerning the variation between states and other geographical units in the utilization of private psychiatric hospitals. In addition, the data concerning the total utilization of private psychiatric hospitals indicate that while in 1980 California had the largest number of private hospitals--28--15 other states exceeded that state's 8.9 rate per 100,000 (Redick and Witkin, 1983).

The data for all private hospitals also indicate the typical ownership patterns for this type of institution, and thus of this aspect of the hidden system. Of the 184 private hospitals in the US in January 1980, 63 (42% of available beds) were nonprofit, while 121 (with 58% of the beds), were for-profit. Among the for-profit hospitals, the majority were owned by corporations (109), 7 were owned by individuals, and 5 by partnerships (Redick and Witkin, 1983). These figures represent an increase in privatization and profitization over time. As NIMH analysts Thompson, Bass and Witkin (1982) note:

> Between 1968 and 1975 the number of for profit psyiatric hospitals run by corporations grew from 62 to 103 (an increase of 66 percent) while for-profit private psychiatric hospitals by individuals or partnerships decreased from 20 to 14, a drop of 30 percent. Not-for-profit, church-related private psychiatric decreased from 17 to 8, a 53 percent percent decline and not-for-profit hospitals increeased only slightly, from 52 to 55, or by 6 percent (p. 712).

As Starr (1982) has noted of American medicine in general, American inpatient psychiatric medicine is becoming increasingly dominated by the corporate sector (Guttridge and Warren, 1984).

One branch of the hidden system, then, is the private psychiatric hospital, often profitmaking and owned by a corporation, which provides care and control of misbehaving or disturbed adolescents (and sometimes children) in return for insurance money. Variations in this system include psychiatric wings of private general hospitals, which may be even more profitable and widespread (Thompson, Bass and Witkin, 1982). This hidden system is used both by the public juvenile welfare and justice system--as a placement alternative for disturbed wards of the court--and by parents as a relief from hostile or uncontrollable youth (Guttridge, 1981; Guttridge and Warren, 1984). While some of the patients in these psychiatric institutions are severely mentally disturbed, manifesting the delusions and hallucinations characteristic of schizophrenia or psychoses, the typical adolescent tends to enter treatment with a conduct or personality disorder type of diagnosis (Guttridge, 1981; Guttridge and Warren, 1984).

RESIDENTIAL TREATMENT CENTERS AND CHEMICAL DEPENDENCY UNITS

Psychiatric hospitalization is not the only dimension to the hidden system of social control; other mental health related institutions have also come to serve the function of care and control of misbehaving youth. Among these other institutions are those which have existed for some time, such as Residential Treatment Centers (RTCs), and those which are of more recent development, such as Chemical Dependency Units (CDUs) of general or psychiatric hospitals. Both RTCs and CDUs represent privatized forms of the hidden system.

The purpose of RTCs is the "provision of round-the-clock care to persons primarily under the age of 18 who are diagnosed as having an emotional or mental disorder" (Redick and Witkin, 1983, p. 1). Over 95% of RTCs in 1979 were private. The 1979 admission rate to RTCs nationwide was almost the same as tne 1980 rate for inpatient psychiatric hospital inpatients: 15,453. But the end-of-the year inpatient census was actually higher: 18,276. The admission rate is similar to the private hospitals at 24 per 100, 000. While there were only 184 private psychiatric hospitals (for all ages) in the US in 1980, there were 368 RTCs. These figures represent an increase in admissions to RTCs since the 1970s, although not as dramatic as that in the private psychiatric hospital sector. In 1980 there were 15,453

admissions to RTCs (Zenoff and Zients, 1983; 192); 29% more than in 1971.

Despite their similarities with private psychiatric facilities, the RTCs are considerably different with respect to cost. While a private psychiatric hospitals fees may exceed a thousand dollars a day, the average expenditures per resident per day in 1979 for these hospitals was $153, according to NINH (Redick and Witkin, 1983). RTC's, on the other hand had a daily per patient expenditure of $69. Despite their private ownership, most of the referrals to RTCs come from the public sector, through social welfare agencies responding to complaints from the child's school, placement or home (Buckholdt and Gubrium, 1979). Like many other private-sector institutions dependent upon public funds, private RTCs face problems when the states cut their budgets. Buckholdt and Gubrium (1979), in a case study of one RTC, describe the typical agency response:

> The county's freeze on referrals unofficially entered the staff's admission and discharge considerations. During the freeze, staff informally spoke of intake interviews as one member stated, "You know you're going to admit him anyhow. We just can't afford not to. "Likewise, staff members were were reluctant to discuss any discharges, and were distressed about the numbers of discharges they had recommended to the county before the freeze (p. 28)

When market principles enter into the provision of services, entrepreneurship in their provision, referral and discharge activities tend to replace need as an operating criterion (Warren, 1981).

Since chemical dependency units are a relatively new phenomenon, data are limited to the local level rather than national statistics. In their survey of this aspect of the hidden system in Minneapolis, Schwartz and Krisberg (1982) found that

> In 1980, there were an estimated 3000 to 4000 juveniles admitted to inpatient chemical dependency treatment programs. Although it is unknown how many juveniles were admitted to such programs in the early 1970s, it is assumed that the numbers were substantially less because there were few chemical dependency centers at that time.

Once psychiatric care is privatized and profitized, the needs aspect of child welfare (or adult) becomes subordinated to the profit potential of care systems. What this means is that providers may withdraw from one aspect of the hidden system if another seems more profitable, or perhaps withdraw from the care and control of juveniles altogether. It seems plausible that one factor in the increase of CDUs, should this become a national phenomenon (and anecdotal data indicate that it may), is the lesser cost and thus greater profitability of running such facilities over psychiatric hospitals. And although insurance coverage will often pay for treatment, there is no need for the elaborate ritual of continued DSM diagnosis to justify incarceration. The expansion of such new forms of privatized social control as eating disorder clinics for both adults and juveniles could augur the transfer of capital away from troubled children to

obese women and bulimic college students. Unlike the public sector, the private sector need not provide.

EVALUATION OF THE HIDDEN SYSTEM

What are social policymakers to make of the development of this privatized, mental-health oriented system of institutional control? Clearly, one problem is that this system has simply arisen in response to a perceived market, rather than being an object of policy discussion, analysis and evaluation (Brown, 1985). As both the critiques (Scull, 1977) and positive assessments (Savas, 1982) indicate, there has been no evaluation of the new private social control system for adults and the elderly, let alone for juveniles. Both those who are in favor of such a system of social control as we have described, and those who oppose it would surely agree on he need for it to be made the subject of deliberate planning and evaluation.

A second aspect of the question revolves around whether inpatient psychiatric hospital treatment for juveniles, when it is not commonsensically voluntary, has more of the character of a welfare benefit, or of warehousing and control. Over the past two decades a social science literature has developed which is highly critical of "asylums" even for adults (Scheff, 1966; Goffman 1961). This

criticism has been extended to juveniles by Szasz (1982), who regards the essentially involuntary placement of juveniles in psychiatric institutions as a form of involuntary servitude. The opposite position is taken by many practitioners in the field of child mental health, who regard their treatment interventions as beneficial for troubled juveniles (e.g. Kovar, 1979).

Some practitioners, and also some representatives of insurance interests, have proposed that outpatient treatment of juveniles and their families would be preferable to hospitalization of the child as a form of treatment (Knitzer, 1982). This proposal is even more cogent given the fact that in many of the families whose child is hospitalized it is the family itself, rather than just the one member, who is emotionally troubled. The child in a sense becomes the family scapegoat by being singled out for hospitalization (Guttridge and Warren, 1984; Warren, 1983).

However, the outpatient solution presupposes that the inpatient option would be utilized less, as well as the outpatient option utilized more, were both made equally available. One problem with this assumption is that proposing outpatient treatment as a solution ignores the "moratorium" effect of mental hospitalization, by which the family system, or parents, are relieved for a short time of the stress caused by adolescent misbehavior (see Sampson et

al. 1964, Warren, 1985). The demand for inpatient psychiatric hospitalization for adolescents may be as much a demand for the inpatient episode as it is for the treatment factor.

Research on deinstitutionalization shows that attempts to provide outpatient treatment options, such as Community Mental Health services, typically result in "net widening" rather than in a reduction of the inpatient population (Brown, 1985). Net widening occurs when a new outpatient system treats not the previously institutionalized population, but a new population previously unserved by psychiatric facilities. Net widening seems to us to be a more likely response to the more ready provision of insurance payment for outpatient juvenile mental health services than any real reduction in inpatient populations.

This solution also ignores the demand from the state for child mental health placement, particularly in RTCs. Parental admission is not the only way in which a child may be placed voluntarily in an inpatient setting; children who are wards of the state may be so placed by their legal guardians. There is some evidence, in fact, that the majority of all inpatient psychiatric placements of juveniles are made by state agencies (Zenoff and Zients, 1983). Where hospitalization is a result of state action, the inpatient mental health system tends to function as a placement alternative in an era of declining public welfare options

(Guttridge, 1981, Warren and Guttridge 1984), or as a safety valve for troubled or troublesome inmates of other control institutions, such as juvenile halls or group homes (Warren, 1983). Taube and Meyer of NIMH for example, cite evidence that among the under 20 age group in Texas State Hospitals in 1974, only 37% were judged to need this level of care (Taube and Meyer, 1975). Outpatient treatment provisions do not address the practical needs revealed by these utilizaton patterns.

Outpatient treatment is in fact available to adolescents and their families through numerous public and private clinics and facilities, although not in a geographically uniform distribution. In a summary of trends in psychiatric care between 1940 and the present, Thompson, Bass and Witkin (1982) state of public sector services in the 1980s that

> Children are being served to a significant (on an outpatient basis) in contrast to the relatively low utilization by children of hospital-based care... The higher utilization is partly due to the inclusion of many former child guidance clinics in the outpatient clinic groups (p. 714).

It appears to us that opening up the outpatient system, or monies available for it, would not necessarily satisfy the demand for inpatient care, and that a closing-off of the inpatient option would be more directly effective. That is, should society decide that inpatient psychiatric treatment is not the way to help troubled juveniles or their families.

These arguments can be extended from private psychiatric

hospitals to RTCs, CDUs, and other, as yet undocumented sectors of the hidden system. One question we as a society can ask ourselves is: should inpatient or residential mental health or drug treatment be a preferred mode of treating troubled adolescents? No matter what answer is given to this question, another question remains to be asked: do we want the care and control of juveniles to be in private, in profitmaking, and in corporate hands?

As we indicated above, one problem of mixing care and control with the profit motive is that profit-sources, not need, becomes the criterion by which different programs are developed, maintained, and eliminated. It would be quite possible to promote a social program of private mental health facilities only to find that the corporation eliminates them in a few years in favor of something more profitable, such as eating disorder clinics.

A basic contradiction emerges from mixing care and control with the profit motive is that the profit interest, not the care and control, becomes the bottom line for judging performance. There has already been considerable documentation of the ways in which private adult social control institutions, from nursing homes to board and care homes, cut cost corners in order to maximize profits (Brown, 1985; Warren, 1981). The corners cut include crucial elements of both care and control: staffing ratios. nutritious and varied food, and

medical care.

Finally, both public and private juvenile psychiatric hospitalizaton--but especially private--involve special legal problems. During the past decade or so, the juvenile court system has become more attentive to juveniles' legal rights. The nineteenth century image of the benign, paternalistic juvenile justice system operating in the best interest of youth has gradually been replaced by a more realistic image of the state and the child in legal opposition. Transferring misbehaving children to the hidden system deprives this new model of much of its power.

The legal rights of minors are much less protected in the mental health system than in the juvenile justice system, and are less protected in the private mental health system than in the public (Dillon et. al., 1992). Until recently, in fact, legal scholarship took very little notice of either the involuntary or voluntary commitment of those under 18 to psychiatric hospitals, despite the great interest in the involuntary commitment of adults (Warren and Guttridge, 1984). We are not aware of any significant legal interest, as yet, in such types of institution as the RTC or CDU.

Like the laws governing adult psychiatric hospitalization, the admission of those under 18 to mental hospitals involves both state legislation and case precedents. Although there has been some interest recently

among legal scholars in child commitment, it has lagged far behind the interest in adult commitment, which began in the early 1970s. Several critical analyses of the under-18s in recent law journals, however, have prompted a reexamination of the issue (Guttridge and Warren, 1984; Zenoff and Zients, 1983).

Since the mid-1970s, there have been various legal challenges to the voluntary admission procedures for juveniles. Zenoff and Zients (1983) note that

> Although unsuccessful in the courts, the attack on parental admission of minors enjoyed considerable legislative success....detailed analysis of present laws reveals that twenty one jurisdictions sharply curtailed non-judicial hospitalization [between 1974 and 1982].

Most of the case legislation has been at the state level. (For a summary, see Zenoff and Zients, 1983). The most significant Federal case, Parham vs. J.R., expressed "the Supreme Court's determination that the due process clause does not require that minors enjoy the same procedural protections as adults before being placed in a mental health facility" (Zenoff and Zients, 1983; 173).

Those state level case precedents which extended some protections to juveniles placed in psychiatric hospitals have generally been held to apply only to institutions which have some significant state interest. Significant state interest may be variously interpreted, including the receipt of state

money, or utilization by public welfare agencies as a contractual placement source. However, it is generally held to exclude institutions which do not take public funds. The Roger S decision in California, for example, which referred to the need for due process in an involuntary commitment case under LPS, was held by the attorney general not to apply to privately funded treatment at private facilities (Dillon et. al., 1982;p 466-467).

In summary, some progress has been made in extending legal rights to voluntarily and involuntarily committed children over the past decade. However, there are still differences, both between juveniles and adults in the mental health system, and between juveniles in the justice and in the mental health system. As a recent Children's Defense Fund report comments:

> only six states routinely mandate child specific reviews once children are in hospitals. Only 17 provide children and adolescents the right or accss to counsel in voluntary admission proceedings. (Knitzer, 1982).

And the comparison can be extended: whatever legal protections have been developed on behalf of minors in psychiatric hospitals have not yet been applied to those in RTCs or CDUs.

One irony of the hidden system is that child advocates still complain of the lack of adequate mental health services for children in need. Knitzer (1982) notes that

> Of the three million seriously disturbed children in this country, two thirds are not getting the services they need. Countless get inappropriate care....The most readily available "help" for these children remains the most restrictive and costly-inpatient psychiatric care. Studies suggest that at least 40 percent of the hospital placements of children are inappropriate. Either the children should never have been admitted to the institutions or they have remained there too long....Of the 44 states responding to our survey, 18 were working to increase residential care. In contrast, states had almost no capacity to provide non-residential services, like day treatment, and were not working to create these services (p. xi).

Others interested in child welfare challenge the charge of inappropriateness in existing residential placements, and assert that they are helpful to troubled children (Kovar, 1979; Zenoff and Zients, 1983).

We would take the position that in a system divided into two--a costly, privatized system and a lower cost (but still expensive) public system of residential mental health care--is not the best way to serve the needs of minors. In a California study we found that at the same time as behaviorally deviant middle class youngsters were being placed by their parents in private facilities, seriously psychotic or schiozphrenic youngsters could not be admitted to the public wards because they were full (Guttridge and Warren, 1984). Again, a system to provide for care whose bottomline is profits and markets is bound to be inadequate in fulfilling the needs of the population served. While some children are in "inappropriate" placements, others are denied

access to appropriate ones.

We would argue, then, that the private aspect of the hidden system is not in the best interests of children and their mental health care. The appeal of a mental health system for the care and control of troubled or troublesome children depends upon the existence and viability of alternative institutions within the society. It seems to us that it is not necessary to treat the problems of children from within the medical model, and in hospitals, with the attendant problems of institutionalism and stigma. Yet at the same time, many of the other places these children might be in--group homes, juvenile halls, foster homes, or even in some cases their own homes--are worse. One of the saddest features of the hidden system, to us, is that in so many instances there are no more humane alternatives.

Bibliography

American Psychiatric Association, Diagnostic and Statistical Manual, 3rd Ed., Washington D.C: APA, 1980.

Brown, Phil The Transfer of Care: Psychiatric Deinstitutionalization and its Aftermath. London: Routledge and Kegan Paul, 1985.

Buckholt, David R. and Jaber F. Gubrium. Caretakers: Treating Emtionally Disturbed Children. Beverly Hills, Calif: Sage Publications, 1979.

Conrad, Peter and Joseph W. Schneider. Deviance and Medicalization: From Badness to Sickness. St. Louis: C.V. Mosby, 1980.

Dillion, C.K. et. al, "In re Roger S.: the Impact of a Child's Due Process Victory on the California Mental Health System." California Law Review, 1982.

Goffman, Erving. Asylums. Garden City, NJ: Doubleday Anchor, 1961.

Grisso, Thomas and Linda Vierling, "Minors' Consent to Treatment: a Developmental Perspective." Professional Psychology, 9, August 1978, pp 171-214

Guttridge, Patricia. Psychiatric and Non-psychiatric Factors Affecting Mental Hospitalization of Juveniles. PhD Dissertation, Dept. of Sociology. University of Southern California, 1981.

Guttridge, Patricia and Carol A.B. Warren, "Adolescent Psychiatric Hospitalization and Social Control," Mental Health and Criminal Justice, ed. L. Teplin, Beverly Hills, Calif: Sage Publications, 1984.

Knitzer, Jane. Unclaimed Childern: the Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services. Washington D.C: Childern's Defense Fund, 1982.

Lerman, Paul. Deinstitutionalization and the Welfare State. New Brunswick, N.J: Rutgers University Press, 1982.

O'Connor, James. The Fiscal Crisis of the State. New York: St. Martin's Press, 1973.

Redick, Richard W. and Michael J. Witkin, Private Psychiatric Hospitals, United States, 1979-1980," NIMH Statistical Note #164, August 1983.

----------"Residential Treatment Centers for Emotionally Disturbed Childern in the United States, 1977-1980." NIMH Statistical Note #162, 1983.

Rose, S.M. "Deciphering Deinstitutionalization: Complexities in Policy and Program Analysis," Milbank Memorial Fund Quarterly. 57, pp 429-460, 1979.

Sampson, Harold, Sheldon L. Messinger and Robert Towne. Schizophrenic Women: Studies in Marital Crisis. New York: Atherton Press, 1964.

Savas, E.S. Privatizing the Public Sector: How to Schrink Government. Catham, N.J: Chatham House, 1982.

Scheff, Thomas J. Being Mentally Ill: A Sociological Theory. Chicago: Aldine, [1966] 1984.

Schwartz, Ira and Barry Krisberg. "Rethinking Juvenile Justice." Crime and Delinquency Vol. 29, 3 pp. 333-364, 1983.

Scull, Andrew T. Decarceration: Community and the Deviant--A Radical View. Englewood Cliffs, N.J: Prentice Hall, 1980.

Spector, Malcolm "Beyond Crime: Seven Methods to Control Troublesome Rascals." in Law and Deviance, H.L. Ross ed. Beverly Hills, Calif: Sage Publications, 1981.

Szasz, T. "The Child as Involuntary Mental Patient: the Threat of Child Therapy to the Child's Dignity, Privacy and Self-Esteem," San Diego Law Review, 14, pp 1005-1027, 1977.

Taube, Carl A. and Nessa G. Meyer, "Children in State Mental Hospitals," NIMH Statistical Note #115, 1975.

Thompson, James W., Rosalyn D. Bass, and Michael J. Witkin, "Fifty Years of Psychiatric Services, 1940-1990" Hospital and Community Psychiatry, 33, Sept., pp 711-717, 1982.

Warren, Carol A.B. Mad Wives: Schizophrenic Women at Midcentury. Draft manuscript, 1985.

---------- "New Forms of Social Control: the Myth of Deinstitutionalization," American Behavioral Scientist, 25, 1981.

---------- "The Politics of Trouble in an Adolescent Psychiatric Hospital," Urban Life, 3, Oct. 1983.

Zenoff, Elyce H. and Alan B. Zients. "If Civil Commitment is the Answer for Children, What are the Questions?" The George Washington Law Review, Vol. 51:171, 1983.

PREPARED STATEMENT OF BILL JOHNSON, MANAGER, LAY ADVOCATES NETWORK OF THE MENTAL HEALTH ASSOCIATION OF MINNESOTA

My name is Bill Johnson and I am presently the Project Manager for the Lay Advocates Network of the Mental Health Association of Minnesota. The Mental Health Association of Minnesota is a voluntary citizen's organization which has received a grant from the McKnight Foundation of Minneapolis to provide advocacy services for mentally ill and chemically dependent individuals throughout Minnesota.

Prior to taking my present position I was a Social Work Specialist at Fergus Falls (MN) State Hospital where I did, for 14 years, act as the Patient Advocate and was, therefore, involved in some 18,000 cases, a significant number of which were juveniles. My experience also includes many years as a police officer and I feel, therefore, that I bring an unusual perspective to the area of children and their rights. I was for many years a member of the Minnesota Department of Public Welfare Humane Practices Committee which studied the impact of institutions on people and I am presently a member (and former Board Member) of the National Association of Rights Protection and Advocacy.

It is my conviction that there is a desperate need for a system of checks and balances to be put in place to protect the legal rights and human dignity of the children coming to the attention of the so-called "helping" professions. It does seem to me that our society has turned to "experts" to solve an apparent increasing number of "problems-in-living" among our youth. This has been accomplished, in no small part, by the aggressive public relations efforts of mental health professionals who have lead a gullible public to believe that they (the professionals) do, indeed, have the answers to all of these problems or, at least, they are more than willing (for a price, of course) to seek solutions.

Unfortunately, this public relations effort has been accompanied by exaggerated success claims, inflated statistics, and is usually totally lacking in any empirical data to support these claims.

There is no doubt that there are many, many children who are having difficulty adjusting to an increasingly complex society. As a parent and grandparent, there is also no doubt in my mind that families are genuinely concerned about the welfare of their children and are seeking help. But, alas, they are sadly lacking in information about program effectiveness. Unfortunately, parents and concerned others often find themselves in a crisis situation and in no position, therefore, to carefully consider all possible options including the obtaining of a second opinion. In such situations it is not surprising that people are lead down the proverbial primrose lane by the treatment industry and/or its individual practitioners. It must also be said that the mental health delivery system in our country is, by and large, made up of kind, compassionate, caring, and competent professionals. Unfortunately, the emphasis continues to be on in-house treatment and the nearly cut-throat competition to fill empty beds simply does not work to the benefit of all too many children. As an example of this competition, two hospitals in the Twin Cities have converted to the exclusive treatment of youth and another one has opened a treatment unit after anticipated medical admissions failed to materialize. It should also be mentioned that the original addiction problem has now been expanded to "dependency","co-dependency" which has the effect of making nearly ANYBODY a proper subject for intervention.

My experience would lead a reasonable person to believe that society, in its attempt to help/control adolescents, is presently using the therapeutic system as a substitute for the juvenile justice system. Indeed, here in Minnesota we have experienced a 55% increase in the admission of children to mental health-chemical dependency treatment systems in one year and somewhere in the neighborhood of 3,400 children were placed in treatment for in excess of 83,000 treatment days! Blue Cross/Blue Shield found that 20% of these admissions did not even meet their admission criteria and I am personally convinced, albeit without firm evidence, that children who heretofor have been simply behavior problems now receive diagnostic labels and are, therefore, proper subjects for psychiatric and chemical dependency treatment exploitation. Indeed, I have had more than one probation officer admit to me that they now put children away for simply possessing a joint or being caught in possession of beer when, in fact, the real problem was that they were behavior problems in school or at home. Since it is easy to simply place children in treatment by parental edict, this is much quicker and cheaper than going through the criminal justice system where juveniles have the right to due process, including legal representation. It is also a well-known fact here in Minnesota that we literally have a "pipeline" from other states who send their children to a couple of our treatment facilities when they do not, in fact, meet the standards for commitment in their own state.

While due process protections seem to be increasing for children (alas, at a very slow rate) I do believe that ultimately reasonable people will come up with due process protections which will guarantee that children will be treated reasonably, fairly and justly. I do remain, however, most concerned about what happens to kids once they get in treatment because, in point of fact, there is little, if any,

system of review. No checks and balances are in place which monitor treatment facilities and, of course, there are few, if any, advocates available to children nor are there grievance mechanisms in place so the children can protest their predicament.

Children remain one of our most, if not our most, powerless groups in society as everything is done in their "best interest." This being the case, almost anything can, and does, pass for treatment. It is my considered opinion that most of this treatment amounts to no more than intimidation and coercion and kids simply get pushed around under the guise of treatment. Most treatment is, in my view, nothing more than behavior modification using adversive techniques. All too much treatment can, in fact, easily resemble a Marine Corp Boot Camp except, of course, that a boot camp is of much shorter duration. Seclusion and even restraint is used (and abused) arbitrarily and capriciously and I have no doubt in my mind that these methods, along with chemical restraint, can only play a large role in dehumanizing our children. I would imagine that the purchasers of in-house psychiatric/chemical dependency services expect a dynamic, active program. However, I submit that this is all too often not the case. Instead, programmed boredom, locked doors, benign neglect, unreasonable rules, contest of wills between kids and staff, and depersonalization are the basis of programing. Behavior, which if displayed outside of the treatment setting would be viewed as natural and expected, is perceived negatively and so charted. Horseplay of most any kind is considered as a symptom of mental illness (inappropriate behavior) and chemical dependency ("using behavior"). Is it any wonder that treatment efforts can, in

fact, be hazzardous to one's mental health??? And kids can easily become nothing more than cloned treatment "junkies".

Concerned parents and a concerned society must, of course, deal with problem children. But I have the most serious reservations that taking kids away from the family, locking them up for long periods of time, and attempting to mold their character will, in the long run, be beneficial to either them or to society.

There are, no doubt, a certain number of children who will have to be put into in-house treatment for their own and societies' own good. When this occurs I would suggest that 1)in-house treatment be the very last resort, 2)it be in the least restrictive alternative possible, 3)for the shortest period of time, 4)utilizing proven treatment modalities, 5)with safeguards against the overuse of seclusion restraints, 6)with grievance mechanisms in place, 7)and with advocacy services available. Children should have clearly defined rights and, therefore, not be at the whim, caprice, and speculation of the treaters. They should be made aware of these rights and there should be unobstructed access to an advocate to represent them. Only in this way can there be a balance maintained between the powerless child and the awesome power of the parent/therapeutic system.

I would, therefore, urge the Select Committee on Children, Youth and Family to seriously support the establishment of meaningful Protection and Advocacy functions within both the Federal and State levels to provide monitoring and education leadership in assuring that our children shall always be guaranteed that their rights will be protected and their human dignity enhanced in our treatment efforts. As it is, all too many of our children who would, if given time, grow out of their problems naturally find themselves labeled, stigmatized, and dehumanized.

Thank you very much.

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POSITION PAPER ON THIRD-PARTY COVERAGE FOR THE PSYCHIATRIC TREATMENT OF CHILDREN

The National Association of Psychiatric Treatment Centers for Children (NAPTCC) is an alliance of non-hospital psychiatric treatment centers for children, adolescents and young adults which has been organized for the following purposes:

1. To promote excellence in the care, delivery, accountability and cost-effectiveness of psychiatric services to America's youth whose treatment needs can best be served in inpatient settings.

2. To advance and encourage standards in psychiatric treatment centers that will foster more favorable attitudes on the part of public policy makers, business and community leaders, unions and insurance companies toward funding of psychiatric treatment for children and youth in non-hospital settings.

3. To support standards, advocacy, educational programs, marketing and research designed to ensure the efficiency, effectiveness and accountability to children and families, to the public and to funders of care provided in psychiatric treatment centers.

The National Association of Psychiatric Treatment Centers for Children defines a psychiatric treatment center as follows:

> A facility or distinct unit of a facility organized and professionally staffed, providing general and specialized treatment programs for children, adolescents and young adults whose primary treatment problems consist of diagnosable nervous and mental disorders, who have sufficient intellectual potential to respond to active psychological treatment, for whom there is a reasonable expectation that their level of functioning will be improved through treatment and for whom out-patient or hospital treatment is not appropriate and a protective environment is medically and psychologically necessary.
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> Psychiatric treatment centers provide a total, therapeutically planned group living and learning situation where distinct and discrete individualized psychotherapeutic approaches are planned, proposed and carried out by an integrated multi-discipline team of mental health professionals which includes appropriate medical/psychiatric presence. Psychiatric treatment centers are licensed in the states in which they operate and must be accredited by the Joint Commission on Accreditation of Hospitals.

The National Association of Psychiatric Treatment Centers for Children adheres to the following basic propositions:

1. Early life experiences have a lasting effect on maturation, behavior, adjustment and overall mental health with the result that public policy should support the successful treatment and resolution of problems in childhood so as to avoid lifelong arrest or inhibition of capacities and to enhance the likelihood of becoming longstanding, contributing and productive members of society. Ensuring conditions that provide needed treatment to children when they are young is preventive in nature and reduces the likelihood of serious, debilitating and costly psychopathology, societal dependency and reduced productivity at an older age.

2. Children, particularly those who are impaired due to nervous and mental disorders, are essentially powerless to influence public policy and have no influence in a free-market enterprise with respect to such things as informed consumer choice. It, therefore, becomes essential that knowledgeable and genuinely concerned adults advocate for and look after the interests of children whose needs might otherwise be neglected.

3. The psychiatric treatment of children should be based on scientifically valid criteria and should address bona fide psychiatric illness and not merely problems of daily living, developmental issues or transitory behavior problems. It must be active, well-planned and thoroughly documented in an appropriate medical record. Whenever possible, treatment should include family members, especially parents, and should support the integrity of the family unit and of parental rights and authority.

4. Society has an obligation to provide every person with an adequate level of health care and equitable access to health care, including psychiatric treatment. Measures kthat negatively affect services and exacerbate existing inequities in access to health care, especially for children, are morally wrong.

5. Most psychiatric treatment for children can be effectively carried out in non-hospital settings. Psychiatric treatment costs are generally unreasonable, and business, labor, government and insurance companies all contribute to this unreasonableness by providing incentives for expansion of inefficient and uneconomic types of services and establishing policies which do not provide inducements for consumers to utilize less costly, more effective alternatives. Coverage for psychiatric treatment centers provides one means by which the current trend toward out-of-control health care costs can be reduced.

6. It is a maxim in free-market health care economics that, if coverage is inadequate, inappropriate use will be made of whatever other coverage exists. Mental illness will always exist and require treatment. When coverage is inadequate, inappropriate or absent, treatment will take place in grossly inappropriate and cost ineffective settings. Inadequate coverage is ultimately more costly to society because conditions not properly or

adequately treated eventually require longer and more costly care and account for great losses in human productivity.

7. It is clinically unsound and unethical to treat a patient in a setting based primarily on insurance coverage as opposed to the treatment needs of the patient. High cost treatment neither ensures quality or positive treatment outcomes and results in limited funds being unnecessarily expended on fewer numbers of needy patients.

8. Psychiatric units of general hospitals which provide acute care to young people are often oriented to serving adults and are not usually professionally staffed or programmatically equipped to deal with the special treatment needs of young people. In contrast, psychiatric treatment centers are exclusively and specifically oriented to the treatment of children and/or adolescents and provide a level and type of care that is suited to their needs.

9. Psychiatric treatment centers are a well-established and essential element in a continuum of services for emotionally ill children and youth and should be recognized as such by public policy makers, insurance companies and other third-party payors.

   A nine-year collaboration between the American Psychiatric Association and the Office of the Civilian Health and Medical Program of the Uniformed Services to ensure quality treatment in psychiatric treatment centers has demonstrated unequivocally that the care provided is necessary and of high quality.

   Psychiatric treatment centers subscribe to such practices as peer review, utilization review and patient care monitoring which carefully screen and treatment patterns in individual treatment centers to ensure that quality of care is appropriate and includes adequate medical presence.

10. Legislation mandating mental health benefits, including coverage for psychiatric treatment centers, is an important legislative step. Treatment for mental and emotional disorders is a necessity. Inadequate or untimely treatment results in tremendous costs to the well-being of the individual, stability of the family and productivity in the work place.

    Because of the stigma and unrealistic feelings of immunity from mental and emotional problems, the public tends to minimize the necessity of adequately insuring itself for mental health treatment.

    In an era where deficits in the government budget and in corporate budgets are driving health care policy and where the most important theme in the health care industry is that efficiency will be rewarded, psychiatric treatment centers for children and adolescents must be seen as part of the solution to health care cost escalation.

Services are homebased. At least 95 percent of the direct contact between counselors and family members will occur in the family's home, at times most suitable to the family's schedules...

HOMEBUILDERS

Homebuilders: The Maine Experience

by Edward C. Hinckley

The development of home-based services for Maine children and adolescents and their families began in 1980-81, spurred by a number of factors observed by the state agencies responsible for children's services.[1] One major factor was an increasing demand for out-of-home, substitute care placements, coupled with decreasing satisfaction regarding the outcome of such placements if a "return to family" was the expressed goal of the child's individual plan.

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The constantly increasing costs of such placements, a reduction in resources for the development of new substitute care facilities and heavy agency caseloads also dramatized the need for services. Added to this was the implementation in 1978 of Maine's "Juvenile Code," decriminalizing the so-called "status offenses" without providing new resources for children who could not consistently live with their natural families.

While these issues were being identified, other factors contributed to the creation of some innovative programs. The balance of a 2-year grant from the federal Law Enforcement Administration, for planning alternative services required as the result of the Juvenile Code, became available to the Interdepartmental Committee for a model program. Children's services representatives in the state's community mental health centers continued to stress how much more effective their therapies and assistance could be if delivered outside the clinical setting;[2] and, finally, the Office of Children's Services, Department of Mental Health and Mental Retardation, received a number of articles describing the "Homebuilder" program developed by Catholic Children's Services of Tacoma, Washington (now operated by the Behavioral Sciences Institute, Inc.).[3]

The first Maine adaptation of the "Homebuilder" program[4] was launched within the children's division of the Bath-Brunswick Mental Health Center in July 1981; the second emerged a few months later as an activity of Families United of Washington County, a youth service agency in Machias. Initially, both of these were funded jointly by the Office of Children's Services and Maine's Juvenile Justice Advisory Group. The third "Homebuilder"-type program, at St. Michael's Family Center in Bangor, a former group home, was jointly funded by the Department of Mental Health and Mental Retardation and the Department of Human Services in the fall of 1981. The fourth, Projects, Inc. in Camden, another youth service agency program, was funded by the Office of Children's Services in August 1982. The following month, the latest program was added to a Portland substance abuse treatment center's outpatient facility (Day One), using funds from Maine's "Alcohol Premium Law."

The state's positive experiences with these programs have fueled a demand for the expansion of existing programs and the creation of new ones which has far exceeded the state's capacity to respond.

Characteristics

Based on the knowledge gained from the five state "charter" programs and from the participation of the four departments that comprise the Interdepartmental Committee, the current Maine

model for homebased services has developed the following characteristics, which are considered essential for successful program operation.

• Services are aimed at families where a child is at risk of removal from the home, either because of the child's behavior (as in the case of a potential juvenile justice referral to court) or because of the parents' needs or behavior (as in the case of an "open" protective case). The primary goal is to enable the child to remain at home for at least one year following the termination of services.

• The secondary goal of the services—which can be described as family intervention, support and counseling—is to enable the child and family to link with appropriate community support agencies or individuals during the intervention and to continue these linkages on their own after the intervention ends. In this way, the programs perform a "case finding" role by connecting physically or socially isolated families with community services.

• Services are homebased. At least 95 percent of the direct contact between counselors and family members will occur in the family's home, at times (including evenings and weekends) most suitable to the family's schedules and preferences. In a state as large and rural as Maine, this necessitates a significant travel budget, but there is no question that meeting in the family's home enhances the success of intervention.

• Services are family oriented. The program strives to involve as many members of the family and extended family as possible in all direct contact sessions, and the involvement of at least one adult caretaker is required. While the child is always the referred client, entire family needs are considered in developing the case plan and resulting "contract" and in designing activities during the intervention. One obvious benefit of this approach is that parents learn how to generalize new methods of parenting from one child's situation to that of another sibling.

• Services are time-limited and of short duration. While 12 weeks is the maximum period of intervention, several programs have a 9-week maximum. This period is fixed in advance and is the same for all families (except in the case of unplanned terminations or extremely rare extensions); the time limit is one of the first things discussed with the family upon opening a case. Although clearly it is not possible to "cure" multi-generational problems in a 9- to 12-week intervention, the dynamics of short-term, time-limited counseling appear to be appropriate in accomplishing the program's primary goals.

• Services are team delivered. Because of staff vacancies or a shortage of resources, attempts to offer family oriented, in-home services with individual counselors have been unsatisfactory. A team of two counselors can offer a wider variety of services to members of a family and the mutual support and interactions that they develop make them more than twice as valuable as two individual counselors working alone. (It should be noted that "two team" programs —those with a total of four counselors—are more cost effective and workable and have greater longevity; the state no longer intends to approve "single team" programs.)

• Services are problem related: Some event has to precipitate the referral. Even in chronically malfunctioning families, some action of a child or family mobilizes neighbors, community, or a state agency to initiate a referral. This event is the initial "problem" that counselors seek to address, but they and family members may quickly identify underlying, related or peripheral areas of need that have to be met first. In this sense, our homebased services are "crisis oriented," though they are not expected to respond to initial referrals on a round-the-clock basis. Once a case has been accepted, however, most programs provide in some fashion for 24-hour response to calls from members of that family, although the response may only be a telephone conversation.

• Finally, and perhaps most important, programs operate under the guidance of a regional, multi-agency, interdisciplinary steering committee. Even before significant joint funding of homebased programs became the rule in Maine, it was found that mandating creation of such a committee—consisting of representatives of child serving agencies within the area served by the project and appropriate area representatives of the educational, human service, mental health and correctional "establishments"—was essential to effective program operation. Each program's steering committee participates in such activities as the development of program policies, identification of referral procedures and priorities, recruitment and selection of personnel and public information and education. The committee is especially effective in coordinating funding requests, handling such issues as staff training and stress relief and responding during times of program overload. In practice, almost all referring agencies are represented on a program's steer-

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ing committee, which helps ensure appropriate referrals, and the chairman is usually a representative of the agency in which the program is housed.

This, then, is the current "Maine model" of homebased services. As indicated, the successful economical accomplishment of program goals (that is, maintaining children in their families and developing linkages for those families' continued support) has sparked increased demand by service providers —primarily mental health centers and child and family service agencies—for similar programs and an increased effort by state agencies to obtain additional program funding.

During the most recent state legislative session, three state departments—Mental Health and Mental Retardation, Corrections and Human Services—each obtained a supplemental appropriation for homebased services, and plans are being made to jointly develop and fund three new programs during the 84-85 fiscal year.

Another significant development is the foundation funding received by one of Maine's oldest residential treatment centers, Sweetser-Children's Home in Saco, for an in-home "Family Preservation" program. Working in conjunction with foundation and state department representatives, this program has been designed to fit the "Maine model" for homebased services, with the understanding that during its second and third years of operation, state agencies will work to replace foundation support with state funds.

Having reached a reasonable plateau in the transition from a few experimental programs to a well-established statewide model, attention is being focused on the areas of training and program stability, management information and program evaluation and cost effectiveness.

Training and Program Stability

Basic prerequisites for members of the counseling teams include successful direct care/treatment experience with handicapped, disadvantaged or "at risk" children and, of secondary importance, a related educational background. Good results have been achieved by highly motivated persons with less than a Bachelor's degree; a "native's" knowledge of a community's or region's mores will often be far more crucial than the credentials or licenses of an outsider in gaining entry into the homes of chronically troubled families.

Counselors also participate in training programs and weekly clinical supervision sessions, which are required by all of the programs. In addition, the supporting state agencies offer an annual training program involving key resource persons from within and outside of the state. A 2-day conference co-sponsored by Maine and New Hampshire, a seminar conducted once a month for nine months and a 5-day residential program have all been used as formats for this special training.[3]

Program stability—including staff retention issues—is the result of many factors which are still being explored. In general, it is believed that programs housed in large, multipurpose agencies may be more stable than those where the homebased service program represents 50 to 75 percent of an agency's total operation. Not only does the larger agency have more staff and other resources to meet specific program needs, it also provides more opportunities for informal sharing among staff members and mutual support activities.

Informal research conducted during the past year on staff stress and turnover indicates that opportunities for staff training and professional development play a key role in staff retention. The state is considering the possibility of offering partial tuition assistance in appropriate Master's degree programs to counselors able to make a 2-year commitment to a program. Finally, self-organized but state-supported monthly meetings of counselors from the various programs have proved to be a vital ingredient in their mutual growth and success.

Management Information and Program Evaluation

Each homebased program was encouraged to establish its own reporting format and evaluative procedures. At six and 12 months after case closure, all programs were expected to make contacts with families served to determine family composition and general level of functioning related to the child originally identified as the client. One of the original homebased projects adopted a Nine Point Scale of Family Function used by other programs in that agency to measure the degree of change between case initiation and case closure. To the program's surprise, the intervention and support services proved to be as effective with so-called "crisis" families as with those in a "chronic" state of maladaptive behavior. One program report contains quarterly statistical synopses and a sample of anecdotal case summaries which present useful information for legislators and others not involved in social service delivery.

Although there are no plans to standardize the narrative reporting from programs, there has been an effort during the past year to develop uniform standards and procedures for collec-

tion of case and statistical data so that information can be regularly collected at the state level, aggregated and used for overall reporting, planning and development activities. Information on referred and accepted families and the intervention provided will be collected at referral, intake (of accepted families), during intervention and at case closure. The expressed satisfaction of the clients, families and referring agencies will also be included.

"Hard" data is not currently available, but some of the original five projects have reported success rates—in terms of maintaining the family unit following intervention—as high as 82 percent.

The following case vignettes illustrate two such successes.

In one case, a protective services worker identified a 3-month-old girl as a "failure to thrive" infant. A normal course of action might have been temporary placement of the baby in a foster home, with the recommendation that the parents seek counseling at a mental health center. However, the case was identified in an area served by a homebased program and a referral was made. The counseling team learned that the mother had been a victim of childhood incest and was unconsciously preventing the father from having any contact with their daughter, their first child. His frustration and anger at this behavior was causing him to react violently to his wife and daughter. Through family counseling, these issues were aired, the mother was introduced to a local support group of incest victims, and the father learned how to re-channel his anger. The infant was never removed from the home but rather began—and continues—to thrive.

In the second instance, a mother with five children by four absent fathers was referred by a public health nurse after her 10-year-old daughter attempted suicide with her 12-year-old diabetic sister's insulin. At a presentation by the counseling team to the program's steering committee, it became clear that the mother had an alcohol problem, that one of the fathers had an incestuous relationship with the 12-year-old, that another father was a drug dealer and was involving the children in drug use, and that the only boy in the family, a 9-year-old, was becoming seriously disturbed, partly because he lacked healthy male role models.

Ironically, the steering committee included representatives of mental health, alcohol and substance abuse prevention, and sexual abuse treatment agencies, yet none had ever had any contact with the family nor realistically expected the family to appear in their waiting rooms. Local school representatives on the steering committee (Guidance and Special Education) knew that the children had been truant 60 to 75 percent of the school year but had no other knowledge about the family.

As a result of the intervention, the drug dealing father was indicted, the incestuous relationship was ended, the mother was connected with a local Alcoholics Anonymous chapter, and a "Big Brother" was found for the boy. The family still has massive needs, but its ability to cope with problems is significantly improved.

Cost Effectiveness

In general, a 2-team homebased service with a half-time administrator, a full-time secretary/bookkeeper, clinical supervision once a week, and necessary travel, training, materials and space resources, can be operated for between $130,000 and $150,000 annually.

One team can provide service for three to six cases at a time, offering three to six direct contact hours per week and six to 11 hours of collateral contact per case. With a maximum of 12 weeks of intervention per case, and on the basis of a 48-week year (to allow for vacation and sick time and some training

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time), two teams can serve a total of 24 to 48 cases per year. Using the higher program cost of $150,000, this represents a "unit" cost of from $3,125 to $6,250 per case. Compared to the costs of various types of alternative out-of-home placements—foster care, $4,500; group homes, $10,000 to $12,000; emergency shelters, $15,000; state institutions, $20,000; and treatment centers, $25,000 to $30,000—which do little or nothing to improve family functioning and have no impact on siblings, these figures represent a substantial savings.

Coupled with the success rates referred to previously, it is no wonder that Maine's youth-serving departments have positive feelings about expanding homebased services to unserved areas of the state. At this cost, and with this history, the Maine model really is "such a deal!". ◻

[1]The Department of Mental Health and Mental Retardation, the Department of Educational and Cultural Services, the Department of Corrections and the Department of Human Services. Since 1977, these agencies have worked together as the Interdepartmental Committee, with a primary focus on the coordination of child and family services.

[2]Maine's Medicaid plan does not provide reimbursement for out-patient services delivered by mental health center staff in any locations other than the mental health center. Private Medicaid providers, however, can claim reimbursement wherever services are delivered, including the home.

[3]See "Homebuilders" by Jill Kinney, CHILDREN TODAY, Jan.-Feb. 1978; "Housecalls for Families in Crisis" by Jack Horn, *Psychology Today*, Dec. 1976; and "Homebuilders: Keeping Families Together" by Jill Kinney, Barbara Modsen, Thomas Fleming and David Haapala, *Journal of Consulting and Clinical Psychology*, Vol. 43, No. 4, 1977.

[4]The "Homebuilder" name has been copyrighted (effective January 1984) by Behavioral Sciences Institute, Inc. (BSI), 1717 S. 341st Pl., Federal Way, Wash. 98003. BSI staff members have encouraged and supported Maine's activities.

[5]One significant resource for information and assistance related to the training of homebased service providers is Iowa Children and Family Services, 1101 Walnut St., Des Moines, Iowa 50309.

PREPARED STATEMENT OF IRA S. LOURIE, M.D., CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM, UNDERSERVED POPULATIONS BRANCH, OFFICE OF STATE AND COMMUNITY LIAISON, NATIONAL INSTITUTE OF MENTAL HEALTH, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Background

In response to inquiry as to whether there is an increase in inappropriate psychiatric hospitalization of adolescents, the Child and Adolescent Service System Program of the National Institute of Mental Health (NIMH) offers the following information. This statement has been prepared for the Department of Health and Human Services by Ira S. Lourie, M.D., a child psychiatrist who directs the Child and Adolescent Service System Program at the Institute.

The recent landmark study by Jane Knitzer, Unclaimed Children[1], reports that there are 3 million seriously emotionally disturbed children and adolescents in the United States, and that 2 million of these children are not receiving appropriate mental health care. Statistics collected by the National Institute of Mental Health indicate that the increase in private psychiatric admissions from 1975 to 1980 was less than 2000 or less than 5 percent (see attachment). More recent national statistics are not available. Several explanations exist for increases in the

[1] Unclaimed Children: The Failure of Public Responsibility to Children and Aolescents in Need of Mental Health Services, Children's Defense Fund, Washington, DC, 1982

rate of hospitalization of adolescents with emotional problems. In some instances these admissions are inappropriate. However, most of these admissions are medically necessary based on either diagnosis or level of functioning as well as the availability of community alternatives.

When they occur, inappropriate admissions are the result of several factors. It is true that increased and/or inappropriate admissions may sometimes reflect a profit motive and/or poor medical practices. The extent of this problem has not been delineated, but is most likely focused in circumscribed areas, around particular programs. A second factor is the inexact nature of psychiatric diagnosis is only a developing science and, therefore, treatment planning becomes an empirical process. Until the effectiveness of different treatment modalities can be better documented, it will not be entirely possible to determine prospectively when hospitalization should be used and when it should not. In retrospect it is often easy to discover cases in which a hospitalization was unnecessary, but, given the state of the art, it is much more difficult to make those determinations prospectively.

The major cause of inappropriate admissions is the lack of available appropriate alternatives. Present funding and program strategies do not allow for the development of the range of programs between traditional outpatient therapy and hospitalization or other residential treatment modalities. Professionals and families are faced with either trying an inappropriate hospitalization or an ineffective outpatient psychotherapy approach. Even if group home or day treatment alternatives

are available, those services are rarely covered by present medical insurance plans. Children can take advantage of these less restrictive alternatives only if they qualify by virtue of their involvement in another child serving system: welfare, juvenile justice or special education programs.

Services for emotionally disturbed children and adolescents need to be comprehensive enough to address a wide range of problems. A continuum of care must be provided in which each individual child can obtain the level and type of services needed at any one time. The components of such a system must include family and community-based resources as well as acute, intermediate, and long-term 24-hour programs. A principle basic to this service continuum is that an individual's needs are expected to change as he or she develops and as his or her family changes. This may be reflected in either steady predictable growth or in rapid unpredictable fluctuations, both of which may require related changes in those services needed.

The primary link between the continuum of services and the child or adolescent is the family. The parents or guardians have primary responsibility for initiating services and must participate in the planning for their provision. Ideally, the parents have ultimate control over what services are sought and accepted. There are exceptions, such as when a court removes such control from a family. Parents have differing abilities to accept and live with the symptoms of a emotionally disturbed child or adolescent. Some can accept treatment

while the child or adolescent lives at home; some cannot. Parents are the most important resource for their child and they must be given the necessary support to fulfill that role. In those cases where parents are not able to aid, tolerate the behavior of, or act in the best interests of their child and the court removes control of a youngster's care from the family, the State becomes the guardian until such time that the parents are again able to perform their role adequately. When the State elects to assume the parental role, it must do so in good faith, and with the best service interests of the child and restoration of the family unit as first priorities.

Within the continuum of care it is necessary to make assurances that the various service components are coordinated, that service needs are assessed and that missing service gaps are filled. While parents often play this role alone because of the lack of help, the role is best accomplished as a cooperative effort between parent/guardian and a community-based coordinator (or an "identified service resource"). While this is similar to the case manager role in the adult chronically mentally ill service system, it differs in the integral part played by the family and in the frequent use of the juvenile court and school special education teams as aides in case planning. The locus of this coordinator role cannot be predetermined, and should be developed in concert with the major needs of the individual and the availability of such coordinating capacity in the family and/or various community agencies. Without such a primary service person responsible for coordinating the treatment plan, it is nearly impossible to assure

adequate services and proper placement for an individual emotionally disturbed child or adolescent.

The Required Range of Services

The services needed by children and adolescents defined as emotionally disturbed fall into five major areas. They are: mental health care, physical health care, family, educational, and environmental. The proper care of each individual child relies on a proper balance and integration of these services. None of these five can be viewed in isolation, as each component is dependent on the others. These needs must be considered in planning for all emotionally disturbed children and adolescents, whether the case is ambulatory or in a 24-hour care setting.

The service needs of the severely emotionally disturbed child or adolescent are differentiated from those who are less severely disturbed by the attention, special quality and length of time required to provide services, such as those available in residential settings and in specially designed educational programs. The needs of the emotionally disturbed child or adolescent are not the same as for emotionally ill adults. With adults the needs relate to housing, maintenance, and vocational rehabilitation. With youth they relate more to the need for a family or family equivalent and for educational and habilitative services.

Mental Health Care This area includes treatment plans geared toward minimizing or alleviating the organic and/or purely emotional deficits or their impact. Modalities used include psychodynamic, behavioral, group and family therapy as well as psychopharmacologic treatment. These interventions may be performed in any one of a range of settings from outpatient to full-time inpatient or residential care, as dictated by the needs of both the patient and his/her family.

Physical Health Care These services are aimed toward maintaining and maximizing physical health, promoting normal growth and development, and treating any related or concurrent health problems.

Family The ability of the family or family equivalent to live with and act as a corrective agent is crucial in the care and treatment planning of a emotionally disturbed child or adolescent. In all but a small number of cases, the family is responsible for the day-to-day care and treatment coordination for a large part (if not all) of the course of the disability. For the most part, the greater the family's ability to support the child, the lesser the need for out-of-home care and more extensive interventions. When the family itself requires support in order to better work with their child, that support should be available.

Educational Services Mastery of learning is a major task of childhood. Mental illness often makes the child or adolescent unavailable for a formal learning experience. Others may have learning or language disabilities. The autistic, psychotic, mentally retarded, or severe behaviorally

disordered child or adolescent will each require different types of educational programs, facilities, and staff. There is a special need for carefully coordinating other service efforts with the efforts of the schools, and maximizing the programs required under P.L. 94-142, "Education for All Handicapped Children Act."

Environmental Needs Emotionally disturbed children and adolescents require a special level of structure in order to allow them to perform at their optimal level outside of family and educational settings. These include recreational and, where appropriate, vocational programs. These programs enhance peer group contact and offer the potential of a full life experience.

Services in these five areas should be provided within a continuum of care which includes placement options in both residential and family settings. Some children will move back and forth between the two settings as their individual treatment needs dictate. In making this determination as to the appropriate placement, three basic factors must be evaluated:

(1) The capacity of the child or adolescent to function in the family environment;

(2) The capacity to function in a community-based educational environment; and

(3) The capacity to function in the community environment.

Assessment of Appropriate Service Level

The assessment of the capacities discussed above requires that a professional team and the family work together to determine the full range of needs and capacities to be addressed. The professional evaluation must include appropriate mental health and physic
al health care professionals as well as educational professionals and those from other community agencies. When 24-hour residential care is felt to be most appropriate, such resources must also be included in the planning effort.

The role of the family is of paramount importance in both planning and in decisionmaking. Parents are responsible for the welfare of the child or adolescent and must participate in, or at least consent to, a particular treatment plan. The cooperation and participation of the family is a major factor in the long- and short-term success of any treatment plan. The capacity of the family to tolerate and work with the child's problem in support of a treatment plan is a major determinant in the selection of the most promising treatment modalities and resources. At times the ideal treatment plan is a compromise between the family strengths and needs and the patient's psychopathology, needs, and capacities.

The first assessment parameter, functioning in the family, requires that the child have a certain level of interpersonal competence. Also, the family-equivalent must be able to tolerate the troubling

symptoms or behavior and support a treatment process. Therefore, the need for structure will be based on both the youngster's level of functioning and the family's ability to establish structure. While the basic concern is that the child receive appropriate treatment for his or her mental illness, it must be remembered that families have a limited ability to protect the child and others from destructive and dangerous behaviors. If family outpatient interventions and/or behavioral management approaches are unsuccessful in mediating the mental illness or in controlling behavior, a more consistent and tightly controlled environment may be necessary. Another concern is that the family or the family equivalent is not made dysfunctional by the youngster's problems. If the family cannot handle the problems that a emotionally disturbed child or adolescent introduces, the parents and/or siblings may themselves develop emotional problems or become less functional.

At the same time the child or adolescent is functioning in the family, he or she must also be able to function in an educational environment. Learning is a major task of childhood and every opportunity to learn must be used. If an individual cannot be maintained in a regular classroom, alternatives should be available in the community. These include special classes in regular school settings (which allow for mainstreaming) and, in cases when a child needs further supervision or a more controlled setting, special day programs.

When a child or adolescent is able to live at home and perform in a community school program, he or she must still have the capacity to function in the community. As with the family, the community must be able to tolerate the behavior. Behavior which is difficult to control, including delinquent acts, may indicate the need for a more consistent and tightly controlled environment. This may be offered in the community by enhancing, through support, the family's ability to control the child or through the use of structure potentially available in the juvenile justice system. Functioning in the community also includes participation in recreational and, where appropriate, vocational activities. This requires the availability of resources that will provide the level of supervision needed by the individual. Of equal concern is the child or adolescent's ability to interact with peers in a nonschool setting. Youngsters with emotional problems must have ample opportunity to interact with children their own age, to benefit from positive peer group experiences, and to be protected from negative ones.

When a youngster is not functioning well in a family-based setting, an assessment must be made as to where additional support is required: in the family, in the school, and/or in the community. When the treatment needs cannot be met in the family-based setting, community resources should be available for support. If it becomes evident that community-based resources do not meet the family's treatment and support needs, out-of-home placement in the most appropriate treatment setting should be considered.

Appropriate Placement in Residential Care

When a child or adolescent appears unable to function in a family, attempts must be made to alleviate the problems before he or she is placed outside the home. Mental health services for the family, or individuals in the family, should be made available. Partial hospitalization (day treatment, evening, or night care) can also be used to help the family and patient live together. When acute hospital care is available along with family crisis intervention, family support services, and therapeutic camps, the need for inappropriate long-term residential care can often be avoided. If these resources are not sufficient within themselves, alternative family situations such as group homes or therapeutic foster homes may allow the child still to receive care in the community although outside the family. For children who cannot live at home or elsewhere in the community because of the nature of their own or their family's problems, 24-hour care in a hospital or residential treatment center should be available.

If the child cannot function in a community-based educational environment a decision must be made as to whether the child would be more appropriately placed in a 24-hour care setting even if the child can function in the family. When the child's inability to function in an educational setting is based on educability alone, community-based habilitation programs, workshops and other sheltered programs should be available as educational alternatives. When such a child is unable to function in

these settings, residential care might be needed to meet the child's learning needs.

Lastly, if the individual cannot function in the community, additional support systems should be available. Highly structured and supervised programs can be used to help the youngster spend his or her time outside the family and educational settings in a helpful and productive way. Some adolescents can benefit most from services in less structured community-based "alternative" mental health services. Patterned after drop-in centers and runaway houses, disturbed youth can often use such settings to remove themselves from age-appropriate adolescent and family developmental struggles. This eases one cause of stress in their environments, thus making both them and their parents more amenable to treatment for underlying emotional problems. In other cases, interventions in the juvenile justice system, such as probation, may facilitate the treatment process. In cases in which the child cannot function well in the community (usually by exhibiting out-of-control behavior in the community), a residential setting should be considered.

When a full continuum of services is available, the child or adolescent's needs can be continually met in the most appropriate setting. This allows for movement from one level of service to the next as the level of functioning changes. This concept of placement is the most appropriate, least restrictive, treatment structure and assures that there is ample opportunity for the youngster in residential care to return to the

family and the community when ready and, conversely, when residential care is needed, that it is available.

Twenty-four hour programs in hospitals or residential treatment programs should offer adequate services in all five areas of service concerns: mental health care, physical health care, family, educational, and environmental needs. It cannot be assumed that 24-hour supervisory care is adequate therapy within itself. Institutions that provide only a caretaking function are not therapeutic and have no place in the treatment of emotionally disturbed children and adolescents. Programs that do not work with the family while the child or adolescent is in care have less chance for a positive outcome.

Mental health care is offered as 24-hour care through various treatment modalities. Individual, group, and family therapies along with the use of psychotherapeutic drugs, behavioral and milieu therapies are among the available techniques. Each should be prescribed as part of an overall treatment plan that integrates all the aspects of residential and community-based programs. Environmental concerns are included in residential programs through the milieu process.

A full range of physical health care, including well-child, developmental, and pediatric treatment resources should be available in all residential settings. While this is self-evident with such medically based problems as anorexia nervosa, it is often neglected in others. This is especially

true with adolescents whose developmental body changes are often interrelated with their emotional problems.

Family needs are the most often neglected in a 24-hour setting. Because these special placements are often provided on a regional basis the distance between the home and placement becomes a limiting factor on many families' ability to be part of the treatment plan. With those patients who have been placed because of the family's inability to work with them, it may be difficult to engage the family in a constructive way. Yet these families must be reached and worked with. If the family cannot visit the program, community services should be used to work with them. Not to work with the family directly or indirectly is unacceptable. There must be preparation for the youngster's return home.

Educational needs must be met in residential settings. This major life task of children must be individualized to allow optimal learning for each child. A wide range of educational opportunities must be made available to meet the various needs of the individual. If appropriate for the patient, a major portion of the day should be devoted to educational activities. Extremely disturbed or retarded children should be offered an individualized, appropriate learning experience.

State and Federal Response

In FY 1984 Congress mandated that the National Institute of Mental Health (NIMH) develop a new service system initiative for severely

emotionally disturbed children and adolescents. As a result NIMH developed the Child and Adolescent Service System Program (CASSP). In FY 1984 $1.5 million was appropriated for this program with $3.9 million in FY 1985. CASSP is the natural product of all the definitional, epidemiological and service delivery issues presented in this statement. The major goal for the program is to promote the development of continuum of care for all severely emotionally disturbed children and adolescents in the communities in the country.

In order to meet this goal the program supports the creation of state-level foci for severely emotionally disturbed children and adolescents (under the auspices of the child mental health authority). All component agencies, public and private, are called upon to become part of a coalition to assure the appropriate provision of services. These agencies at the State level include: mental health, health, education, welfare and juvenile justice programs. Alternative youth services and advocacy groups must also be included as equal partners in this coalition.

Drawing on the experience of the NIMH Community Support Program, the concept of advocacy for system development has been incorporated in this program. All parties and agencies interested in meeting the needs of troubled children must learn to work together at the State and local levels to 1) identify service gaps and barriers, 2) develop needed service options, and 3) develop mechanisms for overcoming barriers by changing regulations, legislation and/or established funding patterns.

Once comprehensive system building has developed at the state level, CASSP promotes the translation of these systems to the community-level. Consistent with the child advocacy recommendations of the Joint Commission, CASSP supports a system which develops policy at the most effective governmental levels and then creates a pyramid system so that policy is then filtered down to local programs and individual children and families. Of course, a major component of this type of system is to develop mechanisms to assure that case-level input is available to the top-level policymakers. Coalitions of service delivery professionals, advocates and consumers are the necessary participants in this type of process.

CASSP, on a first-level, requires that States create an office to focus on services for severely emotionally disturbed children and adolescents. This office is rquired to define the population, perform a needs assessment, develop a plan, and create strategies for the implementation of the plan. All agencies involved with the population should be included at a policymaking level, appropriate for that particular State. States are also required to provide technical assistance to entities (State and local) within their State and in neighboring States.

Ater the State-level program has been instituted, although not necessarily completed, States are next required to demonstrate the same planning and strategy development on a second- or community-level. While these local system building components may be modeled after state-level

programs, it is important for community systems to adapt to the unique characteristics of each individual locality. Just as state-level system building is geared to the available strengths and resources within the State agencies and constituencies, communities must build on a similar combination of available resources.

At the time of the preparation of this testimony, NIMH has 14 active CASSP grants. Eight more States will be funded by July 1, 1985, for a total of 22 grants. (See attached list of 1984 and 1985 applications and funded States.) Some of these grant proposals provide for the expansion of sophisticated State systems. Others are from States in which there had previously been no functional child mental health system. While the success of this program has yet to be evaluated, the concepts hold great promise. A great majority of the States, with or without Federal funding, are moving in the direction described in this statement. At the time of the first grant announcement, in December 1983, 44 out of a possible 54 State and Territorial entities applied for CASSP grants, even though it was widely known that only 10 could be funded. The enthusiasm for the development of coherent, appropriate and comprehensive services for severely emotionally disturbed children and adolescents is at an all time high. We can now look toward a decade in which major advances in the funding and availability of these services are at hand.

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