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KIDS IN CRISIS: A PLAN FOR ACTION

A Report on Children's Mental Health Services

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May 1987

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Acknowledgements

We extend our gratitude to the members of the Task Group who devoted themselves to formulating the ideas and suggestions which are the basis for this document. Those others across the state who reviewed and commented on earlier drafts also deserve our thanks. Finally, we appreciate the cooperation and support of the state Office of Mental Health, especially Child and Adolescent Service System staff.

The overall commitment to this project and the growing interest in children's mental health issues support our optimism that this will not be among those monographs whose ultimate fate is simply to gather dust, but rather will serve as the basis for rethinking and reshaping mental health programs for Wisconsin's children.

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KIDS IN CRISIS:

A PLAN FOR ACTION

Report of the Children's Mental Health Task Group

to

The Office of Mental Health and the Child and Adolescent Service System Program Advisory Committee

May, 1987

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KIDS IN CRISIS: A PLAN FOR ACTION

Report of Children's Mental Health Task Group

CHAPTER 1

I. INTRODUCTION

Sonja, age thirteen, had been a behavior problem since the age of three, mostly due to "hyperactivity". Over the years her pediatrician has prescribed medicine to "slow her down", with only marginal success. Her parents have struggled to get help beyond the weekly counseling sessions or psychotherapy which they and Sonja have attended sporadically over the years. Counselors have changed because of staff turnover and referrals of Sonja to different agencies. Recently Sonja and some friends were caught breaking into a summer residence and stealing alcohol. Her first court appearance is next week.

Alex, an eight year old, will soon be discharged from a private psychiatric hospital. This has been his fourth stay there, each lasting about two months. When he returns home, Alex will find things much the same as they were when he left. Alex's mother is apprehensive about his return as she questions her own ability to control him. She has not been pleased with her contacts with the public social service and mental health systems and doesn't know where to turn for help.

Tammy was sexually abused at the age of nine by her stepfather. At twelve she was put on probation for chronic truancy and running away from home. During her probation, Tammy had to check with her probation agent once each month but has never received ongoing counseling or treatment. She is presently sixteen and awaiting transportation to Lincoln Hills Correctional Institution for car theft because, according to the county social services department, "We've tried everything with her."

Stories like those of Sonja, Alex, and Tammy are repeated often throughout Wisconsin. This report identifies barriers to the provision of better mental health services for children and families and offers recommendations aimed at improving the system of care.

A. CASSP Connection

The Children's* Mental Health Task Group was created by the Wisconsin Coalition for Advocacy under contract with the state Child and Adolescent Service System Program (CASSP). CASSP was created by Congress in 1984, is administered by the National Institute of Mental Health, and operates out of the state Office of Mental Health in the Wisconsin Department of Health and Social Services.

The four major goals of CASSP are:

1. to improve the availability of a continuum or array of services for children with severe emotional disturbance;

2. to develop and/or expand leadership capacity at the state level for children's mental health programs;

3. to establish coordination mechanisms; and

4. to develop program evaluation capacity.

B. Charge to Task Group

The charge of this Task Group has been to assess the current state of public mental health services in Wisconsin and create a series of recommendations for consideration by the executive and legislative branches of state government and for policy-makers who influence program development and implementation at the state and local levels. The recommendations are designed to promote the eventual creation of a comprehensive system of mental health care for children.

C. Task Group Membership

Members of the Task Group were chosen for their relevant program and policy-making expertise. Members are listed at Appendix A.

The group has met on nine occasions since June, 1986; during this time, it collected and analyzed data on the mental health related problems/needs of Wisconsin's children and families, and then created a package of recommendations for consideration of state and local policy makers. The recommendations have been organized so that component parts may be selected by certain agencies to be promoted independent of other parts of the total package.

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* Throughout this report the terms "child" and, "children" will be used to refer to adolescents and youth, as well as to children.

To assist the reader in understanding technical language and jargon which are an inevitable part of reports such as ours, a glossary is included at Appendix C.

II. TARGET GROUP

A. National & State Studies

According to a December, 1986, report released by the federal Office of Technology Assessment, at least 12% (7.5 million) of children under age 18 in the United States need treatment for mental health problems, yet the majority do not receive the proper help (12). These findings are consistent with a massive study of all 50 states published in 1982 by the Children's Defense Fund and authored by Jane Knitzer (6). A needs assessment done by the Office of Mental Health in 1985 supports both of these national reports (15).

B. Children with Severe Emotional Disturbance -- A Definition

The task group focused upon children with severe emotional disturbance and has defined this population as children whose problems are:

1. severe in degree;

2. persistent in duration (expected to persist for at least one year);

3. causing substantial diminished functioning in the family, school and/or community and in the ability to cope with the ordinary demands of life; and,

4. requiring long-term support of two or more service systems, such as mental health, juvenile justice, social service/ child welfare, education, or health.

At early ages, severely disturbed children often come to the attention of service systems via disruptive school behavior, as victims of abuse or neglect, or through parent(s) who experience much difficulty managing the child's behavior.

As children approach and reach adolescence, presenting problems are more likely to include delinquency, eating disorders, severe depression (including attempted suicide), and alcohol and drug abuse. These children and adolescents are virtually always candidates for special services from multiple systems.

Knitzer's study examined both national survey data and current research literature regarding prevalence of emotional

disturbance among children and concluded that about 5% of all children are severely emotionally disturbed. Accordingly, between 60,000 and 70,000 of Wisconsin's 1.3 million children under age 19 are estimated to experience severe emotional disturbance.

This report will show that many of our children with severe emotional disturbance receive no services, inadequate services, and/or inappropriate services, and calls for system reforms aimed at expanded and improved systems of mental health care to more effectively meet their needs.

III. BACKGROUND: Barriers to Providing Adequate and Appropriate Mental Health Care to Children

A. Public Sector Focus

Although the private sector plays a major role in addressing the mental health needs of children and families, our Task Group limited its focus to the public sector. Wisconsin's mental health, alcohol and drug abuse, developmental disability, and social services are administered at the county level, but costs are paid predominantly by state and federal funds. Although state and federal laws and regulations influence expenditure of these public dollars, county boards of supervisors have control over major policy and personnel decisions.

In Wisconsin, counties may choose how to organize and carry out programs. Fifty-one of the 72 counties have separate county social services departments and county departments of community programs. Most counties organized this way combine mental health, developmental disability, and alcohol and drug abuse services under the department of community programs. (See Appendix D for more complete descriptions of DSS and DCP.)

The remaining 21 counties have adopted the human services department (HSD) model in which all social services and mental health services are operated by or contracted for by a single department and supervised by a single board. The HSD model seems to be gaining popularity since it has the potential for improving interagency collaboration: an issue raised later in this report.

Public education programs are offered by Wisconsin's 432 school districts. As with social services, considerable local control is exercised in determining how educational services are delivered. Chapter 115 of Wisconsin Statutes relates to special education for children with exceptional educational needs, including emotional disturbance.

B. Institutional Care on the Increase

Many severely emotionally disturbed children are, at some point during their lives, best served by 24-hour-per-day care and treatment. Further, it is not always appropriate for inpatient treatment to be employed only after strict adherence to a continuum of care requiring progressively less restrictive programs before finally reaching this treatment option. Indeed, the Task Group cautioned against both this assumption and taking a position which may be perceived as "pitting" inpatient against community-based treatment. This is not our intent. However, as will be pointed out, questions regarding the disproportionate (and growing) share of public and private dollars directed toward the most restrictive and expensive (on a cost-per-child basis) options demand our investigation and response.

A national trend shows a rapid rise in use of psychiatric hospitals for children. The National Association of Private Psychiatric Hospitals reported an estimated 450% increase in children admitted to private psychiatric hospitals between 1980 and 1984. Public sector data in Wisconsin also show a significant rise in expenditures for institutional placements.

The concern goes beyond the millions of public dollars allocated annually for institutional placements in Wisconsin. In March, 1987, a series of investigative news articles alleged serious abuses in Wisconsin's largest public children's psychiatric hospital. Despite a per diem rate of approximately $250, employees volunteered criticisms regarding health care, timely development and implementation of appropriate treatment plans, and the provision of basic necessities such as food and bed linen. A significant proportion of the staff was alleged to be incompetent, resulting in an unacceptably low level of patient care and treatment and an undermining of morale among more capable and committed staff.

Although hospitals, residential treatment centers, correctional institutions and other out-of-home placements are appropriate components of a system of mental health care for children, the negative effects which inevitably accompany institutionalization must be carefully weighed in making decisions regarding their use.

Research has shown that all forms of institutional care share the potential for creating an institutional dependence; a successful adjustment to the institutional environment can result in the loss of skills necessary to live successfully in out-of-institution environments (2).

Another drawback related to institutionalization is the stigma and associated development of negative self-concepts

associated with simply being placed in a "mental hospital" or correctional institution. Children who have spent time in institutional placements become more vulnerable to peer rejection and reduced expectations of significant adults when they leave the placement.

Most residential placements fail to maintain community ties, another potential source of harm. The inpatient or residential treatment program is frequently "in the community, but not of it", limiting opportunities to build associations and relationships which lead to the children's assuming roles as contributing members of society.

In many cases, children leaving institutions return to the same negative situations from which they have come, or worse, to a situation where they are no longer wanted.

> Over and over again, the literature attests to the importance of the disturbed child's relationship to his family or family substitute. While it is acknowledged that temporary separations may be in the best interests of both child and family during periods of family crisis, it is also clear that prolonged separations are demoralizing to the child and make it extremely difficult for him to re-enter the family system, which may adjust to his absence. Further, hospitalization of a child can inadvertently reinforce the role of the child as scapegoat. (3)

Thus, even when institutions are capably staffed and have well-designed treatment programs, the potential for harm (not to mention fiscal considerations) should be sufficiently great to stimulate vigorous pursuit of expanded, well coordinated community based services.

1. Public Psychiatric Hospitals

Caution must be used in analyzing data retrieved from Wisconsin's public mental health providers during the past five years since more than one management information system was used and not all counties moved from one system to another at the same time. Further, a number of different interpretations were used by counties in defining populations and services provided. Nonetheless, we believe conclusions can responsibly be drawn from trends indicated by available data provided by the Office of Mental Health.

Figures 1 and 2 show that between 1980 and 1984 there was an overall increase in inpatient utilization for the child/adolescent population, while there was a decrease in outpatient services provided. This is particularly significant when

INPATIENT

Total Inpatients Ages 0-17

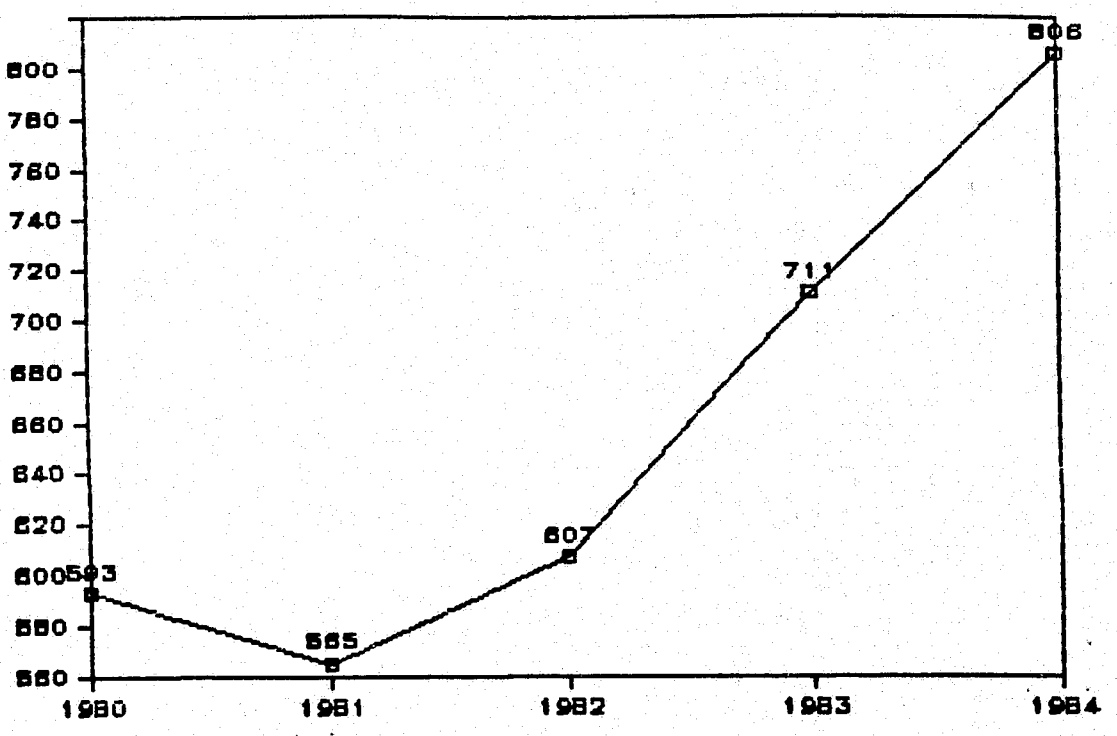

Figure 1. Total individual inpatients (unduplicated count) reported by county 51 boards to DHSS.

OUTPATIENT

Outpatient Quarter-hours of Service (in thousands) Ages 0-17

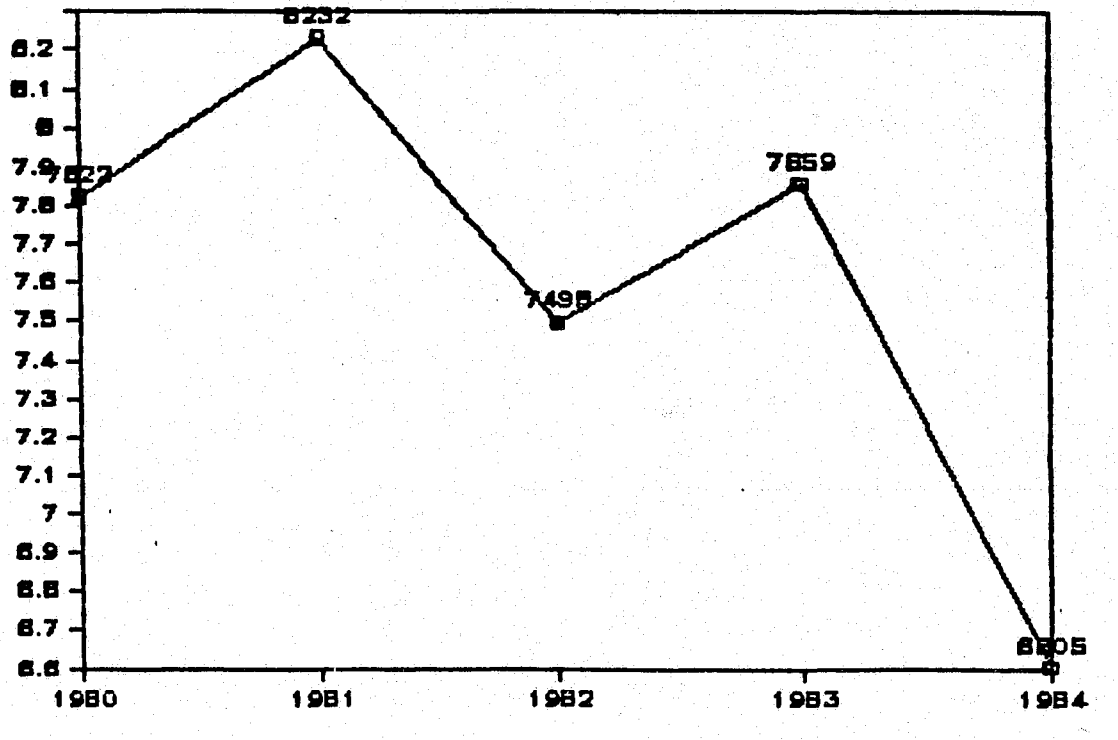

Figure 2. Total outpatient quarter-hours of service reported to 51 boards to DHSS.

contrasted with the trend in adult mental health services. In 1985, Wisconsin was cited as among the leading states in the nation in the development of community-based mental health programs, and dramatic decreases occurred in the number of mentally ill adults served as hospital inpatients.

Dane County, nationally known for its community services for adults with chronic mental illness, provides a graphic example of this phenomenon: in 1979, Dane County reported using 8,988 days at Mendota Mental Health Institute for adult treatment. In 1985, that figure was an estimated 2,000 days of treatment; a four hundred fifty percent decrease over six years.

In the child/adolescent system, Dane County's inpatient days at Mendota Mental Health Institute went from 964 days in 1980 to an estimated 5,200 in 1985; a five hundred forty percent increase over a five year period.

More recent data reflecting actual expenditures for children's inpatient psychiatric care through Wisconsin's Medical Assistance Program (WMAP) is equally astounding. For the state fiscal year 1985, WMAP expended $3,997,000 for psychiatric inpatient hospital care (including both public and private hospitals) for people 21 and under. In state fiscal year 1986, the expenditure was $14,121,000; a two hundred fifty-three percent increase. (See Figure 3.) Care must be taken in analyzing these data since they reflect dates of payment rather than dates on which the service was provided and may not precisely represent the degree to which inpatient costs are actually rising. (The state pays for some services in a calendar year which were actually provided in the prior year.) It is clear, however, is that a substantial increase is occurring in Wisconsin Medical Assistance payments for children's inpatient mental health care.

It is worthy of note that MA consists solely of state and federal dollars, approximately 42% and 58% respectively. A strong incentive is thus created for county officials who are responsible for placement and discharge decisions to use these inpatient facilities rather than less restrictive programs which might be more appropriate, but are supported by limited (sum certain) funds allocated to the county, funds which may be used for other social services.

2. Child Caring Institutions

The most recent DHSS Alternative Care Inventory (see Table 1) reveals that of 4500 children placed in alternate care in 1983 (foster homes, group homes, and child caring institutions), 7.9% (358) were reported to have emotional disturbance as the primary reason for placement. A change in reporting procedures is considered by Division of Health staff to account for at

CHILDREN'S

M.A. INPATIENT COSTS

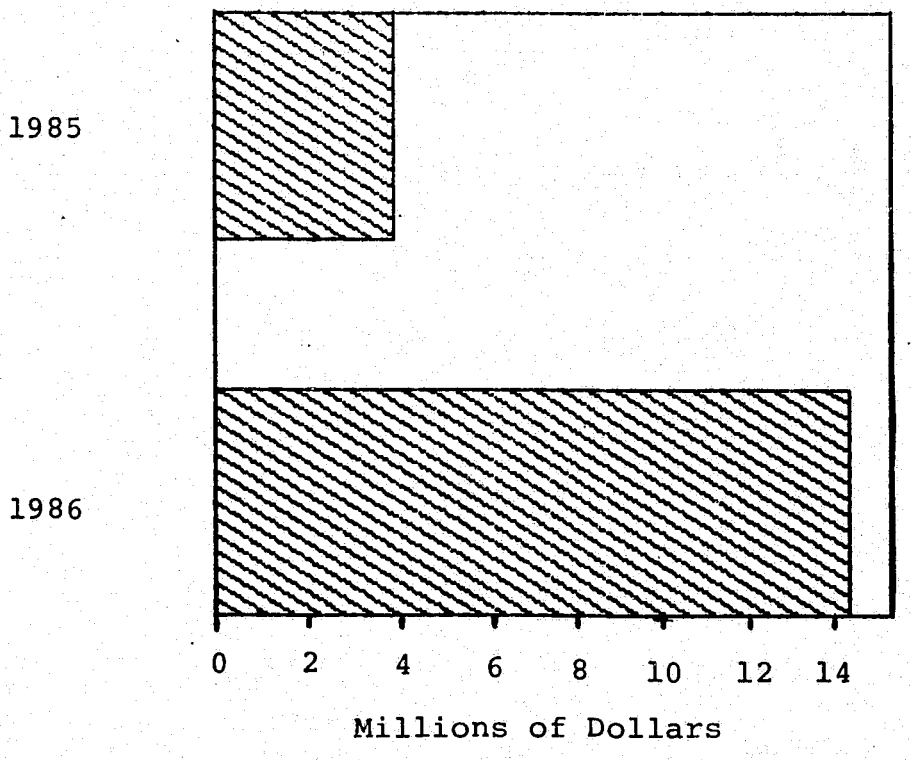

Figure 3. Expenditures through the Wisconsin Medical Assistance Program for Children's Inpatient Psychiatric Care

ALTERNATE CARE

Primary Reason for Placement	9/30/82		12/31/83	
Parents Neglected the Child	754	17.4%	792	17.6%
Parents Lacked Parenting Skills	517	11.9%	467	10.4%
Delinquent Child	489	11.3%	612	13.6%
Parents Abused the Child (includes 140 sexual abuse cases in 1982 and 175 sexual abuse cases in 1983	391	9.0%	440	9.8%
Emotionally Disturbed Child	373	8.6%	358	7.9%
Parents Abandoned the Child	330	7.6%	281	6.2%
Developmentally Disabled Child	258	5.9%	261	5.8%
Parents Abuse Alcohol and/or Drugs	200	4.6%	237	5.3%
Status Offender Child	194	4.5%	249	5.5%
Parents Mentally Ill	151	3.5%	144	3.2%
Parents Deceased	149	3.4%	126	2.8%
Parents Incarcerated	110	2.6%	147	3.3%
Parents Hospitalized for Mental Illness	87	2.0%	90	1.9%
Child is an Unwed Parent	80	1.8%	80	1.8%
Child Abuses Drugs and/or Alcohol	79	1.9%	114	2.5%
Parents Marital Problems	70	1.6%	36	0.7%
Parents are Developmentally Disabled	50	1.1%	26	0.6%
Parents Hospitalized for Physical Illness	24	0.6%	22	0.5%
Child is Refugee Unaccompanied Minor	20	0.5%	7	0.2%
Parents are Physically Ill	10	0.2%	17	0.4%
TOTAL	4,336	100.0	4,532	100.0

Table 1 - Primary Reasons for Alternate Care Placement (foster homes, group homes, and child caring institutions). All reasons for placements are judgments of social workers.

Wisconsin Office for Children, Youth and Families, DHSS, 1983.

least part of the increase. Another 238 children were placed primarily because of their parents' mental illness. An analysis of the remaining reasons for placement suggests that a high percentage of these children are also likely to be emotionally disturbed even though that condition was not offered as the primary reason for placement.

In 1986, approximately $24 million was expended by counties to place children in child caring institutions. The median monthly rate for CCI placements in 1985 was $2,867, a 14% increase over 1982 rates. According to DHSS data for 1984 and 1985, 75% of emotionally disturbed children in CCI's stay longer than six months. The average annual cost per child in 1985 was $34,404. Most of these funds are from the state Youth and Family Aids allocation, designated to serve children who are delinquent (or alleged delinquent) or who have committed a "status" offense, i.e. have been habitually truant from school, run away from home, or violated alcohol laws.

3. Juvenile Correctional Institutions

The Division of Corrections is responsible for the operation of Wisconsin's two correctional institutions for juvenile offenders. Ethan Allen School is located in Waukesha County and Lincoln Hills School in Lincoln County. On June 30, 1986, a total of 526 children were incarcerated in these institutions, 490 boys and 36 girls. In calendar year 1985, 927 children were admitted to the institutions. Of this number, 630 were new admissions, 143 returning from after care, and 154 returning from after care pending a revocation hearing.

During 1985, staff of the Division of Corrections and the Division of Care and Treatment Facilities studied the needs of the juvenile corrections population and estimated that 70-80 of the children have severe emotional disturbance. DOC subsequently recommended that specialized mental health/correctional programs be created to appropriately meet their needs (14). In addition to this group of severely emotionally disturbed children, it is generally believed that a substantial proportion of the remaining children in corrections could benefit from improved mental health services which, due in part to budgetary limitations, are currently unavailable.

Leaders in the Division of Corrections have recognized the efficacy of less restrictive programs for some youth remanded to them for treatment and have, in fact, implemented an "Early Release Intensive Supervision" program as an alternative to institutional placement. However, this program serves relatively few young people and DOC continues to rely heavily on the traditional training school model.

In state fiscal year 1986, $17,629,000 was expended by counties for institutional placements at Lincoln Hills School and Ethan Allen School.

Figure 4 shows comparative per diem or daily rates for state institutes, CCI's, and correctional institutions.

C. Special Education for Emotionally Disturbed Children

Approximately 11,000 (1.2%) of Wisconsin's 916,500 school-age children have been identified as needing special education because of emotional disturbance. (See Appendix B for the educational definition for emotional disturbance.) The Federal Department of Education estimates that 2% of the school-age population is in need of special education due to emotional disturbance, an estimate considered by most professionals to be conservative.

Unlike many other states, the great majority of the emotionally disturbed students identified by the public schools in Wisconsin are served in state approved programs located in local public school facilities. However, there has been an increase in public school segregated programs, now 51 statewide. These segregated programs, in which emotionally disturbed children are segregated from non-E.D. students, do not generally provide educational programming comparable to what is available in the regular public school setting.

In December, 1985, 37 (15%) of Wisconsin's 432 school districts reported an emotionally disturbed child count that reflected a district emotional disturbance prevalence rate of less than three tenths (.3) of one percent. In many of these cases, only one student was identified as emotionally disturbed. This suggests that some districts have chosen to avoid procedures which identify emotionally disturbed children as in need of special education. In the absence of programs for emotionally disturbed students in some of these districts and the related lack of referrals for suspected emotional disabilities, parents are often not informed of their rights under Public Law 94-142 and Chapter 115, Wisconsin Statutes, to pursue an appropriate special education program for their children.

Accepting the Department of Education's estimate, noted above, that 2% of the school age population is likely to require special education for emotional disturbance, approximately 7,330 additional children and youth in Wisconsin would qualify for, yet are not receiving, emotionally disturbed programming.

D. Vocational Education and Transition to Work

A major problem confronting severely emotionally disturbed children is the passage from adolescence to adulthood, a transi-

COMPARATIVE DAILY COSTS

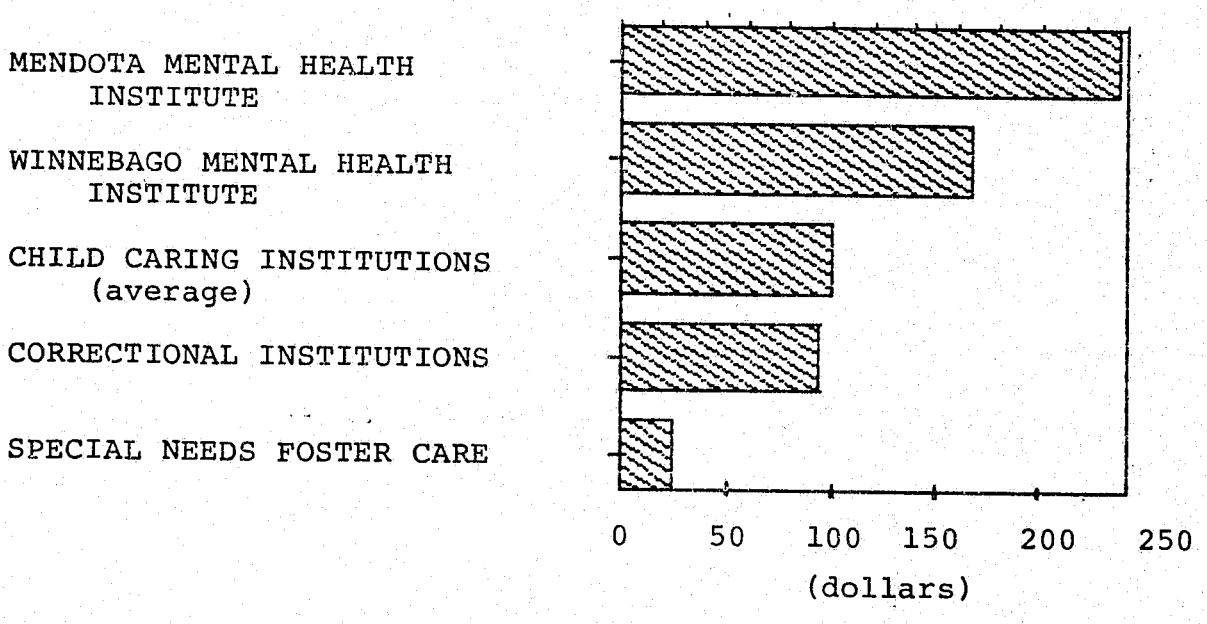

Figure 4. Comparative Daily Costs for State Mental Health Institutes, Child Caring Institutions, Correctional Institutions, and Special Needs Foster Care. (Source: DHSS)

tion in which young people are expected to become self-supporting. Too often this group of young people are poorly prepared for the transition, having experienced failure in school and little other opportunity to demonstrate competency. Skill levels and confidence are low. Many have dropped out of school and hold no credential recognized as evidence of their preparedness to assume a role as contributing members of society.

Without programs to support development of necessary skills, credentials, and confidence to step into the world of work, countless numbers of young people who are or have been emotionally disturbed experience even greater frustration as they enter adulthood, perpetuating the cycle of personal pain and unfulfillment and dependence on public assistance for survival.

E. Services to Target Group -- Either Too Little or Too Much

A high proportion of funds available for treating children with severe emotional disturbances are expended in residential or institutional placements, creating an unbalanced service system. In an era of scarce resources, fewer and fewer dollars are available for programmatic responses to early signs of trouble. Problems frequently escalate to the extent that they can no longer be ignored, then require restrictive and costly interventions.

Although hopeful signs exist (see Section I., "Good News"), the common pattern of service delivery in Wisconsin counties is "underkill" or "overkill"; at one extreme children and families in need of services may receive counseling from a worker with a caseload of 40 to 60 families or outpatient psychotherapy on a relatively infrequent basis, perhaps one or two hours per week. Often these workers have not been trained in treating children who are severely emotionally disturbed. If circumstances worsen, the child may then be placed in an institution providing 24 hours-per-day care. There is little middle ground. The number of programs such as intensive in-home treatment or day treatment fall far short of meeting clearly identified needs; as a result, we continue to spend millions of dollars on costly residential care, much of which is unnecessary and may be counterproductive.

F. Access to Public Mental Health Services

Related to Section E, the Task Group noted that as resources for human services become tighter and competition for limited dollars intensifies, many counties are making fewer services available to families on a voluntary basis and are investing most resources in court ordered services. Few services are available to families upon request unless and until a major crisis occurs (dangerous and destructive delinquent acts, self-destructive

gestures, serious disruption of school and other community activities, etc.). Again, institutional care frequently results.

G. Parent Reluctance to Seek Services

Parents of children with serious behavior problems are often reluctant to seek services. They are ashamed of "going public" with their perceived failure to provide for their child or children; they are confused and intimidated by a complex community of professionals who may be evasive and cold and who offer conflicting and confusing recommendations; and they fear losing control of their child to "the state" as social workers and the court raise the specter of out-of-home placements.

H. Agency Responsibilities - Working Together or in Conflict?

In all counties, departments of social services (DSS's) bear the major responsibility for providing services to children. Foster care, treatment foster care (where it exists), group homes, child caring institutions, case work, some family therapy/counseling, and supervisory services ("probation") are provided or purchased by these agencies. The departments of community programs ("51 boards") typically provide or purchase individual and group psychotherapy, family therapy, and some psychiatric services. In 21 counties, these two agencies are combined into one department of human services.

Communication and coordination between these agencies is, of course, largely a function of the personalities and philosophies of individuals who occupy positions of influence within them. Yet there are other factors which contribute to the way these agencies work together (or fail to). For example, heavy case loads often result in the perception by workers that inter-agency communication is a luxury which, due to time constraints, is unaffordable.

In addition to time constraints and management priorities, other external forces control decisions on spending limited agency resources. This creates conflict between agencies seeking services from one another for their clients. For example, services mandated of county social services departments (such as child abuse and neglect investigations and responding to juvenile court petitions) limit agency staff's discretion about the types and sizes of the populations they serve. Departments of community programs organized under Chapter 51, however, have both discretion about who they serve and the ability to develop waiting lists of those requesting or referred for services. As a result, some prospective consumers referred by schools or social service systems may be deemed inappropriate for available treatment by mental health providers while many others wait

to be accepted into treatment. Resentment builds among agencies, adversely affecting the overall quality of treatment.

Vague and complex statutory definitions of therapy, counseling, and treatment contribute to confusion about responsibility for services for children. For example, many mental health providers believe that schools have both the mandate and resources to provide "counseling" or even "psychotherapy" for both regular and exceptional education children. Schools, in turn, often refuse to diagnose emotionally disturbed children as needing psychotherapy to benefit from educational programs for fear that they, then, will be required by federal and state law to pay for that therapy.

Finally, many children and families, over a period of years, are served by a variety of professionals from different agencies without the benefit of a carefully conceived or coordinated plan of action. No individual or agency monitors treatment progress, modifies services as needed, or stimulates activity when there are recalcitrant service providers. It is common for people to get lost between programs and systems, leading to waste measurable in fiscal as well as human terms.

I. Good News -- Effective Programs and Systems in Wisconsin

The above sections may suggest to the reader that there are no attempts by Wisconsin counties to reduce out-of-home placements, no new and innovative programs, no fiscal risk-taking to reapportion funds among a broader range of services. Such is definitely not the case. Scattered across the state are creative new programs, institutional as well as community-based, and county-wide efforts to reallocate staff time and funds to better serve children and preserve family unity.

A growing number of child caring institutions and psychiatric hospitals have implemented programs based upon the latest technology and are expanding to include family and community based efforts aimed at successful transitions back to the community.

More than one county has created a screening team consisting of mental health, social service, and school professionals; volunteer citizen advocates; and parents, to assess each child presented for out-of-home placement and explore less restrictive alternatives. These undertakings have resulted in improved service coordination, better programs, as well as decreased out-of-home placements.

Several day treatment programs, which combine staff and funds from mental health, social service, and education agencies, have demonstrated effectiveness in treating severely emotionally disturbed children.

The Department of Health and Social Services has a number of initiatives designed expressly to promote redirected resources toward family preservation by providing supports needed to maintain children in their homes.

Yet these programs are exceptions and have not succeeded in reversing the overall trends which continue and expand dependence on inpatient care, often at the expense of community program development.

IV. SUMMARY

Many of Wisconsin's children are in need of help because they are unable to cope unassisted with stresses brought about by physiological and environmental circumstances. The high incidence of suicide, substance abuse, delinquency, school failure, depression, and teenage pregnancy all reflect, in part, the failure of our society to respond to the needs of children in trouble. Calls for assistance by desperate parents often go unheeded by unprepared and overburdened public mental health and social services systems until the problem reaches proportions for which treatment is expensive and the prognosis for improvement guarded, at best.

While attempts to fill service gaps and preserve family unity exist, they are relatively insignificant compared to the overall expenditures and trends showing continued and even increased reliance on "deep end" services in the continuum, and when measured against the thousands of emotionally disturbed children in Wisconsin who receive no special care at all.

The problem, however, is not that we don't know what to do. It's that we are stuck in old habits, motivated by funding mechanisms and out-dated routines. The paucity of community programs leads to continuing reliance on institutions. Administrators with vision are frequently stymied by board policy which makes innovation difficult.

Wisconsin has demonstrated national and international leadership in returning mentally ill adults from hospitals and institutions to the community, creating a balanced service system which includes supports allowing mentally ill people to lead more normal lives. Yet, in the face of this success, the trend is reversed for severely emotionally disturbed children.

This paper provides background information and comprehensive recommendations aimed at creating a balanced and coordinated system of mental health care for children, including supportive services for families. The time to act is now.

CHAPTER 2

I. A VISION FOR IMPROVED MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES

As the task group considered what services are and are not available and struggled with how to organize services, a vision of what children's mental health services should look like emerged. This vision is based on the group's own ideas and experiences and an examination of the service systems developed in Tampa, Florida, North Carolina and Ventura County, California. The elements of an improved mental health service system are set forth below. All elements are necessary in a responsive and effective treatment system for severely emotionally disturbed children.

A. An Adequate Array of Core Treatment Programs and Back-up Support Services Must be Available

On a local or regional level a variety of mental health services must be available to children and families. This should consist of a core of treatment programs and a set of necessary back-up support services.

In developing this array of services several principles must be kept in mind:

- The provision of services should be preceded by a comprehensive assessment of the child's problems and family's needs.

- Services should be individualized so that the problems of the particular child and family can be adequately addressed.

- Services should be available on a voluntary as well as involuntary basis.

- Services should be available at the early stages of a mental health problem as well as when the problem becomes more severe.

- Focus should be placed on services which maintain a child in the community, which enable a child to remain with or be returned to his or her family and which are cost effective.

- Services should be well co-ordinated through an effective case management system.

Before it is determined which services are needed by a child and his/her family, an adequate assessment of the child's

problems and family's needs must be conducted. The assessment should be multidisciplinary in nature and done by professionals who are knowledgeable about mental health problems of children. It is important to see the child as a multifaceted person interacting in a variety of systems and to assess his/her physical condition, learning abilities, interactions with family and peers, and behavior, as well as psychological status. Treatment planning should be driven by the child's and family's assessed needs and not by what services happen to be available.

The following is an array of core mental health treatment programs which should be available to all severely emotionally disturbed children and their families. This is not to suggest that every county must provide all services. Wisconsin's counties vary significantly in their urban and rural nature and level of available resources and trained personnel. However, all services must be sufficiently available so that a county can purchase them locally or regionally as needed for a particular child and family.

1. Early Intervention Services. For children who are at high risk of developing severe emotional problems, such as children who have been abused, who have chronically mentally ill or alcoholic parents, or who are experiencing traumatic life events, support and other early intervention approaches should be provided by mental health professionals through the schools, social service departments, community support programs and other places where these children and their families are identified.

2. Outpatient Counseling. This service is generally provided in an office where people can be seen on an individual, group, or family basis to solve problems. There are many different therapy approaches but in all modalities the goal is to reduce the identified problems or symptoms and help people live better together. Regardless of the form of treatment provided, a general assumption is that intervention should be implemented so that maximum treatment effectiveness will carry over into all aspects of the child's and family members' lives.

3. Medical Care and Medication Management. A significant number of severely emotionally disturbed children have attention deficit disorders, other neurological problems, psychiatric symptoms or other physical problems which need to be carefully evaluated and treated. Psychotropic medications may be an effective adjunct to other treatment strategies by reducing symptoms and helping a child become more accessible to his or her environment. New behaviors, however, may still have to be taught as well as self defeating behaviors modified.

Appropriate medical care and assessment for these children should be sought out and carefully coordinated with other treatment approaches.

4. Intensive In-Home Treatment. For children and youth who are dependent on their parents or other primary care givers, it is recognized that the family can be taught specialized parenting techniques to consciously change identified self-defeating behaviors while reinforcing and strengthening positive behaviors. (Other family members also can be helped to examine how their own, sometimes problemmatic, behavior may have an adverse impact on the child.) In-home treatment may be offered on a short-term crisis-oriented basis or may be more long-term in nature. It is generally provided for up to 10 hours per week and on a flexible schedule allowing professional staff to be available during difficult periods of the day and week.

5. Day Treatment. Day treatment is a structured program which may incorporate educational or vocational and psychological programming or which may be provided only on an after school basis, depending on the child's needs. It is a therapeutic intervention to help the child solve problems and learn more appropriate behaviors. Families should also be involved in the program so they can learn more effective ways to understand and live with their children. A child in day treatment may live with his or her family or in a foster or group home. Day treatment programs may be located in elementary or secondary school buildings, in vocational school buildings, or in the facilities of private schools or community-based organizations which operate them.

6. Treatment Foster or Group Care. Substitute care should attempt to simulate a natural home environment. In most instances the goal is to use foster or group homes as an interim corrective step with the end goal of returning the child to his or her original home as soon as possible. Professionally trained people work with the child and the natural family to assure continuity and to work toward reuniting the child and family. Problem behaviors may have to be remediated and the natural family may have to be taught special parenting techniques.

7. Residential Care or Inpatient Care. This is the most restrictive treatment response. Inpatient psychiatric services should be used primarily for acute stabilization of severely ill children and should not be confused with respite care or longer term residential treatment. It is recognized that an out of control child may

require a more protective environment until he or she gains control or a community based or residential treatment program is made available. Multidisciplinary teams provide an array of services in both inpatient and residential settings. While multiple impact is sought through the provision of psychological, educational, social, and recreational services, and medications within a controlled milieu, treatment effectiveness may not be generalized if the primary care givers are not active participants in this process and preparing themselves to effectively reassume this role. Institutional care should not take place in a vacuum nor be an end in itself. The improvement gained from residential treatment may be lost if good follow up and community services are not provided.

In addition to this array of core treatment programs, backup or support services are necessary. These are services which are used in conjunction with the treatment programs and are necessary components for the effective operation of a treatment system.

8. Case management. Arranging for assessments, involvement in treatment planning, accessing services for the family and child, monitoring the provision of services, coordinating care with other providers (including the school, child welfare or juvenile justice systems) and advocating for the child and family are all essential components of good case management. This service is the critical component in ensuring that the other services in the array are used appropriately and effectively.

9. Crisis Services. When problems are acute and intensive a 24 hour response capability is essential. While this service can be provided by an existing support staff if assigned, the crisis response should be available as a separate entity within the system to back up the entire treatment network. A phone response is one level but a mobile treatment team may be necessary to maximize effectiveness. Existing crisis resources for adults can be built upon.

10. Respite Care. This service temporarily relieves primary care givers by providing someone to stay with the child in the home or by placing the child in a substitute home-like environment. The emphasis is on short-term care and the placement settings are non-medical. Respite may be a key element for a family coping with a difficult to manage child. However, it should be combined with other treatment approaches aimed at improving the child's functioning.

The above array of services assumes that well trained and knowledgeable professionals are available to Wisconsin's children and families regardless of their geographical location. Unfortunately, this is not the case. Thus, steps must be taken to improve training concerning treatment for children with severe emotional disturbances. This should take place at the university level and in the field for current mental health professionals and paraprofessionals.

The recommended array of services can be developed through both the public and private mental health systems, and steps to foster this development should be taken. However, just creating the array is not sufficient to adequately serve severely emotionally disturbed children and their families. Better access to services, assessment of problems, services coordination, and monitoring of quality care must also be available. These issues are addressed in the following sections.

B. Access to Services Must Be Improved

Even when a community has a variety of services available, families frequently do not know what they are or where to find them. Some families will not be able to go through the difficult search for appropriate help until the problem has become so severe that they begin by looking for an out-of-home placement for their child. Thus, in each county one of the local public agencies (social services or mental health) or an agency under contract with the county should have the responsibility for compiling, maintaining, and publicizing a listing of available public and private treatment resources for seriously emotionally disturbed children and their families. When a family contacts the designated agency, a brief screening and assessment with active participation of the family members should be conducted so that appropriate services can be identified and referrals can be made.

C. A Case Management System Must Be Developed

An effective case management system is the glue which holds together the various services a child and family are receiving. It can help children and families get services when they need them, help families deal with the multiple bureaucracies they will face, and in many cases prevent or shorten placements in more expensive and restrictive settings. In each county the social services department, community programs department (51 agency) or an agency under contract with one of these departments must have the responsibility for providing case management for children who are severely emotionally disturbed. There should be a clear written agreement between the agencies specifying which will have case management responsibility. Children who meet the target group definition (see Chapter 1, Section II), including those in out of home placements, should be

referred to, and included in, this case management program. Referral may come from a variety of sources, including the information and referral service described in Section B. above, a private source, the schools, or a juvenile court intake worker.

Once the referral is made the case management program should arrange for an assessment of the child's problems and any needs of the family. The assessment should be done by a multidisciplinary team which may include representatives from other systems serving the child such as school, child welfare, medical, or juvenile justice. A treatment plan should be developed based on this assessment and agreed to by the child, if possible, by the family, mental health providers, other service providers, and the case manager. If the juvenile court is involved, the plan should be provided to the court for review and approval.

The treatment plan should identify both a long-term and short-term goals, specifically identify who is to provide and fund services, and describe expected outcomes. The case manager, then, is responsible for monitoring whether services are provided according to the plan and for updating the plan on a regular basis. In order for this to be effective it will be necessary to identify specific resources for assessment, treatment planning and case management. The Community Options Program (COP) may provide a model from which to learn.

Ideally, the case manager should have some flexible funding to purchase needed short-term services such as in-home treatment, respite care, or crisis management if these services are not immediately available in the service system. Once the treatment plan is developed, the case manager must have an on-going responsibility to access the services outlined in the plan, to monitor the provision of services and quality of care, to coordinate the services provided by various agencies, and to report to the court if it is involved. In order to do this effectively case loads must be kept reasonable in number -- not more than 20 per case manager.

Case managers along with parents also must act as advocates for children and families, especially as they attempt to secure necessary services and to coordinate care. An overview of the case management program and its relation to the rest of the service system is contained in Figure 5 on the following page.

In this model, the case manager is seen as an active participant in the treatment process. He or she should be seen as having the responsibility to: obtain and arrange for appropriate assessments, develop the treatment plan along with the family and service providers, make referrals where appropriate, arrange for the provision and funding of services as outlined in the treatment plan, monitor the provision of

CASE MANAGEMENT

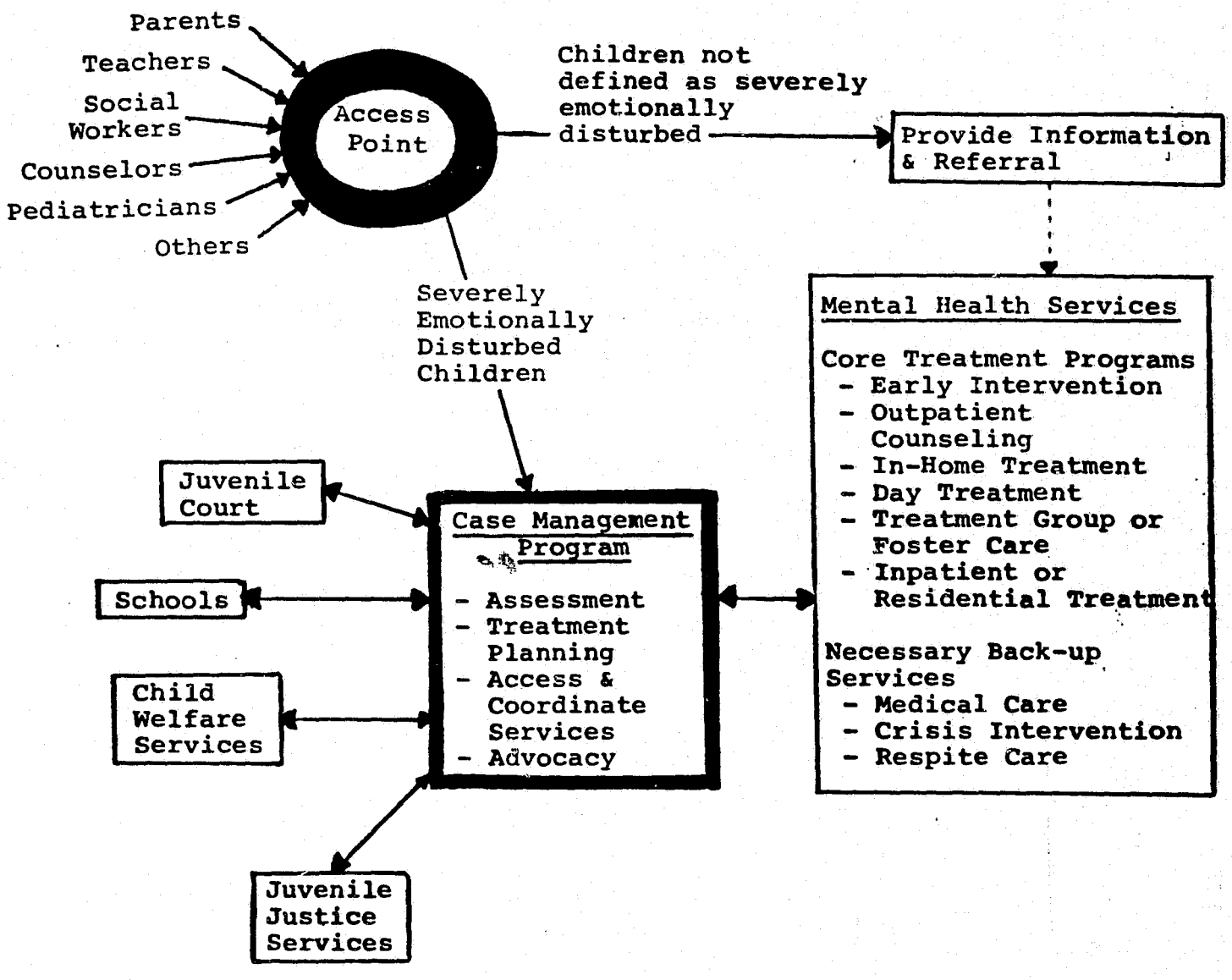

Figure 5. Relationship between the Case Management Program, Mental Health System and Other Service Providers

services, co-ordinate mental health services with schools, social services, juvenile justice or any other service providers involved with the child, and advocate for the needs of the child and family. He or she should not be the gatekeeper for the service system nor should he or she have a purely administrative, paperwork function.

To be most effective a case manager should have some independence from the funding source. Preference should be given to case management programs which are contractors with the county. Only an active, involved person who is responsible for working with the child and family to obtain and coordinate needed services will be effective in improving service delivery to the target group.

Finally, the case manager should have a level of clinical expertise and experience sufficient to provide an understanding of the child's needs in relation to the various systems and services as well as to gain credibility among other involved persons.

D. Assessment Resources Must be Improved

Occasionally a child is identified who presents particularly difficult assessment and treatment planning problems or who has been through a variety of treatment programs with no significant success. In several states and localities specialized assessment teams have been developed involving representatives with expertise in psychiatry, neurology, social work, education, juvenile corrections, alcohol and drug abuse, and so forth. The team or components of it can be brought together to help case managers and service providers develop more appropriate and/or creative treatment approaches for a child and family. The focus of the assessment should be to develop a complete view of the child and family in their various environments, not simply on developing diagnostic labels.

E. Coordination Between Mental Health, Education, Child Welfare and Juvenile Justice Must Be Improved

The lack of coordination between these various systems and their component agencies on both a case specific and systems level has been noted by many as a significant hindrance to providing better mental health services to children and families. Thus, coordination starting at the state agency level and extending to the local level must be improved through interagency agreements and task forces.

Specifically, there should be agreements between the state Department of Health & Social Services and the Department of Public Instruction about how services and initiatives for severely emotionally disturbed children are to be coordinated.

Locally, mental health agencies, social service departments and schools should execute clear agreements about what services they are to provide each other, how intake and referral will be handled, how case management will be provided, and so forth. Protocols for obtaining releases of confidential information should also be developed.

F. Appropriate Checks and Balances to Assure Quality Care Should Be Developed

No treatment system is entirely self-monitoring in assuring quality care. Thus, some external mechanisms -- checks and balances -- must be built in to assure that children and families receive quality treatment and services. The following is a listing of possible approaches which could be used to assure quality care.

1. Appeal mechanisms enable families to raise issues of denial of services, inadequate or inappropriate services, and termination of services. They should include an informal, local problem-solving approach and a more formal appeal to the Department of Health and Social Services or to the courts when the informal approach is not adequate.

2. Periodic court reviews for children who are receiving court ordered or supervised services provide formal oversight and also give a forum for families or others to raise serious problems with the treatment plan.

3. Licensing and certification standards require programs to meet certain minimum standards for children's mental health treatment and provide a way for interested parties to raise issues about substandard care.

4. Systematic data collection about what services are and are not available, who is receiving what types of services, how many people are on waiting lists, etc. provide state and local administrators and policy-makers the information needed for recommending and planning for needed improvements in children's mental health services.

5. External advocacy for children and families through parent support groups, advocacy agencies, attorneys and others enables parents to work for systemic reforms on the state and local levels. It also assists in protecting the rights of children and families in securing appropriate services and resisting overly restrictive, coercive interventions.

6. Quality assurance mechanisms such as peer review, systematic review and analysis of service delivery, and monitoring of services by families and others can also be effective in identifying weaknesses and making recommendations for system improvement.

G. The Effectiveness of the Coordinated Service System

Studies of community based services and case management programs have shown them to be much more cost effective than residential and other out of home care. In Tampa, Florida a case manager who returned 5 children to the community from residential placement was able to save the county $95,000 in one year. This program also successfully diverted seventeen severely emotionally disturbed children from placement last year and thus saved the county approximately $200,000 in placement costs. The community based services which these children and their families did receive, in addition to case management, included intensive in-home treatment, crisis intervention, day treatment and respite care (7).

In Ventura County, California a comprehensive set of services for severely mentally ill children, including a strong case management program, has been developed. For FY 1985-86 this program was able to save the county $322,000 in group home and residential placement costs, $450,000 in inpatient psychiatric costs and $185,000 in juvenile justice incarceration costs. Children have been returned to their home county from out of county placements and where placements have been used they have been increasingly in treatment foster homes rather than larger settings (13).

A study of intensive in-home services in Hennepin County, Minnesota showed that the group receiving in-home services used 1500 fewer days of out of home placement than did a control group who did not receive in-home services. They also had shorter lengths of stay and tended to be placed in temporary shelter care rather than longer term residential or foster care (1). Similar results have been documented for in-home treatment programs in Washington and Maine (9).

All of these examples show the importance of program evaluation. Thus, as Wisconsin makes efforts to expand resources and programs for community-based mental health care, evaluation of the fiscal and treatment outcomes should be an integral part of the process.

II. RECOMMENDATIONS FOR IMPROVING MENTAL HEALTH SERVICES FOR SEVERELY EMOTIONALLY DISTURBED CHILDREN IN WISCONSIN

Overview

In order to significantly improve mental health services for Wisconsin's children, in line with the vision described above, a series of six steps need to be taken. They are summarized below, followed by a more detailed description of each recommendation beginning at Section A.

Development of a greater array of services.

In order to expand services both public and private dollars need to be focused on developing more intensive in-home treatment, day treatment, treatment foster and group care, respite care, crisis services, and early intervention programs. In addition, consultation and training about how to develop and provide these services needs to be available.

Improvement of assessment, case management and services co-ordination.

In this area a piloting approach is recommended so that some counties can begin to establish well defined individualized intake, assessment, case planning, case management, and services coordination approaches for children who are severely emotionally disturbed. These models can then be disseminated to other counties.

Provision of information to families seeking mental health services for their children.

At both the state and local levels information about existing treatment resources in both the public and private systems needs to be compiled and made available to families seeking treatment. Families should be encouraged and helped to organize family support groups.

Clarification of the Mental Health Act and the Children's Code concerning mental health services for children.

In order for services to be more available on a voluntary basis Chapter 51 needs to clearly state that adolescents can receive outpatient treatment without parental consent and that mental health services for children are a responsibility of the 51 system. Chapter 48 needs to be amended so that assessment of a child's need for mental health services is provided when the child is believed to be severely emotionally disturbed and that treatment can be ordered in appropriate

cases. Also the links and referral options between Chapters 51 and 48 need to be clarified.

Improvement of state level leadership and co-ordination.

The various bureaus and divisions within the Department of Health and Social Services need to develop an ongoing children's services committee so that they can work more closely together to improve and expand children's mental health services and services coordination. Also the Department of Public Instruction needs to be more closely involved with DHSS in developing initiatives and coordinating programs for severely emotionally disturbed children.

Revision of administrative regulations concerning licensing and certification of treatment programs providing mental health services for children.

The certification standards for community mental health programs and for outpatient clinics both need to have clearer requirements concerning mental health treatment for children. Regulations for treatment foster care need to be created and the rules for child-caring institutions must recognize the special treatment needs and rights of children who are severely emotionally disturbed. Finally, enforcement of all the standards and codes needs to be improved.

RECOMMENDATIONS

A. Developing a Greater Array of Services

As outlined in Chapter 1, Section III of the report, children's mental health services tend to be clustered around outpatient counseling and inpatient psychiatric treatment or residential treatment in child caring institutions. Services exist at the two extremes without an adequate array of services in between. Thus, the task group strongly recommends that funding, consultation, and training be focused on developing a true array of services and that steps be taken to improve the availability of early intervention programs, intensive in-home treatment, day treatment, treatment foster and group care, crisis services and respite care.

In making this recommendation two essential factors must be recognized. First, a quality array of services depends on well trained and knowledgeable personnel. Thus, consistent efforts must be made to disseminate knowledge about effective treatment approaches for children with severe emotional disturbances and to provide training opportunities for people working for and with these children. Second, a full array of services may not be

available in every county, and counties will develop services based on their unique needs and patterns of service delivery. However, strong efforts must be made to have the array available on a regional basis so that counties can purchase services as needed for individual children and families.

1. Refocus Existing Funding and Develop New Funding Resources to Obtain a Better Array of Services

Dollars generally drive a service delivery system and therefore must be channeled toward the types of services which are to be developed and improved. In order to develop a better array of services both public and private funds should be focused on expanding community based children's mental health services.

a. Expand Medical Assistance reimbursement for community based mental health services

Medical Assistance (MA) currently provides a significant amount of funding for inpatient treatment of children in psychiatric hospitals. Practically all the children receiving treatment at Mendota and Winnebago Mental Health Institutes and the Child and Adolescent Treatment Center in Milwaukee are funded through MA. Also children at private psychiatric facilities may be funded once their insurance runs out. Much of this is due to Wisconsin's use of "separate case eligibility" for children who are placed out of their homes. This means that a child in out of home placement may apply for and receive Medical Assistance benefits regardless of their family's income or assets.

In contrast, outpatient services under MA are limited to children who are eligible under AFDC, SSI or the medically needy program. Also, benefits are limited to traditional outpatient psychotherapy which takes place in the therapist's office or, infrequently, a school. Some day treatment programs may be supported with MA funds.

In order to improve the availability of Medical Assistance benefits for a broader array of community services the following steps should be taken:

(1) Expand MA coverage of community based services.

(a) Expand outpatient benefits by covering case management for severely emotionally disturbed children and by covering treatment provided in a natural or foster home, or in a group home setting.

As discussed above, case management is a critical service for children. Thus, case management services should be covered for severely emotionally disturbed children who are eligible for Medical Assistance. The

definition of case management should include arranging for an assessment of the child's and family's needs, developing an individual treatment plan, arranging for and monitoring the provision of services, coordinating care with other service providers, and periodically reviewing the service plan. Certified providers should include county community programs or social services departments and agencies under contract with these departments which may be providing case management services.

In-home treatment services should also be permitted under the Medical Assistance program. This can be achieved by expanding the locations where outpatient psychotherapy can be performed under Medical Assistance to include a child's natural home, a foster home, or a group home.

(b) Expand the use of day treatment for children and adolescents.

The current administrative rules governing day treatment do not explicitly recognize the special needs of children and adolescents. Thus, a special section should be developed in the rules for day treatment for children and adolescents. Also day treatment which is integrated with educational programming and which takes place in a school should be permitted.

(c) Develop a waiver to divert children from inpatient care or to move children from inpatient to outpatient care.

At least one state has an MA waiver (under the section 2176 waiver authority) directed toward children's mental health care. Wisconsin should develop a similar waiver so that MA funds can be used for a variety of outpatient and community based services for children who would otherwise receive services in an MA funded inpatient setting.

(2) Advance state share of MA inpatient expenditures for certain children to counties to purchase community care.

For children who become MA eligible due to placement in a psychiatric hospital it should be possible to give counties greater flexibility with the state share of MA funds. This could be done by determining for each county a base level of funding for MA inpatient expenditures for children with "separate case eligibility". These dollars would then be given to the county

and could be used to purchase community care. Alternatively, they could be used for inpatient care, in which case the federal MA dollars would also be available. The county should be required to do a multidisciplinary assessment for each child who is potentially eligible for MA funded inpatient care on a separate case eligibility basis and to determine whether community treatment is possible. If it is, the state share funds could be used, along with other available funds, to purchase it.

(3) Improve the monitoring of MA funded inpatient care.

Current rules require, within 14 days of admission, the development of an individual plan of care for children in inpatient care which is funded by MA. The plan is to be developed by a multidisciplinary team made up of facility staff, must be reviewed every 30 days, and must be designed to achieve discharge at the earliest possible time.

This system should be improved by:

(a) Requiring a multidisciplinary team assessment, which involves a case manager from the child's home county 51 agency or social services department (see Section B.) as well as other community mental health service providers, to be conducted prior to admission unless it is an emergency situation.

(b) Requiring review of the child's progress in treatment and the plan for discharge every 60 days by a team which includes the case manager and other involved community service providers.

(c) Clarifying the county's responsibility when a child is determined to no longer need inpatient treatment and private outpatient treatment resources are not available.

(4) Expand the eligibility of severely emotionally disturbed children for MA funded community services through the "Katie Beckett" program.

The "Katie Beckett" program is a special Medical Assistance program for certain disabled children who live with their families. These children and families would normally be ineligible for MA because of family income and asset levels. Under this program children may become eligible for Supplemental Security Income (SSI) and MA if they have a need for the type of care provided in a hospital setting and that care can be

provided in a more cost-effective manner in the community. To date this provision has not been used for mentally ill children. Efforts to bring them into this program and to provide needed outpatient rather than inpatient treatment should be actively pursued.

This will involve clearly defining the characteristics of mentally ill children needing inpatient care, expanding the DHSS ability to handle applications, and disseminating information about the program's availability.

b. Develop capacity building funds to expand early intervention, crisis services, intensive in-home treatment, respite care, day treatment, and treatment group and foster care.

As discussed in Chapter 1, Section III.B., a very significant amount of money is being spent on services to emotionally disturbed children by 51 agencies, county social service departments and the Medical Assistance program. However, most of it is concentrated in inpatient and other institutional care. The goal of the children's treatment system over the next 5-10 years should be to shift a significant portion of these funds to community based services for severely emotionally disturbed children. However, in order to do this the capacity of the community to provide appropriate treatment and backup programs must be developed. All too often inpatient and residential care are used because appropriate services are not available in the community. Thus, funds need to be focused on developing the array of community services and on enabling counties to shift existing dollars from institutional to community services. This has been a successful strategy in the adult system where capacity building dollars for community support programs have been used to enable counties to build a community care system, to reduce their expenditures for inpatient treatment, and to recycle savings from decreased inpatient use. Thus, the following approaches are recommended:

(1) Develop a GPR capacity building fund to develop intensive in-home treatment programs, day treatment programs, early intervention programs, treatment foster care, and specialized crisis and respite services for severely emotionally disturbed children and their families.

Funds under this program should be distributed at first to county programs or private non-profit agencies on a Request for Proposal basis with adequate consultation about program development and evaluation of results. Efforts should be made to fund programs in a variety of both urban and rural counties. The funds

should be focused on counties with a high rate of inpatient or other out of home care for severely emotionally disturbed children. Sufficient allowance for administrative costs should be included.

(2) Use other state and federal funding resources which are focused on "at-risk" children to develop children's mental health services.

Very often children who are "at-risk" of out of home placement, child abuse, drug or alcohol abuse, or involvement with the criminal justice system have an underlying mental illness or severe emotional problem. Thus, funds available under the federal Mental Health, Alcohol and Other Drug Abuse Block Grant; the federal Child Welfare Act; new federal alcohol and drug abuse laws and other similar programs should be used to develop early interrvention programs, intensive in-home treatment, day treatment, and treatment foster and group care and other mental health services for high risk children. In order to do this effectively more coordination and better communication between the various agencies, divisions, and bureaus must be developed at both the state and local level (see Section E.).

c. Promote the development of school-based health clinics, to include mental health providers on school campuses

School-age children in need of mental health services often fail to seek help because they are intimidated by formal clinic settings. Health clinics located in school buildings have emerged as viable resources for a variety of health-related needs. Adolescents experiencing serious emotional problems are more likely to seek assistance in a familiar and convenient setting. Clinic staff should include non-school personnel, provided by county departments of community programs or "51 agencies", an arrangement which would enhance cooperation and understanding among agencies as well as improve direct services to children. General purpose revenue funding should be allocated to pilot several school-based clinics, specifically to include a mental health component.

d. Expand private insurance coverage for a broader array of community based services

For children and families who have group health insurance, the state mandated benefits law, sec. 632.89, Wis. Stats., requires coverage of outpatient psychotherapy up to $1000 per year and inpatient benefits of 30 days or $7000, whichever is less. Outpatient care can be provided in a clinic

certified by the Department of Health and Social Services or by a licensed psychiatrist or psychologist in his/her office.

The mandate plus the implementing administrative regulations, HSS 61.91, should be broadened to cover crisis services, intensive in-home treatment for children and families and day treatment for children and adolescents. These less restrictive and less costly forms of care could significantly reduce the need for inpatient treatment.

e. Clarify the responsibilities of Health Maintenance Organizations to provide mental health services for children

Substantial concerns have been raised about the quantity and quality of mental health services being provided by HMO's to children. Two committees are currently looking at these issues; one is under the auspices of the Mental Health Council and the other under the Council on Developmental Disabilities. Both of these groups should coordinate their efforts and define areas of concern and present them to the state HMO Association with the goal of drawing up an agreement for better services for severely emotionally disturbed children. Areas to be explored should include: assessment by qualified mental health professionals, provision of treatment by persons experienced in working with children and families, the actual availability of mental health benefits, provision of in-home and at school treatment, provision of case management for children involved with other community agencies, the relationship between the HMO and public agencies such as county community programs departments and social services departments and the impact of separate case eligibility under MA on HMO services. By focusing on an improved package of outpatient services HMO's may be able to avoid more costly inpatient care.

2. Provide Improved Consultation, Technical Assistance and Training about Community Treatment Programs

Very often knowledge about how to better provide services is available in the state but has not been widely disseminated. In order to build the capacity discussed above, this knowledge must be more widely available. Thus, the state should provide staff, or contract with an agency, to provide technical assistance to counties about how to develop new services -- both from a programmatic and funding perspective. Also, the state should identify service providers who are providing quality community services and enlist their assistance in working with other counties and service providers in developing new or improved programs. Training for existing service providers should be more available through state and county funded conferences and hands-on training programs. Innovative Wisconsin service providers plus experts from other states should be engaged in

this process. A focus on treatment for severely emotionally disturbed children should also be incorporated into the professional training programs offered by the University of Wisconsin, the U.W.-Extension, and the Vocational, Technical and Adult Education (VTAE) system.

B. Improving Assessment, Case Management and Services Coordination

Improved assessment, case management, and services coordination are the keys to having an effective treatment approach for children with severe emotional disturbances. Without such an approach dollars are wasted through a trial and error approach to treatment and duplication of effort by the various agencies involved. Also, families experience extreme frustration in trying to locate and pull together needed services. A goal of the state should be, therefore, to have a well-defined case management and services coordination system in every county. This would include assessment, treatment planning, arrangement for the provision of services, coordination with other service providers, on-going monitoring of the treatment plan and advocacy for the child and family. Unfortunately, such an approach exists infrequently for severely emotionally disturbed children and their families in Wisconsin.

In addition, adequate assessments are frequently unavailable for children. This is especially true when the child has multiple problems or a long history of abuse, out of home placements, and unsuccessful treatment approaches. Thus, assessment approaches and resources need to be improved.

In order to improve case management, assessment, and services coordination, the following recommendations are made:

1. Pilot a Case Management/Services Coordination Approach in 4-6 Counties During the Next Two Years

Funding for pilots should be sought from multiple sources. These include mental health block grant funds, CASSP demonstration project grants, juvenile justice funds, federal alcohol and drug abuse prevention funds for children at risk, child welfare funds, and education funds. Pilots could be funded from a single source or from a combination of funding sources. Funds for direct administrative costs should be included.

Pilots should be conducted in both urban and rural counties and in counties with various delivery system structures, i.e., Human Services Departments or both Social Services and Community Programs Departments. It may also be advantageous to use counties which are already providing family-based services through their social services department or which have a Family Support Program. The pilot programs should be carefully evaluat-

ed and, if found effective, revised as needed, and phased in across the state.

Components of the pilot programs should include:

a. A centralized point of intake which would receive referrals from families on a voluntary basis, the schools, juvenile court intake workers, or other public or private agencies.

b. Screening to determine whether the child meets the target group definition. If he/she does not, referral to another appropriate treatment resource should be made.

c. Multidisciplinary team assessment if the child does meet the target group definition.

d. Treatment plan development which involves mental health treatment providers, the family, others providing services to the child and family, and the case manager.

e. Case manager who will advocate for the needs of the child and family, monitor progress, facilitate periodic reviews and provide, in general, a locus of responsibility and accountability for coordination, planning, and service delivery.

f. Limited amount of flexible funding available to the case manager to purchase services such as in-home treatment or respite care when these services are not available from other resources.

g. Required multidisciplinary treatment team assessment whenever a child who meets the target definition is being considered for placement into publicly funded residential or inpatient care. Attempts should be made to provide appropriate community-based services for the child and family. If this is not possible, the assigned case manager should continue to monitor the child's and family's treatment while he/she is in the placement and arrange for community services when the placement is ended. The provision of aftercare services should be part of the treatment plan for residential or inpatient treatment.

h. Development of clear interagency agreements setting forth what services the local mental health system will provide to children in the child welfare and juvenile justice systems and in the schools and also what services these agencies will provide for severely emotionally disturbed children. The procedures for accessing services and payment should also be clearly spelled out. DHSS should work with counties to develop standards for such interagency agreements. In order for a county to be accepted as a pilot, the 51 agency, social services department

and local school districts should all agree to participate and to contribute funding or in-kind services.

i. Development of a local consultation team which involves mental health professionals, juvenile corrections and child welfare workers, educators, and medical practitioners which can be brought together around difficult cases. All members of the team should have expertise in dealing with children with severe emotional disturbance.

2. Assessment Resources Should be Improved through the Development of State and Local Consultation Teams

The state should develop or contract with a private agency to develop a broad based consultation team to assist local staff in doing assessments and developing treatment plans for children with unusual or difficult to treat problems. Wisconsin has professional expertise in assessing children's mental health problems at the state universities, the Mental Health Institutes, Medical College of Wisconsin and public and private treatment providers. Someone is needed to determine the special expertise of the various professionals and their availability to engage in occasional assessments of children who meet state developed guidelines of eligibility for a special assessment.

When a child is referred for a special assessment the state or central agency should have the responsibility for assembling the team based on the child's needs. The persons doing the assessment should review a child's problems in the context of his/her total current environment and past history. Recommendations for new treatment approaches should be a key part of the assessment. This effort should review and learn from the activities of the Children's Consultation Service which was available through the Mental Health Institutes in the 1960's and early 1970's.

C. Improving the Provision of Information to Families Seeking Mental Health Services for Their Children

Families seeking mental health services for their children often become extremely frustrated when trying to find out what services are available and how they can be funded. Sometimes they give up until a problem becomes so severe that a more intensive, and often restrictive, treatment approach is needed. Therefore, the task force recommends that both state and local governments take steps to make needed information more available.

1. Each county should designate a staff person or agency whose responsibilities include providing information and referral to inquiring individuals.

The information would include listings of all available public and private mental health treatment resources, eligibility requirements, costs, current availability, contact people, and ways to appeal denial of services. This information should also include procedures used locally which allow parents to seek services through the Mental Health Act (Chapter 51) or juvenile court (the Children's Code, Chapter 48) and the rights of parents in the juvenile court process. Persons in this contact agency should also be able to do an initial screening to refer families to appropriate services and, if needed, attempt to broker the services for them.

2. The Department of Health and Social Services or an agency under contract with the Department should maintain centralized statewide information about available mental health services for children.

This information should include all agencies licensed or certified by DHSS to provide mental health services to children. They also should have listings of all publicly funded treatment resources for children and families. This information should be available to families, county agencies or anyone else trying to locate treatment resources. It also should be used to monitor the availability of resources statewide. Accompanying the resource lists should be a document containing information about evaluating the quality of a service provider.

It may be possible to combine this centralized information function with the consultation team function described in Section B.2. That is, a unit within the Department or an agency under contract with the Department could act as a central clearinghouse for statewide information on treatment resources and could also be responsible for assembling consultation teams for eligible children.

3. The development and expansion of family support groups should be continued and encouraged.

Currently under the CASSP grant the Alliance for the Mentally Ill is organizing family support groups for parents of children with severe emotional disturbances. This activity should be continued over the next several years. Families can be a source of information for other families, can provide needed support, and can act as effective advocates in monitoring existing services and calling for the development of new ones.

D. Changing the Mental Health Act and the Children's Code to Clarify Responsibilities for Providing Mental Health Services for Children

1. The Mental Health Act, Chapter 51.

The Mental Health Act assumes county responsibility for providing services to children but does not explicitly state this as a priority. Further, it does not require any coordination by the 51 system with other service providers who are also involved with emotionally disturbed children. While the act deals with the admission of children to inpatient facilities, it does not require any periodic review after the child is admitted. Finally, the act is silent about who may consent for outpatient psychiatric treatment for children.

a. The Mental Health Act should be clarified concerning the county responsibility to provide services for severely emotionally disturbed children

In order to highlight the special needs of severely emotionally disturbed children, a section should be created in Chapter 51 on children's mental health services. It should set forth the county responsibility to provide services to these children and to coordinate mental health services with the schools, child welfare and juvenile justice systems.

b. The ability of a child to obtain outpatient treatment without parental consent should be clarified

Currently children over the age of 14 can be admitted to inpatient care without parental consent. [Sec. 51.13(1)(c)] Also children over the age of 12 can receive outpatient AODA treatment without parental consent. [Sec. 51.47] However, the statutes are silent in regard to outpatient mental health treatment.

The statutes should permit a child at the age of 12 (or 14) to consent to outpatient mental health treatment as long as medications are not prescribed. Special provisions in regard to billing should be developed.

c. Periodic court reviews of minors admitted to inpatient units should be required

Courts must review all publicly funded admissions of minors to public psychiatric facilities to determine whether the admission is appropriate and the setting is least restrictive. [Sec. 51.13] However, serious questions have been raised about the effectiveness of this review. Also, once the admission is made the court has no ongoing role. To improve the monitoring of such admissions, every six months a court should appoint a guardian ad litem to review whether the minor (over 14) still agrees to the admission, whether he/she is receiving the treatment as set forth in the treatment plan and whether the treatment

is in the least restrictive appropriate setting. If there is a question raised about any of these issues, or at the minor's request, a hearing should be held to review the appropriateness of the continued inpatient treatment. If it is determined inappropriate, the court, with consultation from the local 51 agency, should be able to order transfer of the child to a more appropriate treatment setting.

Linking children who are in psychiatric hospitals with permanency planning requirements under Chapter 48 should be seriously explored.

2. The Children's Code, Chapter 48

Admissions and commitments of children to inpatient mental health facilities and the provision of voluntary alcohol and drug abuse treatment services are authorized under Chapter 51. Unlike the "adult" system, however, the basic presumption contained in Chapter 51 is that the provision of court-ordered non-inpatient "mental health" services to children should be affected through Chapter 48.

While this presumption is relatively clear in Chapter 51, its realization in Chapter 48 is less than clear. Part of the problem is the absence in the Children's Code of specific language which mirrors that of Chapter 51 and there remains today a myth in the juvenile justice system that such services cannot be ordered. Another factor is simply the existence of Chapter 51, which suggests to some a dicotomy, both procedural and fiscal, between the "mental health" system and the "juvenile justice and child welfare" system.

The following proposals seek, at least, to make more clear the relationship between the two Chapters. By making the Children's Code more specific in this regard, we make it more probable that children will receive the services they need.

a. The definition of "Special Care or Special Treatment" should be clarified

Sections 48.13(4) and 48.34(6) refer to "special care or special treatment" which the child may require and which can be ordered by the court, respectively. This term is not defined by statute, theoretically to give the court the broadest flexibility in creating an appropriate treatment or rehabilitation plan. Unfortunately, the lack of definition has too often resulted in a cautious interpretation which is resolved in favor of not providing needed mental health services.

Section 48.02 should be amended to include a definition of "special care or special treatment" which includes, but is not limited to, psychological, psychiatric or AODA services which are

not admissions or commitments to mental health facilities controlled by Chapter 51.

b. Payment for "Special Care or Special Treatment" should be clarified

Section 48.34(6) authorizes the court to order that the special care or treatment ordered by the court be paid for by "an appropriate agency". Although the Attorney General has opined that the appropriate agency could be a department under 51.42 (72 OAG 30), there remains considerable confusion and debate with respect to the meaning of this section. Too often, appropriate services for children are precluded by this fiscal disagreement.

Section 48.34(6) should be amended to specifically authorize the juvenile court to order the appropriate department under 51.42 to pay for the "mental health" services ordered by the juvenile court.

c. The ability to order AODA assessments and their use in the court process should be clarified

Section 48.295(1) authorizes the court, subsequent to the filing of a petition, to order the child and/or parent to be examined so that their physical, psychological, mental or developmental condition may be considered by the court. It is not as clear as it should be that AODA assessments may be ordered under this provision. Further, the listing of persons authorized to conduct evaluations does not include certified AODA assessment personnel.

Section 48.295(1) should be amended to clearly authorize AODA assessments and to allow certified AODA assessment personnel to conduct such evaluations. If this proposal is adopted, s. 48.33 should be amended to require the inclusion of the examination in the court report, and s. 48.355 should be amended to require the court to make specific findings with respect to the child's condition as determined by the examination and other evidence presented at the dispositional hearing.

d. The Department of Health and Social Services should be required to examine children committed to it for mental health and AODA problems

Section 48.50 requires the department to examine any child whose legal custody is transferred to the department, including commitments to corrections under s. 48.34(4m). Although various studies have found that a majority of these children have significant mental health and AODA problems, there is no specific requirement that the department must examine these children for these specific problems.

E. Improving State Level Leadership and Coordination

Millions of public dollars are spent each year on services for emotionally disturbed children, services which include mental health, health, education, residential treatment, out-of-home placements, and other habilitation/rehabilitation programs. Add privately provided and voluntary services and the list becomes even more extensive. The effectiveness and efficiency with which these services are delivered could be greatly enhanced through planning and delivery done cooperatively both within and between state departments which serve emotionally disturbed children.

1. The Secretary of DHSS should convene an intra-departmental committee on children's services to meet monthly to coordinate programs and activities.

Each month chiefs of relevant bureaus and offices within DHSS should be convened by the Secretary or his/her deputy to consider issues relating to children's services. This regular face-to-face meeting is necessary to rehabilitate a system which has grown accustomed to a fragmented approach to program planning and delivery for children.

The Department has successfully used such a model in the area of long term care for adults and should replicate its success in this area. Such a committee should include at a minimum representatives from the Office of Mental Health, Developmental Disabilities Office, Office on Alcohol and Other Drug Abuse, Bureau for Children, Youth and Families, Bureau of Health Care Financing, Division of Policy and Budget, Division of Care and Treatment Facilities, Division of Corrections, and Division of Vocational Rehabilitation.

2. The Department of Health and Social Services and the Department of Public Instruction should develop working agreements on coordination of services and policy development.

Policy staff from the above named components of DHSS should also meet regularly with representatives from DPI, particularly the Division of Handicapped Children and Pupil Services, to coordinate policy development for children at risk of developing, or who already have, severe problems in the areas of mental illness, alcohol or other drug abuse, or juvenile delinquency. They should also develop working agreements on how resources and programs under the jurisdiction of their respective agencies are to be coordinated at the state and local levels.

F. Revising Administrative Regulations on Licensing and Certification

Administrative rules are a major monitoring device for the Department of Health and Social Services. While there are some fairly good standards in the areas of inpatient and outpatient mental health services for child, the codes are deficient in other areas.

1. Each county should be required to provide a fair proportion of community mental health resources for children's services.

The section of the Wisconsin Administrative Code which regulates community mental health programs (Subchapter IV of HSS 61) states in part:

> Of the treatment personnel required for any outpatient services, a minimum of 30% staff time must be devoted to children and adolescent services.

A DHSS legal interpretation suggests that this provision is non-binding since it is a standard intended to modify another section of the Code which has subsequently been deleted. However, in order that children get a fair share of community mental health services, this technical error should be rectified by either revising HSS 61 or Chapter 51 of the statutes to require that community mental health programs serve children in proportion to their numbers in the community.

2. Standards should be developed for treatment foster care.

The section of the Wisconsin Administrative Code which regulates and licenses foster care (HSS 56) does not include a separate distinction for treatment foster care, although foster care reimbursement rates may vary according to the special needs of the child. An administrative rule should be created which sets standards for licensing certain foster homes as specialized treatment or therapeutic foster homes. Parents in such homes would be specially recruited and trained and would receive a higher reimbursement rate for their services. In addition, a stipend would be available for participation in training and other program activities.

3. Patients' rights should be incorporated into administrative rules and regulations for child caring institutions.

Section 51.61, Wisconsin Stats., is a comprehensive patients' rights law which provides for certain individuals in

Wisconsin institutions. The rights to treatment and least restrictive conditions are among those included in s. 51.61. This patients' bill of rights should be made to apply to children placed in Wisconsin's child caring institutions, currently regulated by HSS 52.

4. DHSS should expand its capacity to enforce current and proposed administrative rules.

Recently Wisconsin has reduced its capacity to monitor compliance with rules regulating provision of services to children and families. Regional DHSS staff formerly responsible for monitoring have been laid off or transferred in an effort to reduce state costs. This has had an adverse effect upon DHSS' capacity to identify and investigate possible abuses and seriously compromises the Department's ability to effectively and systematically plan and implement programs in response to the needs of children and families. The Department must expand its capacity to monitor programs if an improved system of care for severely emotionally disturbed children is to be accomplished and sustained.

III. Conclusions

The vision of improved mental health services for severely emotionally disturbed children and their families and the recommendations outlined above are only a starting point. The task group strongly urges policy-makers, elected officials, treatment providers, families, and others to review and discuss our plan for action and then to take the steps necessary to improve mental health services for Wisconsin's children. All of us are willing to work with you in this task and look forward to the opportunities and challenges before us.

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APPENDIX A

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APPENDIX B

Wisconsin Administrative Rule Implementing Subchapter IV of Chapter 115, Wis. Stats. -- Special Education

PI 11.34(2)(h) -- Eligibility Criteria for Emotional Disturbance

Emotional disturbance. 1. Classification of emotional disturbance as a handicapping condition is determined through a current, comprehensive study of a child, ages 0 through 20, by an M-team.

2. Emotional disturbance is characterized by emotional, social and behavioral functioning that significantly interferes with the child's total educational program and development including the acquisition or production, or both, of appropriate academic skills, social interactions, interpersonal relationships or intrapersonal adjustment. The condition denotes intraindividual and interindividual conflict or variant or deviant behavior or any combination thereof, exhibited in the social systems of school, home and community and may be recognized by the child or significant others.

3. All children may experience situational anxiety, stress and conflict or demonstrate deviant behaviors at various times and to varying degrees. However, the handicapping condition of emotional disturbance shall be considered only when behaviors are characterized as severe, chronic or frequent and are manifested in 2 or more of the child's social systems, e.g., school, home or community. The M-team shall determine the handicapping condition of emotional disturbance and further shall determine if the handicapping condition requires special education. The following behaviors, among others, may be indicative of emotional disturbance:

a. An inability to develop or maintain satisfactory interpersonal relationships.

b. Inappropriate affective or behavioral response to what is considered a normal situational condition.

c. A general pervasive mood of unhappiness, depression or state of anxiety.

d. A tendency to develop physical symptoms, pains or fears associated with personal or school problems.

e. A profound disorder in communication or socially responsive behavior, e.g., autistic-like.

f. An inability to learn that cannot be explained by intellectual, sensory or health factors.

g. Extreme withdrawal from social interaction or aggressiveness over an extended period of time.

h. Inappropriate behaviors of such severity or chronicity that the child's functioning significantly varies from children of similar age, ability, educational experiences and opportunities, and adversely affects the child or others in regular or special education programs.

4. The operational definition of the handicapping condition of emotional disturbance does not postulate the cause of the handicapping condition in any one aspect of the child's make-up or social systems.

5. The manifestations of the child's problems are likely to influence family interactions, relationships and functioning or have an influence on specific individual members of the family. It is strongly recommended that extensive family involvement or assistance be considered in the evaluation and programming of the child.

6. The handicapping condition of emotional disturbance may be the result of interaction with a variety of other handicapping conditions such as learning, physical, or mental disabilities or severe communication problems including speech or language.

7. An M-team referral for suspected emotional disturbance may be indicated when certain medical or psychiatric diagnostic statements have been used to describe a child's behavior. Such diagnoses may include but not be limited to autism, schizophrenia, psychoses, psychosomatic disorders, school phobia, suicidal behavior, elective mutism or neurotic states of behavior. In addition, students may be considered for a potential M-team evaluation when there is a suspected emotional disturbance, who are also socially maladjusted, adjudged delinquent, drop-outs, drug abusers or students whose behavior or emotional problems are primarily associated with factors including cultural deprivation, educational retardation, family mobility or socioeconomic circumstances, or suspected child abuse cases.

APPENDIX C

FUNDING CHILDREN'S SERVICES

Community Aids

The major source of funds for county human services is Community Aids, about 75% of which is state general purpose revenue (GPR is collected by the state primarily through income and sales taxes). The remaining 25% is federally funded, with the major source being the Social Services Block Grant. The Alcohol, Drug Abuse, and Mental Health Block Grant contributes $8.4 million to the annual CA total of approximately $228 million.

Two sub-categories of the Federal Social Security Act provide additional dollars distributed through Community Aids. Title IV. B. is the basic federal resource for child welfare services, usually including family counseling, crisis intervention, and emergency caretakers in the home. Title IV. E. includes the Adoption Assistance and Child Welfare Amendments, created in 1980 for the purpose of providing foster care to children who cannot live with their families.

The programs funded through Community Aids are social services and services to individuals who are mentally ill, developmentally disabled, or who are alcohol or drug abusers.

Youth and Family Aids

This program provides money for juvenile delinquency-related services. About 94% of the $34 million annual cost in 1986 was financed from state general purpose revenues.

Under the program, counties are responsible for all costs of services for juvenile delinquents, whether provided within the county or at some other location, including state correctional institutions. YFA money is distributed to counties on a formula basis.

Medical Assistance

Title XIX of the Federal Social Security Act provides 58% of the funds for the Wisconsin Medical Assistance Program. The state provides the remaining 42%. WMAP provides medical and rehabilitation services to low income people who are elderly or disabled or who are members of families on the Aid to Families with Dependent Children (AFDC) program. Another category of people eligible for MA are "medically needy". Federal rules specify certain services that the state must provide, or "manda-

tory" services. Wisconsin has chosen to provide additional "optional" services, including psychotherapy and inpatient psychiatric care.

In fiscal year 1986 total expenditures for MA for the WMAP were $1.02 billion.

Education

Public Law 94-142 (PL 94-142), the Education for All Handicapped Children Act of 1975, is a federal law requiring that all handicapped children receive a free, appropriate public education in the least restrictive environment possible, and makes grants to states which then are distributed to local school districts based on the number of handicapped children receiving special education and related services. In 1985-86, $145 million was distributed to school districts, CESA's, and counties for special educational services. Subchapter IV, Chapter 115, Wis. Stats., the state law governing education of handicapped children, largely parallels P.L. 94-142.

In the 1985-87 budget, the legislature adopted the Children at Risk program, directed at children at risk of dropping out of school. School districts with the most serious dropout problem must develop a plan for serving children at risk, and may receive a small amount of additional state aid if they meet certain criteria in retaining students in school. The plan must address how community services will be used to meet the needs of the child.

Public Law 89-313 provides funding and operational regulations for educational programs and services for handicapped children in state-operated and state-supported schools and agencies and for children in local school districts who transferred from state-operated and state-supported schools and agencies. Programs must comply with PL 94-142 and Chapter 115 standards and regulations.

The Carl D. Perkins Vocational Education Act provides federal funds to states, 10% of which ($608,000 for secondary and elementary and $743,000 for post-secondary) is set aside for handicapped individuals. Handicapping conditions under this act are not limited to emotional disturbance or mental illness.

APPENDIX D

GLOSSARY

Chapter 48 -- (Also Children's Code or Juvenile Code) The section of Wisconsin Statutes which details the authority of the state, through its juvenile courts, to coercively intervene in private family life, including procedures which the state must follow in exercising its authority, the rights of children and parents who are the subject of such action, and the specific options available to the court in response to a child's offense or needs.

Chapter 51 -- (Also Mental Health Code, Mental Health Act) The section of Wisconsin Statutes which sets forth the obligations of the state and counties to provide mental health, alcohol and other drug abuse, and services for people with developmental disabilities. Chapter 51 also includes procedures for voluntary admissions to inpatient facilities, the standards and procedures for civil commitment, and the rights of persons receiving mental health care.

Child Caring Institution (CCI) -- A residential facility, not licensed as a psychiatric hospital, the primary purpose of which is the provision of individually planned programs of mental health treatment in conjunction with residential care; may include education program on-grounds or use public school programs. Cost is usually borne by local YFA budgets.

Children's Code -- (See Chapter 48)

Community Aids -- An annual state allocation to departments of social services which includes some federal and some state (GPR) funds and is the basic funding source for social services for all target populations including families, children, disabled and elderly persons. County departments of social services may elect to supplement the state CA allocation with county tax funds. (See also Appendix C)

Community Options Program (COP) -- COP is a state funded program to provide assessments, case plans, and community services as an alternative to nursing home placement. While few children are served through the COP program, it provides a valuable model for developing local systems of care for severely emotionally disturbed children.

Day Treatment -- Treatment programs that provide extended care to children who do not need 24 hour treatment, but do require more intensive treatment than one or two hours a week of therapy; usually includes education program.

Department of Community Programs (DCP) -- An agency which county government may create to provide mental health programs, alcohol and other drug abuse programs, and services for persons with developmental disabilities as mandated in Chapter 51, Wis. Stats. Currently, 51 of Wisconsin's 72 counties separate these services, organizationally, from other social services (see Department of Social Services).

Department of Health & Social Services (DHSS) -- Administrative entity charged with administering broad range of human services programs in Wisconsin. (See Appendix E, DHSS, for subunit listing.)

Department of Human Services (DHS) -- Agency created by county government which combines DSS and DHS functions.

Department of Social Services (DSS) -- Agency created by county government generally divided into two organizational divisions: the income maintenance unit, which receives applications, determines eligibility, and computes benefits for a variety of public assistance programs including Aid to Families with Dependent Children (AFDC), Medical Assistance, and food stamps; and social services unit, which provides a variety of direct services such as child abuse and neglect investigations, child welfare activities, juvenile court intake and client supervision, alternative out-of-home care, etc. In 51 of Wisconsin's 72 counties, DSS is organized independent of the Department of Community Programs (sometimes referred to as "51 Board", Unified Board, Unified Services Board).

Family Support Program -- A GPR program in which 23 participating counties assist eligible families who have a child with severe disabilities in keeping the child at home by providing funding for goods and/or services unavailable through other programs.

Guardian ad Litem (GAL) -- A GAL is a lawyer appointed by a judge to represent the best interests of a child or incompetent adult in a court proceeding.

Health Maintenance Organization (HMO) -- A system of health care delivery in which enrollees or consumers are offered a comprehensive range of health care benefits for a single, all inclusive, and preset fee. Under an HMO plan, enrollees may use only specified physicians and hospitals. If an enrollee uses services beyond the subscriber enrollment fee, the HMO must absorb the excess costs. HMO's were created to help keep health care costs down.

Inpatient Treatment -- Provision of mental health services to persons staying in a hospital overnight.

Juvenile Code -- (See Chapter 48)

Katie Beckett Program -- The Katie Beckett Program is a Medicaid program for disabled children who live with their families instead of in hospitals or nursing homes. Parents' income and assets are not considered.

Medicaid -- (Also Medical Assistance, MA, Title XIX) The section of the federal Social Security Act created to assist states in providing health care for the poor. States have latitude in determining which services are covered, although certain services are mandated. In Wisconsin, "medically needy" -- those aged, blind or disabled persons, or families with disabled children who meet state income eligibility requirements -- are included. Medicaid is a "sum sufficient" funding source, which means that if the recipient is eligible for the service and the service is needed, it will be provided. Of each MA dollar, approximately 42% comes from state GPR funds; the remaining 58% comes from the federal government.

Medical Assistance -- (See Medicaid)

Mental Health Act -- (See Chapter 51)

Outpatient Treatment -- Treatment provided, usually in community mental health centers or private mental health clinics, and usually in the form of individual, group, or family counseling or psychotherapy.

Residential Treatment Center (RTC) -- (See child caring institution)

Title XIX -- (See Medicaid)

Youth and Family Aids (YFA) -- A sum of money distributed by the state to counties to be used for providing services to children who are alleged delinquent, adjudicated delinquent, or alleged or adjudicated to be in need of protection or services according to Chapter 48, the Children's Code. Counties pay for correctional placements, CCI placements, as well as community-based services out of their YFA allocation. The state distributes over $30 million in YFA funds annually. County departments of social services may elect to supplement the state YFA allocation with county tax funds. (See also Appendix C)

APPENDIX E

ACRONYMS

AODA -- Alcohol and Other Drug Abuse

CASSP -- Child and Adolescent Service System Program

CATC -- Child and Adolescent Treatment Center

CCI -- Child Caring Institution

CESA -- Cooperative Educational Service Agency

CHIPS -- Child in Need of Protection or Services

COP -- Community Options Program

DCP -- Department of Community Programs (county)

DHS -- Department of Human Services (county)

DHHS -- Department of Health and Human Services (federal)

DHSS* -- Department of Health and Social Services

- DCS -- Division of Community Services
  - BCP -- Bureau of Community Programs
    - OAODA -- Office of Alcohol and Other Drug Abuse
    - OMH -- Office of Mental Health
    - DDO -- Developmental Disabilities Office
  - BCYF -- Bureau for Children, Youth and Families
- DCTF -- Division of Care and Treatment Facilities
- DOC -- Division of Corrections
  - BJS -- Bureau of Juvenile Services
- DOH -- Division of Health
  - BHCF -- Bureau of Health Care Financing

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* Following DHSS are sub-units of that department. This list is incomplete and contains only those sub-units which are relevant to the discussions in this monograph.

DPB -- Division of Policy and Budget

DVR -- Division of Vocational Rehabilitation

DOE -- Department of Education (federal)

DPI -- Department of Public Instruction

DSS -- Department of Social Services (county)

GPR -- General Purpose Revenue

EAS -- Ethan Allen School

ED -- Emotionally Disturbed

EEN -- Exceptional Educational Need

HMO -- Health Maintenance Organization

LHS -- Lincoln Hills School

MA -- Medical Assistance or Medicaid

MMHI -- Mendota Mental Health Institute

NIMH -- National Institute of Mental Health

OCI -- Office of the Commissioner of Insurance

RTC -- Residential Treatment Center

SED -- Severely Emotionally Disturbed

WMAP -- Wisconsin Medical Assistance Program

WMHI -- Winnebago Mental Health Institute

YFA -- Youth and Family Aids