Psychiatr Q (2006) 77:251–271
DOI 10.1007/s11126-006-9012-0

ORIGINAL PAPER

The Premature Demise of Public Child and Adolescent Inpatient Psychiatric Beds

Part I: Overview and Current Conditions

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Published online: 16 August 2006

Abstract Current trends on the national landscape of available treatment and delivery systems for children and adolescents with serious emotional disturbance indicate a sharp decline in the availability of inpatient psychiatric services. These trends are troubling as six to nine million children and adolescents in the United States suffer from some serious emotional disturbance, and the majority in need of treatment do not receive behavioral health services. The consequences of untreated mental illness in children are grave, and the cost to society of children's mental health problems is high in both human and fiscal terms. This paper will describe national trends in behavioral health in general and specifically children's mental health, and will detail the experiences of many states to identify possible problems and pitfalls to downsizing and closing child and adolescent inpatient psychiatric beds.

Keywords Child/adolescent psychiatry · Inpatient availability

The President's New Freedom Commission on Mental Health Subcommittee on Children and Family [1] informs us that the mental health problems among children and adolescents constitute a national public health crisis. Former Surgeon General David Satcher reported that "growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them" [2].

Six to nine million children and adolescents in the United States have serious emotional disturbances, accounting for 9 to 13% of all children [3]. One in 10 children in the United States suffers from mental illness severe enough to cause some level of impairment and

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interfere with normal development and functioning [4]. Twenty-one percent of U.S. children aged 9 to 17 have a diagnosable mental or addictive disorder causing at least minimal impairment [3] while 5 to 9% of children this age have a serious emotional disturbance which causes "extreme functional impairment" [5]. One-third of children with a mental health disorder have been diagnosed with two or more disorders [6]. Melancholic depression can be diagnosed in children as young as 3 years of age [7]. At least 25% of adolescents in the United States are at serious risk of not achieving "productive adulthood" [8].

Studies show significant numbers of children and adolescents in need of treatment do not receive behavioral health services [9]; this is particularly true of low-income and minority children who experience disparities in access to, and availability of, quality behavioral health services [1]. The unmet need for behavioral health services remains as high now as it was 20 [4], or even 30 [2] years ago. When children's mental health services are unavailable, unaffordable, or inappropriate, many young people end up caught in the child protection or juvenile justice systems. Every night, 2000 children in the United States wait in detention for community mental health services [6]. In 2001, one million adolescents needed but did not receive treatment for illicit drug use [10].

Children and adolescents represent approximately 7% of the total mental health inpatient population [11]. Hospitalizations for psychiatric disorders account for approximately one-third of all hospital days among youth and adolescents; psychiatric disorders are the leading reason for hospitalization among 5–19 years olds [12]. Inpatient services are estimated to account for approximately half of annual mental health costs for children and adolescents. And while efforts are underway to develop effective community-based alternatives to inpatient care, there are children and adolescents for whom hospital level of care remains appropriate and necessary [13].

The consequences of untreated mental illness in children are grave, and the cost to society of children's mental health problems is high in both human and fiscal terms [14, 15]. Emotional and behavioral problems in children and adolescents that go undetected and untreated can lead to negative outcomes including school failure, family disruption, unplanned pregnancies, out-of-home placements, poor employment opportunities, incarceration, and poverty in adulthood. Early detection and treatment can allow for interventions at a stage where problems can be prevented from worsening [16]. *Mental Health: A Report of the Surgeon General* indicates that 74% of 21 year olds with mental health disorders had prior emotional problems [3]. Childhood is a critical time to prevent mental disorders, as many adult mental disorders appear to have their antecedents in childhood [12].

A spectrum of treatments must be available to meet the mental health needs of children and adolescents. There are many highly effective treatments, which must be tailored to fit individual and family needs. For example, 60–65% of adolescents who have received cognitive behavioral therapy experience relief from symptoms of major depression [17, 18]. Rational Emotive Behavior Therapy was recently demonstrated as effective in a meta-analysis showing its impact to be beneficial and of respectable magnitude [19]. There is evidence in treatment of adolescents following a suicide attempt that maintaining the adolescent in treatment, using any of a variety of treatment modalities, results in significant improvement in functioning [20]. The American Academy of Child and Adolescent Psychiatry, representing over 7000 child and adolescent psychiatrists, recognizes the importance of a continuum of care for children and adolescents to provide different types of treatment and services depending on the needs of the child. Care can range from least intensive, e.g., office or outpatient clinic visits, through intensive case management, to very intensive, e.g., residential or inpatient hospital treatment.

Inadequate funding for children's mental health services is costly: 32 billion dollars to school systems, 14 billion to child welfare systems, 9 billion to juvenile justice systems, 3 billion to provide health care to treat chronic physical health problems resulting from untreated mental health disorders, and over 1 billion in societal costs due to lost adult productivity [17]. Nonetheless, there is no national effort to fully understand mental health disorders among children and adolescents. And while the National Institute of Mental Health recently funded an effort to study a nationally representative sample of children aged 9–17, there is currently no nationwide system to assess the needs of this population. The mental health problems of children and adolescents are often invisible to policy makers and administrators until a crisis occurs [14].

This paper will examine national trends in behavioral health in general and specifically in children's mental health including patterns in utilization data, financing, and capacity to provide specialized mental health services to children and adolescents. In addition, the authors will share the stories and experiences of states that have eliminated or decreased state-provided inpatient treatment resources for children and adolescents in an effort to describe "lessons learned." The goals of this paper are to detail the social and environmental context in which many states are closing inpatient treatment services for children and adolescents.

National trends

A number of national trends can be seen across behavioral health services in general, and specifically in children's mental health. These trends are troubling as they portend fewer resources, be they financial, service-related, or intellectual, for children and adolescents most in need of mental health care.

All services

Utilization data

The total number of psychiatric inpatients in the U.S. declined steadily from 1970 to 2000. The number of inpatient beds and percent of the total that belonged to state hospitals, private hospitals, and general hospitals changed over these decades. In 1970, the distribution was state hospitals—91.8% of beds, private hospitals—3.2% and general hospitals—5.0%. By 1998 the percentages were 42.0, 22.2, and 35.8% respectively [21].

The number of facilities and occupied beds showed a similar pattern. In 1969, there were 310 state and county hospitals with 369,969 patients; private hospitals numbered 150 with a year-end census of 10,963; and the 664 general hospital psychiatric units had 17,808 beds. By 1998 the numbers had shifted: 229 state and county facilities with 56,955 patients; 348 private psychiatric hospitals with 21,478 patients; and 1593 general hospitals with 37,002 patients. In 2000, for the first time in three decades, the number of facilities decreased in *all* three categories [21].

The number of admissions increased progressively from 1969 through 1998, with a progressively greater percentage of admissions accounted for by private psychiatric hospitals. From the 1960's through the 1990's, private hospitals consistently had a greater percentage of admissions than they did percentage of beds as did the general hospitals, reflecting shorter lengths of stay at these types of facilities as compared to the state and county hospitals. Several phenomena affected utilization of private psychiatric hospitals—both chain hospitals and independent hospitals—in the 1990's. First was managed care, and with it

preadmission certification, concurrent utilization review, case management, decreasing rates of reimbursement, and increased administration costs [22]. Second was the privatization of public mental health services [23]. Third was the implementation of treatment in the least restrictive alternative (LRA) [24].

In 2003, the National Association of State Mental Health Program Directors [25] Research Institute conducted a survey of state mental health authorities (SMHA) based on 2002 data. A majority of SMHA respondents reported a decline in beds in all sectors (state, private freestanding, and general hospitals); 55% of SMHA respondents ($n = 24$) indicated this was resulting in a shortage of psychiatric beds. A significant majority of respondents reported states continue to use public beds for the acute, intermediate and long-term treatment despite almost all states operating community-based crisis services, admission diversion programs and prescreening for admission. Finally, about a third of SMHA respondents indicated the shortage of psychiatric beds affected the state's mental health system by increasing the waiting list for state hospital beds (15 states), causing state hospital overcrowding (11 states) and increasing the waiting list for other psychiatric inpatient beds (13 states) [25]. A long-term study by the Center for Studying Health System Change has identified a national shortage of inpatient psychiatric beds [26].

Finances

From fiscal year (FY) '81 to FY '02, total SMHA spending went from $6.1 billion to $25.2 billion in current dollars. However, from FY '81 to FY '02 the mean of SMHA spending as a percentage of state government expenditures decreased from 2.09 to 1.95%. The range amongst states was quite wide in FY '02, from 0.6 to 4.7% [27]. In 1981, SMHA's spent on average 63% of their budget in state hospitals and 33% in the community. In FY '02 that ratio had flip-flopped with 30% of the SMHA budget in state hospitals and 67% in community programs. Much of the financial news of the early years of the 2000's did not bode well for private and general hospital psychiatric programs either. While overall healthcare spending increased by 15.7% between 1992 and 1999, mental health and substance abuse spending decreased by 17.4%. Behavioral healthcare spending went from 7.2% of total private health insurance spending to 5.1% over this same time period [28]. Reimbursement rates have fallen to the point that they often do not meet the total costs of care and treatment [29, 30]. While reimbursement rates fell, the costs to deliver treatment increased, due to workforce shortages, skyrocketing professional liability insurance, escalating pharmaceutical costs and progressively increasing regulatory requirements [28]. The private sector became less available and less able to meet psychiatric patients' needs. Further, in a meta-analysis comparing for-profit and nonprofit psychiatric inpatient care between 1980 and 2001, Roseman and Linder [31] found "unexpectedly," "performance superiority of the nonprofit psychiatric care providers compared with the for-profit providers." They concluded, "The overwhelming majority of the studies undermine a performance rationale for public policy decisions to expand for-profit inpatient healthcare."

Children and adolescents

Falling numbers of psychiatric beds

Determining the number of inpatient beds for children and adolescents has proven far more challenging than for adults. As Joy Midman, Executive Director of the National Association of Psychiatric Treatment Centers for Children points out, there is no uniform definition of

what a psychiatric hospital bed for children or adolescents even is. A hospital bed in one state might be called a residential treatment program in another and a group home in a third. (Personal communication, January 24, 2005). Fifteen states continue to operate over 50 beds within the state for patients under 21 years of age. States continue to operate public beds for the acute, intermediate, and long-term treatment of children and adolescents. States continue to be required to operate such beds despite almost all states funding crises services with mandates including admission diversion from public hospitals.

Despite an overall decrease in inpatient bed availability, "inpatient service use has risen despite federal and state reforms to create alternative community-based systems of care" [13]. In this context it is worthy of notice that children's services in FY '02 received about 9% of what adults received for inpatient services, despite the fact, that on average, children's inpatient treatment was about 1.5 times as expensive as adult inpatient treatment [27].

While psychiatric inpatient treatment is resource intensive, it remains a fundamental understanding that "because some children with severe disorders *do* require a highly restrictive treatment environment, hospitals will remain an integral component of a system of care" (italics in original) [32]. Inadequate recognition of this tenet has contributed to children and adolescents with serious emotional disturbance being "warehoused" in juvenile detention centers [33–37]; stuck in emergency rooms [28]; inappropriately placed in child welfare [35]; involved in self-injurious behavior to the point where "the teenage suicide rate in the United States is a national crisis" [38]; and put in a situations where far too many are at long-term risk for dramatically bad outcomes [39].

Increases in admission rates

As the number of available inpatient psychiatric beds decreases, the admission rates of children and adolescents to psychiatric hospitals have increased. In the 1970's, the National Institute of Mental Health showed a 15% increase in admissions; a separate study found psychiatric admission for those under 18 years old had increased by more than 36% between 1980 and 1986 [40]. The greatest increase in psychiatric admissions appears to be with private psychiatric hospitals, which reported an increase of 60% from 1980 to 1986 [40]. In 1986, children and adolescents accounted for over 36% of total admissions to private psychiatric hospitals but only 16% in public psychiatric hospitals [41]. There was a concern in the 1980's that psychiatric hospitals had become "makeshift solutions" for society's quandaries with troublesome youth [42].

Admission rates continued to increase from 1986 to 1997. The number of youth admitted to inpatient services increased by 142.7% and the rate per 100,000 youths increased by 119.2% across these years [13]. Readmission rates continued to be problematic. In FY 2003, readmission rates in state psychiatric hospitals in the United States was 5.7% for 4 to 12 year olds, 6.6% for 13 to 17 year olds, and 8.4% for 18 to 20 year olds [43]. Current theory and empirical research stresses coordinated care for children and their families across service systems in community-based settings [44, 45]. The continued increases in psychiatric admission rates, however, despite application of medically necessary criteria, suggest the continued need for high-level intensive care for children and adolescents with emotional and behavioral problems delivered in inpatient settings.

Decreasing lengths of stay

Data from the public sector indicate a median length of stay for admissions to state and county mental hospitals for those under age 18 years old as follows: 1970: 41 days; 1975:

25 days; 1980: 23 days; 1986: 43 days; and 1997: 7 days. In other words, the median length of stay in 1997 was 16–17% of what it was in 1986 and in 1970 [21, 46–48]. Data from the private sector [49–52] show a decrease in length of stay of 76% for children and 75% for adolescents from 1988 through 2002. Despite shorter lengths of stay, hospital occupancy rates have been rising, with a 34% increase for children and adolescents between 1997 and 2001.

Rising occupancy rates with shorter lengths of stay means the rate of decreasing psychiatric beds is proportionately greater than the shortening lengths of stay and/or there are more children and adolescents requiring inpatient treatment. The latter phenomenon may be due to an absolute rise in the degree of severity of emotional disturbances in children and adolescents or a progressing failure of community-based services to meet the needs of children and adolescents with serious emotional disturbances.

Shortages in staffing

The 2001 Surgeon General's Report, the American Academy of Child and Adolescent Psychiatry and the National Association of Psychiatric Health Systems have noted a severe shortage of psychiatrists and a dearth of other child-trained mental health professionals [28, 53]. A report commissioned by the California Institute for Mental Health describes significant staffing shortages, particularly among nurses and child psychiatrists [54]. The report highlights inpatient units as well as residential facilities having difficulties securing qualified staff especially for children's programs.

Child-inpatient units are the most difficult to staff, as children's units require a higher staff-to-patient ratio than adult units. Suggested factors contributing to the shortages of child-trained professionals include rising housing costs, static salaries, the implementation of managed care, and opportunities in other industries.

Increases in using emergency rooms (ERs) for psychiatric care

As the number of inpatient beds and specialized staff to care for children and adolescents with serious emotional disturbance has decreased, the number of families relying on hospital emergency rooms (ERs) for psychiatric services has increased. This may be particularly relevant because the strongest demographic correlate of a psychiatric diagnosis in children is poverty [55].

According to the New York National Alliance for the Mentally Ill, psychiatric emergencies in children have reached epidemic proportions [56]. Emergency room doctors report seeing a large number of children whose parents have run out of options for care. Psychiatrists worry that children with serious emotional disturbances aren't getting appropriate care in emergency room settings, and few hospitals have units dedicated to pediatric emergencies or wards specific to child psychiatric cases. In addition, children with serious symptoms may experience additional trauma waiting to receive services between medical emergencies while surrounded by the chaos of the ER [56]. Hospital emergency staff are rarely trained to recognize mental health issues, especially as they present in children, and have no systematic way to identify or refer children to appropriate services. Crisis services have been largely unable to assume the roles of the hospital ER because the capacity of crisis programs has been limited to small numbers of youths [32].

Shortage of children's mental health services

Services and treatment options for children and adolescents with mental health needs are limited at all points along the continuum of care. A study conducted by the Children's League of Massachusetts in 2000 documents a critical shortage of services for children with mental health concerns. Many children become stuck in psychiatric wards and mental health units as they wait for referrals to other therapeutic settings in the community. On the other hand, many children in need of specialized inpatient level of care are refused admittance to child psychiatric wards due to a shortage of beds [57].

A 2001 study by the Washington State Emergency Medical Services for Children detailed the shortcomings of that state's children's mental health system: a lack of inpatient psychiatric beds for children and adolescents; inadequate mental health services to support a community-based model of mental health care; too few outpatient mental health services; significant time delay, due to lack of resources, for child and adolescent evaluations; lack of private mental health providers; limited resources for children and adolescents with dual diagnoses of mental health and alcohol/substance abuse disorders; a shortage of mental health staff, specifically social workers and their services; hospital emergency departments with limited knowledge of mental health referrals for children and adolescents; a lack of emergency department mental and behavioral health screening tools; and a lack of clarity about emergency department's role in identification of non-acute mental and behavioral health concerns [58].

Similar systems shortcomings have been highlighted by other states as well as at the national level. The Lewin Group concluded after studying children's services that "many children are not receiving the care they need from mental health specialists" [33]. Two researchers at RAND concluded that "the majority of children who are likely to benefit from mental health services do not receive any care" [59].

State stories: Child and adolescent psychiatric services across the United States

In the twenty-first century, many states have faced the consequences of previous and/or current closures of children and adolescent psychiatric inpatient treatment facilities. The residents of many states have suffered as a result of inadequate numbers of inpatient beds. Some stories from across the United States follow.

California

While 150,000 children are served each year in the California public mental health system, this represents only 3% of California's children; estimates indicate 10% need these services. Even among Med-Cal clients, who are entitled to public services, only 5% received services in 1999–2000 [60].

Thirty-five of California's 37 counties indicated they had difficulty accessing psychiatric hospital beds in a survey conducted by the California Institute for Mental Health. Eighty-one percent of hospitals reported shortages of child beds and 81% reported shortages in adolescent beds. Despite these shortages, child admissions increased by 20% and adolescent admissions by 18% between FY 1997 and FY 2000 [60].

The California Healthcare Association, nurses, parents and children argue that the state is not providing the proper level of inpatient treatment when and where it is necessary. The situation has been labeled a "significant crisis" [61].

Connecticut

Connecticut's emergency rooms are seeing a progressive increase in children presenting for psychiatric services. At Connecticut Children's Medical Center, emergency room cases have nearly tripled since 1998. At Yale New Haven Hospital, emergency room admissions for children under age 18 have increased about 10% every year for more than a decade. Joseph Wooston, M.D., Yale New Haven Hospital's Chief of Child Psychiatry indicated, "There's been a relentless increase. It's not a trivial human and financial resource issue. It raises havoc in both the emergency room and with kids" [62].

In 2003, Connecticut Community KidCare, which was supposed to be the state's flagship mental health initiative for children, and which had already cost the state over $45 million, was floundering with a dearth of adequate services. KidCare's goal was to expand community mental health programs to divert troubled children and adolescents from overcrowded emergency rooms and psychiatric wards. But wait lists can be remarkably long. Martha Stone, Executive Director of the Center for Child's Advocacy at the University of Connecticut School of Law, compared KidsCare to "the Emperor's New Clothes." She said, "This is not about bureaucratic wait lists; it's about watching kids deteriorate while we're slowly implementing KidsCare. We're not addressing it, and kids and their families are suffering as a result" [63].

Georgia

Within the past few years Georgia has closed four child and adolescent psychiatric units and state hospitals, decreasing the number of acute care beds from 200 to 70. Georgia's current public mental health services for children have been called "so piecemeal and confusing that even in areas where they are available, it may take a broker to find them." At any given time, hundreds of the most disturbed children and adolescents wait months for beds in intensive treatment programs. Many of these individuals go to jail, which is called, "the one place in Georgia's institutions that guarantees a bed for children" [64].

Since 2002, Georgia has assessed children entering youth prisons. Since that time, of 3806 children with psychiatric disorders, 46% have been under the age of 16. The vast majority are guilty of such crimes as running away, criminal trespassing, being unruly, disorderly conduct, obstructing law enforcement officers, simple battery, and violations of probation; 44% have more than one psychiatric disorder with the predominant single psychiatric disorder being mood disorders. The federal government has estimated that 86,000 of Georgia's children suffer from a mental disorder severe enough to disrupt their lives and the major inpatient provider of public beds is the juvenile justice system [64].

Illinois

In 1993, Illinois operated two inpatient facilities for adolescents in the Chicago area. In 1994, in response to a federal class action lawsuit, Illinois merged the two hospitals. In 1997, the state closed the merged facility, relying then on the private sector to meet the inpatient needs of adolescents formerly served by the state. Outcomes have included: increased number of admissions; decreased number of hospital days; increased number of readmissions overall and within one year; inadequate discharge plans; fewer patients' rights; less oversight of abuse; and less coordination with the public system of care [65–67].

In the Rockford, Illinois area, the local mental health center sent 150 kids, age 17 years old and younger to out of town facilities in 2003. Adolescents can be treated locally in a

12-bed adolescent psychiatric unit, which closed its beds for younger patients. The Director of the local mental health center in Rockford indicated, "We have created a casualty-based system. We see kids after problems have gotten serious enough for the family and child to be in crisis." The Director of Mental Health Services at the facility now closed to younger children stated, "With many of these children, if we can successfully intervene, we may literally save them and their families and society great burdens in the future" [68].

Maine

Maine reports a 30% increase in inpatient hospitalization rates of children with mental illness and substance use disorders. The child and adolescent suicide rate in Maine is significantly higher than the national average [69]. Of the 200 juveniles in state correction institutions in Maine, 91% had contact with the community mental health system before their incarceration [70]. On any given day, 40 to 60 of Maine's youth with emotional disorders are behind bars waiting for treatment beds [71].

Massachusetts

In 1993, Massachusetts introduced a statewide Medicaid carve-out managed care plan. A study examining 16,664 Medicaid beneficiaries age one to 17 years old, with at least one claim for a psychiatric or substance use disorder treatment during the two years before and at least one claim during the two years after the introduction of the carve-out, revealed that the managed care plan: 1) served more children; 2) led to a decreased length of stay (LOS) in general hospitals but an increased LOS in the Department of Mental Health (DMH) beds, 3) resulted in increased admissions per child; 4) facilitated a deterioration of continuity of care for disabled children; and 5) did not change DMH's role as the provider of last resort or the safety net [72].

Massachusetts closed the Gaebler Unit, the only public child psychiatric inpatient facility in Massachusetts on January 31, 1992. Massachusetts replaced this hospital with scattered-site intensive residential treatment programs. In 2002, Health Care For All and the Parent/Professional Advocacy League conducted a survey of parents of children with serious emotional disturbances. Based on 301 responses, they learned the following: 1) Children had complex needs: 48% of the children first began to show signs of mental health problems by age 4; 23% had other serious health problems, including substance abuse; 2) families had trouble getting help for the first time: 76% of respondents said providers were not at all helpful or only somewhat helpful at linking them to other resources about their children's diagnoses; 48% said their child's primary healthcare provider never or rarely asks about mental health; 39% experienced a delay in treatment because they couldn't get an appointment or the services they needed were full; 33% waited more than a year before receiving treatment as often as needed; 3) there are difficulties accessing ongoing care: 60% of respondents said they worried at least some of the time that their child will hurt him/herself or others because needed services are not available; 50% said their interactions with the school system had not been satisfactory because, "School system professionals do not understand mental health issues"; 26% said their insurance often or always wouldn't cover services that their child needs; 25% said providers failure to accept their insurance often or always poses a problem in getting mental health care; 4) families had difficulty getting care in crisis: 49% of respondents said their child's main mental healthcare provider is not at all accessible or only somewhat accessible after regular office hours; 36% said their child had been sent home or to a facility far from home at least once because there were no hospital beds available;

29% said their child's last hospital stay was too short; and 18% were admitted to a general hospital or adult unit rather than a psychiatric facility for children [30].

The Massachusetts system of child psychiatric services has created a cast of labeled children. "Boarder kids" are children stuck for days, weeks, or even months in pediatric wards because there are no beds for them in a psychiatric hospital or ward. "Wait-list kids" wait months for case management or outpatient services. And "stuck kids" are in psychiatric hospitals but cannot leave because there is no place for them to go. The result is gridlock [73].

Michigan

The Wayne County Juvenile Detention Facility, in downtown Detroit, holds 196 kids up to age 17. About 56 boys and girls are in its mental health wings. Many of the children in the mental health wards aren't facing charges but are in the detention center on "courtesy holds," awaiting placement in foster care or other housing. This is where Wayne County's most dangerous adolescents and those who have fallen through the system coexist, maintaining a strict regimen of school, meals, therapy and other supervised activities. They rarely go outside, and television, mail and visits are closely monitored.

"This is not where these children need to be," said the facility's quality assurance manager. The Executive Director of the Michigan Association for Children with Emotional Disorders indicated, "Incarceration not only sends a negative message about the child's worth, it has horrible consequences. Kids with mental illness or emotional disorders in these settings are very vulnerable to physical and sexual assaults, worsening of symptoms, and the suicide numbers are four times more than the general population of teens" [74].

When the court determines it's time for a detainee to be released they're either sent to the adult prison system, to a supervised living situation or home on probation, and sometimes with a tether. But there are no reliable services in the community and recidivism is high. As one senior psychologist at the detention facility said, "If we can get them back on the right track they can be contributing members of society. But you see the kids keep coming back and it can be disheartening" [74].

Minnesota

By report from the Office of the Ombudsman for Mental Health and Mental Retardation, "Minnesota's current inpatient psychiatric bed crisis is indicative of a system beginning to fall apart and in desperate need of fundamental reform" [75]. Counties deny services to children without demonstrating reasonable or proven alternatives. There's a lack of support for families trying to help their children with serious emotional disturbances. Parents are referred to the police to go through court as the only ways to access services [76]. One Minnesota child psychiatrist noted, "We see kids who had clear symptoms of depression and anxiety that lead to them failing school and ruining relationships and feeling like a failure and if they had been seen six months ago, they wouldn't have gotten so disabled that they needed to be hospitalized. That's just almost an every-day event" [76].

The demand for emergency and inpatient psychiatric services for children and adolescents rose 68% between 1997 and 2001 [77]. The two emergency rooms at Children's Hospital and Clinics, one each in Minneapolis and St. Paul, see about six children a piece per day for behavioral and emotional problems. Demand for psychiatric beds for children in the Twin Cities has forced children and adolescents to go considerable distances for inpatient services.

Hospitals in the Minneapolis and St. Paul area are reluctant to expand mental health care for children and adolescents because insurance reimbursements don't cover their costs [78].

Missouri

St. Frances Medical Center closed its psychiatric unit in 1992, deciding it could no longer provide mental health treatment to adults or juveniles. One year later, Southeast Missouri Hospital opened an adult unit, but determined it could not afford to treat children. When children are seen in Southeast Missouri Hospital's emergency room, they can be sent as far away as Springfield or Memphis, Tennessee for inpatient treatment [79].

New Jersey

The Substance Abuse and Mental Health Services Administration estimates that in 2002, 100,000 children ages 0–17 years old in New Jersey were experiencing a serious emotional disturbance [80]. However, during that same timeframe, the National Association of State Mental Health Program Directors Research Institute reported that only 17,602 children and adolescents with a serious emotional disturbance in New Jersey received any mental health services [25].

Over the last six years, New Jersey has transformed the array and delivery of children's mental health services. In 1999, a new Commissioner of the Department of Human Services (DHS), who had previously led the Division of Child Welfare, declared the need to "fix" the problems of New Jersey's children's mental health system—not just bandage the system. The result was the 2000 launch of the DHS Children's System of Care Initiative, also known as the Partnership for Children. This Initiative proposed: restructuring the service delivery system for children with serious emotional disturbances and their families; expanding existing services; increasing funding for services; developing a system to help manage children and families with multi-system involvement; and enhancing service planning with a child and family-centered, individualized, parent-involved focus. The Partnership is a behavioral health carve out serving the entire population of children and adolescents with behavioral and emotional problems receiving services from the public sector; this population includes both Medicaid and non-Medicaid eligible children. Unique in the Partnership is the integration of multiple child-serving agencies, i.e., child welfare, mental health, Medicaid, juvenile justice, from a previously fragmented system of care. Reflecting a bonafide commitment to this endeavor, New Jersey's funding of the Partnership grew from $116 million to almost $187 million between Fiscal Years 2002 and 2004 [81].

Despite these efforts, in May 2004, the New Jersey Office of the Child Advocate (OCA) released the report, *Arthur Brisbane Child Treatment Center* (*ABCTC*) *Investigation: An Examination of Conditions of Care and Recommendations for Reform*. The report concluded that ABCTC, New Jersey's only state-run inpatient facility for children and adolescents, failed to meet the baseline standards set by a court-appointed expert [82]. The report found that ABCTC had failed to provide high quality and cost effective mental health services to children [83].

In September 2004, the Child Behavioral Health Advisory Committee provided recommendations to the Division of Child Behavioral Health Services (DCBHS) for replacing services provided by ABCTC [84]. The Committee worked in consideration of the main goal of the DCBHS, "to provide children and families quick access to a broad array of services and resources, to provide choice in service selection, and to engage families to participate

in the development of their child's service plan to meet the unique needs of each child and family."

The overarching recommendation of the Committee was to create Regional Consortia to provide multiple levels of care to children requiring high intensity and/or long-term psychiatric treatment. Regional Consortia would include: three levels of hospital care (local acute inpatient units, regional intermediate units, and specialty care units); step down out-of-home treatment settings; high level clinical teams; specialized family support services; and contractual agreements between components of the Consortia and an administrative body to ensure an adequate capacity to serve these children.

The premise upon which many of the Committee's recommendations are based have been questioned by other groups of New Jersey mental health experts. *Mental Health Needs and Services in New Jersey* was prepared in May 2004 by the New Jersey Psychiatric Association [85]. This report identified, ". . . crises in funding; shortages of trained professionals; lack of adequate residential, substance abuse, children's and support services; as well as discontinuity of care as matters of great concern." The report also addressed the large number of children requiring long-term residential placements being served out-of-state, as well as what was described as "the chronic severe shortage of child psychiatrists" which leads to cutting, rather than expanding, children's mental health services.

On March 31, 2005, the Governor's Task Force on Mental Health issued its Final Report, *New Jersey's Long and Winding Road to Treatment, Wellness and Recovery* [86]. The Governor's Task Force mentions the closing of ABCTC in one brief sentence, ". . . ABCTC is mandated to close in December 2005." Nowhere in this report is it detailed what should or will happen to the children currently being served by ABCTC or the children who will require the services offered by ABCTC once this facility is closed. The Task Force's report documented that due to the complexities and wide scope of New Jersey's children's mental health services, there were a number of important issues that were not addressed in the Governor's Final Report. The majority of these important issues and specialty populations are of direct relevance to the children currently at ABCTC as well as the children who will need ABCTC-type services on January 1, 2006. Important issues and populations not addressed include: developmentally disabled children; child victims of sexual abuse; teenage parents; juvenile sex offenders; truant youth; gang involved youth; youth ages 18–21 with untreated PTSD; and the statewide shortage of Board Certified child psychiatrists.

New Jersey is going to close its only public inpatient psychiatric facility for children and adolescents with no plan for alternative services, at a time when the state's efforts to fulfill its obligations to its children with serious emotional disturbances is already severely criticized. The *Star-Ledger* has reported: November 23, 2004: "the state's juvenile justice system is illegally holding hundreds of mentally ill children in overcrowded conditions with so little care that suicidal behavior has become commonplace" [87]; November 24, 2004: "while hundreds of mentally ill juvenile offenders languish in New Jersey's crowded detention center, those who eventually find treatment are often sent to residential facilities in other states" [88]; and December 9, 2004: "on any given day, 200 New Jersey children with mental health problems are lodged in county juvenile detention centers because the state has no other place to put them" [89].

New York State

In mid-June 2004, Dr. Sharon Campanello, Commissioner of New York State Office of Mental Hygiene, suggested that despite the closing of child psychiatric beds at the Four Winds facility, access in that area of New York State would not be a problem [90]. Four

Winds, a private psychiatric hospital in Syracuse, with 64 beds for children and adolescents, closed its doors after state inspectors found serious deficiencies. The Executive Director of the Hospital Executive Council in Syracuse took exception with the Commissioner's assessment. He felt the significant reduction in pediatric psychiatric beds was in fact a problem. Since the closing of Four Winds, children are staying in the psychiatric emergency room for up to three days rather than for the designated maximum stay of a few hours [91]. The Comprehensive Psychiatric Emergency Program has had to place children outside of the local county, due to the lack of locally available services.

KidsPeace Inc. has opened a 220-bed residential treatment facility in the same area. Their Executive Director was concerned, indicating, "Without that stabilization in a hospital, we may be faced with taking in kids who are much less stable and are not going to be as successful in treatment." He bemoaned the closing of the hospital. While some children and adolescents need to travel far for inpatient services, others are having great difficulty obtaining care at all [92].

Central New York State is not the only part of the state with concerns about the adequacy of child psychiatric inpatient beds. In February 2003, New York State Governor Pataki proposed closing Bronx Psychiatric Center and Bronx Children's Psychiatric Center effective October 2005. Parents lined up against the closure and had very positive comments to make about the public children's facility. One mother of an 11-year-old indicated, "It seems like he was sent to the Center by God. Their skills are making him a better person. If I have to stand here when they tear it down, I will be here. That's how much I care about this place" [93]. Others were equally negative about the closure. Reverend Richard Gorman, a Catholic Priest and chairman of one of the neighborhood community boards said, "Besides being cruel, besides being immoral, closing these two hospitals is just plain stupid" [94]. Assemblyman Peter Riviera, from the Bronx, indicated, "The human capital and costs of the proposal have not adequately been taken into account. The spin by those supporting these closures is inadequate, trivializes the need and importance of each facility and strengthens the wrong priorities" [95].

Ohio

At one time the state operated three children's psychiatric hospitals and there were adolescent units at Harding, Ohio State University (OSU) and Riverside. Now only OSU is left [96]. Ohio has so few beds for mentally ill children that they are often sent hundreds of miles from home and even to other states for treatment. Some families have given up their children to child welfare agencies and juvenile court because that's the only way they can get help [96].

Child welfare agencies in Ohio have 442 children (6% of the 7102 in residential treatment) out-of-state because there are no appropriate in-state services, or because treatment centers won't take them due to their severe behavior problems. This number of children out-of-state doesn't include children sent out-of-state or even out of the country by their parents. The Executive Director of NAMI of Ohio observed, "The child welfare and juvenile justice systems have replaced the psychiatric institutions" [96]. Mike Hogan, Director of the State Department of Mental Health and the former head of the President's New Freedom Commission on Mental Health noted, "The irony is that it's more expensive to ignore mental illness than to treat it" [96].

With little money and hence short stays in existing hospitals, hospitals are doing little more than stabilizing children and setting them up for relapses once they're out the door. And the availability of private hospitals is lessening, through cutback in services or closures. This leaves the remaining facilities functioning well beyond their capacity. In Cincinnati,

for example, Children's Hospital Medical Center admits up to 20 patients a day who otherwise would be admitted to the hospital's psychiatric unit to regular medical/surgical rooms [97].

Without their own state-run facilities, children's service agencies are at the mercy of private treatment centers that can charge as much as $500/day and can pick and choose youths they will and will not admit. Hence, many children are sent out of county and out-of-state. One county paid more than $4 million for 928 youngsters to receive mental health and addiction treatment out of county last year [96].

Oregon

The Oregon Health Plan (OHP) provides services to Medicaid-eligible individuals under a federal waiver, managed care plan. Among services for children excluded from this fully capitated plan are extended inpatient care at Oregon State Hospital, therapeutic foster care, therapeutic group homes, residential treatment centers and psychiatric day treatment; these are all funded by the state. Parent focus groups reported that the OHP fails to provide adequate diagnostic assessments, in-home services, day treatment, case management, psychosocial rehabilitation for adolescents, and crisis intervention. Delays in obtaining services were as long as 15 *years*. Services were better obtained after multiple inpatient hospitalizations, juvenile justice incarceration, or child welfare custody. Agencies appeared to be more actively involvement in cross-agency cost shifting, than in providing services [98].

Pennsylvania

Pennsylvania has closed its adolescent units in state mental hospitals, eliminating dozens of beds that had been available for such youths. They were replaced by privately-run community mental health programs. These private facilities are reluctant to accept youths with histories of aggressive behavior, running away, setting fires, or sexual offenses, in part because regulations do not allow these facilities to be locked. From 1998 and 2000, Pennsylvania's annual expenditures for secure out-of-state residential treatment facilities increased more than fourfold from $3,434,530 to $15,034,087. Philadelphia, for example, has had nearly 200 juveniles at one time in facilities in Virginia, Texas, Georgia, Florida, Kansas and Colorado, all because appropriate in-state facilities were not available.

Other children end up at detention centers. Teens arrive at detention centers on short notice, with incomplete medical histories. And even though children get a physical examination that includes a mental health screening, it may be days (or never) before the detention staff adequately assesses a particular youth. Even then, the centers aren't appropriately equipped to provide psychiatric treatment. It's all they can do to keep these children safe until they move on to another place.

Michael had barely turned 16 when he landed in Shuman Juvenile Detention Center last spring. He was there because of his "assault" in a local community residential treatment program. Due to this behavioral episode, treatment program after treatment program turned him down, seven in all. He finally ended up in a psychiatric hospital in Florida, billed daily to Allegheny County, Pennsylvania [99].

A teenager in Pennsylvania's only maximum security for adolescent girls, in Danville, Montour County, spent much of her days at her desk with a blanket over her head. She was convinced germs were falling on her from the ceiling. Her original offense was truancy. She

landed in the Danville center after treatment failures in three residential placements, resulting in multiple assault charges [99].

At the Allentown Secure Treatment Unit in Lehigh County, there's an 18-year-old youth diagnosed as having schizophrenic disorder with delusional ideation. His original offense: Trespassing. Allentown is the state's facility of last resort for adjudicated boys with severe mental or emotional problems. It sits on the grounds of the Allentown State Hospital—which once had an adolescent unit—but is clearly a "prison" surrounded by its high fence, topped with loops of razor wire. Since it is not a hospital, the young man did not take ordered medications for his entire 13-month stay; under Pennsylvania law, anyone 14 years old or older can refuse medication unless committed to a psychiatric hospital. Allentown's director said the youths he sees now are a tougher population—more violent, more seriously ill—and younger. Typically, the teens filling Allentown's 16 beds are 15 to 18 years old. This past year, they got their first pre-teen, a 12-year-old with clinical depression who had tried to burn down a bank using lighter fluid.

A dozen years ago, Kevin, a 9-year-old boy, was a patient on the children's and adolescent unit at Mayview State Hospital. In the seventh grade, when Kevin next needed the facility, it was closed as the state decided it no longer needed these beds. Kevin spent the next five years in and out of the Shuman Juvenile Detention Center. Now 19 years old, and struggling, Kevin says, "Shuman never knew what to do with me."

Before moving on to become the Director of SAMHSA, Charles Curie, then deputy secretary in the state Department of Public Welfare's Office of Mental Health and Substance Abuse Services, said, "Our plan over the past several years has been to decrease our role as a direct provider of care and increase our role as a purchaser of care." But Curie acknowledged that private providers can and do reject applicants they deem undesirable [99–101].

South Carolina

South Carolina is in the process of closing the William S. Hall Institute (WSHI) and moving most of its residents to a state hospital, built in 1913, that the state had closed a decade ago to save costs. About 70 of the children at WSHI, considered the most severely mentally ill children in the state, would move to the now closed Crafts-Farrow State Hospital. Severely mentally ill children under age 12 years old now at WSHI would go to a state-operated managed care facility yet to be determined. Sixteen dually diagnosed children who are in substance abuse treatment but also have serious mental illness would go to a different state facility yet to be determined, and a dozen girls in residential treatment at the hospital who are in the custody of the Department of Juvenile Justice would go to some private facility. The state was unable to privatize all the treatment because the services aren't available on the open market in South Carolina [102].

Tennessee

An examination of TennCare's (Tennessee's Medicaid managed care program) impact on services to children and adolescents between 1995 and 2000 suggested there were: 1) more individuals served, but with fewer services per child; 2) a shift from treatment to support services; 3) an increase in the number of youth treated in inpatient facilities; and 4) lower average lengths of stay but increased rates of readmission within 30 days of discharge. The study concluded that community treatment was not a substitute for inpatient care in the treatment of children with emotional and behavioral problems [103].

Virginia

In Virginia, problems in obtaining or paying for mental health services are causing thousands of parents to give up custody in order to obtain treatment for their children. Almost one in four children in Virginia's foster care system is there to receive treatment for serious emotional disturbances [104]. Others end up in the juvenile justice system. The percentage of the 1200–1300 youths served per year in Virginia's juvenile correction centers needing psychiatric services increased from 33.6% in 1993 to 61.7% in 2000. In the Fairfax County 121-bed juvenile detention center, 65% of juveniles need mental health services. In the Norfolk and in the Rappahannock juvenile detention homes, 82% of youths reported using alcohol and drugs while 50% met criteria for needing substance abuse treatment [105].

Virginia decreased its public sector child and adolescent beds from 200 to 64 during the 1990's. Is it back pedaling now [6]? The Commonwealth of Virginia is converting a state hospital building on the campus of Southwest Virginia Mental Health Institute into residential treatment of 48 beds for boys ages 12–18 years old with serious emotional and behavioral problems. The state is doing so because, as one local official said, "We can't get treatment here in southwest Virginia." Instead, 21 localities throughout the western part of the state are sending children all over the Commonwealth, some as far as the Atlantic coast, a day's journey by car [106].

Washington, D.C.

A coalition of professionals, parents and non-profit organizations, in a report titled *Children Deserve Our Best*, said that the DC Department of Mental Health (DMH) has not adequately focused on children and adolescents with emotional and behavioral disorders. Estimates indicate the number of children who need mental health services are between 8700–9300, but no more than 2500 currently receive services. The coalition is sharply critical of DMH's decision, in late 2001, to close the children's wing at St. Elizabeth's Hospital, a public psychiatric institution. This left three private facilities, the largest of which was reported by the *Washington Post* in July 2003 to have numerous safety problems and evidence of physical and sexual abuse. Milton S. Glatt, a Professor of Pediatrics and Child Psychiatry at George Washington University Medical Center, compared treating emotionally disturbed children in the District to practicing in a third world country [107].

Discussion

It appears, based on the current state of mental health services for children and adolescents with serious emotional disturbances, that decisions to downsize or close public psychiatric hospitals for this population were ill-informed at best. The expectation that the range of interventions offered by inpatient facilities would be effectively replaced by community-based services has not been fulfilled. Rather, much like the adult population [108], children, and adolescents in particular, seem to be the victims of dehospitalization and transinstitutionalization rather than the beneficiaries of deinstitutionalization.

At the outset of the twenty-first century, do the data indicate an amelioration of the current inadequacy of psychiatric services for children and adolescents? Will emerging developments in social services, advances in psychopharmacology, criminal justice reform, and overhaul of the education system reach those children and adolescents with serious emotional disturbances? Are the organizations and financing of public mental health services

at federal and state levels likely to improve access and effectiveness of needed care and treatment? Have alternatives to inpatient treatment, such as systems of care and wraparound services, been proven to meet the full continuum of interventions such that inpatient level of care can be discarded as an anachronism? Or alternatively, do states, perhaps with federal support, need to redirect themselves to the resurrection of a public inpatient capacity for children and adolescents?

Editor's Note: Part II of this paper will appear in the next issue of this journal.

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