Part V: Current Federal Efforts

Chapter 10

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INTRODUCTION

The complexity of children's mental health problems, the diversity of mental health treatments, and the effectiveness, in general, of treatment have been documented in previous chapters. Despite an incomplete knowledge of the causes of mental health problems in children, it is clear that much can be done to reduce the effects of such problems. Yet substantial data suggest that many children with mental disorders, and at risk of developing such problems, do not have access to adequate treatment services (216,358).

This chapter examines the Federal *role* in providing mental health services to children. Where possible, it considers that role in the context of the entire mental health system—State, local, and private. The chapter describes specific Federal programs with the greatest relevance to children's mental health services. Such programs relate to financing of children's mental health treatment; coordination of mental health and other services; research and training; and prevention and other services. The chapter concludes that although the roles of State and local governments and the private sector in serving the mental health needs of children could be usefully enhanced, greater Federal involvement may also be desirable.

FEDERAL PROGRAMS THAT SUPPORT MENTAL HEALTH AND RELATED SERVICES FOR CHILDREN

Several Federal programs affect the provision of mental health services to children. The discussion in this chapter emphasizes the programs that have the most direct influence:

- the Alcohol, Drug Abuse, and Mental Health (ADM) block grant program, which provides funds to States for community mental health centers (CMHCs);
- third-party payment programs such as Medicaid, Medicare, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which are involved, to a greater or lesser degree, in financing children's mental health care;
- related psychological services under the Education for All Handicapped Children Act (Public Law 94-142);
- the Child and Adolescent Service System Program (CASSP) of the National Institute of Mental Health (NIMH), which is intended to coordinate mental health and other services for severely mentally disturbed children; and
- NIMH training, research, and prevention programs.

Federal contributions to these programs in 1985 and, where they can be determined, estimated amounts devoted to children's mental health services in 1985 are shown in table **8.** Because funds for children's mental health are commingled with resources for adults and for alcohol, drug abuse, and other health-related programs, the precise amount of Federal resources dedicated to children's mental health is not reliably known. The estimates given, therefore, should be viewed cautiously.

Financing of Mental Health Treatment

When considering the role of the Federal Government in the financing of children's mental health treatment, it is important to note that mental health treatment (for all ages combined) is financed primarily by State Mental Health Agencies (SMHAs). In general, Federal and private sources currently bear less of a burden, although

Table 8.—Federal Contributions to Programs Contributing to Mental Health Services for Children, 1985 (dollars in millions)

Federal program[a]	Total Federal contribution to mental health and other health services	Mental health portion, adults and children	Children's mental health portion	
			Amount	Percent of total mental health portion
Mental health services programs:				
Alcohol, Drug Abuse, and Mental Health (ADM) block grant (1981)	*$ 490*	$200b	NA[c]	NA
10-percent set-aside for new mental health programs for children or other undersexed populations (1985)	—	—	**$ 10.6 to $20.0**[d]	NA
Total	*490*	200	**NA**	NA
NIMH Office of State and Community Liaison	*13*	13	**4.7**	360/o
Child and Adolescent Service System Program (CASSP) (1984)			*4.7*	36
Total	13	13	*4.7*	36
Third-party payment programs:				
Medicare (1966)[e]	69,707	NA	NA	NA
Medicaid (1986)	22,854[f]	NA	NA	NA
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (1986)	***1,382.7***	**261.0**	156.6	***60***
NIMH training, research, and prevention programs[g] (1947[h])				
Training	**31.6**	**31.6**	***4.8***	**15**
Research:				
Intramural	*57.4*	*57.4*	5.5	10
Extramural	*98.2*	*98.2*	21.7	*22*
Biometry and epidemiology	11.5	11.5	2.4	*21*
Prevention and special mental health	24.1	*24.1*	10.3	*43*
Communication and education	2.0	2.0	0.2	10
Total NIMH training, research, and prevention	224.8	224.8	44.9	20

[a] Figures in parentheses indicate fiscal year of program's initiation.
[b] Estimate; States have latitude to transfer limited amounts of funds across program lines.
[c] NA = Not available
[d] A General Accounting Office survey of 13 States found that States planned to use from none to all of set-aside funds for children's Services See teXt and table 9
[e] Th, Medicare program for enhancing health care to the aged was enacted July 30, 1965, as Title XVIII of the Social Security Act, and expanded to cover the disabled beginning in July 1973, as legislated by the 1972 amendments to the Social Security Act (Public Law 92-803)
[f] In fiscal year 1985, States paid another $18,382 million in Medicaid.
[g] NIMH does not ordinarily aggregate expenditure data by age group; the figures presented here are rough estimates In addition, NIMH was reorganized in 1985 Program names presented here have changed.
[h] NIMH was created under th, Public Health Service Act of 1944 (42 U.S.C. 29o AA-3) and began functioning in late 1947

SOURCES: ADM block grant: R.L. Fogel, "Early Observations on States' Plans To Provide Children's Mental Health Services Under the ADAMH Block Grant (GAO/HRD-85-84)," letter to Senator Inouye from Human Resources Division, General Accounting Office, US. Congress, Washington, DC, July 10, 1985. NIMH: U.S. Department of Health and Human Services, Public Health Service, National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration, *Twelfth Annual Report on the Child and Youth Activities of the National Institute of Mental Health, Federal Fiscal Year 1985,* presented to the National Advisory Mental Health Council by M.E. Fishman (Rockville, MD: March 10, 1986). Medicare: M. Gornick, J.N. Greenberg, P. Eggers, and A. Dobson, "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," *Health Care Financing Review (1985* Annual Supplement) (Baltimore, MD: U.S. Department of Health and Human Services, Public Health Service, Health Care Financing Administration, December 1985) and Health Care Financing Administration, unpublished data. Medicaid: U.S. Department of Health and Human Services, Health Care Financing Administration, Bureau of Program Operations, Grants Branch, Division of State Agency Financial Management, unpublished data pertaining to fiscal year 1985 Medicaid program expenditure information, BPO-F31, Baltimore, MD, September 1986. CHAMPUS: K. Zimmerman, Statistics Branch, Information Systems Division, Office of CHAMPUS, personal communication, Sept. 5, 1986

comparing the treatment costs that each of these sources pays is difficult. In the case of Medicaid, for example, the only mental health expenditure known is that of mental hospitals. Private third-party payers prefer not to disclose what they pay for mental health services, and the amount actually spent by clients themselves is not known.

The proportion of costs specifically for children's mental health treatment is even more difficult to determine. It cannot be derived from the proportion of services rendered to children for a number of reasons, perhaps the most important being that mental health treatment for children is typically more complex and thus more expensive than treatment for adults (see, e.g., 457).

In 1980, an estimated $21 billion was spent by all sources on mental health treatment for all age groups (277a). About half—$10 billion—of this amount was spent for services rendered in the mental health system (277a). (Most of the other expenditures were for treatment rendered in the general health care system.) In 1983, the year closest to 1980 for which data are available, SMHAs reported to the National Association of State

Mental Health Program Directors (NASMHPD) that they spent a total of $6.8 billion on mental health treatment for all age groups (459). This figure allows *a* rough estimate that more than two-thirds of expenditures for treatment in the mental health system are expenditures made by SMHAS (see figure 4). In turn, most of the revenues to support SMHAs are provided by the States: *76* percent of SMHA revenues in 1983 came from the States, 16 percent from the Federal Government, 3 percent from local governments, and 5 percent from other sources (459).

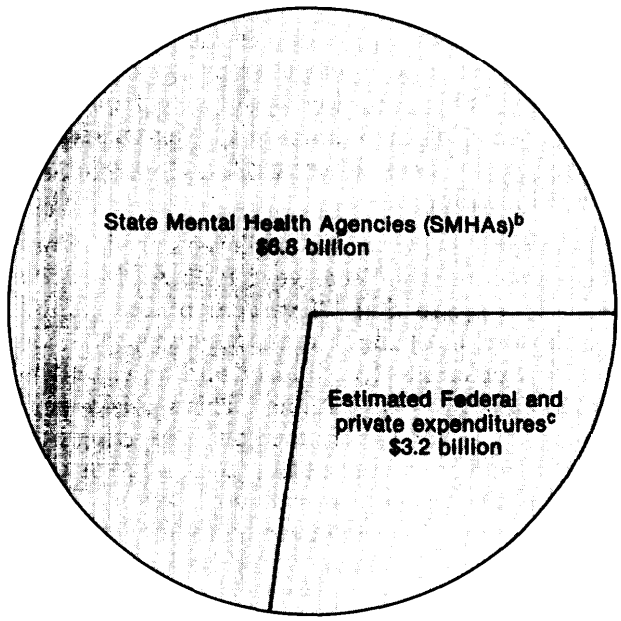
The NASMHPD study also indicated that SMHAs which were able to determine how much they spent on mental health programs exclusively for children spent an average of 7 percent or about $9 per capita on such programs *(459).* For adult programs, SMHAs spent an average of 45 percent of their funds, or $22 per capita. These percentages must be viewed with caution, however, because many of the States surveyed could not determine the allocation of mental health funds by age. Further, in all of the States, a substantial portion of mental health funds was spent on programs for all ages combined (e.g., on State mental hospitals).

Alcohol, Drug Abuse, and Mental Health Block Grant

The ADM block grant was initiated in 1981 (Public Law 97-35) as the successor to a variety of categorical programs—most significantly programs under the Community Mental Health Centers Act of 1963 (Public Law 88-164). It is currently the only major Federal program that provides funds to States to support CMHCs and related community mental health services. ADM block grant funds cannot be used for inpatient care.

As shown in table **8,** Congress appropriated a total of **$490** million for the fiscal year 1985 ADM block grant (considerably less than the $625 million available for categorical programs in fiscal **year 1980** (643b)). States receive a share of the ADM total block grant appropriation through a formula based on population and the level of Federal funds received prior to 1981. Because the formula combines population and prior Federal funding levels, there is no direct relationship between the size of the State's population to be served and

Figure 4.-Estimated Proportions of State v. Federal and Private Expenditures for Mental Health Treatment Provided in the Mental Health System to All Age Groups,[a] 1983



Estimated total: $10 billion

[a] Excludes treatment provided in other service systems (e.g., general health care system).

[b] *Sources* of *revenue for SMHAs:*

States	76%
Federal Government (e.g., Medicaid [$600 million], Alcohol, Drug Abuse, and Mental Health (ADM) block grant [$200 million])	160/0
Local governments	30/.
Other sources	50/.

[c] Federal Government share excludes SMHAS (See note b)

SOURCES: Estimated total: H. Harwood, D Napolitano, P Kristiansen, et al , *Economic Costs* to Society *of Alcohol and Drug Abuse arrd Mental Illness: 1980* (Research Triangle Park, NC: Research Triangle Institute, June 1984); **SMHAs:** National Association of State Mental Health Program Directors, *Funding Sources and Expenditures for State Mental Health Agencies: Fiscal Year 1983* (Washington, DC 1985).

the block grant allocation. Rather the block grant formula tends to "reward" States that relied on Federal funds prior to 1981 and "punish" States that relied to a greater extent on State funds.

For several reasons, it is difficult to determine what portion of ADM block grant funds serves children. First, the ADM block grant is segmented, with separate funding for alcohol, drug abuse, and mental health programs, and the percentage of block grant funds allowed to be used specifically for mental health services differs among States. Second, it is not known to what extent any of the three categories of ADM block grant programs

has services designed specifically for children. Third, CMHCs, which receive the bulk of the mental health funds, must provide specialized outpatient services for children, but there is no requirement that they provide a certain level of service or report how much is spent on children's treatment. This situation is different from that under Part F of the Community Mental Health Centers Act of 1963, when specific funds were targeted for children.

In order to better address children's needs, Congress amended the fiscal year 1985 ADM block grant to require that 10 percent of the mental health portion of block grant funds be set aside for "new programs for children and other underserved areas and populations. " This set-aside represents a partial return to the Part F targeting policy and reflects a recognition by Congress that children are an underserved population. There was some question, however, as to how effective this l0-percent set-aside would be in increasing the availability of mental health treatment services for children.

To assess the impact of the set-aside, the General Accounting Office (GAO) was requested (by Senator Daniel K. Inouye) to study how States were spending 1985 set-aside funds. Of particular concern was whether set-aside funds were being directed to programs for children and whether these programs were actually "new" programs.

To learn how States were spending 1985 set-aside funds, GAO conducted a telephone survey (during April/May 1985) of 13 States representing each of the Federal regions and approximately 50 percent of the Nation's population (see table 9). Three of the 13 States, Iowa, Mississippi, and Texas, planned to spend all of the 10-percent set-aside moneys on new programs for children. Four of the States, Kentucky, Massachusetts, Michigan, and Washington, had decided not to spend any of the set-aside money on new programs for children. New York had decided that less than one-quarter of its total planned set-aside funds ($203,000 of $1,153,000) would be directed toward new programs for children. Pennsylvania had made a similar decision and allocated approximately 20 percent of its set-aside ($230,000 of $1,325,000) for children's programs. The programs for children to be supported were diverse and included enhancing nonhospital residential care, case management, adolescent problem and suicide prevention, and family support (see table *10).*

Table 9.—Fiscal Year 1985 Estimated Allocation of the IO-Percent Set-Aside of the Alcohol, Drug Abuse, and Mental Health (ADM) Block Grant for Selected States (in thousands)' [b]

State	Total ADM award for fiscal year 1985	Mental health portion of total ADM award amount/percent	Total planned set-aside funds as of May 1985[c]	Set-aside funds allocated for: Children	Undersexed areas or populations	Target groups undetermined as of May 1985
California	$48,406	$15,778 (33°/0)	$2,328			$2,328
Colorado	7,004	3,400 (49%)	340	$l44	$l96	0
Florida	24,033	12,855 (53°/0)	1,358	337	1,021	0
Iowa	2,936	203 (7°/0)	20	20	0	0
Kentucky	4,551	1,850 (41 °/0)	669	0	669	0
Massachusetts	18,240	10,106 (55°/0)	1,011	0	1,011	0
Michigan	15,948	4,708 (30°/0)	471	0	471	0
Mississippi	5,165	3,606 (70°/0)	361	361	0	0
New York	40,097	9,700 (240/o)	1,153	203	950	0
Pennsylvania	25,114	13,250 (53°/0)	1,326	230	1,096	0
Texas	21,446	8,457 (39°/0)	846	846	0	0
Vermont	3,313	2,200 (66%)	220			220
Washington	8,977	4,727 (53°/0)	526	*o*	526	0
Total (13 States)	$225,230	$90,840	$10,629	$2,141	$5,940	$2,548

[a] As of Mav 1985.
[b] Set-aside funds are t. b. used for ne. Programs only; therefore, amounts in this table do not represent States' entire expenditures on either children Or other underserved areas or populations.
[c] Some States set aside more than the required 10 percent of the mental health portion of block grant funds.

SOURCE: R.L. Fogel, "Early Observations on States' Plans To Provide Children's Mental Health Services Under the ADAMH Block Grant (GAO/H RD-85-84)," letter to Senator Inouye from Human Resources Division, General Accounting Office, US. Congress, Washington, DC, July 10, 1985.

Table IO.— Planned[a] Use in Selected States of Fiscal Year 1985 Set-Aside Funds for Mental Health Services for Children[b]

State[c]	Services for children
California	Not decided[d]
Colorado	Residential care
Florida	Psychiatric services, summer school session for the handicapped, outpatient, emergency, diagnostic assessment, consultation, case management, crisis intervention, adolescent problem prevention
Iowa	Group home services, adolescent problem prevention, family support
Kentucky	None (funds will be used for other underserved areas or populations)
Massachusetts	None (funds will be used for other underserved areas or populations)
Michigan	None (funds will be used for other underserved areas or populations)
Mississippi	Undetermined[e]
New York	Family support, adolescent suicide prevention, referral
Pennsylvania	Residential care
Texas	Services for students with drug or alcohol problems, weapons violations, etc., services for minority inhalant abusers
Vermont	Not decided[d]
Washington	None (funds will be used for other underserved areas or populations)

[a]As of May 1985.
[b]Block grant set-aside funds were also permitted to be used for underserved populations other than children In addition, some undersexed populations that the States reported were to be served (e g., the homeless chronically mentally Ill) were not targeted by age Some of these programs may address the mental health needs of children.
[c]A sample of 13 States, representing the receipt of about half the Alcohol, Drug Abuse, and Mental Health block grant funds, were surveyed by the General Accounting Office
[d], Not decided'' indicates that the State had not decided whether set-aside funds were to be used for children or for other underserved areas or populations.
[e]'' undetermined" indicates that the State had decided to uSe set-aside funds for children and adolescents, but had not decided which services the funds were to be used for

SOURCE R L Fogel, "Early Observations on States' Plans To Provide Children's Mental Health Services Under the ADAMH Block Grant (GAO/H RD. 85-84)," letter to Senator Inouye from Human Resources Division, General Accounting Off Ice, U S Congress, Washington, DC, July 10, 1985

It is important to emphasize that the entire ADM block grant is small in comparison to State funds and that the 10-percent set-aside for children and other underserved populations is taken only from the mental health portion of the ADM block grant. The entire 10-percent set-aside may be less than **$20** million nationwide—and only a portion of this would be directed to new programs for children. Because there were no new funds, the set-aside requirements might mean that funds for new programs for children will have to be taken from other existing programs, unless States make up the funds for other programs. Some States noted that the requirement that the programs for children or other underserved populations be "new" did not allow for additional funds to be allocated to already existing programs that appeared to be effective. In response to these problems, Congress amended the 10 percent set-aside in fiscal year **1986** to read that 10-percent of mental health block grant funds could be used for "new or expanded" programs for underserved populations, with a "special emphasis" on children or adolescents (Public Law 99-117).

Perhaps the most important impact of the set-aside is symbolic. As States are required to report the amounts of ADM block grant money spent on new programs for children, more attention may be brought to children's mental health problems. Also, because funds from the ADM block grant cannot be spent on inpatient services, the program provides an incentive for States to develop locally based outpatient treatment programs. To the extent that resources for outpatient programs are available, early diagnosis and treatment for children with mental health problems may be more likely.

Federal Third-Party Payment Programs

The Federal Government plays a major and trend-setting role in financing health care services. It is the largest single insurer of health care services (Medicare and partial funding of Medicaid) and has also played a leadership role in the development of health care payment systems. The extent to which certain services and providers receive reimbursement while others do not has a direct effect on the delivery of care (206). Traditionally, coverage for mental health services has been less extensive than coverage for other medical services (e.g., see 20,175a). Mental health coverage is also limited by requirements for the presence of a diagnosable disorder (see ch. 3) as a condition for reimbursement.

Three key parts of the Federal health care financing system are Medicaid, Medicare, and CHAMPUS. In 1985, Medicaid served 11 million (296,297) dependent children under the age of 21, but the amount of mental health benefits provided to these children is believed to be minimal. Medicare provides no significant funding for children's

mental health care, but Medicaid and other third-party payers that do fund such care are often influenced by Medicare's payment policies. CHAMPUS is the largest single health insurance program in the country, providing coverage for health services to military dependents and retirees who are unable to receive services through uniformed service medical treatment facilities. CHAMPUS spends *60* percent of its mental health expenditures on treatment for children.

Medicaid .—Medicaid represents 55 percent of all public health funds spent on children (645) and has the potential to meet the needs of children who are possibly at the greatest risk for developing mental disorders, those who are in poverty and those who are uninsured.

In general, Medicaid provides health insurance to low-income families who meet certain categorical and financial criteria. These criteria, and many of the services provided, are generally set by the States, which provide a very significant portion of the Medicaid funding. Medicaid serves approximately 11 million children. Most important for purposes of this background paper is that while beneficiaries may not be discriminated against on the basis of diagnosis, States are free to set limitations on Medicaid coverage for mental health services **(636).** The percentage of Medicaid funds devoted to mental health care is not known. GAO is conducting a national survey of the mental health services available under Medicaid.

Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides funds to screen, diagnose, and treat children under 21 who are members of families designated as "categorically needy, " and so is a potentially important Federal initiative (434). The developmental assessment that is required as part of EPSDT screening can reveal emotional difficulties and problems in behavior development. However, because of changes in eligibility, children may not be followed long enough for a developmental assessment to be adequate; in addition, few States deliver any substantial amount of mental health care through this program *(358,595).*

Efforts in the late 1970s to upgrade EPSDT into a Child Health Assurance Program (CHAP), and thus to specifically require mental health assessment and treatment for Medicaid-eligible children, were not successful (595).An expansion of Medicaid eligibilit, passed in **1984** (Public Law 98-369) is potentially important for preventing, detecting, and treating mental health problems because it makes additional women and children eligible for medical services. Although this expansion of eligibility is sometimes referred to as a "modified CHAP, " it did not specifically require mental health assessment and treatment for children.

In addition to the expansion of eligibility, another potentially important change in the Medicaid program was incorporated in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (Public Law 99-272), which was signed into law on April 7, 1986. Under the provisions of COBRA, States will be allowed to cover case management services, which were defined as those services that assist individuals eligible under Medicaid to gain access to needed medical, social, educational, and other services.

It appears that Medicaid may ensure that at least some poor people obtain mental health care who would not otherwise do so. An analysis by Taube and Rupp (632a) found that poor and near-poor Medicaid recipients were more likely than nonrecipients to get mental health treatment. As noted above, States have different Medicaid eligibility requirements, so Taube and Rupp were able to compare persons who were of similar socioeconomic status. Taube and Rupp attribute the greater use of mental health benefits by Medicaid recipients to the fact that Medicaid does not allow cost-sharing (i.e., recipients are not required to pay any of the costs of health services). Taube and Rupp's finding, as well as their interpretation, is consistent with other studies which show that the use of mental health care is responsive to the cost of such care, although cost is not the only factor which deter-mines whether people seek mental health care **(206).**

Medicare .—The Medicare program covers the cost of hospitalization, medical care, and related services for most persons over age *65,* persons receiving social security disability insurance payments for 2 years, and persons with end-stage renal disease. Although only a small proportion of Medicare program funds are directly devoted to

children (children who are disabled and dependents of deceased, retired, or disabled social security beneficiaries), Medicare influences health care reimbursement nationwide. Not only have a number of States adopted Medicare rules for payment of Medicaid and other insurance benefits, but non-Federal health insurance providers closely watch Medicare.

The Social Security Amendments of 1983 (Public Law 98-21) mandated that Medicare adopt a prospective payment system' for hospitals (648, 649). Children's hospitals and psychiatric hospitals, along with rehabilitation and long-term care hospitals, have been temporarily exempted from the new payment system; however, the system does apply to psychiatric services provided in nonspecialized units in general hospitals.

Medicare's prospective payment system is based on fixed per-case payment rates for patients in **467** diagnosis-related groups (DRGs), DRGs area patient classification system developed at Yale for purposes of research on health care delivery. There are nine DRGs for "mental diseases" and six for substance abuse (see table 11).

DRG 431, "childhood mental disorders," includes diagnoses of childhood-onset mental disorders (see ch. 3). Because many childhood diagnoses can also be applied to adults (e. g., a problem such as attention deficit disorder, which has its onset in childhood), DRG 431 does not apply only to children. Furthermore, DRG 431 is not the only DRG applied to children with mental disorders. Children with mental disorders that can also receive an adult diagnosis (e. g., adolescents with drug or alcohol abuse problems) are sometimes placed in other categories. Nonetheless, DRG 431 is probably the most frequently used DRG for children, and so deserves careful attention in the event a prospective payment system is considered for the children's mental health care system.

Like most DRGs, DRG 431 does not differentiate patient episodes by problem severity, treatment modality and setting, or the patient's history, The Medicare payment rate for DRG **43 I** is based on an adjusted average (the geometric mean[2] of lengths of stay (LOS) in the hospital among patients with this diagnosis. In the case of DRG 431, this equals 15.4 days. As indicated in table 11, however, DRG **431** is the mental disorder DRG category with the most variation in LOS (632), with few patients being treated close to the 15.4-day mean LOS. Approximately 25 percent of patients in DRG 431 have an LOS less than 10 days, while 25 percent have an LOS greater than 75 days. Since DRG-based payment by Medicare does not take LOS into account, a hospital treating an individual with a childhood-onset mental disorder for 75 days receives the same Medicare payment as a hospital treating the individual for 1 day or for 15.4 days.

Variation in LOS for DRG 431 aside, there are a number of potentially serious problems connected with application of a DRG-based payment system to children's mental health care (581). One basic problem is that there is no theoretical or empirical evidence to indicate that the use of treatment resources is related to a mentally disturbed child's diagnosis. Systems of classifying mental disorders (such as the American Psychiatric Association's *Diagnostic and Statistical Manual or* the World Health Organization's *International Classification of Diseases)* indicate only the related set of conditions that have been found for a particular syndrome. These systems were not designed to be used for reimbursement purposes (19) and do not necessarily indicate the severity of a mental disturbance. Especially for children, mental health treatment decisions may be based on the family's ability to manage the child as well as on the multiplicity of problems faced by the child.

In the absence of a direct relationship between diagnosis and length/intensity/cost of mental health treatment, DRG-based payment will not be likely to match a child's need for services. In the short term, a mismatch between DRG-based payment and the cost of needed services may result in some (probably the most troubled) children's being denied services. It may also result in

'Prospective payment, payment to health care providers based on rates established in advance, is an alternative to retrospective cost-based reimbursement, under which payment to providers is based on the amount and type of services they provide **(648,707).**

'Like the arithmetic mean, or average, the geometic mean is a central value in a distribution of scores that serves as a summary measure of the scores. By relying on logarithms, the geometric mean has the advantage of being less influenced by the uneven distribution of scores.

Table 11.–Lengths of Stay Associated With Mental Disorder Diagnosis-Related Groups (DRGs) Ranked by Interquartile Range

DRG	Length of stay in days			
	Geometric mean[a]	25th percentile	75th percentile	Interquartile range[b] (75th percentile minus 25th percentile
Childhood mental disorders (431)	15.4	9.8	75.5	65.0
Organic disturbances and mental retardation (429)	8.8	9.2	34.4	25.0
Psychoses (430)	10.8	8.7	32.7	24.0
Alcohol dependence (436)	8.1	4.8	26.9	22.0
Disorders of personality and impulse control (428)	8.3	4.8	25.5	20.0
Depressive neuroses (426)	9.4	6.1	25,3	19.0
Drug dependence (434)	9.1	6.9	25.5	18.0
Neuroses except depressive (427)	6.9	4.8	22.4	17.0
Other mental disorder diagnoses (432)	7.2	7.7	23.0	15.0
Drug use except dependence (435)	8.0	4,2	19.4	15.0
Acute adjustment reaction/disturbances of psychosocial dysfunction (425)	5.8	3.3	18.3	15.0
Alcohol use except dependence (437)	3.5	3.1	14.8	11,0
Alcohol- and substance-induced organic mental syndrome (438)	6.9	3.9	15.5	11.0
Substance use and substance-induced organic mental disorder left against medical advice (433)	2.5	1.9	9.6	7.0

[a]Like the arithmetic mean, or average, the geometric mean is a central value in a distribution of scores that Serves as a summary measure of the scores By relying on logarithms, the geometric mean has the advantage of being less influenced by the uneven distribution of scores.
[b]The interquartile range is the range of scores extending equally on both sides of the mean that covers the middle 50 percent of a distribution Of scores Thus, the interquartile range is a measure of variation, in this instance, in length of stay.

SOURCE" From C. Taube, E.S. Lee, and R.N. Forthofer, "Diagnosis-Related Groups for Mental Disorders, Alcoholism, and Drug Abuse' Evaluation and Alternatives," *Hospital and Community Psychiatry 35(5)453-454, 1984.*

unnecessary and inappropriate treatment as hospitals are provided an incentive to treat "simple" cases. The long-term impact on the range and quality of available services is unknown (649).

A second critical problem with the application of a DRG-based payment system to children's mental health care is that the data used to calculate average LOS, on which DRG payment is based, were derived from past experience in a sample of adult acute care hospitals. Data reflecting the types of treatments given to children in specialized psychiatric units or **in psychiatric hospitals were** not **included.**

Even if LOS data were available from hospital facilities that treat mentally disturbed children, however, there would be a serious problem in using such data. Most health benefit programs have limitations on the type and amount of both inpatient and outpatient treatment provided. In addition, most benefit programs provide more generous coverage for inpatient care than for outpatient, residential treatment center (RTC), or day treatment *(600).*

The fundamental problem with application of a DRG-based payment system to children's mental health services is that basing payment on a broad category of diagnosis such as "childhood mental disorders" ignores the body of literature on the variety of treatment needs of mentally disturbed children. This problem exists for other DRGs and other vulnerable populations as well **(649).** A DRG-based prospective payment system may control costs and maintain quality of care for patients who require specific medical or surgical procedures (i.e., non-mental-health care), but it seems inappropriate and potentially harmful to apply such a DRG-based payment system to children's mental health care.

Civilian Health and Medical Program of the Uniformed Services.—CHAMPUS is a health insurance program administered by the U.S. Department of Defense (DOD). CHAMPUS provides health benefits to **6.5** million military dependents and retirees who are unable to receive services through uniformed service medical treatment facilities, and is known as one of the most generous third-party payers for mental health care.

Primarily because few uniformed service medical treatment facilities offer mental health services, CHAMPUS devotes a higher percentage of its benefit payments (16 to 19 percent [643a,655]; also see table 8) to mental health services than do most private insurance plans. Another reason that CHAMPUS devotes a high percentage of its benefit payments to mental health services is that military families often live in areas not adequately served by outpatient mental health professionals; for families in areas not served by outpatient facilities, the only mental health treatment option may be psychiatric hospitalization, or, for children, care in an RTC. Inpatient and RTC treatment are typically more expensive than outpatient treatment; and CHAMPUS spends up to 75 percent of its mental health benefits on inpatient and RTC treatment **(548),** despite the presence of an unusually rigorous peer review system which must certify all care (inpatient, outpatient, residential) as medically or psychologically necessary **(548, 549).**

In their efforts to control the costs of mental health care under CHAMPUS, both Congress and CHAMPUS have implemented provisions for maximum benefits for mental health care in psychiatric hospitals and, more recently, in RTCs. The effect of one such provision—a 60-day "cap" on inpatient psychiatric hospitalization—illustrates how changes in reimbursement policy can change the type of services available. This example is not definitive, however, because the change in CHAMPUS reimbursement policy was not introduced experimentally (i.e., with use of a control group experiencing no changes in coverage). Thus, alternative explanations for subsequent variations in treatment services, such as changes in treatment philosophy, cannot be ruled out.

Under the 60-day cap, exceptional justification of medical necessity has to be provided for psychiatric hospitalization longer than **60** days for both adults and children or CHAMPUS will not pay for the care. Extension of the 60-day limit is granted only if a patient is a danger to himself/herself or others; or if the patient has a medical complication and only an inpatient hospital facility can provide appropriate treatment. The cap does not affect RTCs.

A 1985 DOD analysis of the first year's experience with the 60-day cap concluded that the 60-day limit on inpatient psychiatric hospitalization had resulted in a $34.2 million "cost avoidance, " representing 22 percent of the total CHAMPUS spent for inpatient and RTC mental health care in calendar year 1983 (655). Perhaps as expected, there was a 66-percent increase in RTC admissions in 1983, although the costs of RTC stays were not included in DOD's analysis **(655).** The cost of inpatient care cannot be separated from the costs of RTC care in CHAMPUS's data system. DOD's analysis was adjusted, however, for an estimated **80,000** outpatient visits attributed to the 60-day cap.

On the basis of its **1985** analysis and subsequent monitoring, CHAMPUS more recently estimated that there would be a 100-percent increase in admissions to RTCs between 1983 and 1986 (from 425 in 1983 to about 850 in 1986 [643a]). In addition, CHAMPUS reported that since the imposition of the 60-day cap, there had been an increase in the number of RTCs attached to psychiatric hospitals that had applied and been approved under CHAMPUS (from 13 in December 1982 to 30 in December 1985 [643a]). In order to provide additional long-term control over cost escalation, CHAMPUS has since developed a new policy to limit its payments for RTC care.

As do all health care cost-containment efforts, CHAMPUS's attempts to limit costs raise concerns about maintaining good quality care. CHAMPUS monitors quality through its unusually rigorous peer review system and its approval processes (548, 549). In addition, GAO is studying methods for assessing the quality of care provided under CHAMPUS.

The Education for All Handicapped Children Act (Public Law 94-142)

The Education for All Handicapped Children Act (Public Law 94-142) mandates that all physically and mentally handicapped children be provided a free, appropriate education and the "related services" necessary to obtain an education (see ch. 7). The Federal Government provides a small amount of grant money to States to help them implement this law.

There is continuing debate about whether mental health care is properly included under "related services." Even those who consider mental health interventions necessary for education disagree about where the responsibility for payment lies—with the school system, the welfare system, the health care system, or the mental health care system. There is additional concern about the costs and personnel required when residential treatment is indicated, and about whether the school systems should be required to pay for the entire costs of residential placements or only for the education-related costs (109). Evidence suggests that the services available to mentally disturbed children through Public Law 94-142 vary considerably by State (657). When this background paper was being written, a study was being conducted to determine what related services, including mental health services, were being provided under Public Law 94-142 (666).

Coordination of Services

The State Comprehensive Mental Health Services Plan Act of 1986 (Public Law 99-660)

In response to the perceived inadequacy and fragmentation of services for individuals who are perhaps most in need of coordinated mental health and other system services—the chronically mentally ill, Congress has passed legislation to encourage a continuum of services and coordination among agencies. The most recent legislation in this vein is Public Law 99-660, the State Comprehensive Mental Health Services Plan Act of 1986, passed in November 1986. This law authorizes a total of $20 million in grants to States for fiscal years 1987 and 1988 for the development of State comprehensive mental health services plans and provides direction on the content of such plans. Perhaps most significant, State plans are required to provide for the establishment and implementation of organized community-based systems of care for chronically mentally ill individuals; and to require the provision of case management to each chronically mentally ill individual. The law also expands the focus of the already existing Federal Community Support Program (in NIMH) to include the homeless chronically mentally ill.

It is too early to tell, of course, how States will respond to the new grant program or to what extent the program will affect children. An earlier program to encourage the integration of mental health and other services for children, CASSP, was, as is described below, enthusiastically responded to by States. Neither the new program nor CASSP, however, address the needs of children with mental health problems that are not yet severe or chronic. The analysis in this background paper, like analyses of past national commissions, suggests that the needs of such children are urgent.

Child and Adolescent Service System Program

CASSP, administered by NIMH, is a direct response to the lack of coordination among the settings and systems providing services to children with mental health problems. Modeled after the Community Support Program for the chronically mentally ill, CASSP was created by Congress in 1984 after repeated findings that because of a lack of coordination among systems of care, the individual programs designed to assist mentally disturbed children were frequently not used. The goal of CASSP is to ensure the availability of a comprehensive, coordinated system of care specifically for severely mentally disturbed children and adolescents.

Several themes developed earlier in this background paper point to the need for coordinating mental health and other children's services. Disturbed children often have more than one mental health problem (e.g., an attention deficit and reading disorder that become apparent in school combined with aggressive behavior in the neighborhood). Many troubled children also have educational, physical, legal, economic, or family problems in addition to their mental disturbance. Given the interactions among disturbed children's problems, effective intervention often requires the provision of a variety of multiple mental health and other services. CASSP was based on the belief that coordination among mental health treatment and other service systems is necessary to ensure that severely disturbed children receive all the services they need, organized into a comprehensive treatment plan, and timed to achieve optimal beneficial effects.

CASSP is designed to improve States' capacities to offer aid to severely mentally disturbed children. CASSP assists States in developing systems of care through planning grants, as well as technical assistance and training. States that receive CASSP grants are required, initially, to develop a child mental health authority and to organize a "coalition" of State agencies whose work affects children. Once a comprehensive State-level system is developed, the goal is to replicate the coordination effort at local levels.

It is too early to assess the effectiveness of the CASSP grant program, but the program incorporates a number of elements of an ideal system that have long been discussed. By focusing on the organization of services, it advances the goals of placing children in appropriate settings and having providers make treatment decisions based on clinical needs rather than on maintaining fiscal solvency. CASSP is designed to help States develop mechanisms which may differ across localities and available resources, and it appears to be an important mechanism to facilitate development of such locally controlled systems of care. As described in chapter 9 of this background paper, State authorities and NIMH are jointly developing an evaluation of CASSP's effects.

Research and Training

For research related to children's mental health and for training clinical and research professionals in this area, the Federal Government is virtually the only source of funds. With few exceptions, such as the MacArthur Foundation, neither philanthropic foundations nor individual donors support research or training in the mental health field (309). SMHAs spend very little on research and training. Some critics charge that the funds available to support mental health research are inadequate to take advantage of "exciting" research opportunities or even to foster rational development of the field (309). Research on childhood mental disorders is frequently used as a prime example of the opportunities that are missed.

Funds for research pertaining to children's mental health are available primarily through NIMH. NIMH research grants are available for a range of disciplines, including behavioral science research, clinical research, the neuroscience, pharmacological and somatic treatments, and psychosocial treatments. As shown in table 8, NIMH estimates that roughly $27.2 million was made available in fiscal year 1985 for intramural and extramural research relating to children's mental health (665). This amount represents 17 percent of NIMH's research budget (see table 8).

The main direct source of funds for training mental health professionals to treat children is the clinical training program of NIMH. Since 1983, congressional appropriations committees have requested that NIMH allocate a portion of its clinical training funds specifically to mental health professionals who treat underserved populations, including children. Because NIMH has limited funds overall and commitments to continue existing training grants, however, the impact on children's mental health services has only begun to be seen.

In fiscal year 1985, NIMH allocated approximately 15 percent of its clinical training funds, or $4.8 million, to training programs dealing at least in part with children's mental health issues (see table 8).

A major reason for targeting NIMH clinical training funds to professionals who treat children is that there appear to be insufficient numbers of well-trained professionals to meet children's needs. According to 1976 data (109), only 10 percent of psychiatrists are specifically trained to treat children, and less than 1 percent of psychologists primarily serve children. According to NIMH data, there are approximately 3,000 child psychiatrists, 5,000 clinical child psychologists, 7,000 child and family-oriented social workers, and 1,000 child/family-oriented mental health nurses (358). Estimates of the numbers of professionals needed have consistently been much higher.

Funds for training mental health researchers (as opposed to clinicians) are available through NIMH under authority of the National Research Services Awards Act (Public Law 93-348). Although the Institute of Medicine (309) has called for increased funding of research training in children's mental health, calling this a "relatively unstudied area," only $1.1 million for training researchers was available through NIMH in fiscal year 1984 (664).

Information about the mental health training funds available from agencies other than NIMH is less clear. The Education for All Handicapped Children Act (Public Law 94-142) includes Federal funding for training special education personnel, but this training is directed at all handicapping conditions covered under the law. Although it is **certain that funds could be well used for professional development** in child welfare, juvenile justice, and education agencies to promote the integration of mental health services with these related services, there are currently no major Federal programs to support this kind of integrative training.

Prevention and Other Services

A number of Federal programs provide funds that may be used to support delivery of mental health treatment or that have a clearly positive or preventive role in children's mental health. These include the programs that primarily provide health services, as well as those providing social services, nutrition assistance, and direct or indirect financial payments.

The Maternal and Child Health block grant is a Federal program that provides funds to the States for services to mothers and children, particularly in low-income families. Since adequate health care is vital for promoting normal and healthy development in children, these block grant funds can play a significant role in the prevention of mental illness in children. Medical care providers who treat children who have no link with mental health care providers through the schools or other agencies are often the first to identify emotional or psychological problems that may require treatment (see ch. 7).

A Federal program related to the Maternal and Child Health block grant, the Primary Care block grant, gives Federal funds directly to community health centers for general health care services to medically underserved populations. These general health care services provide a measure of prevention and screening for mental health problems affecting children and their families, and provide a point of contact with health care providers. Similarly, the Preventive Health and Health Services block grant provides Federal funds to States for a variety of preventive health programs, including home health services, rape prevention and treatment services, and demonstration projects specifically designed to deter consumption of alcohol among children and adolescents. Many of these programs serve an important prevention function for mental disorders.

Three other major Federal support programs have important effects on children's mental health. The Title XX Social Services block grant provides funds to States for a wide variety of social services to children and families, including day care, protective services for children, family planning, adoption, and foster care. These services have played a major role in the promotion of child welfare. The Adoption Assistance and Child Welfare Act (Public Law 96-272) funds child welfare services, foster care, adoption assistance for hard-to-place children (including those who are emotionally or intellectually handicapped), and has, in general, been helpful in financing support services to aid children and families in crisis. Project Head Start provides educational, social, health, and nutrition services to low-income preschool children. The long-term effectiveness of Head Start programs in preventing problems is now well recognized (728; also see ch. 9).

Among the other Federal programs that relate to children's mental health, directly or indirectly, are funding programs designed to enable individuals to meet basic health, nutrition, and cost-of-living needs. Such programs include the Child Abuse Prevention and Treatment Act programs; Victims of Crime Act programs; Developmental Disabilities Assistance and Bill of Rights Act programs; Family Planning programs; the Foster Grandparents Program; the Adolescent Family Life Program; the Food Stamp Program; the Supplemental Food Program for Women, Infants, and Children; School Lunch programs; Aid to Families with Dependent Children; Supplemental Security Income; Child Support Enforcement programs; and income tax deductions for adopting special-needs children. As part of the overall Federal effort relevant to children's mental health, these programs provide a considerable amount of assistance. It is not clear, however, that the assistance provided by these programs is coordinated so that individual children are protected. Previ-

ous analyses (e. g., 358,595), anecdotal evidence, and observations of the experts consulted during the preparation of this background paper suggest that a coordinated system for providing children's services would be helpful. Perhaps the evaluation of CASSP and experience under the State Comprehensive Mental Health Services Plan Act will suggest additional ways in which such coordination can be implemented.

CONCLUSION

It is quite well estab ished that a great many children are in need of mental health services—both to treat diagnosable e disorders and to reduce environmental risk factors (see ch. 2). It is also agreed that children's mental health services need to be based on extensive and sound research; guided by appropriately trained personnel; and supported by sufficient funds and incentives to encourage coordination among providers, including those in non-mental-health systems.

Federal, State, local, and private contributions to provision of mental health services are substantial. The gap between the need for children's services and the availability of such services, however, implies that even these considerable efforts fall short of bridging the gap (e.g., 358,359). The mental health services available for children appear to be inadequate. In addition, research on children's mental health and illness appears to be inadequately funded.

Although local control of service delivery is believed to be optimal for the necessary case management of children with problems and potential problems, and although the private sector could arrange to provide more and better mental health services, it may be that a larger role for the Federal Government is desirable. Such a role could include a statement of principle for mental health analogous to that articulated for education in Public Law 94-142, which mandates that all children be guaranteed a free, appropriate education. It could also include increased Federal efforts to eradicate environmental risk factors or reduce their impact on children, to continue to promote coordination of services, and to fund research and training in the children's mental health field.

Photo *credit: OTA*