Journal of Clinical Child Psychology
1985, Vol. 14, No. 3, 188–195

# Changing Patterns of State Responsibility: A Case Study of North Carolina

**Lenore Behar**
*North Carolina Division of Mental Health, Mental Retardation, and Substance Abuse Services*

*Over the past two decades, there has been an increasing focus on the needs of children with mental health problems. Although there has been a commitment to developing a continuum of child mental health services by mental health professionals and others involved in the treatment, education, and care of children, progress has been remarkably slow. The state of North Carolina, in response to litigation, has established a precedent by developing integrated systems of services for seriously behaviorally disturbed children and adolescents that may serve as a model for others. The North Carolina mental health system, primarily through the community mental health centers, has served as the lead agency in this initiative. After 4 years of program development, it appears to be well established that seriously disturbed youngsters can be served in community based systems, especially if a strong and expansive case management function is in place.*

Key words: children's mental health, children's mental health services, state mental health program, North Carolina mental health system

In 1964, the Joint Commission on Mental Health of Children convened to study the status of services to emotionally disturbed children in the United States and to make recommendations that would lead to improving such services. The Joint Commission labeled its analysis of needs and proposed remedies *Crisis in Child Mental Health: A Challenge for the 1970's* (Joint Commission on Mental Health of Children, 1969). These recommendations represented a major contribution to the thinking about and planning for services to children, providing a new emphasis on advocacy and on the responsibility of the states to plan and to organize services. The recommendations also emphasized the importance of a wide array of services provided within a least restrictive, most normal community-based continuum of care.

In 1977, the President's Commission on Mental Health was established with goals similar to the earlier Joint Commission on Mental Health of Children, "to review the mental health needs of the nation and to make recommendations to the President as to how the nation might best meet these needs" (President's Commission on Mental Health, 1978, p. 1). Regarding children's mental health services, this Commission's summary varied little from that of the Joint Commission almost a decade earlier, as it reported:

> As the commission traveled throughout America, we saw and heard about too many children and adolescents who suffered from neglect, indifference, and abuse, and for whom appropriate mental health care was inadequate or nonexistent. Too many American children grow up to adulthood with mental disabilities which could have been addressed more effectively earlier in their lives through appropriate prenatal, infant, and early child development care programs.
>
> Troubled children and adolescents, particularly if they are from racial minorities, are too often placed in foster homes, special schools, mental and correctional institutions, without adequate prior evaluation or subsequent follow-up. Good residential facilities specializing in the treatment of special problems are in short supply.
>
> During the past two decades, many adolescents have struggled to adapt to rapid social changes and conflicting, often ambiguous, social values. There has been a dramatic increase in the use and misuse of psychoactive drugs, including alcohol, among young people and nearly a threefold increase in the suicide rate of adolescents.
>
> Services that reflect the unique needs of children and adolescents are frequently unavailable. Our existing mental health services system contains too

---

Requests for reprints should be sent to Lenore Behar, PhD, Division of Mental Health, Mental Retardation, and Substance Abuse Services, 325 North Salisbury Street, Albemarle Building, Raleigh, NC 27611.

> few mental health professionals and other personnel trained to meet the special needs of children and adolescents. Even when identified, children's needs are too often isolated into distinct categories, each to be addressed separately by a different specialist. Shuttling children from service to service, each with its own label, adds to their confusion, increases their despair, and sets the pattern for adult disability. (President's Commission on Mental Health, 1978, p.86)

Since the President's Commission Report, new attention has been given to the recommendations of both the Joint Commission (1969) and the President's Commission (1978) that state governments assume a major role in the planning, the organizing, and the delivery of mental health services. This in turn has resulted in a better understanding of what the basic goals of children's mental health services should be. These include a commitment to: (a) develop mainstream, integrated, community-based services, whether children's needs are considered from the perspective of juvenile justice, education, child welfare, or mental health; (b) tailor services in the least restrictive, most normalized environment that is appropriate; and (c) include the family in the rehabilitative process.

Clearly, different states have progressed with the challenge of developing children's mental health services at different rates. However, no state's program represents a shining example of a high quality system of children's mental health services integrated with other children's services. The Joint Commission noted in 1969 (Joint Commission, 1969) that "...it is an undesirable fact that there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running a spectrum from early therapeutic intervention to social restoration in the home, in the school, and in the community" (pp. 6–7). In 1984, despite a decade and a half of eloquent needs statements and the beginning of some service programs, a similar description applies to almost all communities and certainly to all states.

However, as emphasis has been placed on state mental health agencies to develop comprehensive, organized child mental health services integrated with the services of other child agencies, a clearer understanding of barriers to implementation has evolved. A major barrier exists in the lack of priority or commitment that decision makers have placed on child mental health services (Knitzer, 1982). Perhaps as an excuse for the lack of commitment to expanding mental health services for children, plans in some states have been stymied by the explanation that little is known about what is effective with these children. Admittedly, rigorous documentation of program effectiveness does not exist for many of the services considered by a consensus of professional opinion to be necessary. Yet, as Knitzer (1982) has noted, "All the knowledge needed to diagnose and help children with serious emotional or behavioral difficulties is not available. But the ways in which mental health services are now funded, organized, and delivered do not begin to reflect what we do know" (p. x). Even in 1969, the Joint Commission reported that "We have the knowledge and the riches to remedy many of the conditions which affect our young, yet we lack the genuine commitment to do so" (p. 7).

In addition to the absence of priority placed on the development of child mental health services, the fragmentation of all children's services represents another substantial barrier in planning, even when a commitment is attained. Most of the children to be served do not neatly divide themselves according to the way administrative agencies have been created. Most children need the services of many agencies for a "comprehensive" approach, and most of the children are the responsibility of multiple agencies, each addressing a part of the child's needs.

Given the multiple needs of the child population, the challenge for the 1980s must include not only the programmatic one of developing a mental health continuum of services but organizing and coordinating the service and entitlements of many agencies.

As an example of how these concepts can be operationalized and of how such integration of services can be accomplished, the development of a well-funded, comprehensive community-based system of services in North Carolina, with mental health as the lead agency, is described in the following pages. This complex effort represents one approach or one model of addressing the problems that have become the unanswered or partially answered challenge to meet the mental health needs of children. Traditional methods of defining children's needs based on the agency that "owns" them have been ignored. Using an expansive definition of mental health, all children with serious behavior problems have been included in the service delivery network, regardless of the agency through which they have entered the service system(s). Although this approach is not necessarily the only model to addressing the needs of children, it does represent an approach that has shown promise.

A team of professionals reviewed the North Carolina system of services and reported in December, 1983:

> The state of North Carolina, under court order, has undertaken to do an enormously difficult task—the organization and implementation of an

> appropriate service program for about 1,000 of the most severely emotionally, neurologically, mentally handicapped and aggressive children in the State. In seeking to carry out this challenge, North Carolina is breaking new ground: there is no previous tradition that can be built upon; no other state has ever made such a substantial commitment of resources and staff to a group of children who typically are failed by not only mental health departments but other service systems as well. Nor has any other state made a commitment to implement an integrated service delivery system to ensure that each child receives a full range of needed services in the least restrictive setting. (Knitzer, LaNeve, Pappanikou, Shore, & Steffek, 1983, p. 2)

## Development of the Service System

Over the past 4 years, the state of North Carolina has fostered the development of integrated systems of services in local communities for seriously emotionally, mentally, and neurologically handicapped children and adolescents who are also violent and assaultive. The integrated service system for this most difficult-to-serve population has been developed under the leadership of the Division of Mental Health, Mental Retardation, and Substance Abuse Services of the Department of Human Resources as the lead agency in combination with all of the child-serving agencies in the state.

The impetus for the development of these services came from the settlement of a class action lawsuit against the state, *Willie M. et al. v. James B. Hunt, Jr. et al.,* filed in 1979 in the U.S. Western District Court. The complaint stated that four minors and "all others similarly situated" had been denied the appropriate treatment and education that were rightfully theirs under a series of federal and state statutes and the U.S. Constitution. At the time the lawsuit was filed, the four minors were in state institutions, three in training schools, and one in a psychiatric hospital; this further defined the class as children who "are or will be in the future involuntarily institutionalized or otherwise placed in residential programs."

Sufficient evidence was gathered in the year following the filing of the lawsuit to suggest that this particular subpopulation of children had significant unmet treatment and educational needs. Therefore, the state decided against the lengthy defense of their position and began negotiating a settlement in September, 1980. The state agreed that a class of children under age 18 had been denied their rights to treatment and education and, thus, were entitled to have these services developed for them in the least restrictive setting. The state of North Carolina looked on this settlement as an opportunity to develop experimental systems of services and as a significant challenge.

A detailed process of identifying the population to be served was developed, with serious behavior problems being the primary consideration. Based on a thorough assessment of each child nominated by any person or agency, a determination was made as to whether or not the child met the following carefully and objectively defined criteria: (a) seriously emotionally, neurologically, or mentally handicapped; (b) accompanying violent or assaultive behavior; (c) receiving services inappropriate to his or her needs; and (d) at risk of being involuntarily institutionalized or otherwise placed in a residential program. The community mental health programs assumed responsibility as the lead agency in organizing the assessment process and eventually the service delivery process. An independent committee reviewed each diagnostic protocol and certified those who met the criteria listed above. Now, after 4 years of an ongoing process to identify children, approximately 1,600 have been certified, with approximately 1,175 active cases at any given time. The remaining 425 have moved out of state, moved into the adult mental health system, joined the military, died, or otherwise become ineligible for services.

Based on an analysis of the diagnostic materials collected on the first 1,000 cases, at the time of their initial assessment, this group of children could be described as follows:

1. *Age:* 78% of the children were ages 12 to 17, with 55% ages 15 to 17. Only 14% of the children identified were under age 12.
2. *Sex:* 80% were male and 20% were female.
3. *Race:* 40% were white, 48% were black, 2% were Indian, and 1% were "other."
4. *Custody:* At the time the diagnostic studies were completed for each member, 47% resided at home; 24% were in a detention facility or in a training school; and 16% were in a child care institution, a group home, or a hospital. In addition, 5% were in foster care and 9% were in other living arrangements.
5. *Family Problems:* The large majority of families of these children (86%) had one or more family problems, which may have included family disintegration, child neglect, child abuse, mental illness, court involvement of the parents, and alcohol or drug abuse by the parents.
6. *Court Involvement:* Over half of the Willie M. children (51%) had been found guilty of a criminal act.
7. *Problem Behaviors:* Of the 1,000 cases, more than 94% had demonstrated three or more problems on a 17-item problem behavior checklist. The most frequent problem behaviors included physical attacks without weapons, verbal aggression, un-

controllable temper tantrums, stealing, running away, physical attacks with weapons and vandalism.

8. *Intellectual Functioning:* As measured by standardized intelligence tests, 65.1% of this population were functioning below the IQ range of 70 to 84; it was recognized that such measures may well be underestimations of intellectual potential.

9. *School Placement:* Of the 1,000 cases, 651 (65%) attended school; 56.1% of these cases were classified as seriously emotionally disturbed or multiply handicapped.

The agreement to provide services for this population of the most difficult-to-manage children in the least restrictive, most appropriate environment was taken very seriously, and the expectation was that the majority of children could and would be served in community-based programs rather than in institutional settings. Based on the recognition that the mental health system in North Carolina was, for the most part, a well-developed and organized system with a strong base in local communities, the Division of Mental Health, Mental Retardation, and Substance Abuse Services was designated to be the lead agency. The assumption of the lead agency role represented a significant expansion of responsibility for mental health programs beyond the traditional position and especially broadened the concept of outreach far beyond the walls of the mental health centers.

It was especially important to keep in focus that the needs of these multiproblem, very disturbed, and assaultive children cut across almost all agencies and were not only mental health problems, but it was the role of the Division of Mental Health, Mental Retardation, and Substance Abuse Services to provide leadership among all the other child-serving agencies in program development. In developing services for this population, it was recognized that many of these children had been the responsibility of child-serving agencies; the failure of previous services to these children stemmed from (a) an absence of appropriately designed treatment and education programs to meet the individualized needs of these children; (b) the lack of linkages, that is, the lack of planned, coordinated movement through the various agencies or service systems; and (c) the attitudes of professionals regarding the "treatability" of this population. A basic set of philosophical assumptions was developed that specified the characteristics of a responsive system of services for the identified population. These assumptions are as follows:

1. A complete system of services ranging from highly restrictive settings to settings that approximate normal family living is needed to rehabilitate these youngsters; to deal effectively with these children, the full continuum of care must be in place; discrete components whether of the more intensive or the less intensive variety, standing alone, will fail.

2. The system must provide for linkages among the various components within the system, as well as to services from other child-caring systems. There must be coordinated efforts between both public and private human service providers, educational systems, and courts.

3. There must be flexibility in funding and in decision making to allow the movement of children through the system as their needs change, requiring less restrictive or more restrictive settings. There must be back-up services and respite services available and readily accessible on a 24-hour basis.

4. There must be a management structure to the system so that shifts in funds and staff are possible, structured to allow for the movement of children discussed above; there can be no admissions criteria or admissions delayed to programmed components.

5. Children are best served close to their own communities to maximize the possibility of family involvement in services and to allow for reintegration of the child into his or her natural environment.

6. Individualized treatment and educational planning, with broadly defined case management as the backbone is essential to the success of the service system. If a focus is maintained on the service needs of each client, the "administrative" labels such as juvenile delinquent, welfare client, mental health client, or special education student can be ignored, allowing each child broader access to services; such needs-based planning should lead to utilization of appropriate services.

A "no eject/no reject" policy must be in place so that all children are served regardless of the perception of "treatability" or "nontreatability."

The development of systems of services on a statewide basis has been a large undertaking, calling for a need to reorganize service delivery patterns to bring about an integration of programs and services by *all* of the child-serving agencies, with area mental health programs as the lead agency. Services for children in North Carolina are, for the most part, organized within counties; however, the concept of area mental health programs has brought about combinations of counties in order to provide a reasonable population base for the delivery of mental health services. Using this approach, the zone concept was developed, with a zone representing a geographic unit with a substantial number of class members to support a complete system of services that was both geographically and economically feasible. By definition, a zone is a community, in the term "community-based," and it has been expected that the children would be served by a continuum of care within their zone.

State funds for five zones were allocated in 1982; in 1983, the entire state, or 16 zones, were funded at a budget of $25 million per year to serve approximately 1,175 children, at an average cost of $21,000 per child served.

Each zone has developed the capacity to provide the following types of services, to be provided individually or, more likely, in combination, based on individual need.

1. Outpatient diagnostic and treatment services to child and family support services.
2. In-home services to child and family as needed for support, crisis stabilization, or as a short-term alternative to other services.
3. Special education services within the local education agency and in an out-of-school setting for those clients needing a more restrictive setting.
4. Training in life skills, prevocational, or vocational preparation.
5. Residential treatment services in small home-type arrangements with individual families, specialized foster care jointly with a foster care agency. Mental health provides intensive training, weekly supervision, and consultation with families and 24-hour back-up respite care.
6. Residential treatment services in group living arrangements.
7. Supervised apartment living or monitored independent living for older class members ready to leave family-style living.
8. Emergency services in outpatient settings, medical and nonmedical residential settings for emergency treatment, crisis stabilization, and intensive diagnostic study.
9. Support services such as transportation for child and family, big brother/big sister programs, recreation programs.
10. Respite services for children living with families, foster parents, in therapeutic homes, or group homes.
11. An integration of quality services by other agencies such as special education, protective services, and probation services.
12. Last and most essential, expansive case management described in detail below.

Many of these services exist at several levels of intensity, totaling 36 program components; they are provided by a variety of public agencies or purchased from private providers. Zone plans also include components as part of the continuum that are operated by the state, such as psychiatric hospitals, reeducation centers, or wilderness camps. The use of these out-of-zone services must include a plan agreed upon by the zone and by the facility regarding admission, provision of services to the child's family, role and function of the case manager, and responsibility for discharge planning. In all out-of-zone services, active case management by the case manager employed by the area mental health program is essential to:

1. Assess, on a monthly basis, the continued appropriateness of such placement and quality of services.
2. Develop transition and stepdown plans as the child's need for less restrictive services emerges.
3. Assure that linkage to other essential parts of the child's ecological system are maintained (i.e., parent(s) or guardian(s), family members, school, possible employers, etc.).
4. Develop linkages to the adult service system if the child is approaching age 18.

The importance of maintaining these regular contacts is one of the reasons that out-of-state placements are considered to be inappropriate for most class members. The mechanism of case management is essential to ensure that the appropriate services are identified, utilized, and coordinated across all relevant agencies and updated, as needed. Because case management is provided in such an expanded manner and because this service is critical to the success of the system of services, it is described here in detail.

A case manager is assigned by the area program to each class member upon certification; each case manager is responsible for 12 to 15 cases. A no eject/no reject policy is in effect; each child must be served, regardless of perceived treatability. It is the case manager's responsibility to review each diagnostic form and gather preliminary information on class members from agencies and individuals involved with the class member through personal contacts, records search, as well as from direct contacts with the class member. The case manager then summarizes all major diagnostic and treatment issues, including a review of all strengths and deficits. Also, he or she indicates whether or not further diagnostic studies are needed and states the nature of any such evaluation. The case manager identifies the least restrictive setting currently relevant for client's needs.

The case manager also schedules community treatment planning conferences to which representatives of agencies who are, have been, or may be, providing services and support are invited together with other individuals as appropriate, including the parents, parent substitutes, and the child. Some of the agencies may have legal responsibilities to the client and therefore have a significant stake in participating in service planning. The case manager should develop the treatment plan and has responsibility to consider all relevant input gathered from record search, factfinding, and the community treatment planning conference. It is expected that the service plan be developed and involve not only input from other concerned agencies, but the plan should clearly state the role that each agency will play and how each agent and agencies should interact in the process. The treatment plan should be coordinated with the education plan, which the child and his or her parents need to understand and to which they must agree.

The case manager reviews and updates the treatment plan every 30 days. A comprehensive review is held with members of the community treatment planning conference every 90 days. At this time, efforts and accomplishments are reviewed, goals and strategies reassessed and adjusted as needed.

It is also the case manager's responsibility to advocate for the child, in court, in school, in the treatment program, to ensure that entitlements are granted and that the child's needs are understood.

### Indications of Effectiveness

Now, after 4 years of program development, there are several indices of the impact of such expansion and integration of services:

1. The state training schools have not been considered appropriate placements for this population of children. Children who become class members while in training school are to be moved to a community program within 60 days. Over the past 18 months, 150 children have been removed from training school and equally as important, the tide has been turned, so to speak, and almost no class members are sent to training schools; at this time, there are less than 20 of the most difficult children still remaining in state training schools, and it appears that community-based treatment might be very risky for them.

2. There are 75 additional children in secure treatment settings, such as state psychiatric hospitals and reeducation centers, that are considered to be appropriate to their treatment needs. This figure represents 6.8% of the Willie M. population being served out of the zone programs and in secure settings or .01% of the total child population between the ages of 10 and 18.

3. Currently, there are approximately 1,175 certified class members, and all are receiving services that they would not have received 4 years ago. Well over half are receiving a complete, appropriate array of needed services; others are receiving partial services and are on their way to fully appropriate services.

4. As the service systems were developed, a data collection system was also put into place with the capacity to assess monthly movement of clients from most restrictive to least restrictive services, from a combination of many services to fewer services, and from expensive services to less expensive services. Preliminary indications are that changes in service utilization are in positive directions. In addition to measures of service utilization, direct measures of client progress are being collected at 6-month intervals. Now that most of the service components are in place, realistic analyses of these data are possible and should provide over the next several months more objective measures of impact and progress.

### "Learnings" Thus Far

The most essential point to be made is that seriously behaviorally disturbed children *can* be served in community-based programs. Given the nature of the population in question—seriously disturbed, assaultive children—there were initial misgivings among many professionals, decision-makers, and citizens about whether community-based services could or should serve this population. Based on 3 years of experience, at this point, the response seems to be extremely positive; however, it should be understood that the North Carolina model works to the extent that:

1. A wide continuum of services, many of which did not exist prior to 1980, is in place.
2. A management system is in place to keep the continuum flexible and responsive.
3. A case management system exists to develop the service plans and oversee the implementation of those plans for each client.
4. A policy of no eject/no reject is in effect to ensure that no children are excluded from the system.

It is interesting to observe that the no eject/no reject policy does work, and very difficult children can be served and do make progress. It would appear that our professional ability to predict outcomes for children, except at the very extremes, may be questionable; possibly our tendencies to predict negative treatment outcomes for many children result in a self-fulfilling prophesy. The concepts of least restrictive and most appropriate services are indeed realistic options for serving children well.

The second observation that can be made perhaps is most obvious in the above discussion. Case management, which has been broadly defined in the North Carolina model, has been perhaps the most essential unifying factor in service delivery. Case management, in its most positive sense, has emerged as: (a) the element of planning and coordinating that has combined the workings of all agencies concerned with the child, (b) the energizing factor that has propelled the service plan into the reality of service delivery, and (c) the case advocacy strength that has sustained a commitment to each child and an optimism about each child's capacity to change. The case managers have represented these strengths for the entire system of services and have kept the systems moving and honest. This type of case management appears to be a critical factor in bringing children and families into the service system and in keeping them involved with the system and the system involved with them, as well. Most important, as discussed above, the case managers have been the strong force in designing and obtaining appropriate services for their clients. The key to the success of the case management component appears to be the clearly defined roles and expectations for how case managers should function and the administrative, fiscal, and psychological support provided to the case managers as employees of the mental health center. Case managers cannot do their complex jobs without having a service system available; however it would appear that the service system does not function maximally without the case managers. It should be mentioned that initially many clinicians responsible for the direct treatment of clients believed that the case managers represented threats to their relationships with their clients, and/or that they were capable of merging the case management function with the treatment function. At this point, it appears that therapists/clinicians generally do not see the case managers as threats to their role with the clients. Regarding the latter point, certainly some clinicians can and do merge these functions, but most believe that the functions are better separated.

A problem area has emerged in the strong tendency to remove children from their natural environment with the belief that effective treatment for children with serious problems can only be accomplished in a residential setting. It is important to recognize that, for some children and families, this is certainly true; however, the experience has been that residential services are overutilized for children and families that, in the long run, would do better not being separated. Historically, few programs have been in existence that would allow for intensive and extensive full-day programming, leaving the child to reside at home as a substitute for long-term residential treatment. Such intensive services, combined with intensive family services and a 24-hour on-call system for crises, does seem effective for many children and families, avoiding problems resulting from separation such as reintegrating the child into the family and the fact that the child may make progress in the residential setting although sufficient change is not made in the home environment.

A second set of circumstances that has historically led to the separation of the child from his or her family is an intense family crisis where a "cooling off period" seems apparent, or where separation for a longer term seems evident to accomplish treatment goals that cannot be addressed while the crisis continues. For some situations, the use of residential treatment may be necessary; however, intensive in-home services similar to those provided by Homebuilders, Inc., of Tacoma, Washington (Kinney, Madsen, & Haapala, 1977) certainly have shown considerable promise in keeping children and families together. These services are provided from 4 to 8 hours per day, or more, if needed, for a time-limited period, usually up to 2 months. The focus of such services is to resolve the crisis, to improve communication and to link the family and child to longer-term services, as needed. For some families, the addition of respite services may add to the effectiveness of such treatment. It is important as a new focus in the treatment of children to develop policies and programs that address more widespread use of in-home crisis services and intensive day services coupled with the belief that separation of child and family is usually not necessary.

A second major problem area in providing services to older adolescents is the importance of helping them to become employable, which is essential in helping them to become independent and is essential to their developing self-esteem. This problem area is certainly well known to those who have worked with older adolescents. Many of the seriously troubled adolescents have serious academic problems, as well as emotional/behavioral problems that have contributed to patterns of poor learning or essentially no learning. Clearly, many of these adolescents have a history of unsuccessful and unpleasant school experiences. They usually have no prevocational or vocational skills and developing such skills in community-based settings has been very difficult. In tight economic times when jobs are hard to find in general, this population of youngsters is most likely to be the last considered for apprenticeship employment or for on-the-job training. Even when they are willing to continue in the public education system, they are apparently also the last considered for vocational education services when the teachers are not trained to work with emotionally or behaviorally disturbed, very difficult students. Nor are these adolescents viewed positively by vocational rehabilitation services, for they do not meet the criterion of showing promise of being employable.

Shore (in press) has noted the importance of addressing the vocational/employment needs of the delinquent population. His approach of "vocationally oriented psychotherapy" has shown much promise, as have less formalized approaches used in some North Carolina programs of developing small training programs within the treatment program settings and/or paying employers to hire and train one or two adolescents at a time. Even with tax benefits to employers to hire handicapped employees, the assaultive or explosive unskilled adolescent is not well tolerated in the workplace. Working out such employment problems has meant taking a one-to-one approach, involving cajoling employers and running interference for the adolescents, as needed. The capacity to develop a prevocational and/or vocational services plan by a case manager independent of a specific program component has indeed led to a more appropriate definition of the adolescent's needs and interests and has therefore led to more tailor-made services, rather than trying to fit the youngster into an existing slot.

Nonetheless, a more systematic approach is needed; a public policy must be effected to add the important dimension of employment to the policies mandating special education and treatment for troubled adolescents.

The Department of Education has recently begun to address this set of problems and has placed priority on research, demonstration and service programs that address the needs of the seriously disturbed adolescent in transition from school to work (Will, 1984). Hopefully, over the next few years, this policy focus will yield positive models and serve to raise the awareness of professionals and of employers of the importance of vocational success for this population.

At this point, 4 years hardly has seemed sufficient, even given the breakneck pace that pervaded all aspects of program planning and program development. Substantive program evaluation any earlier most likely would not have yielded a sound picture of what stable and mature programs can provide for seriously disturbed children and adolescents. Those evaluations are timely now. The value of the preceding years rests in the lessons learned about the problems and successes that occur in widescale program planning and development, including (a) the attitudes that must change about children for community-based programs to succeed; (b) the range of services that must exist and be coordinated for children to be served well in communities; (c) recognition that individualized service plans can supersede the administrative classification of children as welfare children, juvenile justice children, or mental health children and lead to appropriate services for children; and (d) the importance of broadly defined case management as the cohesive element in a system of services.

## References

Joint Commission on Mental Health of Children. (1969). *Crisis in child mental health: Challenge for the 1970s.* New York: Harper & Row.

Kinney, J., Madsen, B., & Haapala, D. (1977). Homebuilders: Keeping families together. *Journal of Consulting and Clinical Psychology, 45,* 667–673.

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services.* Washington, DC: The Children's Defense Fund.

Knitzer, J., LaNeve, R., Pappanikou, A. J., Shore, M. F., & Steffek, J. (1983). *Report to the Division of Mental Health, Mental Retardation, Substance Abuse Services regarding the implementation of Willie M.* Department of Human Resources, Raleigh, NC.

President's Commission on Mental Health. (1978). *Report to the President* (4 vols.). Washington, DC: U.S. Government Printing Office.

Shore, M. F. (in press). Juvenile delinquency in the United States of America: National issues and new directions. In R. F. Tremblay (Ed.), *Juvenile delinquency: International perspective.* Paris, France: Fleurus, Inc.

Will, M. (1984). Bridges from school to working life. *Programs for the Handicapped: Clearinghouse on the Handicapped, 2,* 1–5.

Willie, M. et al. v. James B. Hunt, Jr. et al., Civil No. C–C–79–294–M (W.D.N.C. 1980).