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USING LITIGATION TO IMPROVE CHILD MENTAL HEALTH SERVICES: PROMISES AND PITFALLS

Lenore B. Behar

ABSTRACT: Litigation against state governments has been one of the strategies to improve services for children with emotional and behavioral problems. The results of such litigation have been spotty in terms of expanding and improving services. Cases in North Carolina and Hawaii are used as examples of successful litigation that had substantial impacts, resulting in new, more appropriate services and expanded budgets. The similarities and differences in these two cases are discussed, as are the elements that appear to contribute to success and the risks associated with such litigation.

KEY WORDS: children; education; Hawaii; litigation; North Carolina; youth.

Over the past 30 years, since publication of the report of the Joint Commission on Mental Health of Children (1970), public policy has focused on developing an array of mental health and other supportive services to meet the needs of children with emotional disturbances. (*Child* is usually defined as under age 18, but it may be 21 or 22, depending on the state.) The Joint Commission Report provided a blueprint for a range of services with increasing intensity that were based primarily in communities. This

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Lenore B. Behar, Ph.D., was the Chief of Child Mental Health Services in North Carolina during the entire course of the *Willie M.* case. She was one of the architects of the *Willie M.* Settlement Agreement and the manager of the *Willie M.* system from 1980–1985 and 1998–2000. She also served as the expert for the Attorney General's Office in Hawaii from 1993–1994 in the *Felix* lawsuit, and then was a member of the court-appointed Technical Assistance Panel from 1994–2000. She wrote this article when she was Director of the Program for Child and Family Research, in the Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine. Since then, she has left that position and now does private consulting as the Director of Child and Family Program Strategies.

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Address for correspondence: Lenore Behar, Ph.D., Director, Child and Family Program Strategies, 1821 Woodburn Rd., Durham, NC 27705. E-mail: lbehar@psych.mc.duke.edu.

concept was based on the belief that (1) children are best served in non-institutional settings close to home; (2) the intensity of need for services varied from child to child; and (3) for each child with an emotional disturbance, the intensity of need for treatment varied as he or she improved (or got worse). The Joint Commission Report and subsequent national studies were submitted to the federal government, and both Congress and the Executive branch developed policies regarding service delivery that were supported by these studies. However, the responsibility for developing public mental health services has fallen primarily to state and local governments and there has been wide variation across the states in the ability or the will to commit funds to services for children with mental health needs.

Professionals and advocates, and particularly the parents of these children, have grown impatient with the failure of their lobbying efforts to get more funding. Thus, another course of action—the use of litigation—has been appealing to some, as it offers the possibility of forcing the state to fund services, while also combining the feelings of justified rightness of the effort, and anger over the failures of past efforts. Such litigation has taken two forms: (1) litigation around services for an individual child, which may set a precedent; or (2) class action litigation that is brought on behalf of a group of children who are similarly situated, and thus similarly harmed.

The passage of Education of All Handicapped People (Pub. L. No. 94-142) in 1975 has provided a foundation for legal challenges against the public education systems of the states. Early lawsuits focused on issues of access and clarification of services: Children with what kinds of disabilities were entitled to what kinds of services? Litigation on behalf of children with emotional or behavioral disorders began to take shape toward the end of the 1970s and has continued since then. Two types of lawsuits that emerged were those addressing 1) the quality of institutional services and/or the inappropriate confinement of children to hospitals, and access to or availability of appropriate services in the community; and 2) the failure of a state to meet the requirements of federal entitlement programs.

The first type of suit was based on inappropriate institutional services, including the issue of discharging minor clients to a community that lacked appropriate services (e.g., *Emily Q. v. Bonta,* 1998). The second type of litigation came later, in the 1990s, and it focused primarily on the state's failure to provide services through Early Periodic Screening, Diagnosis and Treatment (EPSDT), a federally mandated program that is part of Medicaid (e.g., *Scott v. Snider,* 1991; *Frew v. McKinney,* 1993; *J.K. v. Eden,* 1991). The second type of suit is the focus of this article, that is, how litigation has been used successfully to expand community-based mental health services for children, using cases in North Carolina and Hawaii as examples. The expected outcomes of these cases have been that (1) the children who meet criteria are identified; (2) a statewide system of services is created to provide education and treatment services; (3) the identified children get individualized plans for appropriate education and treatment services; and (4) these children show progress or they are stabilized.

Based on the philosophy of the Joint Commission (1970), which was expanded and updated by the Child and Adolescent Service System Program (CASSP) as a federal initiative in 1984 (Stroul & Friedman, 1986), these lawsuits sought to provide a range of community-based services and to integrate them through the central organizing entities of case manager and parent. Table 1 offers a listing of the types of services that should be

TABLE 1
System of Service (from *Willie M.*)

Support Network/ Family/Social	*Housing/Residential*	*Vocational*
• Mentors	• Living at Home	• Assessment
• In-home Services	• Respite Care	• Education/Training
• Before/After School Programs	• Foster Care	• Job Placement
	• Therapeutic Home	• Subsidized Employment
• Recreational Programs	• Professional Parent	• Sheltered Workshop
	• Group Home	• Job Coach
	• Supervised Independent Living	• Job
	• Secure Treatment	
	• Therapeutic Camp	
Educational	*Behavioral/Therapeutic*	*Medical/Health*
• Public School/ Special Ed.	• Assessment	• Crisis Stabilization
• In-School Supports	• Individual Therapy	• Evaluation
• Tutoring	• Family, Group Therapy	• Psychiatric Hospitalization
• Residential Education	• Day Treatment	• Medication Monitoring
• Summer Program	• Substance Abuse Services	
	• Wraparound Services	

available through a system of care. The integrating mechanism is the case manager/care coordinator whose function it is to convene a team of relevant providers to design the service plan together with the parents.

In 1990, The Foundation for Child Development published five case studies of litigation that were selected "because they illustrate ways in which advocates have successfully grappled with issues affecting children at risk" (Soler & Warboys, 1990). These cases exemplify the belief "that a successful advocacy effort seldom relies exclusively on litigation or any other single tactic" (preface; Soler & Warboys, 1990). The case presented that addressed children with emotional or behavioral disorders was the North Carolina case, *Willie M. v. James B. Hunt Jr.* (1979), which was one of the earliest successful cases that resulted in expanding a system of mental health and other services for children. Several cases focused on children with emotional or behavioral disorders, as cited above, during the 1980s and early 1990s, with varying degrees of success in substantially changing the availability of services and the systemic approach to delivering those services.

A more recent case that has effectively created such a system is the Hawaii case, *Felix v. Waihee* (1993), renamed *Felix v. Cayetano* in 1996 when the governorship of Hawaii changed. In addition to being class action lawsuits with strong legal basis, these two cases share some of the hallmarks of effective litigation—the effective implementation of Settlement Agreements resulting in improved and expanded services. Thus, these two cases, both heard in federal district courts, will be discussed as examples of successfully implemented lawsuits, looking at both the promises and the pitfalls of using litigation to improve services. As described below, each lawsuit had a profound impact on the state involved, in terms of how services were developed, how budgets were structured, and how services to other children (i.e., non-class members) were affected.

SUMMARY OF *WILLIE M. V. JAMES B. HUNT, JR.*

In October 1979, a class action lawsuit was filed in North Carolina on behalf of four children, the first of which was *Willie M.* The suit claimed that these children and others similarly situated had been denied their rights to educational and treatment services to which they were entitled under a variety of federal and state laws, primarily the right to education and related services, and the right to treatment if involuntarily confined for that purpose. The common characteristics of the class that led to the denial of services rightfully theirs were that the children were violent or assaultive and that they had mental or emotional handicaps, specifically "all North Carolina youth under age 18 who suffer from serious emotional, mental or neurological handicaps; exhibit violent or assaultive behavior; are, or will be, institutionalized; and are not receiving appropriate treatment or education services" (*Willie M. v. Hunt,* 1979). The defendants were the Governor, the Secretary of Human Resources (now named Health and Human Services), the Chairman of the North Carolina School Board, and the State Superintendent of Public Instruction. Judge James McMillan heard the case in the Federal Western District of North Carolina; this was the same judge who had presided over the Charlotte-Mecklenburg desegregation/busing case some 10 years before.

There has been wide variation across the states in the ability or the will to commit funds to services for children with mental health needs.

In September 1980, just 11 months later, the parties agreed to a settlement that obligated the state to identify, educate, and treat all children who met the criteria of the class, as defined in the lawsuit. The court order established a panel of five members and a full-time panel administration to oversee the state's progress in fulfilling its obligations. The panel met 1 to 2 days per month and had a full-time administrator to keep a watchful eye on the state's activities. The court order provided for payment to the plaintiffs' attorneys for their continued involvement with their clients.

The plaintiffs' attorneys and the defendants, primarily the leadership within Mental Health/Developmental Disabilities/Substance Abuse Services (MH/DD/SAS), jointly crafted the Settlement Agreement. The agreement required a full continuum of community-based services (as described above in Table 1) to be developed through the public system of local mental health authorities. The Attorney General's staff presented the terms of the Settlement Agreement to the Legislature and reminded the Legislature that a federal takeover was one consequence of failure to comply with the requirements of the Settlement Agreement. They implied that Judge McMillan could hand over to federal marshals the systems that served the class members, as had been done a few years earlier with the prison system in Alabama. The North Carolina Legislature took the court order very seriously and regarded funding for these services as mandatory. Because the Legislature viewed funding the requirements of the lawsuit as an obligation, they appropriated large amounts of funds semi-annually, beginning in 1981. The disadvantage of this position, discussed in more detail below, is that state funding for other children with emotional or behavioral disorders, who represented 98% of the client population, did not increase for the next 20 years, essentially. While the Legislature recognized the responsibility of meeting the requirements of the Settlement Agreement, they did not embrace the concept of providing services that would prevent children from reaching the point of serious violence or assaultiveness. Nor did they provide state funding for services that would address the needs of other children with serious emotional or behavioral disorders that did not result in violent or assaultive behaviors. Thus, the *Willie M.* lawsuit successfully gained resources for the class members, and it set the agenda for all of children's mental health for many years to focus almost exclusively on this population.

The major impact of the Settlement Agreement was to ensure that a full continuum of services was available across the state for class members, and that these children received services tailored to their needs, rather than fitting the children to the existing services. Over the course of the 19 years that the State of North Carolina was under the supervision of the court, a statewide network of services was developed specifically to meet the needs of the *Willie M.* population. This network of services was a fine demonstration of what could be done with adequate funding for a very "deep-end" population. The *Willie M.* Program included an array of high-quality services and a good quality-assurance program, statewide staff training, and a data system that allowed ongoing assessment of the progress of programs and children. From the beginning, MH/DD/SAS required that all relevant agencies and providers participate in the design of the service plan, called the "treatment-habilitation plan." In most cases, the other agencies and providers willingly participated in treatment-habilitation planning sessions, as they saw the *Willie M.* Program as a vehicle for getting needed services—and paying for them. Only in later years was there a push for other agencies to participate in the funding of services, using their entitlement dollars or other funds; and only in later years was there an emphasis on using Medicaid funds. Initially, it was easier for the local mental health centers to use the state *Willie M.* dollars as they were more flexible; but as the budget grew, it became clear to the leadership in MH/DD/SAS and the Legislature that other existing funding sources should be used. The use of Medicaid funds was encouraged, as this source was approximately 65% federal and 35% state funds, which was a better use of state funds than funding services with 100% state dollars.

In the Willie M. case, the Settlement Agreement obligated the state to provide a full continuum of services to the children and ensure that the services addressed the individual needs of each child.

The requirement that class members be identified on a continual basis was met, beginning in 1982, through a clearly defined process of identification and certification of class members. The size of the class grew from 982 in 1982 to 1,660 in 1999, the latter figure representing .09% of the state's population of children under age 18. As many class members had serious, ongoing disturbances, they tended to remain in the class for an average of 5 years, which, for many, represented reaching their 18th birthday or aging out. Newly identified class members were added to this "carryover" population. The average age when class members were identified showed a modest decline over the years from 14.37 in 1982 to 13.03 in 1999. The number of class members per 100,000 children rose from 59.4 in 1982 to 90.4 in 1999. The racial distribution has remained stable over the years and parallels that of North Carolina's population, with approximately 57% White, 38% African-Americans, and 5% other ethnic groups. The *Willie M.* population has been consistently and predominantly male (about 81%).

The approximately 1,660 class members (1999 figures, which have remained constant over the past 2 years) received highly individualized services based on a treatment-habilitation plan. The plan was the product of the family and the child's service team, which was made up of the public or private agency staff, or individual providers who were involved with the family. Service plans were reviewed for needed changes every 6 months, but could be changed more frequently based on the needs of the child.

The treatment of these children was based on a risk and resilience model, which assumed that, by developing protective factors, the child could compensate for the risk factors (Masten, Hubbard, Gest, Tellegen, Garmezy, & Ramirez, 1999; Vance, Fernandez, & Biber, 1998; Richman & Fraser, 2001a). Children in the *Willie M.* class have backgrounds that, for the most part, put them at high risk for negative outcomes, which include dropping out of school, teen pregnancy, adult mental illness, involvement in the criminal justice system, and/or substance abuse. The categories of risk used to describe the population include (1) problems of early development, (2) presence of childhood disorders, (3) negative life experiences, and (4) social drift. Table 2 provides a listing of subcategories. Children who had four or more risk factors within these categories were considered at risk for poor outcomes. The average class member had 15 risk factors when he or she entered the program, which means that these children were at very high risk.

Based on the assumption that assets and strengths (i.e., protective factors [resilience]) would provide a counterbalance to the risk factors (Masten et al., 1999; Richman & Fraser, 2001a; Richman & Fraser, 2001b), each service plan focused on goals that would increase the child's strengths in areas of noted deficits. Outcomes of such focused treatment yielded some positive results, as noted in Table 3.

In 1999, the total budget for the *Willie M.* Program was $91.2 million. Funding consisted of 60% state mental health funds and 32% Medicaid funds, which provided $83.9 million for treatment and $7.3 million for

TABLE 2
Common Risk Factors Among *Willie M.* Clients as a Group

Risk Factor	*Percentage*
Early Development	
Neurological impairment or developmental delays	48.2
Negative Experiences	
Witnessed extreme conflict or violence	93.3
Negative relationships with one or both parents	90.9
Removed from their homes at some point	87.8
Documented as being physically abused	73.0
Experienced substantiated neglect	45.6
Stressed Families	
Single, divorced, or separated families	91.5
Families living in poverty	91.1
Families made frequent moves	67.2
Siblings born within two years	46.0
Parents with Considerable Problems	
Mental disorders	76.8
Substance abuse problems	75.3
Criminal involvement	55.7
Social Drift	
Academic failures or dropouts	68.0
Negative peer groups	62.0
Childhood Disorders	
Problem with repeated aggression	100.0
Behavioral or emotional problems	99.7
Trouble with the law	98.9

education (8%). The serious nature of the class members' problems and the commensurate cost of providing services and the supports listed above, at an average cost of approximately $50,000 per year per child, created an expensive program. This average cost reflected a wide range of variations in per-child cost, as shown in Table 4.

It is most important to realize that this high price tag is not typical of the full range of children with emotional disturbances; but this is the cost of treating one of the most difficult populations within this group.

In 1998, when the State of North Carolina was found by the court to be in compliance with the terms of the Settlement Agreement "to the extent practicable," those concerned about the availability of future protections

TABLE 3
Psychosocial Protective Factors Among *Willie M.* Clients as a Group

Protective Factor	*Upon Entry into Program (percentage)*	*After at Least One Year in Program (percentage)*	*Difference (percentage)*
Competency			
Perceives self as being competent at some activity	96.2	99.5	3.3
Shows problem-solving skills	41.6	72.8	31.2
Engaged in hobby or extra-curricular activities	36.7	70.8	34.1
Good reader	24.9	39.6	14.7
Judged as good student	10.6	29.2	18.6
Family Support			
Children feel their parents care	82.5	96.3	13.8
Other adults or children helping with child care	83.0	93.7	10.7
Parents consistently employed	75.8	90.2	14.4
Fair discipline at home	59.0	86.1	27.1
Parents with high school degree or better	62.7	81.4	18.7
Families with regular rules, routines, and chores	50.6	77.1	26.5
Children have positive relationship with parents	52.5	76.4	23.9
Families with regular church involvement	32.9	51.6	18.7
Social Skills			
Children perceived as “likable”	57.3	87.2	29.9
Described as having a sense of humor	52.8	84.8	32.0
Shown ability to get alone with adults	40.3	74.4	34.1
Shown ability to get along with other children	31.1	68.6	37.5
Shown empathy or nurturing behavior	23.2	57.3	34.1

TABLE 3 (*Continued*)

Protective Factor	*Upon Entry into Program (percentage)*	*After at Least One Year in Program (percentage)*	*Difference (percentage)*
Social Support			
Positive relationship with someone at school	54.3	80.9	26.6
Adult mentor outside the family	48.0	76.7	28.7
Special support from peers	33.0	62.6	29.6
Some reliance on inner faith	32.7	61.4	28.7

and services counted on the fact that the Settlement Agreement essentially had been written into state law. Within months of this decision, the Legislature asked the Department of Health and Human Services for a 5-year plan to broaden the system of care and its rich funding to other populations of children with serious need for mental health treatment, despite their recognition that compliance with the Settlement Agreement was in part attributable to the level of funding. The legislators moved quickly to

TABLE 4
Costs of Treatment and Habilitation Services for *Willie M.* Clients, Fiscal Year 1998–1999

Cost of Services ($)	*Number of Children*	*Percentage of All Children*	*Total ($)*	*Percentage of All Expenditures*	*Cost/Child ($)*
0–23,999	903	47.4	6,200,000	7.7	6,866
24,000–49,999	352	17.9	13,000,000	16.1	36,931
50,000–74,999	255	13.0	15,900,000	19.8	62,353
75,000–99,000	202	10.3	17,600,000	21.8	87,129
100,000+	225	11.5	27,900,000	34.7	124,000
State Total	1,965	100.0	80,600,000	100.0	41,038
	1,607.7 (average caseload)		80,600,000		50,133

repeal the law and required that the 5-year plan be completed in 1 year. It remains to be seen if much of the program can be protected, which is a considerable challenge given the very weak status of the state budget.

SUMMARY OF *FELIX V. WAIHEE*

In October 1993, a class action lawsuit was filed against the Governor of Hawaii, John Waihee, and members of his administration, specifically the Director of the Department of Health and the Superintendent of the Department of Education. The suit was filed on behalf of Jennifer Felix by her mother and by others similarly concerned with children who had been denied their right to a free and appropriate education and related mental health services necessary to address their mental health needs. The complaint stated a series of violations of the rights of these children by the State of Hawaii and by the two major departments of state government, the Departments of Education and Health. The common characteristics of the class were that the children were under age 20 and they were eligible for education and mental health treatment services under the Individuals with Disabilities Education Act (IDEA)* or Section 504 of the Vocational Rehabilitation Act (1973); and that they either had not been identified or had not received the services necessary to help them benefit from their educational experience. Judge David Ezra of the Federal District Court of Hawaii heard the case.

In October 1994, the governor and his top administrators signed a Consent Decree, which was primarily crafted by the plaintiffs' attorneys and the Attorney General's Office. There was limited input from the Departments of Health and Education, which would be responsible for implementing the agreement. In the Consent Decree, the State of Hawaii promised to identify children who met the criteria of the class definition and to develop and expand, to the needed capacity, a comprehensive system of education and related mental health services and placements. They further promised to develop an integrated system of care for class members, in keeping with CASSP principles, and thus to make a seamless system of education, treatment, and support services (Stroul & Friedman, 1986). Thus, the State of Hawaii's obligations under the Consent Decree would bring them into compliance with IDEA and Section 504, regarding the specific population of children in need of educational and mental health services. They further promised to complete these requirements by June 2000. Other features of the Consent Decree included the appointment of

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*Formerly the Education of All Handicapped People (Pub. L. No. 94-142), which was also partially the basis for the *Willie M.* lawsuit.

a court monitor and a three-person Technical Assistance Panel, one of which was the court monitor. The monitor and Technical Assistance Panel worked as much as was needed, which averaged 25% to 33% time. A full-time executive director and staff for the monitor's office were hired to handle daily activities.

During the first year of the state's response, the focus was on developing an implementation plan that met the approval of the parties—the plaintiffs' attorneys, the Attorney General's Office, the Governor, the Departments of Health and Education, the parent organizations, and the advocacy organizations. The first plan underwent several modifications throughout the following 5 years, and each modification improved the likelihood of state compliance. As in the *Willie M.* Settlement Agreement, the major requirement was to ensure that a full system of services was available to the class members and that the services provided addressed the individual needs of each child. However, in the *Felix* case, the emphasis was on the schools as the agency of primary responsibility, thus requiring a strong working partnership between the school system and the mental health system. During the course of response to the lawsuit, one of the most difficult administrative dilemmas was deciding how this partnership could best be forged. Ultimately, the decision was that all children needing mental health services as part of their Individualized Education Plan or 504 Modification Plan would be served through the schools, except those who required intensive outpatient or residential treatment services. The former included day treatment and other combinations of intensive services. The schools were to provide the care coordination for those receiving services through the schools; and the state child mental health agency was to provide care coordination for those needing more intensive service. The lead agency within the Department of Health was the Child and Adolescent Mental Health Division (CAMHD), and they consistently led service planning and implementation for that department. Within the Department of Education, the Division of Special Education assumed the leadership; however, over time it became clear that other parts of the department were critical to successful implementation, so a coordinating office within the education agency was established.

From 1994 to the present, the education agency had more obstacles to overcome than the mental health agency, primarily because of their broader mission, larger population, and lack of earlier attention to and understanding of the target population. Further, there were greater leadership problems within the education agency, which was deeply entrenched in old ways and the "old guard." A new school superintendent was hired in 1998, and this brought about substantial change in commitment and practice. However, the Department of Education was clearly behind in meeting its own goals, as stated in the Implementation Plan. The areas in which the school system failed to make sufficient progress included the identification of children, the timely review of qualifications for IDEA, the hiring of sufficient numbers of certified teachers and special education teachers, the appropriate placements of children in special services/classes, and the development of an integrated data and tracking system with the Department of Health, Child and Adolescent Mental Health Division (CAMHD).

In the* Felix *case, the emphasis was on the schools as the agency of primary responsibility, which required a partnership between the school system and the mental health system.

The progress in the mental health treatment system was steadier, primarily because the leadership more readily embraced the importance of change. However, that agency and its local entities, the Family Guidance Centers, were also unable to make progress as rapidly as was needed because there were not sufficient numbers of trained care coordinators or, in some cases, other types of service providers. During the first few years of the settlement period, CAMHD implemented a rocky managed care demonstration project in one part of the state, and eventually closed that project in favor of a statewide change to contracting for all direct service except care coordination. These changes had a negative impact on private service providers who saw their autonomy being challenged by the contracting process.

In 1996, both agencies, education and mental health, embarked on a unified, intensive training program to (1) inform all providers of education and treatment services about the requirements of the lawsuit and the importance of identifying eligible children; (2) increase their skills in identifying children, and planning and delivering services to them; and (3) incorporate parents as part of the decision-making team.

By June 1995, the number of children identified as meeting the *Felix* criteria was 1,550, or 825 per 100,000 (.82%) of the school-age population, a low figure compared with other states. By June 2000, an improved identification process was established and the number of eligible children rose to 5,449 per 100,000 (5.5%), a more acceptable figure compared with the national averages (U.S. Department of Education, 2000).

In the schools, training to increase skills evolved into a focus on behavioral management training and training to use student support teams as the primary step in intervention. In the treatment system, training focused on care coordination and the use of evidence-based interventions to the extent available. It was a priority to use the Multisystemic Therapy for children with conduct disorders (Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1998).

Unlike most other states, the state agencies in Hawaii can exceed their budgets and ask the Legislature to cover the deficit; then these additional funds, upon justification, also become a part of the following year's budget. This somewhat unusual method of state funding has allowed for substantial growth in the treatment system, with a budget increase from $40 million in 1994 to $95 million in 2000. Expenditures were distributed across levels of care as depicted in Table 5. The average cost per child served is $9,131, which is substantially less than the average cost of $50,133 in the *Willie M.* Program. However, the target populations are clearly and substantially different.

In 2000, when Hawaii was to have fulfilled the requirements of the *Felix* Settlement Agreement, it was clear that although substantial progress had been made, more time was needed for full compliance, especially by the education system. The compliance date was extended several times, until the court expressed profound frustration and declared that November 1, 2001, was the final date, after which the state's services for these children would be put in receivership. The court's impatience was fueled by lack of progress within the education system, but also by the posture of the Hawaii Legislature, which wanted to investigate the use of funds—with a plan to decrease funding.

OBSERVATIONS

Both the *Willie M.* and *Felix* cases are considered to be successful lawsuits because the States of North Carolina and Hawaii agreed to provide

TABLE 5
Cost of Services by Client by Level of Care for *Felix* Clients
Fiscal Year 1999–2000

Level of Care	*Number Served*	*Cost($)*	*Number of Units*	*Unit Costs ($)*
School-based[a]	9,759	26,728,292	464,489	47.60
Intensive outpatient	4,034	24,368,570	617,414	153.05
Residential	802	44,616,675	139,753	174.26
Total	10,482	95,713,537	1,221,657	116.55
Average cost per child		9,131.23		

[a] Includes only mental health services in schools, not special education services.

remedies for the defined population of children by expanding and increasing services, and increasing budgets sufficiently to do so. In both cases, the expected outcomes were that (1) children who met criteria were identified; (2) a statewide system of services was created to provide education and treatment services; (3) the identified children received individualized plans for appropriate education and treatment services; and (4) these children showed progress or they were stabilized. These four sets of expectations were met in both cases, as defined by the criteria set by the federal courts and measured by the monitoring bodies of the courts. The other common characteristics of these cases that helped to ensure the state's compliance included active supervision by the court, court-appointed person(s) to oversee the state's activities, persistent plaintiffs' attorneys paid for involvement, and involvement of advocacy and/or parent groups.

COMPARISONS

A structural difference in these two class action lawsuits is the length of time the states took to come into compliance with their respective Settlement Agreements. In January 1998, some 18 years after the October 1979 filing of the complaints, Judge Graham Mullen of the Western District Court of North Carolina found that the State of North Carolina had fulfilled its obligations "to the extent practicable." Although the State of Hawaii has not met its obligations, and is under threat of further court action, there is reason to believe that those obligations will be met in less than a 10-year period for the suit filed in 1995. The major difficulties remain within the education system, but there now appears to be effective leadership and the will to make needed changes and expansions in services. The mental health services essentially appear to be in place.

In meeting the obligations of a Settlement Agreement, the education agency had more obstacles to overcome than the mental health agency.

Both the *Willie M.* and *Felix* lawsuits have resulted in improvements in the organization of services by requiring multiple agencies to coordinate their plans and services for the involved class members. In both states, the leadership was able to institute more sophisticated approaches to service delivery for the class members than could be achieved for others receiving mental health treatment or special education services, which resulted in clear inequities and resentments. In both states, the mental health agency was able to require much more data on each child throughout his or her course of treatment than could be required about other clients in the system, such as children who were not class members, or adults who were receiving mental health treatment. Payment to providers was linked to the submission of these data. In North Carolina, it was required that the service plan be linked to measured risk factors and to a focus on building protective factors. In Hawaii, it was required that providers use standardized assessment tools and evidence-based practices when possible and, when this approach to treatment was not used, they were required to justify it. The courts defined the criteria for success in both states. The courts' monitors reviewed the clinical and educational status of class members to determine whether the state agencies made a good-faith effort to comply with the requirements, and whether they were successful in bringing about improvements in class members' functioning. As each state approached compliance, the court required a self-monitoring system to be in place. Although both programs had systematized the monitoring of provider performance and child outcomes, the *Felix* Program used a more comprehensive array of standardized instruments. In addition, the *Felix* Program used a specific method of review, which had been designed to measure system performance and child status and progress in similar class action suits on behalf of children (Groves & Foster, 1995). The state's response to the *Felix* lawsuit benefited from 1) occurring 15 years later, when more validated instruments had been developed; and 2) having a monitor and Technical Assistance Panel that worked to establish more objective means of evaluating progress.

Both the* Willie M. *and* Felix *cases were successful lawsuits because the States of North Carolina and Hawaii agreed to provide remedies for the children by expanding and increasing services, and by increasing budgets.

A major, substantive difference between these two cases lies in the definition of the population of children considered to be class members. The class members in the *Willie M.* case are defined as "all North Carolina youth under age 18 who suffer from serious emotional, mental or neurological handicaps; exhibit violent or assaultive behavior; are, or will be, institutionalized; and are not receiving appropriate treatment or education services." Although the class action lawsuit was based, in part, on the rights of children under IDEA, there was no requirement that the class members meet the criteria for IDEA. And although the Chairman of the North Carolina School Board and the State Superintendent of Public Instruction, the state education agency, were included as defendants, the involvement of the public education system was minimal, in terms of major changes in that system, for children with serious emotional or behavioral problems.

The children in the *Felix* case include all Hawaii youth under the age of 20 who have educational disabilities as defined by IDEA or Section 504 and who need mental health services. Given this difference in definition, the *Willie M.* class members represent a smaller percentage of the child population of the state and they have, as a group, more serious impairments, presenting greater challenges to treatment and requiring higher per-child expenditures. The *Felix* class members represent a broader group of those with emotional or behavioral disorders, ranging from mild impairments to those with impairments similar to the *Willie M.* class. Another difference lies in the requirement that the *Felix* class meet the definition of IDEA or Section 504, bringing together the responsibilities of the education and treatment systems. The requirement of violent or assaultive behavior for the *Willie M.* class often brought together the responsibilities of the juvenile justice and mental health treatment systems.

There are positives and negatives to both the narrowly defined population of the *Willie M.* case and the broader population of the *Felix* case. The narrowly defined population resulted in a wealth of needed resources being made available for a small, but very much impaired, sub-group of those in need, to the exclusion of others with serious mental health problems. Thus, it skewed the entire service system for child mental health in North Carolina. In North Carolina, funding for the larger number of other children with mental health needs was compromised for almost all of the 19 years, and it never reached the total dollar amount of state funding that services for the 1,600 class members did. During the same time period of 19 years, the number of other children served in the mental health system rose from 20,000 to 78,000. Much of the funding was through Medicaid, which left unaddressed the needs of those with serious emotional disturbances who were not eligible for Medicaid coverage.

Because the class members had such extensive problems and were so difficult to treat, the per-child cost was extremely high, giving the impression to some that all children with emotional or behavioral disorders required such a high dollar commitment. The advantage of such a narrow focus has been the demonstration that assaultive children with serious mental health problems *can* be served in community-based programs, and many of them *do* get better. Further, the implication is that if these most difficult children can be served and their conditions ameliorated, then much appears to be gained in serving those less seriously impaired or those less difficult to treat.

The narrowly defined population, with its precise characteristics, also made clear who was eligible for class membership and who was not, which prevented the issue of whether the resources were spent on non-eligible children. The specificity of the class definition, however, encouraged practitioners to try to "wiggle" children into the class in order to get treatment for them, which resulted in stretching diagnostic and descriptive information. The practice of attempting to stretch the boundaries also resulted in numerous challenges to the definition and to the decisions made by a review committee. Handling these challenges required procedures that involved resubmissions, appeals, and finally hearings for cases that were pushed forward, sometimes with success, but most without.

Class action lawsuits can be effective in bringing about change for the target population of children with the need for mental health services.

The broader approach of the *Felix* case resulted, as intended, in a higher percentage of the child population identified and treated. Children with a much broader range of needs were served, but those children whose emotional disturbances did not produce educational problems may not have received the full array of services needed. The *Felix* population had a wider range of problems, from mild to severe; and the costs of treatment varied accordingly. Thus, the average cost-per-child-served was substantially lower than in the *Willie M.* population. With a more diffuse definition, there was the belief by some that resources were being wasted on children who did not really have emotional or behavioral disorders and/or did not need treatment. Because the definition of the class hinged on being identified within the educational system, other issues emerged, including (1) concerns about the over-identification of children with mental health needs compared with other impairments; (2) the need for extensive training of school personnel in the identification and referral process; and (3) the reluctance of some school personnel to identify those in need of special settings and/or treatment. With two major agencies involved equally in the remedy, the requirements for joint planning and joint service provision stretched the limits of both systems.

Another issue that is exemplified by both lawsuits is the fragility of the expanded services and funding. In both lawsuits, as soon as the court oversight was diminished or eliminated, the legislative funding body made efforts to expand the eligibility criteria (North Carolina) or to decrease the funding (Hawaii). Despite the gains, newly developed or expanded services seem to require constant oversight, either by plaintiffs' attorneys, advocates, and/or parents.

CONCLUSIONS

These somewhat different legal experiences in two very different states with very different populations of children have demonstrated that class action lawsuits can be effective in bringing about change for the target population. They also have made clear that there is a price to pay for such emphasis on one segment of the population of children in need. However, the hope is that what was learned from these cases has been generalized to services for other populations of children. Hopefully, in both locations, practitioners and administrators have learned that (1) very difficult children can be served in community-based programs using an integrated system of care, (2) teamwork across agencies benefits the treatment and education of children, (3) families have a vital and positive role in the habilitation or rehabilitation of their children, and (4) individualized planning for each child's unique strengths and deficits has positive effects on the life of each child.

Although these class action suits have been major successes in gaining services to which children are entitled in the two involved states, there remain many states in which similar children have not received the services necessary for them to benefit from their educational programs or to live in relatively unrestricted community settings. It would seem prudent for other states to expand their services to meet the requirements of IDEA and avoid similar legal actions and high administrative costs. However, the history of litigation on behalf of similar children suggests that state leaders seem to assume or hope they are in compliance with relevant laws until challenged. It would indeed be unfortunate if these challenges must be made state by state.

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