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Report on Services for Severly Disturbed Children in Oregon

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REPORT ON SERVICES FOR SEVERELY DISTURBED CHILDREN IN OREGON


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"To inform its members and the community in public matters and to arouse in them a realization of the obligations of citizenship."
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REPORT
ON
SERVICES FOR SEVERELY DISTURBED
CHILDREN IN OREGON

To the Board of Governors,
The City of Portland:

I. INTRODUCTION

Committee Assignment

Your Committee was assigned in March, 1969 to
“ascertain what public and privately financed facilities are available for
psychiatric assistance to severely disturbed children, what progress is being
made to increase the availability of such programs and facilities, and to make
recommendations as to how more adequate and comprehensive programs can
be implemented.”

Your Committee organized and began its task in September, 1969. After the
resignation of its original chairman and a period of inactivity, the reorganized
Committee resumed its study in March, 1970. A bibliography of materials re-
viewed by your Committee is set forth in Appendix A. A list of persons interviewed
is found in Appendix B.

Definitions and Classifications

Emotional disturbance in children, as in adults, varies widely in degree.
The spectrum ranges from mild or occasional interference with “normal” behavior
patterns to total inability to live and function in the social environment. In carry-
ing out its assignment to consider “severely disturbed” children, your Committee
has adopted the definition used by Dr. Eugene E. Taylor in his important 1964
study. Children who are victims of “severe” emotional disturbances are those
“who are so disturbed that they cannot live and adjust in their own homes,
or in an ordinary foster home, be educated in a regular school classroom, or be
given adequate help by outpatient therapy for themselves and their families.”(1)

Dr. Taylor classified severely disturbed children into three groups.(2)
1. Child suffering temporary but extreme reactions to stress, to the extent
that permanent emotional damage will occur in the absence of special
psychiatric treatment (“transient situational disturbances”);
2. Chronically disturbed, but non-psychotic children who display extreme
reactions over a longer period of time;

Both of the first two groups include children whose behavioral manifestations
of severe emotional disorder may range from extreme aggression toward others or
destruction of property, running away from home, hallucinations and disabling
fears to severe depression and withdrawal from normal childhood activities. The
distinction in the first two groups is between recent development of such extreme
symptoms and chronic, long-standing persistence of them.

Psychotic children suffer extreme dissociation from reality. Some are “autis-
tic,” paying no attention to anyone, ignoring the presence of others, refusing to

(1) Eugene E. Taylor, M.D., Needed Services for Severely Emotionally Disturbed Children
in Oregon (1964), p. 1 (hereinafter cited as “Taylor”). This study was prepared for the
State Mental Health Planning Board. Dr. Taylor at that time was a member of the Uni-
versity of Oregon Medical School Faculty in Child Psychiatry and also a staff psychiatrist
of the Multnomah County Community Mental Health Clinic. He presently devotes full
time to the latter position.

(2) Taylor, pp. 18-21.
talk, or acting as if they are aware of nothing going on around them. Others are "symbiotic," manifesting similar extreme symptoms of withdrawal, except for an excessive clinging to the mother and severe panic in the mother's absence.

Emotionally disturbed children, for purposes of the Committee's work, are distinguished from the mentally retarded. While some mentally retarded children may also suffer from severe emotional disturbance, their mental retardation arises out of physiological conditions and may require quite different programs from those aimed at childhood emotional disturbance. Also to be distinguished from emotionally disturbed children, although this is sometimes difficult to do, are those whose abnormal behavior results from neurological or other physical handicaps, rather than from psychological factors.

In discussing "children," your Committee refers to persons through secondary school age, i.e., birth to age 19. Within this definition, distinctions are often drawn in programs between emotionally disturbed children of school age (6 to 19) and pre-school children (birth to 6). Within the school age group, a further distinction is often made between adolescence (roughly ages 13 to 19) and pre-adolescence (ages 6 to 12). Your Committee's discussion follows these classification definitions where relevant.

II. PREVALENCE OF SEVERE EMOTIONAL DISTURBANCE IN OREGON CHILDREN

Children 14 years old and younger make up about 30 percent of Oregon's population. Children up to 19 years of age constitute some 40 percent of our total population. Studies indicate that about 7 percent of Oregon's children suffer some degree of emotional disturbance serious enough to require mental health services and about one-half of one percent of Oregon's children are afflicted with severe emotional disturbance requiring residential treatment.

Applying these percentages to 1970 population figures, a current estimate would be that approximately 56,000 Oregon children are so emotionally disturbed as to need some form of professional care, of whom about 4,000 are severely disturbed to the extent of needing intensive treatment. (3)

All children who are victims of severe emotional disturbance would not require residential treatment at the same time. Dr. Taylor in his 1964 study estimated that there would be about 770 new cases of severe emotional disturbance in Oregon children each year. He concluded that intensive treatment facilities were needed for about 1,000 severely disturbed children in Oregon at any one time, of which about one-third would serve children under the age of 12 and two-thirds would serve children over that age. (4) Dr. Taylor described these needed facilities as 320 beds for full time residential hospital care, 400 day treatment spaces, 110 therapeutic nursery spaces, and about 165 spaces in therapeutic foster homes for individuals or groups. A 1970 report of the State Division of Mental Health closely follows Dr. Taylor's conclusions as to the number and categories of severely disturbed children requiring intensive treatment at any one time. (5)

Your Committee believes that these estimates of the prevalence of severe emotional disturbance in Oregon children and needed facilities for treating them are very conservative. They are based primarily on conditions existing prior to the completion of Dr. Taylor's study in 1964. Since that time, there has been considerable population growth which has undoubtedly increased the numbers of children afflicted with severe emotional disturbance. Moreover, there has been no substantial expansion of treatment facilities for severely disturbed children since 1964. There is, therefore, no reason to believe that there has been any reduction in the prevalence of severe emotional disorders by reason of therapeutic treatment.

(4) Taylor, pp. 17-18, 21-25.
III. PRESENT FACILITIES FOR SEVERELY DISTURBED CHILDREN

The shortage of residential treatment and intensive care facilities for severely disturbed children in Oregon is nothing less than shocking. It is all the more so because the gap between the needs of children and the available services has been recognized for years, with practically no improvement in the situation.

**Full-time residential treatment facilities.**

With one possible exception, there is no publicly-operated institution or facility in the State of Oregon providing full-time residential treatment of emotionally disturbed children. Edgefield Lodge, operated by Multnomah County, might be regarded as a full-time residential treatment facility. It affords a five-day per week residential treatment program for 30 children, ages 6 to 12, open only to residents of Multnomah County. Its practice of sending children to their homes on weekends is intended as an important part of its efforts to treat a child in the context of his family environment.

The need for at least 320 full-time residential treatment spaces for severely disturbed children found by Dr. Taylor in 1964 is answered only in part by private organizations, with various limitations on their services. Parry Center in Portland provides full-time residential treatment to 40 children, ages 6 to early adolescence. Like most private facilities, it cannot accept children who set fires or require physical restraint to avoid injury to themselves or others or destruction of facilities. Christie School near Portland affords full time residential care to 40 girls, ages 10 to 16, with similar limitations on the type of children who can be accepted. Waverly Children's Home in Portland provides full-time residential treatment for 20 to 24 disturbed pre-school children between the ages of 4 and 7. It can also furnish foster home care for children discharged from intensive treatment. The Children's Farm Home in Corvallis provides full-time residential care for 50 children, ages 12 to 18, but cannot accept overtly psychotic children who present the above mentioned hazards to safety of themselves and others.

Several other private facilities in the Portland area provide some degree of treatment for emotionally disturbed children in full time residential care programs which are not limited to children with severe emotional disturbance. The State Mental Health Division currently counts a total of 174 beds in the state for full time residential care of disturbed children.\(^6\)

Thus, the present full time residential treatment facilities in Oregon for disturbed children serve a maximum of about 174 children at any one time, are located only in Portland and Corvallis areas, and exclude children whose behavior constitutes extreme safety hazards.

The institutions providing full time residential treatment to emotionally disturbed children have large waiting lists. Severely disturbed children who must be in a custodial or residential facility, but cannot be admitted to one of the few existing facilities are often committed to one of the Oregon's state mental hospitals, for lack of any other place to put them. Four hundred and fifty children between the ages of 12 and 17 were admitted to Oregon's state mental hospitals in the two year period ending June 30, 1968, of whom 59 were in these hospitals on that date.\(^7\) Another 13 children under the age of 12 were admitted to these mental hospitals in the same period. Children committed to Oregon's state mental hospitals are not housed separately from adult patients. Until 1969, there were no special programs for children in the mental hospitals. A modest program limited to adolescent children now exists, but it is in no sense a treatment program comparable to those at Parry Center or Christie School. No special program exists at all for the few children under the age of 12 committed to the mental hospitals.

Many other childhood victims of severe emotional disturbance find themselves before juvenile courts as a result of "delinquent" behavior. Some juvenile detention centers provide diagnostic and temporary treatment services to such children. The Child Guidance Clinic in Portland, for example, has a contract with Multnomah County under which it gives priority in its services to diagnosis and short term

\(^6\) Ibid., p. 4.

\(^7\) Oregon State Mental Health Division, Mental Health Division Programs (1969), p. 27.
treatment of disturbed children involved in juvenile court matters. These services obviously represent a band-aid for cases of severe emotional disturbance when hospitalization or other special residential treatment is needed.

In the absence of a proper treatment facility, some severely disturbed children are committed to McLaren (boys) or Hillcrest (girls), the state training schools for delinquent children. The superintendent of Hillcrest in 1964 estimated that 30 of 120 girls committed there needed intensive psychiatric treatment. In a 1961 study of 100 boys committed to McLaren, Dr. Prasanna Pati, the school's psychiatric consultant, found that 40 evidenced symptoms of severe emotional disturbances, and that many others were cases of "neurotic delinquency" (boys who demonstrate neurotic anxiety and guilt through antisocial acts) and "character neuroses" (boys with character problems such as extreme dependency and sexual confusion).

A few other full-time or day residential treatment spaces have been available in Oregon from time to time as experimental or temporary programs funded by public or private grants. An experimental program known as the Child Diagnostic Center was in operation by Edgefield Lodge under contract with the State Division of Mental Health from October 1968 to June 30, 1970. It provided full-time residential treatment for five children at a time, until it was discontinued for lack of further legislative funding. A total of 78 children was admitted while it operated, out of approximately 700 requests for services.

Day Treatment Facilities

As to day care treatment for emotionally disturbed children, such facilities presently exist only in Multnomah County. Until recently, there were only the 30 spaces available at Edgefield Lodge, open only to children of Multnomah County residents, as against the statewide need of 400 spaces cited by Dr. Taylor and others. Recently a day treatment program for adolescents was begun at St. Vincent Hospital under the leadership of Dr. Robert B. Forman. St. Vincent Hospital, however, discontinued this program when it moved to its new facilities in January, 1971. In November, 1970, Dr. Harold Boverman, child psychiatrist on the staff of the University of Oregon Medical School, began a therapeutic day school program in Portland under a grant from the Lewis W. and Maud Hill Foundation of St. Paul, Minnesota. This program presently treats 10 children at a time and will expand to a maximum of no more than 30 children by September, 1971.

Other Treatment Facilities

Short-term crisis and diagnostic treatment has been available for a varying number of children from time to time at the University of Oregon Medical School Hospital in Portland as part of that school's training program in child psychiatry. There are, of course, other programs which attempt to provide some service to children afflicted with severe emotional disturbance but which do not meet the need for residential and intensive treatment. Community mental health clinics exist in 26 counties, intended to serve over 90 percent of Oregon's population. About 42 percent of the cases seen in community mental health clinics are children. In the year ending June 30, 1968, some type of service was provided by community mental health clinics to 6,390 children, of whom 2,783 were under 12 years of age and 3,607 were over that age. These children represent a wide range of emotional disorders. Only a fraction of them are cases of severe disturbance. Under their present limited funding these clinics can provide at best only comparatively short term out-patient help for severely disturbed children and

(8) Taylor, p. 72.
(10) As noted earlier, Edgefield Lodge may be regarded as providing residential treatment, rather than day care.
(12) Community mental health clinics are presently financed on a matching basis of 50 percent state funds and 50 percent local funds. Lack of adequate local funds has been a major limitation in this financing plan.
their families. Needed residential and intensive treatment programs are almost always unavailable because of the comparatively high cost to serve only a limited number of children.

The 110 therapeutic nursery spaces cited by Dr. Taylor in 1964 as needed for pre-school age victims of severe emotional disturbance are totally nonexistent. The need for 165 or more spaces in therapeutic foster homes for individuals or groups is currently answered by two homes under the administration of the Public Welfare Department serving a total of 21 children.\(^{(13)}\)

**Summary of Existing Services**

The following table summarizes the disparity between needed and available facilities for severely disturbed children in the State of Oregon.

<table>
<thead>
<tr>
<th>Facility or Service</th>
<th>Beds or Spaces Needed (1964)</th>
<th>Beds or Spaces Presently Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time residential treatment</td>
<td>320</td>
<td>174</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>400</td>
<td>30+</td>
</tr>
<tr>
<td>Therapeutic nursery care</td>
<td>110</td>
<td>-0-</td>
</tr>
<tr>
<td>Therapeutic foster homes for individuals</td>
<td>165</td>
<td>21</td>
</tr>
<tr>
<td>or group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The result of the continuing shortage of needed facilities for treatment of children afflicted with severe emotional disturbance is plain. Instead of furnishing the needed care and treatment to most of these helpless victims of severe emotional disturbance, we are committing them to adult mental hospitals, locking them up in training schools and juvenile detention facilities for delinquent children, and—in probably the majority of cases—simply leaving them and their families to suffer without any meaningful help. When these children reach adulthood, we will probably send many of them to prison as criminals or commit them to mental hospitals.

In addition to grossly inadequate treatment facilities and programs the educational needs of emotionally disturbed children have also been largely unmet. A 1971 report of the State Educational Coordinating Council points out that classroom programs for the education of emotionally disturbed children are supported by state aid in only six school districts and two intermediate education districts in Oregon.\(^{(14)}\)

While Portland School District No. 1 and some other school districts provide teaching services for children in residential treatment facilities such as Parry Center, very few school districts offer a district-wide program of special classes for emotionally disturbed children. One of them is the Parkrose district in suburban Portland. Under the leadership of Dr. James Carlson, Parkrose provides special classes for children too disturbed to function in the regular classrooms. The cost of these classes is about $1300 per child per school year. This compares to costs of about $800 per child per school year to teach the district's regular classroom programs. Part of the cost of the Parkrose special classes is paid by the State Mental Health Division.

About one-fifth of the grade schools in the Portland School District are included in its program to prescribe special education for emotionally disturbed and other handicapped children, and a few other special programs exist on a more or less experimental basis at particular schools. These programs presently serve neither adolescents of high school age, nor the majority of grade schools in the Portland School District.

\(^{(13)}\) Information supplied by Ron Marshall, State Mental Health Division.

\(^{(14)}\) State Educational Coordinating Council, *The Delivery of Educational Services to the Handicapped in Oregon* (January, 1971) p. 36.
IV. PAST STUDIES:
THE SAD HISTORY OF FAILURE TO RESPOND TO KNOWN NEEDS

The Existing Reports

Oregon may well be the best-documented state in the nation as to prevalence and needs for treatment of emotional disturbance in children.

Studies were made in 1937 and 1950.(15) The study of Dr. Eugene E. Taylor was completed in 1964, addressed specifically to the needs for services to severely disturbed children. Dr. Taylor studied the prevalence of severe emotional disorder in Oregon children, as heretofore described, and pointed out the need for a network of intensive care facilities to serve at least 1,000 children in the state at any one time. To supplement the existing treatment spaces to help meet the need for at least 320 spaces, Dr. Taylor recommended creation of 200 additional spaces at existing public institutions and facilities. He was critical of the indiscriminate practice of housing children in state mental institutions without distinction in facilities or programs from adult patients. He further recommended that local community health clinics take the lead in developing and coordinating intensive treatment services.

Dr. Taylor pointed out that residential and other intensive treatment services for severely disturbed children are illusory unless they are adequately financed. Proper full time residential treatment could not be provided in 1964 at less than $500 to $600 per child per month. Day-treatment costs in 1964 were at least one-half the full time residential treatment costs. Worthwhile therapeutic foster home care in 1964 would have cost at least $150 per month per child. Today, these costs are at least 30 percent higher. The average cost for full time residential treatment at Parry Center is currently $875 per child per month. The current schedule paid by the State Department of Welfare for foster home care ranges between $59 and $89 per month per child, depending upon age of the child.

Dr. Taylor concluded that such cost could be met only by public funding of most of it. He recommended that the additional necessary funds be provided by state monies through the Mental Health Division budget, state welfare purchase of care, increased use of federal supporting monies, and education funds for special programs in public schools.

The Mental Health Division in a 1965 report(16) adopted Dr. Taylor's recommendations substantially in toto, as part of a comprehensive plan for statewide mental health services to the entire population. A state-funded report was published in 1968 by Greenleigh Associates, Inc., entitled Child Welfare Needs and Services in Oregon. It also supported most of the recommendations for services to severely disturbed children made by Dr. Taylor in 1964, and by the Mental Health Division's 1965 study. Like both of the earlier studies, the Greenleigh report contemplated creation of additional full time residential treatment spaces for emotionally disturbed children primarily in state institutions, and recommended against housing children with adults in those institutions.

The preliminary findings of the state-funded Pilot Program at Edgefield Lodge were published in a 1969 report to the Legislature.(17) It demonstrated once again the need for full time residential care facilities, as well as the equally important need for adequate "after care" for children following discharge from intensive treatment in a residential facility.

Finally, a milestone national study was published in 1969 by the Joint Commission on Mental Health of Children, Inc.(18) It confirmed on a national scale what was already known in Oregon: The failure to meet needs of emotionally disturbed children is of crisis proportions. It also made recommendations which

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(15) University of Oregon Medical School, Child Guidance Program, Child Guidance in Oregon (1937); Committee on Mental Health, Governor's State Committee on Children and Youth, Mental Health Services for Children and Youth (1950).
included the creation of a “child advocate” system to point up the specific needs of children to governmental planners and administrators.

With this background, a professional study group reported to the Governor of Oregon in 1970:

“The Study Group believes that with the Report of the Joint Commission on Mental Health of Children, Inc., and the Greenleigh Report, there is no longer a need for further reports and general surveys of the issues. Additional study in the name of restraint and caution is an excuse for inaction.”

Failure to respond to the studies

Notwithstanding the series of studies in the last seven years, there has been no meaningful progress in creating facilities needed for treatment of severely disturbed children. Meanwhile, the funds being expended to house emotionally disturbed children in adult mental hospitals and juvenile detention and correctional facilities, and to diagnose ills which cannot be adequately treated, cannot be expected to produce substantial rehabilitative results in terms of mental health.

Why have the needs for treatment facilities to serve severely disturbed children been unmet in the face of repeated studies and recommendations? The simple answer has always been lack of adequate funds. This answer, however, is too simple. It overlooks the availability of funds which state and local governments have chosen not to use, and ignores judgments of priority which have been made in using available monies.

Many federal programs make funds available to state and local governments for facilities and services in the mental health field and for handicapped children. Some are on a grant basis, and others provide matching funds in various proportions. The Oregon Legislature has been reluctant to take full advantage of such federal programs. Its reluctance appears to be based on fear that federal funding will decrease or be withdrawn in future years, leaving state and local governments to provide more money for continued operation of a program or facility.

While the Legislature's beliefs are probably well-founded in the history of federal funding programs for state and local government projects, the very purpose of a federal program is often to help get much needed facilities and services started in the state. For example, the Community Mental Health Act of 1963 provides funds for construction and operation of new community facilities for mental health treatment, including those limited to treatment of children, in “catchment” areas of 75,000 to 200,000 population. The Act provides federal matching funds for 50 percent of construction costs, and a portion of the operating costs for professional and technical personnel which declines over an eight-year period from 75 percent to zero. To date, federal funds under this Act have been utilized in Oregon to establish only one community health center, which is operated by Sacred Heart Hospital in Eugene.

The State Division of Mental Health proposes to use federal funding to assist in financing its plan being submitted to the 1971 Legislature for creation and operation of regional small group residential treatment centers throughout the state for severely disturbed children.

Beyond failing to utilize federal funds, state and local governments in Oregon have made judgments in spending available funds which have contributed to the shocking inadequacy of facilities and services for severely disturbed children. It has been state policy since at least 1959 not to construct or create state institutions for treatment of severely disturbed children, but to attempt their treatment through local mental health programs. Thus, the 1966 proposal of Dr. Treleaven, the former director of mental health, to construct a state institution for severely disturbed children was not included in the 1967 budget. Similarly, Dr. Taylor's 1964 recommendations to create facilities at existing mental institutions to provide needed full time residential treatment of such children has never been implemented.

(20) 42 USC p. 2681 et seq.
While it is probably a sound judgment to provide intensive treatment services to severely disturbed children on a local or regional basis within the state, instead of at a single state institution which may be far removed from the community to which the child will return, the result has been that the needed intensive treatment facilities were never established anywhere. Under existing legislation, primary responsibility for supplying mental health services, other than operation of state mental institutions, lies with the 26 community mental health clinics. The clinics may, but are not required to, provide full time residential or other intensive care facilities, and they have not done so. One county, for which the State Division of Mental Health made a special matching appropriation for in-patient care, refused to provide the local funds necessary to implement the program.

Programs to "purchase care" for treatment of severely disturbed children in private residential facilities are inadequate because private facilities do not have the capacity to meet the need. There is simply not enough care to be purchased.

Thus, the concept of providing mental health services locally or regionally within the state has been confused with delegating to local government and private groups the responsibility for determining what services should be provided. Not surprisingly, local government has declined to construct and operate high cost full time residential treatment facilities and other intensive treatment services for severely disturbed children. Community mental health clinics, instead, provide comparatively low-cost diagnosis, counseling and out-patient therapy services to the general population, including children under the heading of "Child Guidance," and fail to meet the needs of severely disturbed children. The result is that we have neither state nor local public treatment facilities and services for these children, and we continue to house them with adults in state mental institutions, confine others to correctional facilities for delinquent children, and do very little to alleviate the suffering of the remainder.

There are undoubtedly other factors underlying the failure to meet recognized needs for treatment facilities for severely disturbed children. One of them is a well known lack of coordination in planning for and spending funds available for direct and indirect mental health services to children. The state-local problem already described is part of this. At the state level, funding for mental health services is administered by at least three state agencies. The Mental Health Division budgets and spends for operation of state mental institutions and the state's share of community mental health clinics. The Department of Welfare administers purchase of care funds, including purchase of foster home care. The State Department of Education has some funds for special education programs for handicapped children, including emotionally disturbed children. In addition, the State Department of Corrections and local juvenile courts also spend some funds for limited mental health diagnosis and treatment. The diffusion of responsibility for spending available funds among multiple agencies of state and local government makes it difficult to reallocate monies to meet the most pressing needs in any particular year or biennium. Unfortunately, this division of responsibility appears to be required to some extent by federal laws in the welfare and education areas. There is no reason, however, why the state agencies cannot coordinate the exercise of their respective responsibilities for mental health services to children.

Another factor hindering development of treatment programs has been lack of clear-cut professional consensus on the efficacy of various treatment methods and procedures. Very few studies exist on this point. This problem, however, should not deter treatment programs favored by a substantial body of professional opinion. The most effective treatment programs will not be proved until they are tried so that their results can be evaluated.

Finally, programs for emotionally disturbed children simply do not have the political support that services to other groups of handicapped children enjoy. We have state institutions for blind, deaf and mentally retarded children, and special local school programs for them. Various fraternal and civic groups take a special interest in the welfare of these children, as well as crippled and otherwise physically handicapped children.

Humanitarian concern for these children is based on their obvious organic defects. Often overlooked is the fact that part of the disability of physically handicapped children is frequently emotional disturbance which inhibits adjustment to
living with their physical impairment. No such organized support has existed for emotionally disturbed children without physical handicaps. Their withdrawal symptoms or their aggressive behavior may confine them beyond public view in some detention or correction facility for delinquent children, where they will receive little or no treatment for the causes of the symptoms. Thus, when budget trimming occurs in state and local government, funds for needed facilities and services for emotionally disturbed children, as well as for mental health in general, have always been among the first items to be cut back or deferred indefinitely.

V. PROPOSALS OF MENTAL HEALTH DIVISION AND GOVERNOR TO 1971 LEGISLATURE

The Governor's budget submitted to the 1971 Legislature proposes total expenditures by the Mental Health Division in the 1971-1973 biennium of $67,253,000. Of this, $62,753,000 would come from state general fund revenues, and the balance from federal and other funds. The total budget compares to expenditures of about $60,100,000 by the State Mental Health Division in 1969-1971. The proposed 1971-1973 Mental Health budget represents about 8.2 percent of the total state general fund budget, as compared with about 8 percent of total state general fund expenditures in 1969-1971.

The State Mental Health Division proposes a special mental health program for children in its 1971-1973 budget requests. It sought to allocate about $915,000 of its budget to this program. The Governor's budget cut this to about $610,000, or less than 1 percent of the total Mental Health Division budget. The following table summarizes where the cuts were made:

<table>
<thead>
<tr>
<th>Mental Health Division Request</th>
<th>Governor's Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Consultant Services</td>
<td>$115,754</td>
</tr>
<tr>
<td>Small Group Treatment Homes</td>
<td>437,455</td>
</tr>
<tr>
<td>Day Treatment Centers</td>
<td>137,319</td>
</tr>
<tr>
<td>Long-Term Group Homes</td>
<td>62,640</td>
</tr>
<tr>
<td>Day Treatment Services</td>
<td>104,000</td>
</tr>
<tr>
<td>Hospital Care</td>
<td>37,800</td>
</tr>
<tr>
<td>Consultation and In-Service Training</td>
<td>20,000</td>
</tr>
<tr>
<td><strong>$914,968</strong></td>
<td><strong>$610,133</strong></td>
</tr>
</tbody>
</table>

The particular items in the proposed mental health program for children are summarized as follows.

**Diagnostic and Consultant Services**

A team of about three professionals would be employed to catalog all mental health services available to children in Oregon, assist in diagnosis, referral and placement of children for treatment throughout the state, and work with local community mental health clinics.

**Small Group Treatment Homes**

This is the most important item in the proposed children's program for the needs of severely disturbed children. It is addressed to the long recognized need for at least another 150 beds for full time residential treatment of such children to bring the total of such beds up to 320. The Division proposes to create a number of regional residential facilities in the state to house and treat small groups of perhaps six to eight severely disturbed children in each home. A child would be treated for approximately three to nine months, and then transferred to his home or to a foster home for less intensive after-care. Since physical facilities would

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(22) Information on this proposed program is based on the State Mental Health Division's report, *Mental Health Program for Children* (December 1, 1970). See also H.B. 1869, introduced in the 1971 Legislature, which would authorize the State Mental Health Division to create comprehensive mental health services for children throughout the state.
be leased, most of the funds for this proposal would be for treatment services and other operational expenses, and not for construction.

Article XIV, Section 3, of the Oregon Constitution requires state institutions created after 1958 to be located in Marion County, unless otherwise authorized by a statewide election. Facilities located outside Marion County prior to 1958, however, may be expanded without holding an election. An Attorney General's opinion obtained by the Division of Mental Health holds that the proposed residential treatment centers for severely disturbed children are subject to the requirements of this constitutional provision. To meet it, the Division proposes to locate the first small group treatment homes in the Pendleton-LaGrande area under the auspices of the Eastern Oregon State Hospital, and a second in Salem. These two would begin operating during 1971-1972. Another two would begin in 1972-1973 in Eugene, operated technically by the Lane County Community Mental Health Center, and in The Dalles in association with the state's Columbia Park Hospital.

These four small group treatment homes would provide a total of approximately 24 to 32 more residential treatment spaces in the next two years, adding to the total of about 174 presently existing in private facilities. Obviously, Oregon would still be far short of the need for at least 320 such spaces in the state, as estimated by Dr. Taylor and the Mental Health Division. While more small group treatment homes might be begun after 1973, it will be years before even the number of residential treatment spaces needed now are available for severely disturbed children.

Day Treatment Centers and Services

A day treatment center for 30 children is proposed for Eugene, to be operated as part of the Community Mental Health Center there. As mentioned earlier, day treatment for emotionally disturbed children is presently available only in the Portland metropolitan area. Dr. Boverman's program presently has only the temporary funding of a private foundation grant.

Long Term Group Homes

This proposal, which was cut out entirely in the Governor's budget, was to create a state funded and operated home in 1971-1973 for moderately disturbed children who are often shuffled from one foster home to another. This facility would help meet the critical need for "after-care" and interim care of children discharged from full-time residential treatment.

Hospital Care

This proposal is for purchase of short term crisis care for disturbed children in existing hospitals where it is available. It would be primarily for diagnosis and treatment of acute symptoms of severe emotional disturbance with some back-up help for—and assistance with access to—other services. Such crisis care and inpatient diagnosis service is badly needed.

Consultation and In-Service Training

These funds are primarily to aid local community mental health clinics and to provide help to school districts in developing programs for moderately or mildly disturbed children.

Committee's Comments

Your Committee believes that creation of state funded and operated full time residential treatment facilities located throughout the state is a sound approach toward meeting the needs of severely disturbed children, and is long overdue. The Governor's budget, however, cuts even the modest Mental Health Division proposal for funding this program by some 40 percent to $262,000. This probably means creation of only two small group treatment homes in 1971-1973, adding approximately 12 to 16 spaces, instead of four homes, adding about 24 to 32 spaces. Even under the Mental Health Division's proposed funding of this program, most children requiring full time residential care would continue to be housed with adults in the state mental institutions.

(23) SJR 9 pending before the 1971 Legislature proposes to submit a repeal of Art. XIV Sec. 3 to the voters.

(24) Ibid., p. 7.
Your Committee believes that the Governor's action on this item of the children's program represents a serious misjudgment of priorities. We believe that even the Mental Health Division's 1971-1973 proposal of four new residential treatment homes at a projected cost of $437,000 is far short of meeting the crisis in needed treatment for severely disturbed children. In the Committee's opinion, creation of such treatment facilities should approximately double the space proposed by the Mental Health Division.

Moreover, the Governor's deletion of all funds proposed by the Mental Health Division for a long-term group home fails to recognize the frequent need of children discharged from full time residential treatment for a longer period of less intensive, but equally important "after-care" in the supervised environment of a group home. The long-term group home, proposed by the Mental Health Division, like day treatment centers, is needed as supportive service to more intensive residential treatment, as well as alternative treatment services for less severely disturbed children.

The Committee notes that neither the Mental Health Division's proposed children's program nor the Governor's budget does anything to meet the long recognized need for some therapeutic nursery spaces for emotionally disturbed children of pre-school age. As mentioned earlier, with the exception of a few spaces at Waverly Children's Home in Portland, these facilities at present do not exist anywhere in the state. Most mental health authorities recognize that early diagnosis and treatment of emotional disturbance is highly desirable.

Your Committee approves the Mental Health Division's proposed children's program as at least a first step in recognizing that local community mental health programs cannot meet the need for full time residential treatment facilities for severely disturbed children. The insufficiency of existing facilities for such children is a critical matter of state-wide concern, and the state should take responsibility for both creating and operating additional needed facilities. Your Committee's criticism of the program is that neither the Mental Health Division's proposal nor the Governor's budget goes far enough or fast enough in creating these needed facilities.

VI. SUMMARY AND CONCLUSIONS

1. Responsibility for Mental Health of Children

The mental health of Oregon children is a matter of statewide concern. The alleviation of suffering of emotionally disturbed children and their families is as important to all citizens of our state as our responsibility to blind, deaf, crippled, retarded and otherwise handicapped children and their families. It may be even more important, in terms of the security and well being of Oregon citizens in general, since emotionally disturbed children frequently cause physical harm to others and damage to property in acting out the symptoms of emotional disease.

Ultimate responsibility for planning, creating and carrying out programs for diagnosis and treatment of emotionally disturbed children should lie with the State Mental Health Division. Local communities have not had the financial or personnel resources to create and operate adequate mental health programs for children. This is particularly true of severely disturbed children, who require full-time residential treatment facilities. Such care requires a comparatively high expenditure of funds. There is a tendency to treat such children as "delinquent" and to assess blame for the condition to them and to their parents. Beyond this, there is a great need for central coordination of all mental health programs in Oregon funded through various agencies, public and private, state and local. The agency best suited at the present time to oversee the needed coordination is the State Mental Health Division.

2. Critical Insufficiency of Treatment Facilities for Severely Disturbed Children

While mental health programs for all children, and indeed for the population generally, are not adequate, the situation faced by severely disturbed children and their families is particularly critical. Oregon lacks at least 150 full time residential treatment spaces to meet the need for 320 spaces known as early as 1964. In all probability, more spaces than that are needed. The existing 174 spaces are entirely private, (aside from Edgefield Lodge), and private resources are not available to
expand them to meet the level of need. Very few families have the means to afford the cost of such treatment. None of the 174 spaces is available to children whose behavior creates extreme safety or security hazards.

Local community mental health clinics and other programs provide some mental health service to children, but do not have the facilities for needed comparatively long-term, full-time residential care for severely disturbed children.

3. Regional or Local Treatment

While ultimate responsibility for and control of mental health services to children should lie with the state, treatment should be carried out on a local or regional basis. The goal of treatment, after all, is to return children to a "normal" community environment with their families. Removal of children long distances from their homes for treatment makes it difficult to counsel their families and to integrate treatment with return to their family and community environment. The need for after-care of a child discharged from intensive treatment in a full time residential facility is recognized, but very difficult if the child returns to a home far away from the residential treatment center.

This is one of the reasons for which your Committee condemns the housing of emotionally disturbed children with mentally ill adults in state mental institutions. There are other important reasons for condemning this practice. Among them is the fact that children need special treatment programs, and cannot be expected to conform to the standards of living and treatment of mentally ill adults in state mental institutions. Your Committee particularly condemns the practice of housing very young children with adults in state mental institutions, even though this occurs less frequently than in the case of adolescent disturbed children.

Your Committee also believes that the long term group house proposal in the Mental Health Division budget, which was deleted from the Governor's budget, is closely related in priority to the small group treatment centers. This proposal would provide residential setting for less intensive, but much needed, after-care of children discharged from full-time residential treatment.

4. Priorities

While the Committee approves the State Mental Health Division proposal to the 1971 Legislature to start a mental health program addressed specifically to children, it regards the budget for this purpose as entirely inadequate in amount and far short of meeting the existing crisis in lack of facilities for treatment of severely disturbed children. The Committee believes that the needs of these children and their families at this time have higher priority than other needed mental health services and facilities, because of long standing neglect of the problem which has caused it to be of crisis proportions.

If additional funds cannot be allocated from the total Mental Health Division budget to speed up the creation of new full-time residential treatment facilities for children, and to fund the other children's services proposed by the Mental Health Division, then your Committee urges that a judgment of priorities based on unmet mental health and welfare needs demands that such additional funds be allocated from the 91.8 percent of the proposed state general fund budget currently allocated to non-mental health functions.

Priority in the location of particular full-time residential treatment homes within the state should be determined on the basis of the residence of children and their families needing the services, and the existence or absence of present treatment facilities. To the extent that Article XIV, Section 3, of the Oregon Constitution interferes with this goal, it should be amended or repealed by the voters.

The concept of small group residential treatment homes for severely disturbed children is not new. It has been used effectively in the state-funded pilot program operated by Edgefield Lodge from October 1968 to June 1970.

5. Use of Federal Funds

Until adequate mental health facilities and programs are created in Oregon, the state should take advantage to the maximum possible extent of federal funding programs such as the Community Mental Health Centers Act and Title IV of the Social Security Act.
6. Citizen Support for Adequate Mental Health Services for Children

As mentioned earlier, mental health services for children, particularly severely disturbed children, have very little political support. This is demonstrated not only by the inadequacy of facilities and services, but by the well known tendency at state and local levels to eliminate or defer new programs in this area when budget trimming becomes necessary.

Emotionally disturbed children, with their often aggressive tendencies and "delinquent" behavior patterns, do not arouse the sympathy that most people have for the child who is deaf, blind, crippled or otherwise handicapped in a way which does not create any threat of harm to the safety or well being of others.

The voices crying for more facilities, services and expenditures for emotionally disturbed children have thus far been primarily those of professionals in the field. Families of disturbed children need immediate help, and are not able to undertake long term political action to induce state and local government to provide better programs and facilities.

There are many other citizens, however, who are aware of the crisis which is the subject of this report. These include volunteer workers in juvenile detention facilities and mental health services, school personnel who often see disturbed children in the classroom and many citizens who know disturbed children in families in their own neighborhoods or among their friends and acquaintances. Such people are better able to be comparatively impartial and objective. Their voices in support of proposed programs and funds for emotionally disturbed children are badly needed.

7. Continuing Study of Treatment Programs

The Division of Mental Health should sponsor continuing study of the efficacy of various treatment programs for mentally disturbed children, and use these studies in policy decisions on priorities in services.

8. Special Educational Services for Emotionally Disturbed Children

School districts should not be responsible for treatment of emotional disturbance in children. Nevertheless, emotionally disturbed children living in the community must be educated, and their education has a close relationship to their treatment. Educational services for such children should be provided by local school districts through both special classes and special programs for individual children in regular classrooms. Ultimate responsibility for planning and development of educational services for emotionally disturbed children should lie with the State Board of Education, working in close coordination with the State Mental Health Division.

The Committee endorses the further recommendation of the State Educational Coordinating Council(25) that the Mental Health Division and the Special Education Section of the State Department of Education should establish and maintain formal procedures for coordination of their activities. This coordination is essential to insure that the development of new programs for emotionally disturbed children is accomplished with a minimal amount of duplication and fragmentation, and with full appreciation of the close relationship of the educational and treatment needs of emotionally disturbed children.

9. Access to Mental Health Services for Children

In studying the problems of severely disturbed children, your Committee was impressed by the difficulty often experienced by laymen in ascertaining where to go when a need for mental health services is recognized. Few citizens understand even that community mental health clinics exist, much less what services they offer. Your Committee has reviewed several "horror" stories of frantic families searching for months—and even re-locating—to obtain adequate diagnosis and treatment for an obviously disturbed child. Various state and local agencies have some degree of responsibility for counseling in this area, but there is no well recognized "door" through which a family may go when it recognizes its need for help for a child behaving abnormally. There should be such a "door" in every county and

principal city, accessible 24 hours a day. More accessible services would probably reduce the incidence of severe disorders by early diagnosis and treatment of moderate emotional disturbance.

If community mental health clinics are to serve as this "door" they need far more publicity as to their existence and location. If some other local or regional facilities are to serve as this "door," the State Mental Health Division should take responsibility for seeing that they are created and making their existence, location and services known to the public generally, and particularly to all persons who may come in contact with disturbed children.

The facility which serves as a "door" would not necessarily have to perform any diagnosis or treatment functions. Its main purpose would be to serve as an obvious place to which anyone seeking mental health services for a child could go and be referred to the appropriate services and facilities for diagnosis and treatment.
VII. RECOMMENDATIONS

1. Ultimate responsibility for planning, creating, coordinating and carrying out programs for diagnosis and treatment of severely disturbed children should lie with the State Mental Health Division.

2. Intensive mental health treatment services should be carried out on a local or regional basis, rather than through institutions serving the entire population of the state.

3. The State Mental Health Division's program for children should be adopted by the 1971 Legislature without the cuts proposed in the Governor's budget, and sufficient additional funding should be provided to double the space proposed by the Mental Health Division in creating small group residential treatment homes for severely disturbed children.

4. If additional funds beyond the $915,000 proposed by the Mental Health Division for its entire child services program cannot be allocated from the total Mental Health Division budget to speed up the creation of new full time residential treatment facilities for children, the necessary additional funds should be allocated from the remainder of the state general fund budget.

5. Priority in the location of particular full time residential treatment homes within the state should be determined on the basis of the residence of the children and their families needing the services, and the existence or absence of present treatment facilities. Article XIV, Section 3 of the Oregon Constitution should be amended or repealed, if necessary to accomplish this goal.

6. Until adequate mental health facilities and programs are created in Oregon, the state should take the maximum possible advantage of federal funding programs.

7. Private citizens, and not just mental health professionals, must press governmental bodies for necessary programs and funding to meet the needs of emotionally disturbed children in Oregon, particularly the severely disturbed.

8. The Mental Health Division should sponsor continuing study of the efficacy of various treatment programs for mentally disturbed children.

9. Ultimate responsibility for planning and development of educational services, as compared to treatment, for emotionally disturbed children in Oregon, should lie with and be exercised by the State Board of Education, working in close coordination with the State Mental Health Division.

10. The Mental Health Division should assume responsibility for creating and making well known to the public the nature and location of available mental health services for children.

Respectfully submitted,
Harry J. Beeman
John F. Cramer, Jr.
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APPENDIX A

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APPENDIX B
PERSONS INTERVIEWED BY THE COMMITTEE

Harold Boverman, M.D., Psychiatrist, University of Oregon Medical School, Portland, Oregon
Keith Larson, Ph.D., Professor, Department of Special Education, Portland State University, Portland, Oregon
Kenneth Gaver, M.D., Director, Oregon State Division of Mental Health, Salem, Oregon
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Lendon H. Smith, M.D., Pediatrician, Portland, Oregon
Ross C. Miller, Executive Director, Parry Center, Portland, Oregon
The Hon. L. W. Newbry, State Senator, Ashland, Oregon (by letter dated June 12, 1970)
Edgar Taylor, Director of Special Education, Portland School District No. 1, Portland, Oregon
Herman Frankel, M.D., Director of North Prescriptive Education Program, Portland School District No. 1
Miss Ruth Cahill, Department Head, Family and Children's Services, Multnomah County Public Welfare Commission
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Carl Morrison, M.D., Director, Child Guidance Clinic, Portland, Oregon
Ron Marshall, Director of Child Care Project, State Mental Health Division, Portland, Oregon
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