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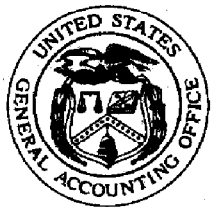
Fact Sheet for the Committee on Education and Labor, House of Representatives, and the Committee on the Judiciary, U.S. Senate

July 1994

JUVENILE JUSTICE

Admissions of Minors with Preadult Disorders to Private Psychiatric Hospitals



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GAO

United States
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General Government Division

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July 26, 1994

The Honorable William D. Ford, Chairman
The Honorable William F. Goodling
Ranking Minority Member
Committee on Education and Labor
House of Representatives

The Honorable Joseph R. Biden, Jr., Chairman
The Honorable Orrin G. Hatch
Ranking Minority Member
Committee on the Judiciary
United States Senate

The 1992 reauthorization (P.L. 102-586) of the Juvenile Justice and Delinquency Prevention Act of 1974 (P.L. 93-415) mandated that we study admissions of minors with preadult disorders (i.e., disorders that are generally associated with minors, such as conduct or attention deficit disorders) to private psychiatric hospitals.[1] As discussed with your Committees, we agreed to obtain available data on (1) the frequency with which minors with preadult disorders have been admitted to private psychiatric hospitals; (2) the average lengths of stay and methods of payment; (3) the statutory procedural protections afforded such individuals in selected states; and (4) the conditions of confinement, such as services provided, sleeping arrangements, and visitation policies at selected hospitals.

To obtain this information we

- contacted federal agencies, state agencies, and industry sources to obtain available data on (1) the number of minors with behavior disorders that have been admitted to private psychiatric hospitals, (2) the average lengths of stay, and (3) the methods of payment used;
- reviewed the statutory procedural protections for minors being admitted to psychiatric hospitals in four states and prior studies that examined various states' provisions for regulating admissions to psychiatric hospitals; and
- visited four private psychiatric hospitals to observe the conditions of confinement and services provided to minors.

[1]While the act requires us to develop data on juveniles with "behavior disorders," it is not a diagnostic grouping in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 3rd ed. rev. Washington, D.C.: 1987. Thus, at the suggestion of knowledgeable health care professionals, we used a grouping of "preadult disorders" as the equivalent to behavior disorders. Also, we used the term minor rather than juvenile throughout this fact sheet to be consistent with the terminology used in state statutes.

Appendix I provides a more detailed discussion of our objectives, scope, and methodology.

Results in Brief

We encountered problems in obtaining data regarding the extent to which minors with preadult disorders have been admitted to private psychiatric hospitals and the methods of payment used to pay for their care. For example, the most recent national data available were for 1986 admissions. In addition, national data on the methods of payment used for psychiatric care for minors diagnosed with preadult disorders do not exist. Of the 10 states with the greatest number of psychiatric hospitals, only California could provide data on the number of minors with preadult disorders who were admitted to private psychiatric hospitals.

The California data showed that the number of minors through age 17 with preadult disorders who were admitted to private facilities decreased from 711 in 1986 to 684 in 1989 and finally to 553 in 1991. Also, the average length of stay decreased from 33 to 25 and then to 19 days in 1986, 1989, and 1991, respectively. In all 3 of these years, almost two-thirds of the minors' hospitalization costs were paid by private health insurance.

According to some health care officials, the health care industry was overly aggressive in marketing inpatient psychiatric services in the 1980s. This aggressiveness may be indicated by the increase in the number of private psychiatric facilities from 184 in 1980 to 520 in 1990, with the largest growth occurring between 1984 and 1988. In addition, the number of minors age 13 through 17 with preadult disorders admitted to private hospitals increased by nearly 29 percent, from 11,088 in 1980 to 14,278 in 1986.

These health care officials said that health care practices have changed since the 1980s. Changes included improvements in medication management and increased emphasis on external reviews by insurance carriers. Both changes could lead to a reduction in the admissions of minors to private hospitals. While not sufficient to draw firm conclusions, a slight drop in the number of psychiatric hospitals between 1990 and 1992 (from 520 to 510) and reported California data are consistent with the changes cited by the health care officials we interviewed.

Procedural protections for minors placed in psychiatric hospitals vary by state. For example, in California a minor age 14 or older who objects to being admitted to a private psychiatric hospital can generally request an independent review of the admission decision. In contrast, in Georgia the minor has no such right. Of the four states we visited, three had increased procedural protections for minors within the past 5 years. The fourth state had not substantially changed its procedural protections in the last 5 years.

Concerning conditions of confinement, we found that the procedures for treating and providing services to minors were roughly similar at all four

hospitals we visited. For example, hospitals scheduled a substantial portion of each day for patients' treatment and activities and developed treatment programs for each patient on the basis of the severity of the diagnosed illness. In addition, patients were provided educational services.

Background

In a 1989 publication, a former administrator of the Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP) stated that

> "There are no comprehensive data on the number of juveniles being treated in inpatient psychiatric . . . units in private hospitals and free-standing residential settings. . . . The overwhelming majority of juveniles propelled into these programs are voluntary admissions—meaning that they do not go through the juvenile courts—and the services are largely paid for by third-party health care insurance and their parents."[2]

Minors can be placed in psychiatric facilities without their consent by a legal guardian or a parent. In addition, minors, depending on their age, can admit themselves. The admissions process varies depending on the age of the minor and on the person requesting the admissions. Further, each state establishes its own requirements for admitting minors to psychiatric facilities with and without the minors' consent. Generally, the requirement for the minor's consent depends upon the minor's age. For example, in Texas a minor under age 16 can be admitted by a parent without the minor's consent. Such admissions are classified as "voluntary," even though the minor may object. Court-ordered admissions are classified as "involuntary."

"Preadult disorders" is a classification for a number of diagnoses associated with minors. These disorders include attention deficit, conduct, and separation anxiety. Each of these disorders can be defined. For example, the essential feature of conduct disorder is a persistent pattern of behavior in which the basic rights of others and major age-appropriate societal norms are violated. The behavior pattern typically is present in the home, at school, with peers, and in the community.

According to the National Association of Psychiatric Health Systems (NAPHS), private psychiatric hospitals offer programs that are generally intensive and include scheduled activities for a substantial portion of the day and evening. While each patient's treatment program is individualized on the basis of the severity of the illness, many program elements are common to all patients. In a private psychiatric hospital, each day is likely to include 5 to 6 hours of therapy, which may be individual, group, or family therapy. Also, these hospitals generally offer specialized therapy, such as art and recreational therapy. Besides the therapeutic and recreational activities, minors in private psychiatric hospitals are provided educational services.

Some child advocacy groups have raised concern about the appropriateness of placing some minors in private psychiatric hospitals.

[2]Ira M. Schwartz, (In) Justice for Juveniles, Lexington Books, (New York, NY) 1989, pp. 136-137.

For example, the Coalition for Juvenile Justice[3] recommended a national assessment of the placement of minors in such hospitals.

Data on Minors With Preadult Disorders

Few data are available on the extent to which minors with preadult disorders have been admitted to private psychiatric hospitals. To collect data, we contacted numerous national and state level agencies (as shown in table I.1 of app. I). We found that the most recent relevant national data available were for 1986 from the Department of Health and Human Services' Center for Mental Health Services (CMHS). Of our contacts with the 10 states having the largest number of private psychiatric hospitals, California was the only state that had relatively current data on minors with preadult disorders in private psychiatric hospitals.

In California, the number of minors admitted to private facilities with preadult disorders decreased from 711 to 553 for calendar years 1986, 1989, and 1991. The average length of stay for these minors also decreased over this period (see table 1).

Table 1: Minors With Preadult Disorders Admitted to Private Facilities in California

	Calendar years		
	1986	1989	1991
Number of minors	711	684	553
Average length of stay (days)	33	25	19

Source: State of California.

Private hospitalization costs for minors with preadult disorders were paid for by private health insurance for an average of almost 65 percent of these minors during the 3 years we reviewed.

A former NAPHS president and the medical director for a hospital we visited said that entrepreneurial elements of the health care industry perhaps were overly aggressive in marketing inpatient psychiatric services during the 1980s. These officials said, however, that the alleged questionable practices of the past decade are unlikely to occur in the 1990s because of significant changes in recent years in the health care and the insurance industries—changes that include improvements in medication management and treatment technologies, as well as greater emphasis on external reviews by insurance carriers.

National data generally support the statements of the health care officials regarding the trends in the 1980s. The number of private psychiatric hospitals steadily increased from 184 in 1980 to 520 in 1990 but declined slightly to 510 in 1992. Further, the number of minors age 13 through 17 with preadult disorders admitted to private psychiatric hospitals increased from 3,495 in 1980 to 6,230 in 1986 and to nonfederal hospitals with psychiatric units from 7,593 to 8,048 for the same period.

[3]The Coalition for Juvenile Justice is the national coalition of state juvenile justice advisory groups created under the provisions of the 1974 act, as amended. Its responsibilities include reviewing federal policies regarding juvenile justice and delinquency prevention and advising the President and Congress on operations of OJJDP and legislation pertaining to juvenile justice and delinquency prevention.

The average length of stay for minors with preadult disorders in private psychiatric hospitals increased from 47 days in 1980 to 61 days in 1986 (although they decreased in nonfederal general hospitals with psychiatric units from about 37 days to 20 days for the same years). Surveys by NAPHS of its member hospitals showed that the average length of stay for minors with preadult disorders had decreased each year since 1986, from 49 days in 1986 to 35 days in 1991.

See appendix II for further data on admissions, average length of stay, and methods of payment.

Procedural Protections for Minors

In 1979, the U.S. Supreme Court recognized that a minor has a legitimate interest in not being committed to psychiatric facilities unnecessarily but held that an evaluation of the minor by an admitting physician is required. Our analysis of statutes in four states showed that procedural protections vary for minors admitted to psychiatric facilities.

In Parham v. J.R., 442 U.S. 584 (1979), the Supreme Court said that a minor has a legitimate interest in not being committed without reason; thus, an independent clinical evaluation should be conducted before the minor is committed. While the Supreme Court recognized that a minor does have a "liberty interest" in not being committed unnecessarily, Parham was limited to a Fourteenth Amendment analysis of a minor's rights when commitment is in a state (public) hospital. Therefore, the protections enunciated in the Parham decision do not necessarily apply to private psychiatric hospitals.

Our review of the laws showed that procedural protections vary across California, Georgia, Texas, and Virginia. Statutes in these four states permit a parent or legal guardian to admit a minor to a psychiatric hospital, but restrictions on these admissions vary from state to state. For example, in California and Virginia, a minor age 14 or older can object to being admitted and can have a hearing to determine the appropriateness of the admission. In Texas, a parent or legal guardian cannot admit a minor age 16 or older. However, in Georgia a minor does not have the right to object to admission, regardless of age. Table 2 provides a summary of the four states' procedural protections. See appendix III for more detailed information on the prior studies and procedural protections provided in the four states.

Conditions of Confinement for Minors

The conditions of confinement for minors were similar at each of the four hospitals we visited. The hospitals scheduled a substantial portion of each day for patients' treatment and activities. Reportedly, patient treatment programs are individualized on the basis of the severity of each diagnosed illness; and daily routines are likely to include several hours of individual, group, or family therapy. Also, specialized therapy was to be prescribed according to the skills evaluated or to be developed in individual patients. In addition, patients are provided educational services either through arrangements with local school districts or by teachers on the staff.

Concerning conditions of confinement, our review addressed educational services, medical services, mental health services, sleeping arrangements, visitation policies, and methods for minimizing unnecessary admissions. (See app. IV for more details on conditions of confinement at these hospitals and selected patients' profiles.)

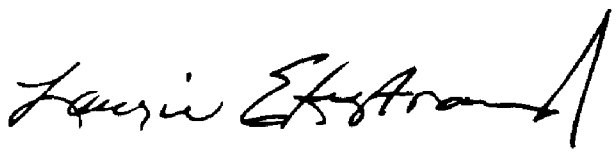
Table 2: Selected Procedural Protections Provided Minors Admitted to Psychiatric Hospitals in Four States

Statutory protections	California	Georgia	Texas	Virginia
Does the statute allow a parent or legal guardian to commit a minor and if so, at what age?	Yes, but objecting minor 14 or older has right to a review.	Yes, minors of any age.	Yes, if younger than 16. No, if 16 or older.	Yes, if younger than 14, for a period of 90 days; if 14 or older, for 72 hours pending a court hearing.
Does the minor have the right to object to admission?	Yes, if 14 or older. No, if younger than 14.	No.	Yes, if 16 or older. No, if younger than 16.	Yes, if 14 or older. No, if younger than 14.
Does the statute have a neutral fact finder requirement?	Yes, independent psychiatrist.	Yes, admitting physician.	Yes, independent psychiatrist.	Yes, qualified evaluator and court.
Is a hearing allowed either before or after detention?	Yes, for minor 14 or older, within 5 days of the minor's request.	No.	No.	Yes, for objecting minor 14 or older, within 72 hours.
Is an attorney or guardian ad litem appointed for the minor?	No, but a patients' rights advocate represents minors.	Under certain circumstances.	No.	Yes, for objecting minor 14 or older.
Is periodic review allowed and, if so, what is the frequency?	Not addressed in statute.	Not addressed in statute.	Yes, at least every 6 months.	Yes, every 90 days.
Are noninstitutional alternatives to inpatient psychiatric hospital admission considered?	Yes.	Yes.	Yes.	Yes.

Source: GAO analysis of state statutes.

We are providing copies of this fact sheet to the Attorney General, the Director of the Office of Management and Budget, and other interested parties. Copies will also be made available to others upon request.

Major contributors to this fact sheet are listed in appendix V. Please contact me on (202) 512-8777 if you have any questions concerning this fact sheet.



Laurie E. Ekstrand
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of Justice Issues

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Abbreviations

AACAP	American Academy of Child and Adolescent Psychiatry
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMHS	Center for Mental Health Services
GED	general eqivalency diplomas
NAPHS	National Association of Psychiatric Health Systems
OJJDP	Office of Juvenile Justice and Delinquency Prevention
ROPES	Reality Oriented Physical Experiences

Objectives, Scope, and Methodology

The 1992 reauthorization (P.L. 102-586) of the Juvenile Justice and Delinquency Prevention Act of 1974 (P.L. 93-415) mandated that we study admissions of minors with behavior disorders to private psychiatric facilities and other residential and nonresidential programs that serve minors. Specifically, the legislation required us to review (1) the frequency with which juveniles with preadult disorders have been admitted to private psychiatric facilities in the United States during the 5-year period ending December 1992, (2) the average lengths of stay and methods of payment, (3) the statutory procedural protections afforded such individuals, and (4) the conditions of confinement.[1]

Minors can receive psychiatric care as inpatients or outpatients in such facilities as public and private psychiatric hospitals and residential treatment facilities. We agreed with your Committees to provide available data on the number of minors admitted to private psychiatric hospitals. We also agreed to provide available data on the diagnostic reasons for such admissions, the average length of stay, the methods of payment, the procedural protections provided to minors, and the conditions of confinement of minors with preadult disorders.

In conducting this study, we encountered several data limitations and definitional concerns. First, we discovered that national data that are diagnosis-specific on admissions of minors are limited to 1980 and 1986. We tried to obtain data from the private psychiatric hospital industry, but they did not have the specific data needed. Second, "behavior disorders" is not a recognized diagnostic grouping. We used "preadult disorders" on the basis of the recommendation of health care professionals from organizations and hospitals we spoke with while conducting this review. Third, to be consistent with the terminology used in state statutes, we have used "minor" rather than "juvenile" throughout this fact sheet. Where possible, we focused on minors who were 13 through 17 years of age. However, in some cases, the available data included anyone under age 18.

We reviewed relevant literature identified by computerized searches of several databases, including those of the National Center for Juvenile Justice,[2] the Department of Justice's Office of Juvenile Justice and Delinquency Prevention (OJJDP), and the Mental Health Policy Resource

[1]We used the term minor rather than juvenile throughout this fact sheet to be consistent with the terminology used in state statues.

[2]The National Center for Juvenile Justice, located in Pittsburgh, PA, is the research division of the National Council of Juvenile and Family Court Judges, Inc.

Center.[3] To obtain further national overview perspectives, we contacted industry and professional associations, such as the American Hospital Association, the American Psychiatric Association, and the National Blue Cross and Blue Shield Association. Also, we contacted pertinent federal government organizations, as well as various public and private organizations in selected states (see table I.1).

Table I.1: Federal, State, and Local Government and Private Sector Organizations Contacted

Federal organizations
Department of Health and Human Services
Center for Mental Health Services (Rockville, MD)
National Center for Health Statistics (Hyattsville, MD)
Department of Justice
OJJDP (Washington, D.C.)
National industry and professional associations
American Academy of Child and Adolescent Psychiatry (Washington, D.C.)
American Bar Association (Washington, D.C.)
American Hospital Association (Chicago, IL)
American Psychiatric Association (Washington, D.C.)
American Psychological Association (Washington, D.C.)
Children's Defense Fund (Washington, D.C.)
Coalition for Juvenile Justice[a] (Washington, D.C.)
Mental Health Policy Resource Center (Washington, D.C.)
National Association of Health Data Organizations (Falls Church, VA)
National Association of Psychiatric Health Systems[b] (Washington, D.C.)
National Association of Psychiatric Treatment Centers for Children (Washington, D.C.)
National Association of State Mental Health Program Directors (Alexandria, VA)
National Blue Cross and Blue Shield Association (Chicago, IL)
National Center for Juvenile Justice (Pittsburgh, PA)
California public organizations
State Department of Mental Health
Office of Statewide Health Planning and Development
County Mental Health Patients' Rights Offices
Alameda County
Los Angeles County
San Diego County
San Mateo County
California private organizations
California Association of Hospitals and Health Systems (Sacramento)
California Psychiatric Association (Sacramento)
Community Psychiatric Centers (Northern Region)
California Psychological Health Plan (Los Angeles)
Legal Services for Children (San Francisco)
Mental Health Advocacy Services, Inc. (Los Angeles)
Protection and Advocacy Services, Inc. (Glendale)
Georgia public organizations

(continued)

[3]The Mental Health Policy Resource Center, located in Washington, D.C., is a nonprofit research organization concerned with mental health policy issues.

Federal organizations
Department of Human Resources Division of Mental Health, Mental Retardation and Substance Abuse, Child and Adolescent Services
Texas public organizations
Attorney General's Office
Department of Health
Department of Mental Health and Mental Retardation
Senate Committee on Health and Human Services
Virginia public organizations
State Department of Mental Health, Mental Retardation, and Substance Abuse Services
State Department of Criminal Justice Services, Office of the Secretary of Public Safety
Virginia Commission for Youth
Virginia private organizations
American PsychManagement, Inc. (Falls Church)
Health Management Strategies International (Alexandria)
Mental Health Management, Inc. (McLean)
Virginia Hospital Association (Glen Allen)

[a]This organization was formerly called the National Coalition of State Juvenile Justice Advisory Groups.

[b]This organization was formerly called the National Association of Private Psychiatric Hospitals.

Data on Admissions, Lengths of Stay, and Methods of Payment

To gather available data on (1) the number of minors with preadult disorders admitted to private psychiatric facilities, (2) the average lengths of stay, and (3) the methods of payment used, we contacted federal government and industry sources to obtain available national statistics. Also, we contacted public agencies in the 10 states having the largest number of private psychiatric hospitals.

National Statistics From Federal Sources

National statistics regarding admissions of minors to psychiatric facilities are reported by the Center for Mental Health Services (CMHS). However, the information CMHS collected had scope and/or timeliness limitations for our purposes.

CMHS periodically conducts detailed patient sample surveys. These surveys obtain information on patient characteristics, such as age, major diagnoses, length of stay, source of payment, and whether the admissions were court ordered or voluntary. At the time of our review, the two most recent CMHS surveys of psychiatric facility inpatient characteristics covered 1980 and 1986 admissions.[4]

National Statistics From Private Sector Sources

In addition to the national statistics obtained from CMHS, we also contacted the four largest psychiatric hospital chains in the United States and requested admission statistics. These corporations, however, did not have

[4]A CMHS official told us that because of budget constraints patient-characteristic surveys have not been conducted in the 1990s, although such a survey is tentatively scheduled to begin in 1995.

the data requested and/or expressed concern about providing proprietary or confidential information. As an alternative, we contacted the National Association of Psychiatric Health Systems (NAPHS),[5] an organization whose membership from 1986 through 1992 accounted for about 65 percent of all private psychiatric hospitals in the United States. We used NAPHS data to develop trend statistics on voluntary and involuntary admissions of minors and the average length of stay for minors admitted with preadult disorders. NAPHS was unable to provide us with other relevant data.

Data Requested From 10 States

Because of the limitations in the available national data, we attempted to collect data from the 10 states having the largest number of private psychiatric hospitals (see table I.2). Generally, this collection effort involved contacting the public agencies responsible for mental health services in that respective states. We found that diagnosis-specific data on admissions of minors to private psychiatric facilities were available for only one state, California.[6] The other nine states did not have diagnosis-specific data covering admissions of minors to private psychiatric facilities. Therefore, we were only able to use California data, which we obtained for calendar years 1986, 1989, and 1991.

Table I.2: Ten States With the Largest Number of Private Psychiatric Hospitals, 1984, 1986, and 1988

			1988	
State	**1984**	**1986**	**Number**	**Percentage**
California	24	37	49	11.0
Florida	15	22	35	7.9
Georgia	10	13	18	4.1
Indiana	14	14	17	3.8
Louisiana	4	11	20	4.5
Massachusetts	8	10	10	2.3
New York	12	12	12	2.7
Pennsylvania	14	16	19	4.3
Texas	20	33	65	14.6
Virginia	14	15	15	3.4
Subtotal	135	183	260	58.6
All other states	85	131	184	41.4
Total U.S.	**220**	**314**	**444**	**100.0**

Note: The states listed are those having 10 or more hospitals in at least 2 of the 3 years shown.

Source: U.S. Department of Health and Human Services, Center for Mental Health Services and National Institute of Mental Health, Mental Health, United States, 1992 Rockville, MD: 1992, pp. 50-51.

[5]Until January 1993, this organization was named the National Association of Private Psychiatric Hospitals.

[6]Since 1983, California's Office of Statewide Health Planning and Development has obtained comparable information (including age and diagnosis) about patients discharged from hospitals in the state. During our review, 1991 was the most recent year for which survey results were available.

Procedural Protections

To review the procedural protections for minors admitted to private psychiatric hospitals, we selected four states to visit—California, Georgia, Texas, and Virginia. As table I.2 shows, each of these states is among 10 states having the largest number of private psychiatric hospitals during the period covered in our review. In addition to geographical coverage, such as east and west coast representation, other factors we considered in selecting these four states are as follows:

- California had the largest number of minors. The number of private psychiatric hospitals in California grew from 24 in 1984 to 49 in 1988, an increase of 104 percent. In 1989, California enacted legislation giving minors aged 14 through 17 the right to challenge their inpatient psychiatric hospitalization and to have an independent review of such admissions.
- Georgia's population of minors was ninth largest in the country. It is headquarters for one of the largest psychiatric hospital chains in the United States. The number of private psychiatric hospitals in Georgia grew from 10 in 1984 to 18 in 1988. Georgia has not passed legislation regarding procedural protections for minors in the last 5 years.
- Texas had the second largest number of minors. The number of private psychiatric hospitals in Texas grew from 20 in 1984 to 65 in 1988, an increase of 225 percent. In the fall of 1991, national attention focused on Texas, as the state Attorney General's Office began investigating allegations of fraud, abuse, and mismanagement by private psychiatric hospitals. Moreover, in the 1993 session, the Texas state legislature began addressing psychiatric care issues and enacted several new laws in June 1993.
- Virginia's population of minors was eleventh largest in the nation. In Virginia, unlike the three states previously discussed, the number of private psychiatric hospitals remained fairly constant during the period shown in table I.2. In 1990, Virginia enacted legislation specifying procedures for the voluntary and involuntary commitment of minors.

In our analyses of the current statutory procedural protections in California, Georgia, Texas, and Virginia, we reviewed applicable legislation with respect to protections afforded minors admitted to public and private psychiatric hospitals. Also, in each of these states, we interviewed regulatory agency, health care, insurance company, and/or patients' advocacy officials (see table I.1) to obtain their perspectives on existing procedural protections. We developed seven questions to show the differences in how the four states provided various procedural protections to minors admitted to, or while in, psychiatric hospitals. However, we did not determine if the minors actually received the procedural protections.

Conditions of Confinement

To review conditions of confinement for minors admitted to private psychiatric facilities, we visited a total of four hospitals—one in Georgia, two in Texas, and one in Virginia. We used our judgment to select facilities to visit. We limited our selections to private, for-profit, stand-alone

psychiatric facilities—each a member of NAPHS—in three of the four states in which we collected data on procedural protections.[7]

In preparing to visit hospitals, we found that few objective criteria existed for evaluating conditions of confinement for patients in psychiatric hospitals.[8] On the basis of our review of the existing criteria, we identified those topics on which to collect data—educational services, medical services, mental health services, sleeping arrangements, visitation policies, and methods for minimizing unnecessary admissions.

In reviewing the conditions of confinement at private psychiatric hospitals we visited, we focused only on those topics that we believed to be most relevant to minors to determine the range of treatment, services, and living conditions. Specifically, at each of the four psychiatric hospitals visited, we interviewed staff and toured the facilities to obtain information on educational services, medical services, mental health services, sleeping arrangements, and visitation policies. We also discussed the hospitals' admissions criteria and methods for minimizing unnecessary admissions.

We did not verify the policy and procedural information presented to us by hospital staff. Also, as agreed with your Committees, we did not make clinical evaluations, such as the need for the inpatient admissions nor the effectiveness of the treatment received. The results of our visits cannot be projected to other facilities, and because our visits were announced and coordinated in advance, the results may not be fully representative of the respective facility's day-to-day operations, although we have no reasons to believe otherwise.

We requested patient profiles from three of the hospitals to show the types of problems associated with minors who were admitted to the facilities. We selected three profiles to include in this fact sheet. We did not verify the data or review the patients' case files.

We performed our work from June 1993 through April 1994. We did not verify the data that we received, but we examined the supporting documentation to review the methodology, sampling techniques, and data checks used to develop the data. Since no federal agency has responsibility for the issues discussed in this fact sheet, we did not obtain agency comments.

[7]We did not visit any hospitals in California because we could not arrange a visit during the time we were in California. However, we did meet with members of the state's psychiatric care community (see table I.1).

[8]We reviewed criteria from (1) the Joint Commission on Accreditation of Health Care Organization's Accreditation Manual for Hospitals and its Mental Health Manual; (2) NAPHS "Membership Requirements, Standards, and Guidelines," Jan. 1993, and proposed model state legislation, "A Uniform Act for Improving Mental Health And Substance Abuse Treatment Services Provided by Licensed Inpatient Facilities," Dec. 1992; (3) the American Academy of Child and Adolescent Psychiatry's proposed staffing standards in its "Model for Minimum Staffing Patterns for Hospitals Providing Acute Inpatient Treatment for Children and Adolescents with Psychiatric Illnesses," Dec. 1990; and (4) the Abt Associates, Incorporated study, which used criteria to assess the conditions of minors confined in detention and correctional facilities. However, they were either too vague, too subjective, and/or not directly relevant to psychiatric hospitals.

Data on Admissions, Average Length of Stay, and Methods of Payment

Table II.1: Number of U.S. Psychiatric Facilities by Type, 1970-1992

Year	Private psychiatric hospitals		Nonfederal general hospitals with psychiatric units		State and county mental hospitals	
	Number	Percent change	Number	Percent change	Number	Percent change
1970	150		797		310	
1976	182	+21.3	870	+9.2	303	–2.3
1980	184	+1.1	923	+6.1	280	–7.6
1984	220	+19.6	1,347	+45.9	277	–1.1
1986	314	+42.7	1,351	+0.3	285	+2.9
1988	444	+41.4	1,484	+9.8	285	
1990[a]	520	+17.1	1,815	+22.3	286	10.4
1992[a]	510	–1.9	1,630	–10.2	285	–0.3
Percentage change during 1970-1992		+240.0		+104.5		–8.1

[a]Estimates from the National Association of Psychiatric Health Systems, "In Perspective: Psychiatric Hospitalization" Washington, D.C.: undated, p.1.

Source: U.S. Department of Health and Human Services, Center for Mental Health Services (CHMS) and National Institute of Mental Health, Mental Health, United States, 1992 Rockville, MD: 1992, p. 21.

Table II.2: U.S. Inpatient Occupancy Count for Minors by Type of Facility, 1986, 1988, and 1990

End-of-year census by type of facility	Census (inpatient occupancy count) as of December 31[a]					
	1986		1988		1990	
	Number	Percent	Number	Percent	Number	Percent
Private psychiatric hospitals	10,615	41.9	11,612	44.2	10,238	42.3
Nonfederal general hospitals with psychiatric units	4,794	18.9	5,962	22.7	6,696	27.7
State and county mental hospitals	8,332	32.9	7,449	28.3	6,759	27.9
Other facilities	1,576	6.2	1,274	4.8	506	2.1
Total	**25,317**	**99.9[b]**	**26,297**	**100.0**	**24,199**	**100.0**

[a]The inpatient numbers represent 1-day census or occupancy counts, not total annual admissions.

[b]Total does not add to 100 percent due to rounding.

Source: Developed by GAO using data provided by CMHS and National Institute of Mental Health (Rockville, MD). Generally, the published statistics reflect about a 4-year lag. For example, the Department's most recent comprehensive statistical report Mental Health, United States, 1992 was based on 1988 data.

Table II.3: Psychiatric Services Inpatient Admissions of Minors Ages 13 Through 17 in the United States, by Type of Disorder, 1980 and 1986

Admissions by type of facility and disorder	Year			
	1980		1986	
Private psychiatric hospitals	**Number**	**Percent**	**Number**	**Percent**
Preadult disorders	3,495	4.9	6,230	6.0
All other disorders	11,162	15.7	32,876	31.4
Total	**14,657**	**20.6**	**39,106**	**37.4**
Nonfederal general hospitals with psychiatric units				
Preadult disorders	7,593	10.7	8,048	7.7
All other disorders	34,173	48.0	37,247	35.6
Total	**41,766**	**58.7**	**45,295**	**43.3**
State and county mental hospitals				
Preadult disorders	3,612	5.1	4,763	4.6
All other disorders	11,209	15.7	8,095	7.7
Total	**14,821**	**20.8**	**12,858**	**12.3**
Other facilities				
Preadult disorders	[a]		1,320	1.3
All other disorders	[a]		5,994	5.7
Total	[a]		**7,314**	**7.0**
Total minors admitted				
Preadult disorders	14,700	20.6	20,361	19.5
All other disorders	56,544	79.4	84,212	80.5
Total	**71,244**	**100.1[b]**	**104,573**	**100.0**

[a]Data not available.

[b]Details do not add to 100.0 percent due to rounding associated with subtotals.

Source: Developed by GAO from unpublished data provided by CMHS.

Table II.4: Psychiatric Services Inpatient Admissions of Minors Ages 13 Through 17 in the United States by Legal Status, 1980 and 1986

Admissions by type of facility and legal status	Year 1980	1986	Percentage change
Private psychiatric hospitals			
Voluntary	12,984	37,068	+185.5
Involuntary (noncriminal)	1,647	2,038	+23.7
Involuntary (criminal)	26		
Total	**14,657**	**39,106**	**+166.8**
Nonfederal general hospitals with psychiatric units			
Voluntary	36,240	39,496	+9.0
Involuntary (noncriminal)	5,526	5,799	+4.9
Involuntary (criminal)			
Total	**41,766**	**45,295**	**+8.4**
State and county mental hospitals			
Voluntary	7,044	4,648	–34.0
Involuntary (noncriminal)	7,409	7,880	+6.4
Involuntary (criminal)	368	330	–10.3
Total	**14,821**	**12,858**	**–13.2**
Other facilities			
Voluntary	[a]	4,929	
Involuntary (noncriminal)	[a]	2,047	
Involuntary (criminal)	[a]	338	
Total	**[a]**	**7,314**	
Total minors admitted			
Voluntary	56,268	86,141	+53.1
Involuntary (noncriminal)	14,582	17,764	+21.8
Involuntary (criminal)	394	668	+69.5
Total	**71,244**	**104,573**	**+46.8**

[a]Data not available.

Source: Developed by GAO from unpublished data provided by CMHS.

Table II.5: Percentage of Psychiatric Services Inpatient Admissions of Minors Ages 17 and Under to NAPHS Member Hospitals, 1990-1992

Admissions by legal status[a]	1990	1991	1992
Voluntary			
Parental consent	36.9	46.2	45.3
Parental and child consent	55.2	49.2	47.4
Subtotal	**92.1**	**95.4**	**92.7**
Involuntary			
Noncriminal	7.7	4.0	6.9
Criminal	0.2	0.6	0.4
Subtotal	**7.9**	**4.6**	**7.3**
Total	**100.0**	**100.0**	**100.0**

[a]The source reports showed admissions data for patients under age 18 but not specifically for ages 13 through 17. Also, the reports present admissions data as percentages and do not show the supporting details (i.e., numbers of patients admitted). The NAPHS survey reports for 1987 through 1989 do not include any statistics showing admissions by legal status.

Source: National Association of Psychiatric Health Systems annual survey reports.

Table II.6: Average Length of Stay of Minors Ages 13 Through 17 for Inpatient Psychiatric Services in the United States, 1980 and 1986

Type of facility and diagnoses	Average length of stay (days) 1980	1986
Private psychiatric hospitals		
All diagnoses	47.5	44.3
Preadult disorders	46.8	61.1
Nonfederal general hospitals with psychiatric units		
All diagnoses	21.0	15.7
Preadult disorders	36.5	19.7
State and county mental hospitals		
All diagnoses	54.4	36.8
Preadult disorders	65.2	39.0
Other facilities		
All diagnoses	[a]	30.6
Preadult disorders	[a]	30.7

[a]Data not available.

Source: Developed by GAO from unpublished data provided by CMHS.

Table II.7: Average Length of Stay for Patients Diagnosed With Preadult Disorders at NAPHS Member Hospitals, 1986-1991

Year	Length of stay (days)[a]
1986	48.7
1987	43.7
1988	42.6
1989	38.7
1990	35.9
1991	34.8

Note: The most recent year for which we could obtain data was 1991.

[a]According to NAPHS officials, NAPHS survey reports excluded patients with lengths of stay of more than 120 days to avoid skewing the averages caused by extended stays.

Source: National Association of Psychiatric Health Systems, annual survey reports.

Table II.8: Inpatient Admissions of Minors Ages 13 Through 17 to Private Psychiatric and Nonfederal General Hospitals in the United States, by Payment Source, 1980 and 1986

	Private psychiatric hospitals		Nonfederal general hospitals with psychiatric units	
Payment source	**1980**	**1986**	**1980**	**1986**
Commercial insurance	11,000	32,322	26,344	29,625
Medicaid	1,466	1,675	8,660	4,758
CHAMPUS[a]	1,052	2,113	578	1,234
Social service funds	127	127	540	701
Personal resources	197	657	2,177	3,760
No fee payment	26	672	581	442
Other	789	1,540	2,886	4,775
Total admissions	**14,657**	**39,106**	**41,766**	**45,295**

[a]CHAMPUS is an acronym for Civilian Health and Medical Program of the Uniformed Services.

Source: Developed by GAO from unpublished data provided by CMHS.

Procedural Protections

In 1979, the U.S. Supreme Court recognized that a minor has a legitimate interest in not being committed to a psychiatric facility unnecessarily. The Supreme Court held that an independent evaluation of the minor by an admitting physician meets the due process requirement. Our review of the literature and our analysis of statutes in four states showed that procedural protections vary for minors admitted to psychiatric hospitals.

Supreme Court Decision

There has been relatively little federal case law on the constitutional scope of minors' rights regarding commitments to psychiatric facilities. The major Supreme Court decision concerning this issue—Parham v. J.R., 442 U.S. 584 (1979)—addressed the protections to which a minor is entitled when being committed by a parent to a state hospital. The Supreme Court said that a minor has a legitimate interest in not being committed without reason; thus, an independent clinical evaluation should be conducted before the minor is committed. However, the Supreme Court also decided that a formal hearing is not necessary, and the "independent" evaluation can be performed by the admitting physician at the hospital, as long as the physician has the authority to refuse to admit the minor.

While the Supreme Court recognized that a minor has a "liberty interest" in not being committed unnecessarily, Parham was limited to a Fourteenth Amendment analysis of a minor's rights when commitment is in a state (public) hospital. Therefore, the protections enunciated in the Parham decision do not necessarily apply to private psychiatric hospitals. Moreover, the Parham decision deals with the initial commitment of minors. The Supreme Court's decision does not address the process required for periodic review of a minor's continuing confinement, nor does the opinion address the process required if a minor contests confinement by requesting a release. Thus, states still have wide latitude in establishing procedural protections for minors in the context of private psychiatric hospital admissions.

Our Review of Statutory Procedural Protections in Four States

To obtain information, we examined the statutory procedural protections currently afforded minors admitted to psychiatric hospitals in California, Georgia, Texas, and Virginia. We developed seven questions from these sources that, when applied to the statutes in the four states, showed the extent to which the states contained these attributes and thus provided procedural protections to minors committed to or in psychiatric hospitals. The questions were as follows:

- Does the statute allow a parent or legal guardian to commit a minor and if so, at what age?
- Does the minor have the right to object to admission?
- Does the statute have a neutral fact finder requirement?
- Is a hearing allowed either before or after detention?
- Is an attorney or guardian ad litem appointed for the minor?
- Is periodic review allowed and if so, what is the frequency?
- Are noninstitutional alternatives to inpatient psychiatric hospital admission considered?

In recent years, three of the four states selected for review enacted legislation that provided additional protections for minors in psychiatric hospitals.

Under California's legislation, a minor of any age can be committed to a private psychiatric facility by a parent or legal guardian. However, a minor age 14 or older has 10 days to request a review of the admission if the minor's costs of commitment are being paid by private insurance or a private health service plan. The review must be conducted within 5 days of the request by a licensed psychiatrist who has training and experience in treating adolescent psychiatric patients. At the review hearing, a patients' rights advocate must be present to represent the minor. Neither the minor nor the psychiatric hospital will be allowed to have attorneys represent them. The hearing psychiatrist will issue a binding decision on the basis of whether (1) the minor continues to have a mental disorder; (2) further inpatient treatment is reasonably likely to be beneficial to the minor's mental disorder; and (3) the placement in the facility represents the least restrictive, most appropriate available setting for the minor within the constraints of reasonably available services, facilities, resources, and financial support.

Under Georgia legislation, a parent or guardian may have a minor (under age 18) committed to a private psychiatric facility. Further, a minor age 12 or older can commit him/herself. There are no specific statutory procedures or time limits for reviewing continued inpatient care, however, psychiatric hospitals have a statutory duty to release any patient who no longer needs inpatient treatment. In addition, a minor who has committed him/herself, a parent of such a minor, or a parent who has voluntarily committed a minor may request release from the hospital. The facility must release the patient or begin involuntary commitment proceedings within 72 hours of receiving such a written request for release. A court has the power to appoint a guardian or attorney at any time; however, the statute does not specify procedures for requesting the appointment of an attorney or guardian. The minor also has the right to see an attorney or independent physician if the minor can afford to hire one.

Under Texas legislation, a minor under age 16 can be committed by a parent, whereas a minor age 16 or older can commit him/herself. Further, a minor age 16 or older cannot be committed by a parent. A minor who has committed him/herself, or a parent who committed a minor younger than 16, may request the minor's release. Upon the filing of such a request, the

minor must be released within 4 hours unless the minor's physician has reasonable cause to believe that the minor might meet the criteria for emergency detention or court-ordered mental health services. The general criteria for emergency detention are that (1) the minor is mentally ill, (2) the minor demonstrates a substantial risk of serious harm to himself/herself or others, (3) the described risk of harm is imminent unless the minor is immediately restrained, and (4) emergency detention is the least restrictive means by which the necessary restraint may be accomplished. The general criteria for court-ordered mental health services are that the proposed patient is mentally ill and, as a result of that mental illness, the proposed patient (1) is likely to cause serious harm to him/herself; (2) is likely to cause serious harm to others; or (3) will, if not treated, continue to suffer severe and abnormal mental, emotional, or physical distress, will continue to experience deterioration of ability to function independently, and is unable to make a rational and informed decision on whether to submit to treatment.

In Texas, if the minor's physician has reasonable cause to believe that the minor might meet the previously mentioned criteria, the minor must be examined within 24 hours after the request. The minor must be discharged unless the examining physician determines that the patient does in fact meet the criteria. Once such a determination is made, the physician must, by 4 p.m. on the next business day, either file an application for emergency detention or court-ordered mental health services and obtain a written order for further detention, or discharge the minor. Such an order is issued by the appropriate county court.

Under Virginia legislation, a minor younger than age 14 can be committed by a parent without the minor's consent, whereas a minor age 14 or older can object to being admitted. Such admissions must be approved by a qualified evaluator (psychiatrist or psychologist), who examines the minor within 48 hours and makes specific written findings. An objecting minor age 14 or older may be admitted to a facility for up to 72 hours pending a review of the admission by the juvenile and domestic relations district court for the jurisdiction in which the facility is located. Upon admission, the facility must immediately file a petition for judicial approval. The objecting minor must also be examined within 24 hours of admission by a qualified evaluator. The district court appoints a guardian ad litem[1] for an objecting minor age 14 or older upon receipt of the petition and the results of the evaluation. The court conducts a review in the best interests of the minor and evaluates the views of the minor, the consenting parent, the evaluator, and the attending psychiatrist.

To authorize hospitalization of the objecting minor age 14 or older, the court must find that (1) because of mental illness, the minor either presents a serious danger to him/herself or to others, or has a seriously deteriorated ability to care for him/herself in a developmentally age-appropriate manner; (2) the minor needs and is likely to benefit from proposed inpatient treatment for a mental illness; and (3) inpatient treatment is the least restrictive alternative that meets the minor's needs.

[1]A guardian ad litem is a guardian appointed to represent the interests of a minor.

If these determinations are made, the judge issues a court order authorizing hospitalization for up to 90 days. Upon the expiration of the 90-day period, the facility must file a new petition with the court, which indicates that the minor continues to meet the previously stated criteria.

Conditions of Confinement

According to the National Association of Psychiatric Health Systems (NAPHS), programs for private psychiatric hospitals are generally intensive and include scheduled activities for a substantial portion of the day and evening. NAPHS said that while each patient's treatment program is individualized on the basis of the severity of the illness, program elements generally are common to all patients. In a private psychiatric hospital, each day is likely to include 5 to 6 hours of therapy, which may include individual, group, and family therapy. Also, these hospitals generally offer specialized therapy, such as art and recreational therapy, prescribed according to the skills to be evaluated or developed in an individual patient. Besides the therapeutic and recreational activities, minors in private psychiatric hospitals may be provided educational services. The educational services may be provided by teachers on the hospital staff or offered at the hospital by teachers from the local school district.

In addition to providing summary data on hospital services, we have included profiles of three minors who hospital officials considered to be representative of minors admitted to psychiatric hospitals.

Conditions of Confinement Observed at Four Private Psychiatric Hospitals

Three of the four hospitals we visited offered inpatient programs to both minors and adults, and the fourth hospital treated only minors. All four facilities were private psychiatric hospitals. The inpatient programs for minors in the hospitals we visited range in size from 35 to 120 beds. Our review relating to conditions of confinement addressed educational, medical, and mental health services; sleeping arrangements; visitation policies; and methods for minimizing unnecessary admissions. We relied on the statements made by the hospital staffs regarding the conditions of confinement and available services without any verification.

Educational Services

According to hospital officials, two of the four hospitals (both in Texas) maintained accredited schools on site. Minors at both hospitals attended classes within the hospital for 3 to 5 hours per day and earned credits that are transferable to their home schools. According to officials at the other two hospitals (in Georgia and Virginia), the facilities did not maintain accreditation because the minors' lengths of stay were so short that accreditation was unnecessary.[1] Minors at the two hospitals with nonaccredited schools attended classes 2 to 3 hours each morning. During these classes, the minors received group instruction and individual

[1]We did not obtain data of the length of stay at all of the facilities.

tutoring that included assistance with assignments from their community schools.

Medical Services

According to hospital officials, all four hospitals provided physical examinations for newly admitted patients. Nurses were on site and physicians were on call at all times to provide other medical services, as needed. In addition, the hospitals had arrangements with community medical facilities to provide any emergency medical services needed.

Mental Health Services

Officials at all four hospitals stated that minors received psychiatric and psychological services, as needed, to meet the hospitals' requirements and the minors' individual needs. The minimum requirements for individual psychiatric and psychological consultations at the four hospitals ranged from once a day to once a week, and requirements for group sessions ranged from 3 to 14 sessions per week.

Hospital officials added that all four hospitals encouraged parents of minors to participate in family counseling sessions. Two hospitals provided these sessions to the extent they were needed and could be arranged with the families. The other two hospitals conducted family therapy sessions once or twice a week. Some patients at three of the four hospitals had families who lived in distant locations. Consequently, officials at these hospitals either used conference calls for family therapy sessions or coordinated family therapy with mental health practitioners in the families' communities.

According to hospital officials, the ratio of clinical staff assigned to minors at the four hospitals we visited ranged from one staff member per 0.6 patients to one staff member per 4.5 patients. The clinical staff generally included nurses, therapists, and social workers assigned to the wards. The nursing component varied by acuity.[2]

Sleeping Arrangements

According to officials at all four hospitals, minors slept in rooms that accommodated one to three patients. One hospital treated only minors. Units for minors at a second hospital were located separately from the buildings that housed adult patients, and the other two hospitals used locked doors to separate the units for minors from those for adults. Rooms for males and females were located on opposite ends of the minors' units in three of the hospitals. At the fourth hospital, rooms for males and females were located within the same areas of the units, but entrances to each room could be observed from the nurses' desk.

Visitation Policies

According to officials at all four hospitals, family members were allowed to visit minors. One hospital had set aside 1.5 hours on 3 evenings during

[2]"Acuity" refers to the severity of the patients' mental conditions. A unit with patients having more severe conditions would have more nurses than a unit having the same number of patients but with less severe mental conditions.

the week for these visits and 3.5 hours on Saturdays and Sundays. Another hospital designated one half-hour on 2 evenings during the week and 1 hour on Saturdays and Sundays for family visits. The other two hospitals did not restrict family visits to specific times.

Methods of Minimizing Unnecessary Admissions

According to hospital officials, many patients were referred by psychiatrists who were not affiliated with the hospitals. All four hospitals required psychiatric evaluations before or immediately following admission. The hospitals had specific admission criteria that required a diagnosis of a mental illness and precluded admission of patients who could have been treated in a less restrictive environment. Three hospitals also stipulated that patients must be a danger to themselves or others and/or unable to care for themselves to be admitted. All four hospitals provided for second opinions if requested by the patient, family, or other interested party. Further, at all four hospitals private insurance companies required that utilization reviews be performed to control costs for their members.

Summary of Observations on Conditions of Confinement for Minors in Four Private Psychiatric Hospitals Visited by GAO[3]

Key Questions

Patient Classification: What Are the Age Limits for Children's Programs and Adolescents' Programs?

- **Hospital A**
  Generally, children's programs were for patients age 3 through 11, and adolescents' programs were for those age 12 through 17.
- **Hospital B**
  Generally, children's programs were for patients age 8 through 12, and adolescents' programs were for those age 13 through 18.
- **Hospital C**
  Generally, children's programs were for patients age 4 through 12, and adolescents' programs were for those age 13 through 18.
- **Hospital D**
  Generally, children's programs were for patients age 4 through 11, and adolescents' programs were for those age 12 through 17.

[3]The following information was developed by GAO on the basis of visits to selected hospitals—one in Georgia, two in Texas, and one in Virginia.

Educational Services: What Educational Services Does the Hospital Provide to Patients Who Are Minors?

- **Hospital A**
  The on-site accredited school had 9 classrooms for grades kindergarten through 12. Patients were to attend classes 3 to 5 hours per day. Classes were taught by three teachers on the hospital staff and by two teachers from the local school district. Patients could earn transferable credits, high school diplomas, and general equivalency diplomas (GED). Special education programs and college correspondence courses were available.
- **Hospital B**
  The on-site accredited school had 15 classrooms for grades 2 through 12. Patients were to attend classes 4.5 hours a day. Classes were taught by teachers on the hospital staff. Patients could earn transferable credits, high school diplomas, and GEDs. Special education programs and college correspondence programs were available.
- **Hospital C**
  The on-site school was not accredited because lengths of stay were not sufficiently long to justify it. Patients were to attend class 2 hours each morning. Special education teachers on staff were to provide group instruction and individual tutoring, including help with assignments from community schools. The staff placed students in community special education programs upon discharge, as needed.
- **Hospital D**
  The on-site school had one classroom for children and two classrooms for adolescents. The school was not accredited because lengths of stay were not sufficiently long to justify it. Patients attended classes 3 hours per day. Classes were taught by teachers on the hospital staff. Patients could earn transferable credits and GEDs. Special education programs and college correspondence programs were available.

Medical Services: How Frequently Does the Hospital Provide Medical Consultations to Patients Who Are Minors?

- **Hospital A**
  A physician was on site several hours per week to perform examinations required for admitting new patients and to see other patients on an as needed basis. Nurses were always on site and a physician was also on call 24 hours per day, 7 days per week. Emergency hospital care was available as needed.
- **Hospital B**
  A physician was on site as needed to examine patients and to provide other medical services. Nurses were always on site, and a physician was on call 24 hours per day, 7 days per week. Emergency hospital care was also available as needed.
- **Hospital C**
  A physician was on site part of each day of the week to obtain medical histories and examine each patient admitted within the preceding 24 hours. Nurses were always on site, and a physician was on call 24 hours per day, 7 days per week for consultations. Emergency hospital care was also available as needed.
- **Hospital D**
  A physician was on site each weekday to examine new patients and to provide other medical services. Nurses were always on site, and a physician was on call 24 hours per day, 7 days per week. Emergency hospital care was also available as needed.

Mental Health Services: How Frequently Does the Hospital Provide Psychiatric/Psychological Consultations to Patients Who Are Minors?

- **Hospital A**
  Assigned psychiatrists saw each patient daily for about 10 to 45 minutes and more frequently if needed. The assigned social workers saw the patients one to five times per week as needed. Mental health workers, nurses, and psychologists consulted with patients as needed. Patients attended two group sessions per day, 5 days per week, and other sessions as prescribed.
- **Hospital B**
  Patients were to have at least one individual therapy session and three to five group sessions per week. These sessions were conducted by psychologists, social workers, or other licensed therapists.
- **Hospital C**
  Therapy included at least five individual sessions per week with the assigned psychiatrist. Nurses, social workers, and other staff provided five group therapy sessions per week for adolescents and three per week for children.
- **Hospital D**
  Patients received individual therapy with assigned psychiatrists at least once every 1 to 2 days. The patients participated in group therapy sessions twice per day, 7 days per week.

Mental Health Services: What Other Therapeutic Services Do the Minors Receive in the Hospital?

- **Hospital A**
  Patients received discharge therapy and 2 to 3 hours per day of activity therapy, which included recreational or occupational therapy and physical conditioning. Also, speech/language counseling, aerobics, and dietary/nutritional counseling were available as needed.
- **Hospital B**
  Patients received Reality Oriented Physical Experiences (ROPES) therapy[4] and recreational and discharge therapy. Also, speech/language therapy, aerobics, and dietary/nutritional counseling were to be available to patients as needed.
- **Hospital C**
  Patients received art, recreational, and discharge therapy as well as speech/language therapy, aerobics, and dietary/nutritional counseling as needed. A contractor provided ROPES therapy during the summer months.
- **Hospital D**
  Minors received ROPES, music, art, recreation, and discharge therapy. Also, speech/language therapy and dietary/nutritional counseling were available as needed. Including individual and group sessions, patients were in some type of therapy program for a total of 12 hours each day.

Mental Health Services: How Extensive Are the Counseling Services Provided by the Hospital to Parents of Patients Who Are Minors?

- **Hospital A**
  Counseling with the patient and family was conducted as needed and as could be accommodated by the family. Parents were encouraged to participate in treatment as much as possible. Conference calls were used for out-of-town families.
- **Hospital B**
  Counseling with the patient and family was conducted as needed and as

[4]ROPES therapy is a program that uses individual and group activities on specially designed obstacle courses that are intended to improve a patient's trust and communications with peers and raise his/her self-esteem.

could be accommodated by the family. Many patients were from distant locations; thus, family therapy was coordinated with practitioners in the patients' home communities to minimize travel for those families.

- **Hospital C**
  Family therapy sessions were to be held twice per week for patients who were minors and their families. Travel requirements did not generally preclude families from attending these sessions because most lived within 15 miles of the hospital.
- **Hospital D**
  Family therapy sessions were to be held one or two times per week, and parenting classes were offered once per week. Conference calls were used for out-of-town families. On a Saturday near the end of the patient's stay, the parents spend the entire day with the patient, during which time they participated in role-playing activities.

Mental Health Services: What Is the Hospital's Staff/Patient Ratio in the Children's and Adolescents' Units?

- **Hospital A**
  The direct care ratio was generally one staff member per 2.5 patients, but this number varied on the basis of patient acuity. Direct care staff included a program director, nurses, mental health specialists and technicians, and social workers.
- **Hospital B**
  The direct care ratio was generally about one staff member per 2.7 patients, but this varied on the basis of patient acuity. The direct care staff included therapists, nurses, mental health care aids.
- **Hospital C**
  The ratio of clinical staff (i.e., nurses, social workers, and activity therapists in the units) was about one staff member per 0.6 children and one staff member per 0.7 adolescents. The nursing staff level changed on the basis of patient acuity.
- **Hospital D**
  The ratio of nurses and therapists assigned to the units was generally one staff member per 3.5 patients in the children's unit, and one staff member per 4.5 patients in the adolescents' unit. The nursing staff level changed on the basis of patient acuity.

Sleeping Arrangements: What Residential/Sleeping Arrangements Does the Hospital Provide for Minors?

- **Hospital A**
  The child and adolescent building was separated from the adult buildings. It included four separate wings for the school, the adolescents' residential program, the children's residential program, and the adolescents' inpatient program. Patient rooms were single and double and included private bathroom facilities. The rooms were located on the outer edges of large, open, multipurpose areas. Wings were coed but nurses stations provided a view of the entrances to all rooms.
- **Hospital B**
  The hospital treated only minors. These patients were housed in five identical buildings that contained two units each. A unit consisted of four single and four double patient rooms, bathroom facilities, a kitchen, and a living area. Half of the patient rooms and bathroom facilities were for males and were separated from the other half, which were for females, by the living area. A patient was assigned to a unit on the basis of age, admission status, and security needs.

- **Hospital C**
  Locked doors separated the adolescents' and children's units from the adult units. The former consisted of patient rooms and recreation rooms. Patient rooms accommodated two or three people and included a private bathroom. Rooms for males and females were at opposite ends of the units.
- **Hospital D**
  Locked doors separated the adolescents' and children's units from the adult units. The adolescents' and children's units had multipurpose areas and patient rooms that accommodated two patients each. The patient rooms in the adolescents' unit included private bathroom facilities. The children's unit had a playroom and separate common bathroom areas for males and females. Males and females were housed at opposite ends of each unit.

Visitation Policies: What Are the Hospital's Policies/Practices for Visitation of Patients Who Are Minors?

- **Hospital A**
  The hospital did not designate specific times for visitation. Families were generally encouraged to visit patients and could have done so anytime, as long as the visit was not detrimental to the treatment program. Hospital staff did ask families to schedule visits around school sessions.
- **Hospital B**
  The hospital did not designate specific times for visitation. Families were generally encouraged to visit patients and could visit anytime, as long as the visit was not detrimental to the treatment program. Hospital staff did ask families to schedule visits around therapy sessions.
- **Hospital C**
  Family members were allowed to visit 1.5 hours on Tuesday, Wednesday, and Friday evenings and 3.5 hours on Saturdays and Sundays.
- **Hospital D**
  Family members were allowed to visit one half-hour on Tuesday and Friday evenings and 1 hour on Saturdays and Sundays.

Methods of Minimizing Unnecessary Admissions: How Are Unnecessary Admissions for Inpatient Care Minimized. for Example, Are Specific Justification Criteria Established and Followed? Is There a "Neutral Fact Finder" Who Must Approve or Review the Commitment?

- **Hospital A**
  Many patients were referred by outside psychiatrists and child protective services. All were to be evaluated by a staff psychiatrist before admission. The admission decision was made on the basis of diagnosis criteria and approval of the applicable insurance company. To be admitted, a patient must have been a danger to him/herself or others or be incapable of caring for him/herself. The patient would not have been admitted if care could have been provided in a less restrictive environment. A reviewer at a managed care company was considered to be an independent reviewer. Staff would have arranged for a second opinion if requested by the patient, family, or insurance company.
- **Hospital B**
  All patients were referred by mental health care professionals at other facilities. All patients were to be evaluated by a staff psychiatrist before admission. The admission criteria required that a patient have a diagnosed mental illness and the capability to respond to treatment. A patient was not admitted if he/she could have been treated in a less restrictive environment. Most patients had insurance coverage that included utilization reviews by managed care companies. If requested, the hospital

allowed the family to arrange for a second opinion from an independent mental health care professional.

- **Hospital C**
  All new patients were to receive a psychiatric evaluation before or immediately after admission. To be admitted, a patient must have been a danger to him/herself or others or unable to care for him/herself due to a psychosis. Patients were not to be admitted if they were incapable of benefitting from treatment or if they could have been treated in a less restrictive environment. Second opinions were obtained from a staff psychiatrist or the facility's clinical director if an admission was questioned. Some insurance companies performed utilization reviews of admissions.
- **Hospital D**
  Many patients were referred by outside psychiatrists. All new patients were to receive a psychiatric evaluation and a utilization review by hospital clinical staff immediately after admission. Admission criteria required that a patient was to have a diagnosed mental illness and the capability to respond to treatment. Most patients must have been a danger to themselves or others or unable to care for themselves. (This criterion did not apply to patients with attention deficit disorders.) A patient was not to be admitted if he/she could have been treated in a less restrictive environment. Some insurance companies performed utilization reviews of admission. The hospital arranged for a psychiatrist who was not on staff but had privileges at the hospital to provide a second opinion at the family's request.

Patient Profiles

The following three case studies are of minors who were admitted to psychiatric hospitals we visited. The hospitals provided us with the case history information regarding these patients, who they considered to be representative of minors admitted to psychiatric hospitals.[5]

First Patient Profile

A 15-year-old male patient had a history of multiple symptoms. He was suspected to be hyperactive at approximately age 6, and he was treated with Ritalin from age 8 through 12. The patient often served as the scapegoat within his peer group. He experienced increasing difficulties, including aggressive behavior at school and at home. He lied, stole, ran away several times, and began to exhibit suicidal behaviors as well as signs of substance abuse. Beginning in the fall of 1989, he was hospitalized several times and ran away almost continually until July 1991.

The patient briefly returned to his adoptive mother's and stepfather's home, but when his behavior again deteriorated and he became suicidal, he was admitted to a hospital in January 1992. In May 1992, the patient was transferred to another psychiatric facility's open unit for boys aged 14 to 17.

The patient's stay in this facility focused on family relationships and behavioral acting out in the school setting. The patient was involved in

[5]We did not review the patient records; We edited the profiles as provided.

individual therapy, group therapy, substance abuse counseling, experiential therapy, recreational therapy, family therapy, and milieu therapy. In group therapy, he was successful at identifying and expressing feelings about many of his problems. He was also able to identify his behavioral patterns and address identity issues. However, because he did not make sufficient progress in identifying and utilizing new ways of handling family and school situations, other placement options were pursued for the patient.

Because his mother abandoned him, the patient was discharged in January 1993 to a therapeutic foster home. He has been recommended for continued individual and group therapy and placement in a structured setting that would allow guidance for managing his emotions and behaviors.

Second Patient Profile

This 17-year-old male patient had a history of disruptive behavior in school and difficulty following rules at home. These behaviors became more severe with adolescence, and the patient's parents have found it more difficult to provide sufficient limits for him. There have been long-term tensions between the parents that seem to have worsened due to the difficulties in managing the patient's behavior. There is a great deal of anger between the patient and his mother, and at times sarcasm is a major mode of family interaction. The patient resents his younger brother, who is seen as "the good child."

The patient was admitted to the hospital because he was out of control and because he was at serious risk for impulsive, self-destructive behavior. He was (1) experiencing symptoms of depression, (2) not following his parents' rules, (3) driving recklessly, (4) performing poorly in school, and (5) heavily abusing marijuana and alcohol.

Recent family tensions resulted from the father being diagnosed with multiple sclerosis. The patient has paid little overt attention to this, even though both parents are very worried about it.

In addition, the patient feels that he cannot control his use of marijuana. He has also used alcohol heavily, but not as heavily as marijuana. The patient was recommended for the adolescent dual diagnosis track and for continuing care and relapse prevention after leaving the hospital.

Psychological testing done just prior to admission revealed that the patient had a serious depression, with an impairment in self and object relations, very poor impulse control, and difficulty planning ahead and seeing the consequences of his actions. It appeared that affect of any kind was very difficult for him to manage and that his defense mechanisms were primitive and nonadaptive. The patient's IQ scores had dropped significantly since 1989.

During hospitalization, the patient exhibited depression, but he consistently denied feeling depressed. He did describe feeling less irritable

while in the hospital. Although he said he had cravings for marijuana, the patient did not describe any significant physical withdrawal symptoms. Within the security of the hospital setting, he did not exhibit risk-taking behaviors. The patient was positive about his involvement in the dual diagnosis program and did seem interested in learning more about substance abuse and the problems it could cause. He consistently focused on those issues and not the problems related to school and family functioning. It appeared that the patient had low self-esteem and felt very badly about his relative lack of success in school. He began to look at his history of avoiding responsibilities and problems and described being angry with his parents, who he felt had not been firm enough with him.

Throughout the hospitalization, the patient frequently relied on denial and avoidance in dealing with issues. He gradually became aware of his long-term difficulties with managing anger, and he noted that this was a problem in his family. The patient was started on nortriptyline, with dosage gradually raised to 75 milligrams a day. While taking this drug, the patient seemed to experience some decrease in irritability and a slight lessening of depression. Although the patient was relatively compliant with hospital staff, he would verbally challenge his parents but would respond when they set firm limits. He appeared to be very narcissistic and have limited abilities to appropriately cope with any stress.

Although the patient did seem interested in working on substance abuse, he began to complain about the hospital program and felt he had no need for working on any other issues. He took little responsibility for his own behavior. It appeared he was not going to be able to avoid drugs outside the hospital environment, both because of his own impulsivity and the family difficulties in setting limits for him. The patient agreed to placement in a chemical dependency program and application was made for him to go to a residential treatment program. By the time of discharge, the patient seemed to have some commitment to staying off marijuana and alcohol but was not yet sure whether he could do this on his own. His parents were supportive of ongoing substance abuse treatment and his placement in a residential center.

Third Patient Profile

The patient, a 12-year-old female, has been increasingly depressed over the past 3 years since her family moved from a large house to a small, two-bedroom apartment. Her mother and stepfather have separated several times since the move, and her mother is currently hospitalized due to an overdose. Her parents plan to separate again once the mother is out of the hospital. The patient's grades have declined, and she has failed two classes. She has been increasingly angry and abusive toward teachers; she was suspended last year for refusing to follow directions. She has severe conflicts with peers, and many peers at school want to beat her up. She is experiencing a diminished appetite, severe insomnia, poor concentration, no interest, and frequent crying over minor things. The patient has recurrent thoughts of suicide, and she has engaged in self-mutilation. She was admitted after threatening to take a drug overdose (like her mother did).

There are multiple stressors. First, the mother's physical illnesses have required several hospitalizations, including psychiatric hospitalization. Second, the patient has experienced frequent separations of her mother and stepfather. Third, the patient feels her stepfather does not care about her and alleges that he whips her with a belt. Fourth, the patient feels unloved by her birth father, who she says has disowned her. Fifth, her 10-year-old brother has muscular dystrophy, is bedridden, relies on a breathing machine, and requires a visiting nurse 12 hours a day. Sixth, her home is overcrowded and overstimulating. In addition to the parents and 10-year-old brother, the two-bedroom apartment also houses a 3-year-old brother and a 16-year-old sister.

The patient is hypersensitive with others and reacts quickly to what she perceives as criticism. She is emotionally reactive and may react quickly in a suicidal or self-destructive manner. The patient shows characteristic signs of emotional incest and role reversal in the family, i.e., being both her mother's parent and caretaker. The patient reports beginning alcohol use this past year at age 11 with her friends.

Because of her age, the patient was initially admitted to the Child Program, which made her very angry. She wanted the privileges and expectations of older adolescents. To prove that she was more mature, the patient often alluded to her use of alcohol and cigarettes. On the unit, the patient immediately demonstrated oppositional, impulse, and verbally abusive behaviors but not hyperactivity. She had great denial about suicidal feelings and self-mutilation. She also engaged in a number of oral behaviors such as sucking her thumb, chewing her fingers, and biting her fingernails. These behaviors correlated with her tremendous sense of unmet dependency at home, which lacks nurturance and consistency. Formal psychological testing highlighted depression, visual motor integration problems, and features of attention deficit disorder.

The patient showed a modest stabilization in her impulsivity and depression. Her issues around food continued and clearly related to conflicts regarding maternal deprivation. She was finally discharged in October 1993. At that time, the patient showed a modest stabilization in her impulsivity and depression. She continued to have oppositional tendencies and was not very motivated to return to school. Meanwhile, her mother was pursuing eligibility for special education services for her. The patient and her mother were given a referral for additional therapy, and the Department of Social Services was to provide additional support, including a plan for homemaker assistance.

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