Crisis in Child Mental Health: A Critical Assessment

Formulated by the Ad Hoc Committee

Group for the Advancement of Psychiatry
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The delivery of mental health services to disturbed and retarded children has long been endangered by the tensions arising out of the many polarities in modern American society. Caught in a complex web of conflicting interests, competing policies, and jarring confrontations, the needs of our children have gone unmet. It was under the stimulus of the frustrating confusion produced by these interlocking forces that Congress created the Joint Commission on Mental Health of Children.

The Commission met for a period of three years and in 1969 produced a report that sought to embody the best thinking in the land on the needs of children. As the various mental health professionals read this book, studied it, evaluated it, and began to respond to it, it was evident that this work might have enormous impact on the structuring and shaping of mental health care for children on every level. Indeed, no sooner was the Commission’s report published than many legislators turned their energies toward sitting and using its contents as a base for organizing legislative approaches to the funding and structuring of major programs for children. It therefore became a matter of extraordinary importance for all concerned professionals to respond to this report, and to do so in depth.

In the fall of 1969, the GAP Committee on Child Psychiatry conducted a forum discussion for GAP on the work of the Joint Commission on Mental Health of Children. The issues set forth at that time aroused genuine concern among those present, so much so, indeed, that the President of GAP took the unusual step of appointing an ad hoc committee to review the report of the Joint Commission and to formulate a series of recommendations based on this work. The ensuing pages are the response to this charge.
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This is the second in a series of publications comprising Vol. VIII. For a list
of other GAP publications on topics related to this subject, please see page 138.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has an active membership of approximately 200 psychiatrists who are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisions a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

CRISIS IN CHILD MENTAL HEALTH: A CRITICAL ASSESSMENT was formulated by the Ad Hoc Committee on the Report of the Joint Commission on Mental Health of Children. The members of this committee as well as all the regular committees and the officers of GAP are listed below.

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The Joint Commission on Mental Health of Children represented a truly national effort. Its work constituted an activity joined in by all mental-health-related organizations of major stature, an undertaking that drew experts from every part of the land and that focused and expressed some of the most vital streams of creative intellectual energy that flow through our culture. The final outcome of the Commission's deliberations lies in the content of two publications. One is the Report of the Commission, a 578-page book entitled CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's; the other is a summary of the report, a pamphlet of 42 pages entitled DIGEST OF CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's. The book is the definitive statement of the findings of the Commission. The two publications are the first of a series; six subsequent books are scheduled to appear. However, the measure of the activities of the Joint Commission will undoubtedly be defined by the impact of these two initial works. The book CRISIS IN CHILD MENTAL HEALTH will accordingly be the focus of this report.

This book is encyclopedic in scope. Merely to list some of the chapter titles speaks for the multiplicity and richness of the issues dealt with, for example, "Poverty and Mental Health," "Children of Minority Groups," "Emotionally Disturbed and Mentally Ill Children and Youth," "Education and Mental Health of Children and Youth," and "Employment." But these

titles tell an additional story. They display the broad social sweep of the Commission's report and thus provide us at once with a sense of the work's greatest strength and its most significant weakness.

It is abundantly clear that careful study of a given area requires a degree of isolation. Ultimately all things are interconnected. Yet if we would study and cope with a specific group of issues, we must to some extent separate these from the great totality of the universal matrix and deal with the matters at hand. So it is with such all-embracing concepts as health and mental health. Ultimately we can include under these rubrics the full organic range of all human behavior, social and individual, conscious and unconscious, healthy and diseased. Such an approach allows for soaring, dramatic generalizations and broad idealistic positions; this level of discourse, however, tends to slight many of the difficult details, the hard, gritty substance of which makes it a challenge to synchronize even small and limited program segments.

In addressing themselves to such areas as poverty, minority problems, and education in the largest sense, the framers of this volume have relegated mental illness among children, the treatment of the sick, and the prevention of sickness to a tertiary position, one chapter among ten, a detail in the larger pattern.

It is a difficult time to undertake a meaningful critique of the Commission's report. At the moment of this writing, federal and state programs are being retracted everywhere. Research is hard hit, funding is cut, a series of resignations has shaken the Department of Health, Education, and Welfare, children's services are threatened, and the recent White House Conference on Children was clearly ordered to proceed dimmundo. If the report of the Joint Commission on Mental Health of Children is to have a telling effect, can any of us who seek to advance the cause of care for children dare to criticize it? Will this not provide grist for quotation-out-of-context to the very forces whose efforts we seek to counter?

These are serious questions indeed, and as we sat together to consider the report, they led to some grim self-examination. Our painfully arrived at conclusion is this: In the short run we, and our constituents, the families and children, might well pay a price for such critical reactions. But in the long run, we believe that it is better to express our views and try to influence progress in the field in the direction that seems to us most constructive. Eventually, we believe, this will make our best contribution toward providing valid solutions for those pressing and urgent problems that initially engendered the report.

Let us address the question: Why were such a Commission and such a report necessary at all? Why was there no attention given to children by the original Joint Commission on Mental Illness and Health? Why the essential discontinuity implicit in separating child mental health from adult? To put it another way: Why are children's programs so few in number and so inadequate? The report goes to some pains at the outset to state that our society claims to be child-oriented but that we do not appropriate money for and we do not really take care of our children when they are sick and hungry. But the report does not raise the obvious question: Why not? There is no attempt to understand the underlying factors in our confusing attitudes toward children. Those of us who recall the earlier Joint Commission's report, ACTION FOR MENTAL HEALTH, will vividly remember that a whole chapter was devoted to exploring the reasons for our fear of mental illness and our social reaction to the emotionally sick person. None of this appears in CRISIS IN CHILD MENTAL HEALTH; there is commentary galore, but no attempt at understanding. From the point of view of mental health, this is an error of the first magnitude.

Lack of commitment to children

An examination of our society reveals a variety of anti-child attitudes, some covert, some readily visible. In house and apartment rentals, in many vacation resorts, in the best restaurants, in most shops and theaters, children are regarded as
obstacles to the smooth transaction of business. Media programs to further the well-being of children have been meager and late to develop. Often adults barely disguise their feelings that their own freedom and fun begin only after the children’s bedtime.

In the arena of large governmental operations we can still follow the same theme. When the community mental health centers were originally set up, it was stipulated that all ages be served. Nonetheless, most of the initial community mental health centers did not and do not provide facilities to serve children. The enabling legislation required that each center must serve all the people in a limited, defined area called a catchment area. All, that is, except the children. For children, four or five centers, each with its own catchment area, might drain their child population into some one distant location. Theoretically, it is even more important for children than for adults to be treated close to home. Nonetheless, the rules protected everyone, except children. Since at least a third of our population falls into the “child” category, we have a peculiar phenomenon to deal with here.

Congress noted this fact and in 1969 enacted legislation designating certain funding elements to be used for children; the President signed the bill, but instructed the executive department not to grant funds for such special “categories” as children—thus, in effect, negating the language of the legislation.

In the National Institute of Mental Health, too, the same sort of special discrimination is visible. There is a series of divisions into which NIMH programs fall; all of these are operating units with the exception of the children’s division. That one is only a “coordinating” group. It is the only one of its kind.

One could go on showing the peculiar lack of commitment to children and children’s services throughout our culture, both in government and out of it. This is as true within the professional community as among laymen. But what needs to be done is to help us come to grips with why this situation prevails. It is the considered opinion of the committee preparing this report that a study of the anti-child attitudes abounding in our culture—including those that we professionals reflect—needs very much to be undertaken in its own right. It is not enough to deplore; we must understand. It is only through understanding that we can hope to facilitate the very programs and methods that all of us work for. To whatever extent the report of the Joint Commission on Mental Health of Children fails in its mission, it will be due in material measure to the innate resistance to helping children that glows in the subconscious of our national consciousness. This needs study and public awareness; it saddens us that the Commission did not explore it. It will be more depressing still if the mental health professionals do not take this issue up and grapple with it.

Another important failure of the report is that it did not take a long and honest look at the professional issues and impediments to the realization of mental health programs. Perhaps this omission was due to a reluctance on the part of the staff and board members to face the inevitable embarrassment that comes when professionals display their own difficulties in public. But as clinicians we are all too aware that if people are to master anything, they must first sort out those elements that block mastery, that resist change, that defend the status quo. Only when these resistances have been clarified and resolved can genuine freedom for action emerge.

**Polarization in the professional community**

There are a number of polarizing issues that permeate the professional community, divide it, and drive the several groups of trained people into opposing and sometimes into warring camps. That this has its impact is indubitable; how great the effect on the development of programs and services is not easy to specify. Let us list some of these polarities:
There is, first, the interface between health and sickness. This translates into an intense struggle within the professional community between "medical" and "non-medical" models for delivery of mental health services, that is, direct doctor-to-patient treatment versus programs for groups or populations, or for intermediate agents to administer. This in turn is closely allied to a second polarity: the interface between prevention and treatment. These two issues tend to produce more or less overt battles between educators and social psychologists on one side and psychiatrists and clinical psychologists on the other. Obviously, in such realms no categories of this kind are firm, but the tug of war is very real. It is visible, for example, in the character of attack leveled by RE-ED proponents on residential treatment.

Another division splits the forces working for children from those working for adults, with a third group expressing commitment to programs for families. One can readily see that the help a child receives will be different in each situation—directed primarily to him, reflected to him through help to adult members of the family, or shared between him and others in his environment.

A primary concern of those who work with children and those who work with adults lies in the area of parenting. This function as such has received too little attention as a point of convergence of several approaches. It would seem well worth a more considered appraisal.

A fourth area of divisiveness lies between the clinical psychologist and the psychiatrist. This is a quietly bitter battle engaged in on a variety of fronts. It can be seen in the struggles around behavioral therapy approaches versus psychodynamic positions, in questions about which discipline should administer which program, and the like. Status, territory, money, power, theoretical bias, and a host of other profound human motives play a role in this competition.

Fifth, there is the uneasy encounter between education and therapeutics: many educators are moving in the direction of both prevention and repair, and their relationships with clinicians are often mutually distrustful. Again, the attention paid to this enormously important area is, to date, a sort of pact of non-recognition on everyone's part.

The sixth is the strife within psychiatry itself between community approaches and work with individuals. This affords an endless supply of disputatious grist in regard to such central matters as models for training, modes of organizing services, techniques for delivery of service, and so on, with deeply felt positions sorting themselves out and hardening within and among the agencies in the land.

The very existence of these differences breeds an inevitable defensiveness in the parties to the conflict. One loses one's sense of self-criticism, and it is all too easy for a professional to lapse into smugness and hauteur, to view himself as the fount of truth and probity, and to fail to keep alive the necessary tinge of ironic self-doubt about his own methods that will make him open to further growth and learning. There is an avoidance of the sick discernible on the part of some professionals, but it might well be matched by some gratification in sickness on the part of others—with neither group allowing themselves the necessary freedom to question their own motives. This freedom is the essential touchstone of really good professionalism, as well as an important protection for the vulnerable public.

This leads to the next interface, that between certain consumers and the clinicians. This occurs on many levels. There is a group of parents of psychotic children who militantly denounce the therapists whom they view as unjustly blaming father and mother for everything that went wrong. There is a population of homosexuals marching on parade to protest anyone labeling them as sick. The New Left youngster is wary of the "headshrinker," whom he views as an instrument that
the "System" is employing to get the radical to accept society's yoke and "adjust."

Again, there is the kind of inner interface, the special personal turmoil, that comes to the professional clinician who works with children. He is a member of a small and very much needed group of specialists, and the day he finishes training he is likely to find himself offered well-paid and responsible positions, or, at least, he is able to charge relatively high fees for his services. Neither of these possibilities might lead him to work where the need is greatest, for example, in an industrial school, in an inner-city ghetto, or in a backward rural area, even though his own ideals might incline him in this direction. This seldom addressed inner conflict is no small item in determining the actual channels along which services are delivered.

It may be that the answer to some of these problems will lie in the relationship between mental health and health in the larger sense as the country's thinking develops in the direction of a National Health Service of some kind. Certainly, such major shifts in service funding will have profound effects on styles of service delivery and on professional roles and decisions.

Finally, there is the interface—a subtle one here—between differing models of development. The pediatrician defines development one way, the neurologist somewhat differently. Neither one sounds much like the psychoanalyst, who in turn finds his views at variance with those of the behavioral psychologist, the Piagetian researcher, or the child-development specialist. While these approaches are various aspects of the whole rather than mutually exclusive, the question of which schemes are employed will profoundly affect the nature of facilities and staffing patterns as one begins to concretize the details of services for children.

Thus, the report of the Joint Commission on Mental Health of Children makes much of children's needs and the country's needs but does not deal with some of these more parochial problems that are central to what stands in the way of meeting the needs. No commission is able to resolve these matters completely, but they cannot be ignored or swept under the rug. At the least, they need clear public statement with a careful exploration of the strengths and weaknesses of each position. This in turn could lead to mutual, shared evaluative research. Lacking this, a given legislator is all too likely to be besieged by groups of conflicting experts, all speaking vigorously with deep conviction from complex positions, the details of which are obscure and technical, but the methods of which are radically antithetical and promise results that are guaranteed! No wonder legislation for children is piecemeal and chaotic.

These are areas the Joint Commission might have done well to clarify. Somebody should.

Neglect of clinical issues in the commission's report

We have a peculiarly apt documentation of these problems in the very structure of the book CRISIS IN CHILD MENTAL HEALTH. One has only to open it to the index to observe that there is only one chapter devoted to clinical matters, and that, mirabile dictu, this is the only chapter with appendices! There are indeed a number of appendices to the total text, but they are reserved for the usual location of such materials: at the end of the book. No chapters have their own appendices except for Chapter 6, the clinical chapter.

This strange phenomenon stimulated the curiosity of several of the authors of this Ad Hoc Committee report and led to their exploring the matter. As the background history unfolded, it was reported that all during the course of the Commission's life a continuous debate had prevailed between the clinician and nonclinical behavioral scientist. Time and again, the clinicians had begged, pleaded, and demanded to know what the Commission was going to do about the sick children. No clear answer was ever forthcoming. The National Association for Mental Health held conferences about the emotionally ill
child in order to make up for this deficit. Somehow this did not find its way into the work of the Commission. Finally, when the life of the Commission was half over, a Committee on Clinical Issues was appointed to deal with this “omission.” (Even at this late date, the mere conception that a Commission on Mental Health of Children would omit detailed and careful scrutiny of the area of mental illness and treatment seems bizarre. But, as reported, it happened.) The Committee on Clinical Issues produced a report that presumably should have been the basis of the “clinical chapter” in the final report. In fact, however, these issues either did not get into the final document or were altered sufficiently to change their thrust. In the final text, for example, the “clinical chapter” contained a diatribe attacking established clinical practices in the field of residential treatment.

This microcosm of political infighting, however, is the consequence of a failure to face the interdisciplinary issues directly. These things are not engaged in the text of the report; only their effects are visible. Woe betide us if the same sequences emerge in the area of legislation—and woe to the sick child and his parents. Even within the disenfranchised population of childhood, the sick are peculiarly without representation. Indeed, most of those who speak of them seek to be rid of their burden rather than to deal with their turmoil. All professionals seek prevention of mental illness. But one might indeed wonder about the widespread wish on the part of some professionals to prevent illness at the expense of treatment.

The proposal of a child advocacy system
Where the report of the Commission comes through most strongly is in its recommendation for advocacy. Indeed, this is its chief recommendation—that there be established in the United States a system of child advocacy starting with a group of advisers to the President, a group of advocates at cabinet and subcabinet level, and then a hierarchy of advocates in every state, every municipality, and every neighborhood in the nation. As described in the report, the chief power of the advocate will lie in access to money; the political implications of introducing such an element into the American scene are not analyzed at all.

As we consider this, it is this failure to engage the political that troubles us. There are so many overtones and possible interpretations and misinterpretations of this vast concept of advocacy that to leave it at the level of the report abandons it to numerous forms of attack—and this vulnerability might, in effect, delay or destroy it.

Thus, one might imagine one version of advocacy, with a director at the side of the President and a chain of command down to the community level, as giving rise to a fear of a car over the minds of children. The director could be viewed as a setter of policy who could affect the education, the recreation, the mental health, the remedial programs, and thus, ultimately, the fate of every child in the country. To what extent will the pattern of child care and provisions for children thus come under the influence of the political processes in the country? One of our members feels so keenly about the dangers latent in this proposal that he is against any form of governmentally run advocacy. In his view, only a carefully titrated balance of control by both public and private sectors has any hope of avoiding these hazards. There is no totalitarian government that does not institute some mechanism for control over the minds of children; advocacy, no less than any other governmental instrument that impinges on children, needs to be viewed from that perspective as well. How could safeguards be built in that would prevent such fears from arising and scuttling the program before it gets started? Another of our members suggests that such an agency has to be put into the hands of Congress, and thus, of necessity, become more immediately responsive to pressures from constituents. The matter, to say the least, is difficult. We would like to emphasize,
there was a need for placement, no therapeutic environment was accessible.

Finally, the report of the Joint Commission on Mental Health of Children did not provide a definitive plan for the financing of children's programs in general or of advocacy in particular. It is not so much that the Commission didn't try; it simply proved impossible to cost out advocacy. As a result, the funding of such services remains in a kind of limbo.

We cannot help but observe in passing that such “difficulties” are not external problems of budget and resources. They are internal problems of ambivalence and uncertain commitment. It was not hard for the American people to fund a highway program, through an onerous gasoline tax; the highway program costs many billions, but we want it and no one objects. It was not hard for us to fund an oil and mineral development program through an oil depletion allowance; again, huge sums are involved, and again, we maintain it despite a fairly considerable objection. And it would not be hard to fund a child advocacy program if it really represented a genuine value of our culture. We could, for example, ask every one who filled out a federal income tax form to state on the form how many TV sets he owns and place a tax of $2.00 per year on the possession of every TV set in the country; that would give us a comfortable sum to work with at least to get the program started. Or we could cut the oil depletion allowance in half and devote that fraction to children's services. Or we could do many other things, if we wanted to. Perhaps the answer lies in a less direct approach; some of us feel keenly that a program of National Health Service built on a developmental model would cope with these issues. Indeed, the Joint Commission pulled together a sizable body of material bearing on money for children's programs, and we could come to grips with this question of financing in a variety of ways.

But it is a cruel requirement to place on a professional group that it come up with a means of financing something, an
expensive something, that nobody really wants to pay for. The
issue of cultural attitude is at the center here once again: it is
difficult to develop such programs without active societal support.
This underlines the immense importance of studying the way
our culture views and values children.

To sum up, it seems safe to say that the question of advocacy
needs the most careful study in terms of its financing and also
in terms of its political meanings and its realistic limitations in
the light of the dearth of services to help children.

One of the problems with the concept of advocacy—or with
any large-order umbrella idea of that sort—is that it tends to
obscure the acerbic and uncomfortable fact that we are still in
the very early stages of knowledge about child mental illness
and child mental health. Our expertise here is different from
our mastery of physics, chemistry, and engineering. Notions
like advocacy, someone put there to “take over the problem,”
have a way of blinking this diamond-hard reality. The popular
conception that is likely to emerge, and to lead to eventual
frustration and disappointment, is that no longer will so many
of these problems be chronic, hard to treat, and slow to improve
—that now all will be taken care of, the difficulties resolved.

It is all too easy to shut one’s eyes to the very large number
of children and adolescents who need prolonged, intensive care,
and the many cruelly disrupted families who need a myriad of
support services. The kind of commitment implied in such
programs as these is simply colossal, and the most realistic
clinical experience would have to be injected at every stage of
program development.

In this connection, we wonder whether the existing pattern
of community mental health centers will be involved in formu-
lating and incarnating advocacy structures. Are they not an
apt nucleus upon which to build patterns of new services and
new functions for children? Could they not be developed as
essential links in the advocacy chain? There are potentials here
that should be weighed.

The concept of a mental health grid

We would suggest, however, that well before an advocacy sys-
tem could function, it would be necessary to develop the con-
cept of a mental health grid. This idea, developed in detail by
Dane Prugh, is already stated in CRISIS IN CHILD MENTAL HEALTH.
It implies a pattern of services where one dimension would be
the developmental level of the child and another dimension
the kinds of services necessary for each age group. To illustrate
this, we could mark on one axis of our framework the child as
fetus, the child as newborn, the child in the first year of life,
and then the toddler, the pre-schooler, the kindergarten student,
the early grade school attender, and so on up. On the other
axis we could list the different levels of health and competence:
the superior and gifted level, the normal healthy level, the
normal child exposed to stress (for example, divorce, surgery,
death in the family), the level of early symptom formation, the
more severe symptomatic pictures, until we reach the stage of
gross emotional, intellectual, and neurologic breakdown. For
each level of disturbance at each age there would need to be an
appropriate agency available so that any child, with any degree
of dysfunction, would be provided for.

To spell this out in somewhat greater detail such a grid
would be directed at once to four basic goals:

ENHANCEMENT
EDUCATION
PREVENTION
REMEDICATION

It is the essence of the grid concept that it is tied specifically
to an overriding sense of levels of development. At each stage,
the interventional means to achieve these goals would neces-
sarily be different. The grid would therefore include a variety
of community programs as well as institutional structures. In effect, it would mean one spectrum of agencies designed to serve the unborn child; another array for the very young infant; a somewhat different group of services for the toddler; then the necessary schools, clinics, residences, and so on for the pre-school youngster; similarly, appropriate agencies to meet the needs of the kindergarten-grade school child; next, those for the puberty youngster. These in turn are not identical with what must be provided for the middle adolescent, who is again different from the youth on the verge of adulthood. A somewhat more careful delineation of the types of agencies needed at each developmental level is given in the Appendix.

Each community in the country needs to engage in such self-scrutiny with this perspective in mind: How many points on the grid are cared for by existing facilities? And how well? And what blanks are there? Then let the advocate appear, with his money and his authority, along with his responsibilities and his accountability.

Advocacy, as we see it, would have meaning only if help is provided in two very major phases. The first task would be that of community diagnosis and community remediation. Money alone cannot help children. The law alone cannot (and demonstrably has not been able to) help children. It requires a vital commitment within communities to sort out what they have and what they need. And the kind of governmental help that is required to initiate and work along with this type of self-evaluation will be very different from that required for the second-phase advocate, who will turn his attention directly to the children themselves and begin to deal with individual cases and particular families. He can do his work only when the initial mental health grid has taken some kind of form, when he has some services available for the children in need or at risk, and when what is available approaches what is necessary.

This preliminary step, the harnessing of community interest and the creation of at least the minimal necessary services, should not be exclusively oriented toward prevention or toward treatment. It must be directed toward both. When there is a choice that must be made, treatment should have priority. This has urgency and primacy. But often enough the same agency and approach that will help with the one will also serve the other. And in the largest sense we would see neither treatment nor prevention sacrificed; they are both essential. They should both be supported and advanced.

Dual areas of treatment and prevention

This brings us to our final point. We want to see the programmatic creativity of this country focus on two separate areas:

One would be for treatment and all that it implies: for recruitment and training of young people for classical professional as well as new forms of caretaking roles; for creating and funding of facilities and services devised along the developmental grid noted above; and for the support and furtherance of research in child development and child mental illness.

The other would be for prevention, with major attempts to use clinical consultation in devising mental health programs for all the media; for mental health methodology in the education of children as well as in teacher training; for mental health counseling for families and individuals; for the identification of vulnerable populations; and for reaching out a supportive hand to the minds and growth of children in the first three years of life and to their parents.

These two areas should develop and grow side by side and should mutually enliven and enrich one another. And the attempt to undertake them should not be delayed until all our social, racial, economic, political, urban, and international problems are solved.
It is in this final area that we are most at odds with the report. By striving to express a view on everything, we feel, it has lost sight of the necessary emphasis on the most cogent. The report confuses figure and ground, and the quick thrust, the vitality of the immediate, are muddled and obscured. There are things that should have priority, and we feel that throughout the lines are blurred.

It is a great flawed work we have here, but we would see its aspirations realized. They are the yearnings we all strive for.

**EPILOGUE**

It is clear from the context of this report that only a portion of the original charge to the Ad Hoc Committee has been fulfilled; the reaction to CRISIS IN CHILD MENTAL HEALTH: CHALLENGE FOR THE 1970's has been accomplished. The formulation of a series of recommendations concerning the nature of services needed for children has only been adumbrated. In considering this, the members of this committee felt keenly that an ad hoc committee, by definition a short-term, circumscribed instrument, was not the best site for the task of sifting through the many plans for implementing advocacy, for sorting out priorities, and for selecting modes of implementation. Such a task deserves ongoing primary commitment from a group who can devote a major segment of their energies to these ends. Numerous plans are being advanced from many quarters, congressional as well as professional. All of these proposals need careful scrutiny, with a winnowing of the wheat from the chaff. This is not a business that lends itself to a brief survey or a rapid overview. In short, it is not material for an ad hoc approach.

We feel that the suggestions we have endorsed, such as the mental health grid and the review and definitions of advocacy, are worthwhile, and we stand by them. To the extent that we have developed other specific recommendations, they are these:

1. Mental health professionals should undertake a study of the anti-child attitudes abounding in our culture, including those that we as professionals reflect. It is not enough to deplore; we must understand.
2. Mental health professionals should take a long and honest look at the professional issues and impediments to the realization of mental health programs, and should make the results of their investigations known in clear public statements that carefully explore the strengths and weaknesses of each position.

3. A program of evaluative research of long-standing child guidance clinics and other methods of service should be established. This could be done in any number of ways. One, for example, would be to select five recognized, reputable child guidance clinics and to carry out follow-up studies of children seen at these centers in the years 1950 to 1960. We have by now accumulated a sizable population of alumni of various ages who have been treated at such centers and a sizable control group of people who have dropped out or who were on waiting lists but for some reason were not treated. The analysis of data gathered from these studies might be of invaluable help in the planning of future programs.

4. Mental health professionals should explore and analyze the political implications and the various possible models of an advocacy system and should suggest the protections the advocates and the public will need.

5. Advocacy must also be reviewed in terms of its realistic limitations in the light of the dearth of services to help children. The concept of the mental health grid is suggested as a way of identifying services available and lacking in each community. Then let the advocate appear with his money and authority along with his responsibilities and his accountability.

6. Areas of treatment and prevention should be developed and grow side by side, and programs to provide them should have first priority. For example, day care centers could become child development centers and should serve the dual roles of treatment and prevention. They would also serve as education centers to help in the education of child mental health specialists.

At best that is a fraction of what needs to be reviewed and to this end, we recommend the formation of a new GAP committee to accomplish the task.
APPENDIX

THE GRID

A. For the unborn child:

Major sites for intervention:

- nutrition
- medical care
- genetic concerns
- awareness of child rearing needs

1. Where the child is not wanted, abortion early in pregnancy should be an option open to all women.
2. Programs to provide a regular medical check-up for every pregnant woman.
   a. In some areas, this might imply special financial rewards for clinic attendance and achievement (keeping weight down, etc.). This would be far cheaper than the cost of care for a damaged child.
   b. Back-up programs to help out with other children in the home and with husbands in late and/or complicated pregnancy.
3. Back-up institutions (hospitals, clinics) for medical complications and for delivery.
4. Screening programs for detection of genetic damage in unborn infants.
5. Programs for nutritional support to pregnant women.
6. Programs for the education of pregnant women and concerned family members in child care and personality development.

B. For the newborn and young infant:

- Major sites for intervention:
  - nutrition
  - protection
  - stimulation

1. Programs for regular medical well-baby check-ups for all babies required by law.
2. Back-up hospitals and clinics to care for sick babies.
3. Day care nursery services to give protection and care to young infants with working mothers.
4. Full infant care for cases of maternal incapacity.
   a. Adequate hospital back-up for mothers with mental or physical illness.
5. Full infant care for battered or abandoned children.
   a. Protective and treatment services for families with battered children.
6. Programs of nutritional support for all infants.
7. A system of designating certain infants as AT RISK
8. Home visiting programs for infants AT RISK to provide, and to teach families to provide, optimum stimulation.

C. For the toddler:

- Major sites for intervention:
  - protection and medical care
  - detection of children AT RISK
  - treatment for families and children

1. Detection programs for the precocious or gifted child.
2. Back-up counseling and specialized training for parents of children with unusual gifts.
3. Programs for continued provision of regular medical checkups for all children.
5. Nursery school day care services for children of working mothers.
6. Residential settings for abandoned or battered children.
8. Mental health outpatient facilities for identification of the nature of child and family problems.
9. Home visiting programs to support families with children AT RISK with emphasis on giving optimum stimulation and avoiding excessive stimulation.
10. Outpatient treatment facilities for families with troubled or limited children and for the children themselves.
11. Therapeutic nursery settings as part of such outpatient care.
12. Residential treatment settings for children with serious emotional or intellectual difficulties.

D. For the pre-school child:
1. Similar to C. 1-12 above.
2. Availability of day school programs as an integral part of the community educational system for all children from age three on up to kindergarten age.

E. For the grade-school child:
Major sites for intervention:

education
remediation

1. Programs for the detection and evaluation of unusual gifts in children and for the realization and enhancement of these talents.
2. Adequate schooling and basic health examinations for all children.
a. Sex education, how to understand yourself, getting along in groups, how families work, etc., should be part of regular schooling.
3. Pattern for community reporting of children AT RISK by doctors, clinics, hospitals, and schools.
4. Provision of an advocate to respond to such reports by working with families and agencies to provide services.
5. Provision of adequate community resources to allow the advocate to fulfill his function.
a. Outpatient mental health clinics for child and family.
b. Special classes and special supports within the school system for children with emotional and intellectual difficulties.
c. Diagnostic centers providing brief inpatient care for unusual cases.
d. Special day schools with associated mental health support services for more disturbed children.
e. Day hospital care.
g. Humane custodial care for the child with massive neurologic damage.
6. A pattern of family support services.
a. Family therapy.
b. Availability of homemakers for long-term family support.
c. Family crisis intervention services.
d. Back-up outpatient and inpatient psychiatric services for individual family members as needed.
F. For the pubertal youngster:
   Major sites for intervention:
   education
   treatment
beginning career planning
 coping with adolescent sexuality
1. Where talent or unusual intellect is noted, refer to advocate for help in specialized training, opportunity, and family counselling.
2. For all youngsters, adequate schooling:
   a. Sex education, family life, personality problems, how to understand yourself, etc., should be a necessary part of public school education.
3. Special classes for youngsters with emotional or intellectual problems.
4. Vocational planning and career consultation to help children and families begin to consider potential routes for future education and for training.
   a. Possibilities for early vocational training placement at end of junior high school.
5. Outpatient mental health clinic facilities.
6. Day programs such as day hospital care for youngsters needing greater support.
8. Halfway houses for youth who can stay in the community but not at home.
9. Residential treatment centers.
10. General health support services.
    a. Private physicians
    b. Clinics
    c. Hospitals
11. Settings for unmarried pregnant girls:
    a. Special schools for youngsters who live at home.

b. Residential centers for youngsters who cannot live at home.
12. Advocate in juvenile court to obtain maximum community service support for youngsters brought to court.

G. For the adolescent:
   Major sites for intervention:
   education
   training
   treatment
help with independence
1. Appropriate patterns of education and training:
   a. Special schools or classes for the talented.
   b. Academic schools or classes for youngsters who would go on to college.
   c. Commercial business courses for youngsters who seek secretarial or business careers.
   d. A wide range of vocational training opportunities for appropriate candidates with built-in apprenticeship arrangements worked out with industry and labor.
   e. Special schools and classes for handicapped children, including separate facilities for children with intellectual, physical, or emotional problems.
2. Adequate specialized medical services.
   a. Practitioners and clinics trained in adolescent medicine.
   b. Full range of services for management of pregnancies of unmarried girls.
   c. VD control clinics.
   d. Family planning programs designed especially for teenagers.
3. Drug Programs.
   a. Education and counseling centers to give service to school, parents, and youngsters about drugs.
   b. Group programs for youngsters who desire to come to grips with a drug problem.
   c. Therapeutic halfway houses for youngsters who feel they cannot handle a drug problem at home.
   d. Methadone treatment clinics.

4. Community-supported teen centers with active social and recreational programs.
   a. A pattern of contests for teenagers such as drag racing, sports, cooking, sewing, crafts, science fairs, dancing, poetry, bands, etc., with meaningful rewards as a regular part of community life.

5. A range of mental health programs.
   a. Community-run hostels for runaways and transients.
   b. Outpatient clinics.
   c. Day care programs.
   d. Short-term diagnostic and crisis-care inpatient units.
   e. Residential treatment centers.
   f. Hospital beds or cottages including closed-ward care for youngsters needing more protection.

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