UNIVERSITY of PENNSYLVANIA

Richard J. Gelles, Ph.D.
Joanne & Raymond Welsh Chair of Child Welfare & Family Violence
Research Director of the Center for the Study of Youth Policy
School of Social Work
3701 Locust Walk
Philadelphia, PA 19104-6214
Tel. (215) 573-7133
Fax: (215) 573-2099
E-Mail: gelles@ssw.upenn.edu

January 16, 2001

Ms. Marion M. Higa
State Auditor
State of Hawaii
Office of the Auditor
465 S. King Street
Room 500
Honolulu, Hawaii 96813-2917

Dear Ms. Higa,

We have carefully reviewed the combined agency response to the our draft report, "Follow-Up Review of the State's Efforts to Comply With the *Felix Consent Decree.*"

The combined agency response, in our judgment, does not provide substantive or significant corrections to our report, nor does the combined agency response provide substantive or empirical evidence to support the claims regarding inaccuracies or incorrect conclusions. In our judgment, the combined response continues a multi-year pattern of the agencies' responding to criticism by either questioning the competence of report authors, begging key questions, or claiming that changes have occurred in the interim between the drafting of the report and the agencies' response(s).

Our main conclusions stand uncontradicted after the agencies' response.

1. **There is a definition but not a "working definition" of the Felix class.**

   The combined response provides a new explanation for why the agencies have not developed a working definition, including the Supremacy Clause of the U.S. Constitution and the requirement to conform with the definition included in the Consent Decree. With regard to the former, at least one state, Kentucky, has legislated a working definition of procedures for identifying children eligible for

special education and mental health services.

Rather than dismiss our findings, the Office of the Attorney General should consult with the new U.S. Attorney General for an advisory opinion about whether the Supremacy Clause does in fact preclude the Hawaii Legislature from legislating a working definition. Similarly, the Attorney General should seek an advisory opinion from the new U.S. Attorney General and the new officials at the U.S. Department of Education regarding whether developing a working definition for the definition included in the consent decree is allowable. Given that there is a new incoming administration in Washington, it would be worthwhile to determine whether this administration will be more flexible or different than the current administration regarding IDEA and ADA.

We agree that Hawaii does have a definition of the "Felix class." One way or another, clinicians, psychologists, and IEP teams are operationalizing the definition in the consent decree. However, we reiterate again that there is no working definition. Our central point is that they are doing so without any benchmark or standard set of procedures for how to do this. Because the agencies continue to refuse to provide a working definition (or claim that one exists, when it in fact does not), we recommended that the legislature take responsibility for this critical and central task.

If the agencies or the legislature would develop a working definition, the combination of a working definition with strong, independent assessments at the front end, could have an enormous positive effect on the entire system (e.g. size of the class, kinds of services provided, closer matching between services and individual needs, and better services of children).

2. **Best Practices**

Our review of the literature, included in the report, indicates that the agencies have still not adopted an evidence-based best practices approach to providing special education and mental health services. The attached documents substantiate our findings, given that CAMHD is running a basic "Best Practices" conference six years after the issuance of the consent decree. Many of the presenters at the recent conference were experts and consultants who have been involved with the Felix case for the past six years.

3. **Outcome Evaluations**

Our central point remains uncontroverted by the combined responses—the agencies are still not using scientifically or clinically appropriate methods to assess outcome. With regards to aggregate outcomes, the agencies do not use a scientifically acceptable design to assess treatment specific outcomes. At the individual level, the

case file review indicates a lack of individual child outcome assessment. Service testing, as we stated, is a method for assessing process, not child outcome.

4. **MST**

We are completely aware of all the reports and literature on MST. However, the use of MST for the Felix population should be viewed as experimental and not required for the class. The agencies' combined response admits that MST has "potential," not proven value for the Felix population: "the potential viability of MST with youth with more emergent mental health problems." Using MST on a new or different population should be viewed in the same way one would view using a successful pharmaceutical intervention for a related but different problem. Such an expansion typically requires experimentation and clinical trial before wider use.

MST is perhaps the most rigorously evaluated intervention for adolescents with delinquency problems. There are indeed consistent statistically significant outcome data showing the effectiveness of MST. On this everyone agrees. However, the agencies' response fails to add that the actual effect sizes of the outcomes are quite small. MST has not been widely used for a "Felix type" population. There is nothing inappropriate with using MST for Felix-eligible children, and MST may in fact produce favorable outcomes. However, we believe that:

a. It was disingenuous of the Department of Health to commence MST using emergency funding. MST cannot be justified as an essential, appropriate, or proven service for Felix-eligible children. MST is not a normal or core service used for Felix-eligible children, and thus it would in no way help achieve any benchmarks in the consent decree to use MST. If the DOH wanted to use MST for Felix-eligible children, it would have been more appropriate to fund this outside of the emergency funding route. If MST was in fact scientifically proven to be helpful for "Felix-eligible" children, at that point, it would have been appropriate to seek funding under the Felix Consent Decree umbrella.

b. DOH is still not using scientifically appropriate methods to evaluate MST.

c. MST cannot yet be considered an essential service need for the Felix class.

5. **Qualifications of the Consultants**

The agencies standard response to Auditor's Office reports is to criticize the credentials of the authors of the report. That tradition is continued in this response.

The agencies' combined response takes our own statements out of context. While we stated that Gelles and Schwartz did not have specific expertise in IDEA or special education, we emphasized numerous times that our entire team had extensive experience and expertise. The formal team included a board certified child and adolescent psychiatrist with extensive expertise in mental health and special education. The team also included a doctorate level social worker with experience in special education and evaluation research. During the project we also consulted with two members of our Center for Children's Policy, Practice, and Research—a senior faculty member of the University of Pennsylvania School of Law who specializes in child and family law and former clerk at the U.S. Supreme Court; and a senior faculty member in the School of Social Work who was the former head of the U.S. Children's Bureau. Our findings and recommendations may be controversial, but they are not based on a fundamental misunderstanding or lack of knowledge about the controlling federal legislation or the consent decree.

Our response covers what we believe to be the major issues of our report. We have not provided a point-by-point response to some of the underlying questions raised. With regards to maintenance of effort issues, we used the exact language provided to us by Russell Suzuki.

Sincerely,

[signed]

Richard J. Gelles, Ph.D.
Joanne and Raymond Welsh Chair of Child Welfare and Family Violence

[signed]

Ira M. Schwartz, Dean
School of Social Work

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917

MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

January 2, 2001

COPY

The Honorable Paul G. LeMahieu
Superintendent of Education
Department of Education
Queen Liliuokalani Building
1390 Miller Street
Honolulu, Hawaii 96813

Dear Dr. LeMahieu:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Follow-Up Review of the State's Efforts to Comply with the* Felix *Consent Decree*. We ask that you telephone us by Thursday, January 4, 2001, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Thursday, January 11, 2001.

The Board of Education, Department of the Attorney General, Department of Health, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

EARL I. ANZAI
ATTORNEY GENERAL

BRUCE S. ANDERSON, Ph.D., M.P.H.
DIRECTOR OF HEALTH

DR. PAUL G. LeMAHIEU
SUPERINTENDENT

STATE OF HAWAII
DEPARTMENT OF HEALTH
1250 PUNCHBOWL STREET
HONOLULU, HAWAII 96813
(808) 586-4410

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
425 QUEEN STREET
HONOLULU, HAWAII 96813
(808) 586-1255

STATE OF HAWAII
DEPAERTMENT OF EDUCATION
1390 MILLER STREET
HONOLULU, HAWAII 96813
(808) 586-3310

January 12, 2001

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawai'i 96813-2917

Dear Ms. Higa:

Re: Follow-Up Review of the State's Efforts to Comply with the *Felix Consent Decree*

Broadly stated, your follow-up report of the State's compliance efforts with the *Felix Consent Decree* had the potential of being a helpful document to assist everyone with the understanding of the State's obligations under the Individuals With Disabilities Education Act, Section 504 of the Rehabilitation Act, and the *Felix Consent Decree*. That potential was lost, however, because of a lack of understanding of IDEA, *Felix Class Youths*, and best practices in children's mental health in your office and by your consultants.

Working Definition of *Felix Class*

The first issue of concern that may explain many of the consecutive mistakes contained in your report, is that the consultants that you retained have no educational or legal background. It is important to emphasize that the Legislature requested the Auditor's office to retain an independent consultant with national expertise in the areas of IDEA, mental

health and related litigation. Both Drs. Gelles and Schwartz acknowledged having little if any experience in education and IDEA. This may explain some of the confusing recommendations made in your report.

The starting point of our response begins with Chapter 2 of the your report. It starts out by determining that "[t]he Departments of Education and Health have made significant progress in establishing a system of care for *Felix* children. We certainly have no dispute with that conclusion. However, your report then goes on to state that "**this effort continues to be impaired by a lack of a working definition of the *Felix* class. . .**" Your report recommends to the Legislature that it enact state law to develop a statutory working definition based upon guidelines suggested by your consultants. See, page 13 of your report.

The State has a working definition of *Felix* children. As you have correctly stated on page 6 of your report the State has provided you with its working definition

> **The "Plaintiff class" is "all children and adolescents with disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and mental health services."**

This is the definition adopted in the *Felix Consent Decree*, of which we did not believe there were any misunderstandings by you or your consultants. It is evident, however, that you and your consultants maintain a different understanding of who the *Felix* children are or should be, which explains many of the erroneous conclusions that you have reached.

On page 13 of your report, you recommend that the Legislature enact a statutory definition for eligibility that provides that ***"[t]he Felix class includes children age zero to 20, residing in Hawaii, who require special education or mental health services as a result of one or more of the following conditions.*** [Emphasis added.] Your recommendation then includes conditions, only one of which would constitute inclusion into your *Felix* definition. Among the conditions are speech/language impairment, mental retardation, among others while excluding

mobility impairment, vision impairment, hearing impairment, and epilepsy.

Such a proposal cannot be adopted because it would conflict with the *Felix Consent Decree* definition and would violate the Supremacy Clause of the United States Constitution, to the extent that it is intended to restrict eligibility for *Felix* services to children who would be eligible under the *Felix* definition. Such a statute would only open the floodgates to litigation. On the other hand, it can be interpreted that the proposed statute would expand, not narrow the children eligible for services because using the word "or" allows for eligibility upon having one condition rather than requiring both a learning disability and a mental health problem.

The Supremacy Clause of the United States Constitution provides that "[t]his Constitution, and the Laws of the United States which shall be made in pursuance thereof, and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges of every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding. (Art. VI of the United States Constitution.) Thus, because the proposed statute is intended to narrow the *Felix* eligible child, e.g., exclude time limited emotional disorders such as "adjustment disorders," such a statute would conflict with federal law and be unenforceable under the Supremacy Clause.

It is curious that you recommend that "[t]he legislated definition should also clarify that mere diagnosis of an emotional or behavioral disorder is insufficient for inclusion into the *Felix* class. See, page 14. As explained herein, that **is** the existing condition for *Felix* eligibility but is not what you are recommending to the Legislature.

This flaw in your report clearly evidences a misunderstanding of the consent decree and the requirements of IDEA and Section 504. It further evidences a lack of understanding of other laws, such as the Americans With Disabilities Act, which must be understood as well in order to understand the full extent of the State's obligations to handicapped children. As an example, on page 17 of your report, you advise that "a wheelchair ramp would not be funded through *Felix*, but counseling and special education programs would be."

You should understand that a wheelchair ramp may be a State obligation under Section 504, and therefore, could be an obligation under *Felix*, but also that the ADA would also be implicated and would be a State obligation regardless of which law applies.

Best Practices Implementation

An important area of focus that the report mentions repeatedly is "best practices." There are many references made to "best practices" concerns, but little is offered to explain what specifically you are referring to. The term is used globally without operationally defining it, and therefore, is confusing as to the true concern.

Given the intense focus that CAMHD has given to exploring, evaluating and supporting services which are empirically supported, we do not understand how your finding is supportable It is not clear if the CAMHD efforts were not understood by the consultants, or if they were not meeting the auditors office's expectation.

Attached to this document are two items which demonstrate just a few of CAMHD efforts to address best practices issues. In addition, CAMHD is recruiting behavioral and training specialists to support dissemination of these best practice guidelines.

Outcome Evaluation

Page 9 of your report notes that the Department of Health is not assessing outcomes and effectiveness. This is completely untrue. In Attachment 3 is our outcomes module that is operational at this time. We can currently account for improvement in functioning and life status indicators.

We disagree with your conclusion that there has also been no significant progress made in service testing scores. We suspect that your information is stale. Please see Attachment 4 for details. There are currently 15 complexes in full compliance or awaiting presentation to the court for their compliance. There is a need for 31 to be in compliance by July 2001. Complexes in compliance have now crossed district, size and geographic boundaries.

On page 12 of your report you mention the need for an independent evaluation center. CAMHD supports this initiative. However, without the legislature having such a body, CAMHD contracted for the University of Hawaii's Social Science Research Institute (SSRI) to serve as our independent evaluator. At this point, it is not clear if the legislature supports developing a public policy institute at this time. We are aware of the Washington State Institute for Public Policy which serves this function for the Washington State legislature and would support Hawaii's legislature in developing a similar body. Without this, CAMHD will continue to work with SSRI to complete an independent review of any new programs as required by the legislature.

MST Issues

There are several comments offered throughout your report concerning CAMHD's implementation of MST. Unfortunately, there are several errors that cause leaps to inaccurate statements. First of all, it is evident that your office does not understand how CAMHD is implementing MST. CAMHD is implementing MST with two different sub-populations within the *Felix* plaintiff class. The first use of MST is with those *Felix* eligible youth that demonstrate willful misconduct issues. *Felix* class youth referred to MST home-based teams present high rates of serious antisocial behavior (i.e., violence and drug abuse). This use of MST does not seem to be questioned by your office. This is the population that accessed services with funding provided by the FY 2000 emergency appropriation. And this is the funding that is requires that CAMHD contract with an independent evaluator to submit a report to the legislature. SSRI has provided this report. (Attachment 5)

There is another sub-population of *Felix* eligible youths for whom we are implementing MST. It is true that multi systemic therapy (MST) is best validated in treating serious antisocial behavior in adolescents (e.g., MST has been highlighted by the U.S. Department of Justice, the National Institute on Drug Abuse, and the Center for Substance Abuse Treatment). However, considerable evidence supports the potential viability of MST with youth with more emergent mental health problems. For this population, a recently published NIMH funded research of MST as an alternative to emergency psychiatric hospitalization of youths with serious mental health problems (i.e., suicidal, homicidal,

psychotic), studied, in a randomized trial (Henggeler, Rowland et al., 1999), and determined that MST was more effective than emergency hospitalization at decreasing youths' externalizing symptoms and improving their family functioning and school attendance. MST was as effective as hospitalization at decreasing internalizing symptoms. With regard to out-of-home placements, over the first 4 months post referral, MST produced a 72% reduction in days hospitalized and a 49% reduction in days in other out-of-home placements (Schoenwald, Ward et al., 2000). Moreover, care giver and youth consumer satisfaction were higher for the MST condition than in the comparison condition.

At the highest levels of the mental health treatment research community, MST is considered to have great promise. For example, the Surgeon General's Report on Mental Health (1999) included several positive references to MST, and MST received favorable notes by four different reviewers in the Surgeon General's "National Action Agenda for Children's Mental Health" released January 4, 2001. Similarly, highly respected academics have reviewed MST quite favorably. For example, Alan Kazdin (1999) wrote "In the broad contexts of treatment research and services delivery, MST is quite special . . . There is strong evidence in behalf of MST and that alone would provide a firm basis for distinguishing this treatment from the tsunami of available techniques."

In spite of such accolades and previous successes, MST developers and researchers remain committed to determining the conditions needed to optimize favorable outcomes for youths presenting serious clinical problems and their families. Such commitment is reflected in the rigorous research,. Studies of MST are being conducted by investigators at leading universities across North America and Europe. Support of these projects clearly demonstrates the commitment of the investigators at the Family Services Research Center, Medical University of South Carolina to further understanding of MST outcomes.

On page 30 of your report, it is stated that MST has never been used for sex offenders. Although CAMHD is not currently implementing MST with Felix youth adjudicated for sexual offenses, it should be noted it is the only published randomized trial with juvenile sexual offenders in the field (Borduin et al., 1990). Long-term reductions in recidivism were observed.

Indeed, the results of this small trial have recently been replicated in a larger trial of MST with juvenile sexual offenders conducted by Dr. Charles Borduin at the University of Missouri. The corresponding research report is currently in preparation.

In summary, formal MST programs are operating in approximately 25 states, serving approximately 5,000 youths and families per year. Based on data collected as part of a 32 site study of MST programs funded by NIMH, approximately 10% of participating youths were referred by schools for SED. Similarly, several MST programs are specifically focused on serving the mental health needs of particular schools.

The lack of knowledge of MST by the Auditor's office on this very promising and effective best practice can only be attributed to the misunderstanding of IDEA, *Felix* class youth and best practices in children's mental health. It is unfortunate that such an lack of awareness and oversight was made in such a potentially helpful document.

Ensuring That Services Are Effective

There has been long standing concern regarding the effectiveness of the education and related services being provided children. This is addressed on a number of fronts

Concern being expressed over the effectiveness of educational and related services being provided each child constitutes the major portion of each Individual Educational Program (IEP) planning meeting. The IEP starts with an assessment of present levels of performance addressing the strengths and needs of each child. Proper and appropriate assessment is a major issue in each IEP session. These matters are addressed on an individual basis for each child.

The State collects attendance data, testing data, and behavioral data on all children, including children with disabilities. At the present time this data is recorded and collected in various forms by various offices and departments. The Department of Education is committed to the development and implementation of an Integrated Management Information System that will make this information more readily available and

accessible for decision making and improved accountability. The ISPED system is scheduled to be field tested in March 2001 and is scheduled to be fully implemented and operational by June 30, 2001.

There are specific benchmarks that can be utilized for the assessment of the impact of educational and related services. If the services are successful and appropriate, the child maintains a high level of school attendance, demonstrates consistent improvement in academic performance and assessments, makes successful transitions from school to school and from grade to grade, and finally, completes school making a successful transition to post-school activities.

Best Practices

Our programs are maturing, service providers have been found, and data has been gathered. With these components, it has become possible to evaluate program options and make determinations regarding the quality and effectiveness of various programs. The Department of Education is currently engaged in the development and implementation of a Best Practice Guide for the Provision of School Based Services. As the Department of Education continues with the move to the full implementation of its program of school based services, the Best Practices Guide will serve as the Standard for the provision of services.

The move toward school-based services with the addition of site based school psychologists will facilitate the move to the full implementation of "Best Practice Standards" in the offering and provision of services. Experience has demonstrated in other states and geographic areas that the active presence of the school psychologist on the IEP Team has strengthened the provision of appropriate services for children with disabilities. The school psychologist has the knowledge of mental health issues and the awareness of appropriate instructional modalities to actively assist the other members of the Team in appropriately addressing each child's needs within the scope of proper and appropriate educational practice.

Voucher Services

We have had a market-driven approach to the provision of related mental health services for the last four years. Beginning with Kapolei and the Big Island Demonstration Project, the market driven approach has consistently increased the cost of providing services. Getting the "Management" back into the provision of managed care would appear to be in order at the present time. A market-driven approach only works to the State's advantage when the supply is greater than the demand. That is not the case here and it appears that the consultants are utilizing a mainland thinking not applicable in Hawai'i. Critical shortage of professionals allows the professionals to drive the market and the cost. Voucher services will not solve this problem and would only exacerbate it.

Uniformity of Budget

The Legislature addressed this issue in the 1999 Legislative session with the creation of EDN-150 by Act 91, SLH 1999, The Budget Act. The Department of Education has been providing consistent data since then. The Child and Adolescent Mental Health Division (CAMHD) of the Department of Health has been using a consistent format for the presentation of budgetary data for the last two years. These have been submitted to the Legislature in the quarterly Felix Legislative Reports.

Maintenance of Effort

There appears to be some confusion of terms here. Maintenance of Effort under the consent decree refers to a base level of expenditure that was determined back in 1994. The State was required to maintain this level of expenditure over the period of compliance and has exceeded this level of expenditure every year since 1994.

Sustaining program capacity and the provision of services is another issue. The Revised Consent Decree (August 3, 2000) requires that program capacity be sustained once it is developed and put in place. Your use of the words "maintenance of effort" is different from the consent decree's use of the words.

Legislating Goals and Parameters For Funding

Your report makes this recommendation and connects it with best practices principles and procedures without any elaboration as to its meaning. Any effort to restrict the State's ability to comply with the consent decree's obligations by conditioning the funding for the implementation of the consent decree will jeopardize the State's compliance effort and could result in further contempt of court issues being raised.

Respectfully submitted,

EARL I. ANZAI
Attorney General

DR. PAUL G. LEMAHIEU
Superintendent

DR. BRUCE S. ANDERSON
Director of Health

Attachments

MST CITATIONS

Borduin, C. M., Henggeler, S. W., Blaske, D. M. & Stein, R. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 35,* 105-114.

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