

**Willie M.:**

**A Legacy of Legal, Social and Policy Change on Behalf of Children**

**Kenneth A. Dodge, Ph.D.**

**Janis B. Kupersmidt, Ph.D.**

**Reid Griffith Fontaine, J.D., M.S.**

## Foreword and Acknowledgments

This monograph provides a history of the Willie M. program from 1979 to 1999. The years from 1979 to 1992 are summarized only briefly, with greater focus on the more recent history of the program during the past decade. The information about the early years of lawsuit and program were derived from Mark Soler and Lauren Warboys's chapter on the Willie M. case in *Stepping stones: Successful Advocacy for Children* and was enhanced by numerous interviews.

The authors would like to thank especially Charles Davis, Lenore Behar, Eric Vance, Gustavo Fernandez, William Hussey, Marci White, Sandra Johnson, Mike Pedneau, Joan Kaye, Jerry Hartzell, Bob Hargett and Melinda Lawrence for participating in interviews with us and for providing assistance in conducting background research. We would also like to thank others affiliated with the North Carolina Division of Health and Human Resources who assisted us in conducting our background research. The authors would like to acknowledge that much helpful information about different aspects of the program was obtained from written and videotaped material generated and provided to us by the Willie M. Section. Finally, the authors would also like to thank Yevonne Brannon at the Center for Urban Affairs at North Carolina State University and the staff at Innovation Research and Training for their assistance in completing this project.

## Table of Contents

<b>Introduction</b>	6
<b>Part I: The Legal History of the Willie M. Class Action Law Suit</b>	9
A circus of media attention is engineered	9
Willie M., et al., Versus Governor James B. Hunt, Jr., et al. is born	10
The legal team prepares its class action suit	11
Plaintiffs file a class action lawsuit, and defendants respond	19
Will the case go to trial? Defendants initiate settlement discussions	21
The heart of the settlement: The right to treatment	23
An independent review panel takes center stage	24
The review panel goes to work	25
The 1992 Plan is proposed by new leadership	31
The Willie M. case comes to a close	35
<b>Part II: The System of Services that Is the Willie M. Program</b>	41
The Willie M. treatment program forges new territory	41
The Willie M. Section matures within DMH/DD/SAS	42
A compliance plan is developed in 1992	42
The philosophy of the Willie M. service system guides service delivery	46
The Willie M. Training Branch is created	48
The Willie M. Nomination Branch is created	52
The Willie M. Program Evaluation Branch is created	52
The Willie M. System of Care is created	55
Service providers played a crucial role	55
The Willie M. case manager position is created	55

The Individualized Habilitation Planning System is developed	55
The Willie M. Section provides a wide array of services	57
Secure treatment facilities are a part of the Willie M. continuum of care	58
Butner Adolescent Treatment Center	60
Tom Ray Residential Treatment Center	61
Whitaker Residential Treatment Center	61
Training schools	61
Comparison of secure treatment facilities	62
<b>Epilogue: The Contributions of the Willie M. Program</b>	
<b>to Children’s Mental Health Services</b>	63
The Willie M. Program took ownership of children that nobody else wanted	63
The Willie M. Program created a new approach to treatment	64
The Willie M. Program created seminal concepts in service delivery	66
The Willie M. Program demonstrated the virtue of focusing on measurable goals	68
The Willie M. Program changed the way scholars theorize about child psychopathology	68
The Willie M. Program established a truly innovative cost-accounting system	69
The Willie M. Program contributed many novel services to children	69
The Willie M. Program demonstrated innovation and breadth in training	69
The Willie M. Program demonstrated the crucial value of human relationships	
in mental health treatment	70
<b>References</b>	71
<b>Notes</b>	72

## List of Tables

<b>Table 1</b>	Willie M. Program History and Participants	44
<b>Table 2</b>	Areas of Desired Outcomes	45
<b>Table 3</b>	Primary Indicators of Functioning	46
<b>Table 4</b>	Paragraph 9 of the Second Set of Stipulations	47
<b>Table 5</b>	The Willie M. System of Services	59
<b>Table 6</b>	Capacity of Secure Treatment Facilities Where Willie M. Consumers are Served	60
<b>Table 7</b>	Characteristics of Treatment Settings	62

## Introduction

Few episodes in the history of American social movements have ended in reforms as important and far reaching as those that grew from the case of Willie M. This is the story of a lawsuit leading to legal reform, of politics leading to promising practice, and of floundering leading to new funding. This report attempts to capture some of the reasons for the success of the Willie M. case, the contributions that it has made to mental health service delivery on behalf of children, and the cause for concern now that the official story has concluded. Of course, like many social reforms, critics believe that the reform has been a mess from the beginning and that only by dismantling the change will justice be served.

The story starts with four adolescent children in North Carolina who were adjudicated delinquent in juvenile court. These children were violent, but they also had demonstrable mental health problems. The state of North Carolina, like most other states across the country, was at a loss about what to do for, about, and to these children. The mental health and education systems had routinely rejected these and other similarly situated children, expelling them from school and calling them psychiatrically untreatable. Funds were not available to provide adequate placement and treatment, even if such treatment could be discovered. There was nowhere for these children to go except to prison, euphemistically known as reform school or training school, or an adult ward of a psychiatric hospital. These children are the prototypes for a broader class of children that continue to perplex our society even now, 20 years later, in the wake of sensationalized tragedies at public schools in Columbine, Colorado, Padukah, Kentucky, and points in between.

Back in 1979, a foresighted District Court judge, a team of liberal attorneys, and key players within the North Carolina state mental health system (such as Lenore Behar, the state director of children's mental health services) designed a lawsuit to ensure that appropriate services were provided. When the lawsuit that they brought was settled, the dollars began to flow. Initially, it was estimated that only several hundred children might qualify as members of the class, but the numbers of children who actually qualified as members of this group grew to 1,650 in 1999. By then, North Carolina was spending over \$100 million annually on this group, at an average of \$51,000 per child per year.

In response to constant careful oversight by a dedicated review panel that had been assigned the arduous task of monitoring the state's compliance with its own voluntary settlement, over the course of 18 years the state created a marvelous new system of care for children, one that has become the foundation for the design of children's mental health delivery systems across the country. The case of Willie M. inspired innovative concepts in children's mental health service delivery, concepts such as individualized treatment plans and the creation of new treatment forms where none had existed before, child-based rather than program-based treatment, "wrap-around care," treatment in the least restrictive alternative setting, a continuum of care, building strengths rather than ameliorating deficits, paid paraprofessional mentoring, and therapeutic group homes. The state invested in the training of a new breed of professionals assigned to work with children who became known as "Willie M. kids."

Novel approaches to assessment were also created, including measurement that directly connected a child's current status and needs to treatment plans. This measurement included not only assessment of the child but also assessment of the environmental risk and protective factors that surrounded the child; thus, the focus of treatment planning was bounded not by the child but by the entire community. Furthermore, the initial assessment was later tied to outcome goals and became the Assessment and Outcomes Instrument (AOI). Because the service system was closely watched by the court and the court was constantly asking the state to provide documentation of its compliance with the settlement, the state had to develop a quantitative system of measuring treatments and outcomes for children. This system meant that the state accumulated more data on troubled children than ever before, and the body of scientific knowledge about these children also grew.

These innovations did not occur readily. The state was slow in delivering on its promise, and on numerous occasions the review panel had to ask the oversight judge to call the state back into court and to cite the state for noncompliance. The administrator of this review panel throughout the late 1980s was Marci White, a polite but unforgiving watchdog. She became the major thorn in the side of the state, criticizing, demanding, receiving, and demanding more. The criticism continued, the state became even more embarrassed, and the taxpayer dollars increased.

But change finally occurred. The state shrewdly figured out that the only way to get out from under the thumb of the review panel was to co-opt its enemy, the panel's administrator. In 1992, the state

hired Marci White to become the Willie M. Program Director. In the blink of an eye, White had gone from criticizing the state to being the state, which had in effect told her to put up or shut up. Over the next six years, she did, indeed, put up. White and three colleagues (Eric Vance, Charles Davis, and Gustavo Fernandez) became like the Four Musketeers as they pushed through legislative reform, trained professional staff, and worked tirelessly to bring the state into compliance with the federal court. Eventually, White and colleagues returned to court to argue, with data, against the very review panel that White had built. Ironically, their success meant the demise of their program, because in 1998, the legal case was officially closed. The state was officially in compliance. The plaintiffs withdrew all cause for action. The Willie M. Program was over.

In some respects, the plaintiffs were victorious: in 1999, state legislation mandated that qualifying children receive continuing services of the sort that the program had created, and it authorized funding under the name Assaultive and Violent Children's Funds. In other respects, the closing of the case meant that the program could be folded in to the regular state mental health, education, and corrections systems, to be gobbled up by the very bureaucracy that had been the subject of the suit in the first place. Indeed, the legislation that mandated services and authorized funding in 1999 was quickly repealed only one year later. In the year 2001, has the system changed from its state 22 years previously?



## **Part I:**

### **The Legal History of the Willie M. Class Action Law Suit**

#### **A Circus of Media Attention Is Engineered**

April 1979: A news conference starts the ball rolling. As lights flash and cameras roll, a sober but folksy judge from the same state as Senator Sam Ervin of Watergate fame tells stories of emotionally disturbed children who were being neglected or, worse, mistreated at the state's training school. He scolds the state for not acting to help these children. He implies that some "do-gooder" lawyer should sue the judge who assigns children to this awful fate, even if that judge is . . . himself.

Sometimes the only way to catalyze change is to embarrass the players through the media, and so District Court Judge George Bason of Wake County, North Carolina, decided to use the media in order to draw attention to the sad plight that faced adolescents in the juvenile courts. The news conference he called he called attracted state and local television stations and newspapers. In dramatic fashion, he told a story of an emotionally disturbed boy, Thomas H., who had come through the doors of his court room over and over. . . and over.

Entering the halls of juvenile justice in North Carolina in the 1970s meant going through a revolving door. Like many states, North Carolina saw a growing trend in the number of case workers, lawyers, and judges in the juvenile justice system who were becoming frustrated by the lack of rehabilitative options for adjudicated children. This frustration was fueled by the common observation that more and more juvenile offenders were becoming repeat offenders and that more and more repeat offenders were becoming serious offenders. In addition to being concerned about children who were adjudicated criminally "delinquent," juvenile justice professionals were discouraged by the lack of services and the frequency with which non-delinquent children who were adjudicated "abused," "dependent," "neglected," or "undisciplined," were returning to court later as delinquents. Some experts in the field believed that the recurring cycle of adjudication was fueled, at least in part, by the fact that the state failed to provide professional services through which these children's emotional and behavioral problems could be curbed. State mental health professionals and educators were not willing to take responsibility for

servicing adjudicated children. Instead, they abdicated this responsibility to the corrections system. The corrections system knew only how to incarcerate children. In addition, the longstanding position of the state of North Carolina had been that there was no money—the taxpayers were not willing to pay for the kinds of services that these children needed. Although these social and political forces were not unique to North Carolina, what evolved as a result of these conflicting interests certainly was. The outcome of this media grandstanding proved to be the most innovative system of care for adjudicated children in the entire country.

### **Willie M., et al., Versus Governor James B. Hunt, Jr., et al. Is Born**

Early in 1979, Judge Bason was assigned a case in which Dorothea Dix State Hospital had charged a resident youth offender, Thomas H., with criminal assault. Thomas H. was not the typical juvenile offender that appeared before Judge Bason, or any other judge. He was both troubling to others and troubled internally. He was violent, and he needed treatment for a psychiatric disorder. Thomas H. had been tried and convicted in Bason's court in years past and, as a result, had been sent to Dorothea Dix, because there existed no alternative facility for convicted juvenile offenders with mental health needs. The services that Thomas H. did receive at Dix Hospital apparently had no rehabilitative effect on him, for once again, Thomas H. stood before Judge Bason and awaited his future.

The good judge felt much as many juvenile justice workers did at the time. He had seen adjudicated children appear before his court again and again, only to be returned to Dorothea Dix Hospital, and he believed that the state had turned its back on them. Early in 1979, he took it upon himself to visit the institution into which these children had been placed, and he concluded that the facility more closely resembled a jail than it did a school or rehabilitative facility. Children were being medicated without close observation or follow-up. They did not receive more costly psychotherapy, and their educational planning was suspect.

Judge Bason, realized that, as judge, his legal power to help Thomas H. was limited. He needed the help of others. In a flash of brilliance, the judge realized that he needed to get Thomas H. to sue . . . the judge. In order to pull off this plan, and in an attempt to make sure that Thomas H. was well represented, Bason solicited the assistance of Melinda Lawrence, a Raleigh attorney in private practice

who had experience working with juvenile offenders. Lawrence was the kind of fireball liberal attorney who knew how to be a thorn in the side of a government bureaucrat. When Lawrence first met Thomas H., she was disturbed to find him so heavily medicated that he could not stay awake to answer her questions. Initially, she was unsure whether to cry, to walk away from it all, or to become enraged. Rage won. Lawrence realized the crucial nature of the case and agreed to represent Thomas H. in defense of the new allegations against him. She assured Judge Bason that she would not let him down.

And so the scene shifted to Raleigh, where in April 1979 Bason called the press conference with the intention of using the media to focus broad attention to the miserable lack of state facilities and programs for emotionally disturbed children within the corrections system. Bason was convinced that the state's so-called training school, the sole facility for convicted juvenile offenders and located in a secluded county, was unable to provide the services that were deemed necessary for many of the emotionally disturbed children who were adjudicated and required to reside there. At the press conference, Bason announced that he had successfully solicited the efforts of three attorneys, each representing a repeat offender in a different county, and that he had asked them to join together to file a class action suit on behalf of juvenile offenders in need of rehabilitative services. The press conference was, given the political atmosphere at the time, highly controversial, and it received a considerable amount of attention from the local media.

Shortly thereafter the *Raleigh Times* published an article that was sympathetic to Bason's cause: "It is a disgrace, as Bason says, that a state that can afford a brand-new multi-million dollar veterinary school to cure cows and cats, won't treat its own badly sick children." The article drew considerable attention from the public as well as government officials. It also caught the eyes of two independent Raleigh attorneys, who would eventually respond to the article by contacting the judge in order to offer their services, whether or not they would be paid for their efforts. The litigation team was growing and gaining support and focus. The ball was now rolling and would not be stopped.

### **The Legal Team Prepares Its Class Action Suit**

Initially, the plaintiffs hoped that litigation would not be necessary. There was a possibility that, in response to Bason's press conference, the state would appropriate sufficient funds for new mental health

services for children. However, it was not long before the plaintiffs realized that it was unlikely such a gift would be placed in their laps. Taxpayers did not seem willing to pay for the intensive mental health needs of children, and state legislators cried “No money!” to explain why they could not offer an appropriation. Implicitly, the public believed that juvenile delinquency is a moral problem that should be punished, not prevented, and that revenge was a more righteous response than rehabilitation (or, in many cases, first-time habilitation). These children are the ones that no one wants. They vandalize schools, rob stores, and start fights. They are the “deviant peer influences” that parents try to keep away from their own children. These children are the ones who cause headaches for school officials, who often prefer to expel them than to educate them. They cause headaches for mental health professionals, who use words such as “incorrigible” and “untreatable” to describe them.

The plaintiffs’ attorneys believed that the state was not owning up to its responsibility to provide funds to design and implement services for these children. Therefore, they moved forward with their course of action. The initial litigation team consisted of lawyers Lawrence, Ann Slifkin, and Michael Swann, all of whom represented Wake County children and had been recruited by Judge Bason (although neither Swann nor his client was involved in the lawsuit when it was ultimately brought). In addition, two public interest legal organizations supported the effort. Carolina Legal Assistance was the state legal services organization charged with representing persons with mental health problems, and the Youth Law Center, based in San Francisco, California, was involved in a large variety of issues related to the juvenile justice system throughout the entire country.

As a result of all of the publicity that Judge Bason’s news conference received, other parties expressed interest in providing support to plaintiffs’ attorneys. Robert McDonnell, an attorney who represented a juvenile offender in Mecklenburg County, contacted the Wake County litigation team in order to join forces. Also, after reading the *Raleigh Times* article, Sandra Johnson and Jerry Hartzell, private lawyers in Raleigh, jumped on board. With the exception of Hartzell, the other attorneys who were ultimately involved in bringing the lawsuit (Lawrence, Slifkin, McDonnell, and Johnson) each had experience in representing children in all aspects of juvenile court, including representing juvenile offenders in criminal trials and sentencing hearings.

Now that the team was assembled, the lawyers had several fundamental, albeit complicated, questions to answer before they could proceed with litigation. Like a renegade group plotting the overthrow of the government as they knew it, they schemed and argued. First, they had to determine what the boundaries of the class of plaintiffs would be. They were suing not only on behalf of their four clients but also on behalf of all similarly situated children in North Carolina. Who were those children? What criteria should determine whether a youth qualifies as a class member? Second, the team needed to decide what specific legal claims to bring, given that the most promising claim of wrong-doing often varied across counties and judges. So just what charge were they bringing, other than moral apathy? Third, the best venue in which to bring suit needed to be identified. Was this a local, state, or federal case, and in what jurisdiction? In some ways, the answer to the second question depended on the answer to the third, and vice-versa, making these questions even more difficult. These questions were legal, political, and personal. Fourth, the legal team needed to decide whom to name in the class action as defendants. Finally, and perhaps most importantly, the plaintiffs' lawyers needed to recommend an appropriate remedy. Just what did they want to have happen? If they were to file a cause of action in an attempt to secure services for juvenile offenders, they needed to know ahead of time what those services would entail, who would receive them, and how they could document whether the state was fulfilling the remedy.

Defining the criteria that would determine which youth would qualify as class members was a particularly tricky issue to resolve for several reasons. The most fundamental concern was to set up criteria that would not be overly inclusive or exclusive. The legal team did not want to organize a class of plaintiffs that included youths who did not need, and were not likely to benefit from, mental health services, nor did they want to leave out youths who did need, and were likely to benefit from, rehabilitation. They frankly were concerned relatively less about the four named delinquents and more about the general problem facing a broader group of wayward children. This was, after all, a *class-action* lawsuit.

Practical and political considerations guided their decision making. A main concern was to define the class so that it included non-delinquent, adjudicated children in addition to delinquent offenders such as the children who were represented by the litigation team members. Plaintiffs believed that state mental health and education professionals would be more willing to welcome the opportunity to design and

provide services for this broader class of children than they would be for a class limited to juvenile delinquents.

The class had to be defined so that it would lend itself to a convincing argument for a state-wide rehabilitation program. Including too many youths would undermine this goal, because it would appear too unreasonable an expectation that the state should provide mental health services to youths whose conduct problem patterns were not that severe. Excluding too many juvenile offenders could hurt the plaintiffs' argument because the governing court might interpret an overly restricted class as small enough that the state need provide only one or two isolated facilities. This possible outcome was feared by the litigation team, because isolated facilities that contain only the most difficult children often end up functioning more like prisons than treatment programs. At the same time, there remained a strong interest on plaintiffs' part in settling the case before moving forward with litigation. If the class was overly inclusive, the state would be less likely to settle out of court. If the class was defined in a way that was overly exclusive, the state would be more likely to move for settlement but for a proposed resolution that plaintiffs could not accept (such as a single, small-scale facility), thus forcing the case to litigation.

The legal team also needed to agree on the specific causes of action to request. The plaintiffs' interests were not clearly guided by legal precedent. This ambiguity allowed for creative lawyering, but it also made for somewhat risky decision making in the formation of their actionable claims. The lack of clear legal precedent meant that the plaintiffs had more freedom in terms of what causes of action they could bring, but it also meant that they would be less certain as to how certain causes of action would be received by the court (as well as by the defendants). Within the litigation team, there also existed differences as to what individual lawyers thought was most important in the case. Several members of the team were more concerned with the rights of and relief for the four juveniles than others were, although all were invested in the larger picture of whether the case would set a legal precedent and have important policy implications. The issues to be resolved seemed to mushroom as the legal strategy took form.

When Judge Bason first solicited the assistance of the litigation team, he had suggested that the suit be based on a constitutional "equal protection" claim, but plaintiffs agreed early on that this was not their strongest legal claim. Instead, the team preferred arguments via the Due Process Clause of the Fourteenth Amendment and the "cruel and unusual punishment" clause of the Eighth Amendment of the

U.S. Constitution. The plaintiffs cited cases in which the court had previously found that juveniles who had been involuntarily confined in treatment or correction facilities had the right to appropriate treatment. Plaintiffs also cited the well-known federal Education for All Handicapped Children's Act (Public Law 94-142), which ensured that qualifying children would receive public education and related services, including psychotherapeutic treatment. It was hoped that this statute would be persuasive in the court's decision making. However, the main reason that the named plaintiffs needed to bring a lawsuit of this nature was that, as defined within the Education for All Handicapped Children's Act, delinquent children had not been included in the pool of handicapped individuals who were protected. Thus, there were important policy implications in this approach. Lastly, the plaintiffs cited state statutes that ensured necessary treatment for all residents of mental health facilities, including children who had been committed to them due to violent behavior.

The litigation team also needed to agree on the best forum in which to file the class action: state or federal court. The advantage of filing the litigation in state court was that plaintiffs could argue according to state law that certain members of the class qualified for mental health treatment. However, the scope of this state statute was not known, as it had not been tested in previous cases. Also, the manner in which the class was defined dictated that many members of the class were unlikely to qualify under this state statute. To make this option even riskier, it was unclear as to what type and degree of mental health treatment those members of the class who did qualify under the statute would be entitled to receive, depending on how the court interpreted the statute in light of this specific case.

One last fear related to filing in state court tipped the scales in favor of federal court litigation. The plaintiffs were concerned that it would be politically difficult for state court judges to enforce a settlement or finding that mandated state-funded services, because such a settlement would entail ordering state politicians and officials to create and to maintain new services and, in the process, spend a considerable amount of taxpayer money. Politically, state court judges rely on the good will of state politicians and state voters. State court judges would have their political hands tied on this one.

After the litigation team settled on filing in federal court, the decision as to what county to file in became an easy one. Judge James McMillan of the Western District Court in Charlotte was heavily favored by the plaintiffs to hear the case. Enter another strong personality. In years past, Judge McMillan had

been the judge in the famed Mecklenburg County School Board case, which had led to the first court-ordered busing to end school segregation in the South. McMillan was known to be one of the more liberal judges in the state (and in the country at large), and it was agreed that he would be most receptive to the plaintiffs' plea for services. Because McMillan heard most of the civil cases filed in Charlotte, the plaintiffs knew they had an excellent chance of him being assigned the case if they were to file there. McDonnell represented a client, named Willie M., who had recently been adjudicated in Mecklenburg County, which was within the jurisdiction of the Western District. It was decided, then, that McDonnell would be named lead counsel and Willie M. would be listed as the first named plaintiff in order to satisfy the requirements that would allow litigation to be filed in the Western District and brought before Judge McMillan. Henceforth, the case was known as the Willie M. case.

The next question was whom to name as defendants. The two main groups of individuals who needed to be considered in order to identify and to name as the most appropriate defendants were those who were responsible for the lack of services and those who would be needed in order to remedy the situation. As with the naming of plaintiffs, it was important not to be overly inclusive or exclusive. A long list of defendants would be safer in the sense that all persons responsible and actionable would be more likely to be included, but it could pose problems. First, the court could interpret this strategy as a shotgun approach and hold plaintiffs responsible for justifying the various defendants listed. This requirement would likely take up considerable time in court, an outcome that the plaintiffs wanted to avoid because of the potential effect that a delay could have of swaying the judge against them early on in the litigation. The second reason an overly inclusive list of defendants could cause problems is that a favorable settlement or court finding might be harder to enforce—that is, the responsibility of service implementation and maintenance could be more easily diffused among the large number of defendants. The plaintiffs wanted to avoid an overly exclusive list of defendants for a more obvious reason: if litigation commenced and it was thereafter realized that the primary parties responsible for services had not been named, it would be increasingly more difficult to name them as the case continued.

The plaintiffs settled on five groups of defendants. First, the directors of the institutions where the named plaintiffs currently resided were listed as defendants because it was anticipated that they would be needed in order to appropriate relief for these specific youths. Second, the Mental Health, Youth Services,



and Social Services divisions of the Department of Human Resources (DHR) were included because of the possibility that they would be needed to develop appropriate services for class members. As a result, Sarah Morrow, the secretary of DHR was named as a defendant. Third, chief administrators of the Department of Public Instruction were named because this department was directly accountable under federal and state special education laws—laws that were central to one of the plaintiffs' main legal arguments in favor of services. Fourth, at Judge Bason's suggestion, the juvenile court judges (including Bason himself) who adjudicated the four named plaintiffs were named as defendants because of their role in committing the plaintiffs to the facilities where they presently resided. This was a smart legal tactic because the plaintiffs' attorneys knew that the juvenile court judges were sympathetic to their cause of action (like Bason, other judges were frustrated with being unable to assign children to appropriate services). By naming these judges as defendants, the plaintiffs were loading the defendant (or opponent) list with potential witnesses who, if questioned, would likely be sympathetic to the plaintiffs' position.

Lastly, the plaintiffs named Governor James B. Hunt, Jr., and the state budget officer as defendants. This grandstanding move was a thoughtful tactic in that the governor was chairman of the National Governors' Council on Children and had been outspoken during his campaign about identifying children as a primary focus in his administration. It was anticipated that the governor would also make a sympathetic defendant and possible witness and that the state budget officer would be essential for appropriating funds for establishing mental health services and treatment facilities for class members.

Naming Governor Hunt was a calculated and important decision. The governor appointed the secretary of human resources and the chairman of the State Board of Education. He also had line authority over the state budget officer. There was always an interest on the litigation team's part in having as defendants the persons in the executive branch who were "ultimately responsible" for setting agendas, seeking funding, and designing and running services. This approach was adopted, at least in part, as a way to deal with the tendency of employees within the different state level departments, divisions, and agencies, as well as agencies at the local level, to respond to requests for services with "That is someone else's responsibility, not ours." The buck stopped with the governor himself.

There was also the question of what remedy would be appropriate. The plaintiffs needed to decide this issue early, as they would have to present arguments in favor of their selected remedy if they could

first show that the youths' civil and constitutional rights had been violated. In other words, after establishing that class members had been the victims of the state's wrong—doing, the plaintiffs would then need to make a case as to what was needed to correct the wrong-doing. Two issues seemed particularly important. First, and most important, what remedy would best correct the oppressive situation that had evolved—or, what outcome would be most likely to improve the state of affairs for class members? This issue was straightforward and, in an ideal scenario, would be the only issue considered: children's rights have been violated, what would it take to correct the harm that they had suffered as a result of being violated? This issue, however, was not independent of the second issue. The plaintiffs knew that their cause of action, given the absence of legal precedent, was not the strongest and thus remained hopeful that the state would agree to settle. Also, in the probable chance that the state did not settle and the case was forced to trial, the plaintiffs needed to make sure that they argued in favor of a remedy that the court would find to be reasonable. A remedy that was perceived to be unreasonably burdensome for the state might eliminate any chance of convincing the state to settle and could also backfire at trial if the judge were to see it as unfair and use judicial discretion to reduce the remedy significantly.

Finally, the complaint needed to establish that class members were entitled to appropriate services in the least restrictive setting possible. This argument directly paralleled the rights dictated by the Education for All Handicapped Children's Act for children with physical disabilities. That act required schools to mainstream handicapped children as much as possible. The plaintiffs liked that concept, because it humanized their clients and fed on the public's fear of far-away state institutions as insane asylums that destroyed innocent children. What could gain more sympathy from both the right and left wings than a lawyer trying to keep children at home?

The selected remedy, then, needed to delineate the appropriate services for class members. The attorneys decided that they would propose a remedy of programs and services that would be designed to create alternatives that would allow for appropriate treatment of class members in treatment facilities or community services other than state hospitals or training schools.

## **Plaintiffs File a Class Action Lawsuit, and Defendants Respond**

On October 5, 1979, the plaintiffs' attorneys filed a complaint in the Western District Court in Charlotte. In this complaint, they defined the class of plaintiffs as "North Carolina citizens under the age of eighteen who a. now or will in the future suffer from serious emotional, mental or neurological handicaps, which handicaps have been accompanied by behavior which is characterized as violent or assaultive; and b. are or will be in the future, involuntarily institutionalized or otherwise placed in residential programs; and c. for whom the Defendants have not provided appropriate treatment and educational programs." The complaint further stated that the purpose of such action was to reduce, to the extent practicable, the institutionalization of youths who were violent and assaultive.

The case was assigned to Judge McMillan as had been anticipated. The complaint described the class and outlined the factual allegations against the directors of the institutions where the named defendants were in residence. Beginning with Willie M., detailed descriptions of the four named plaintiffs were given. The youths were presented as children who were emotionally disturbed and exhibited unsocialized aggression, as opposed to repeat offenders or criminals. In the complaint, the plaintiffs also argued that these children were placed in juvenile training schools or psychiatric facilities *only* because the defendants failed to provide the services that they were entitled to and that such failure was causing the children's physical and mental injuries to increase in number and escalate in severity. The plaintiffs suggested three types of relief for class members: (a) temporary placements for the four named plaintiffs, (b) immediate efforts to identify other class members and provide them with temporary placements, and (c) the development and implementation of treatment facilities and educational programs for all class members.

Less than two weeks after the complaint was filed, the defendants filed their response. In addition to the governor and the judges, other sympathetic figures were known to be in key positions in state government. Would these figures accept the plaintiffs' demand? Not initially. Instead, the defendants adamantly denied that the state had violated plaintiffs' rights and provided a detailed reminder of the criminal convictions that originally led to the plaintiffs' institutional assignments. The defendants further argued that there was not a recognizable class set forth in the complaint and that the problems and treatment needs of the named plaintiffs were specific to those offenders and not necessarily generalizable

to a larger class of juvenile offenders. The defendants also claimed that the lawsuit was actually a suit against the state of North Carolina and the NC State Treasury, and thus was prohibited by the Eleventh Amendment of the Constitution.

A hearing was held on the filed complaint and motions and on February 12, 1980, Judge McMillan ruled on each of them. Although McMillan granted the defendants' motion to dismiss the State Budget Office and the controller of the Department of Public Instruction as defendants, he denied the defendants' motion to dismiss the plaintiffs' complaint against the juvenile court judges. This finding was extremely fortunate for the plaintiffs because they knew that the juvenile court judges were sympathetic to their claim. If McMillan had granted the motion to dismiss the judges, the plaintiffs would have suffered a major loss, because the other named defendants, with the possible exception of Governor Hunt, were unlikely to be helpful in attaining services. Perhaps even more importantly, the judge denied the defendants' motion to change venue. Had he granted this motion, the plaintiffs would have had to pursue their suit elsewhere and that would have seriously hurt their chance of success. McMillan could not have heard the case in a different venue as he would no longer have jurisdiction, and McMillan was a key piece to the puzzle. There was another reason McMillan's ruling was a good sign for the plaintiffs. McMillan could easily have granted the motion for change of venue and escaped the scrutiny of the case, but he did not, which suggested that he wanted to hear the case himself, possibly because he was in favor of the plaintiffs' cause.

After McMillan denied the defendants' motion to dismiss the juvenile court judges, Judge Bason and Judge Larry T. Black, two of the three judicial court judges named as defendants, obtained their own counsel and filed separate answers to the complaint. This was the second post-complaint event that served to buttress the plaintiffs' case. The judges argued that, although the complaint did not state any valid legal claims against them personally, many of the factual allegations outlined in the complaint were valid and justifiable. This was an important step in setting the tone of the case because, in the absence of court solicitation, two named defendants had come forth and provided support for the plaintiffs' complaint—and not just any of the named defendants, but defendants who both had expertise in working with the named plaintiffs and also had expert legal knowledge of the issues before the court. Lastly, it didn't hurt matters for the plaintiffs that these particular named defendants were highly respected District Court justices in North Carolina.

Among the several concessions and admissions in Bason's and Black's answers to the complaint were key assertions that would be of great benefit to the plaintiffs. First, the judges admitted that there was a significant number of children in the state of North Carolina who fell within the class as it was defined in the complaint and that the class had been appropriately defined. This admission was important because it went directly against one of the initial arguments put forth by defendants—namely, that the complaint did not adequately define a class of members in the first place. Black further admitted that Willie M., the named plaintiff whom he had previously adjudicated, suffered from a treatable psychological condition, which if treated could improve so that he could carry on in a less restrictive environment. This assertion mirrored the type of sentiment that the plaintiffs had expressed in their complaint in describing class members and predicting their outcomes if appropriate services could be provided. In order to drive the point home, Black conceded that he was forced to commit Willie M. to training school simply because there existed no suitable program in the state. Bason responded similarly in his account of Thomas H., the named plaintiff who had been adjudicated in his court. He gave a full account of the series of events that had led up to his assignment of Thomas H. to training school. Bason further asserted that there were other juveniles whose cases presented the same scenario and that the state lacked adequate facilities and programs that were necessary to treat these children. The evidence in favor of the plaintiffs' position was continuing to mount.

### **Will the Case Go to Trial? Defendants Initiate Settlement Discussions**

As time passed, the plaintiffs became increasingly aware of the urgency of their situation. With the exception of Willie M., the named plaintiffs were all in their late teens, and it was important that the case progress at a faster rate before the named plaintiffs became 18 and aged out of the class. If the named plaintiffs reached 18 before the case received a ruling, then they would become ineligible for the remedy, if any, that was mandated by the court. As a result, the plaintiffs' attorneys filed a motion for preliminary relief in May 1980. This motion called for the defendants to respond immediately and to begin developing a long-term plan for each named plaintiff so that each youth could begin receiving treatment before more time passed and the children became ineligible.

In response, Judge McMillan did something that was unusual and unexpected by both parties, although it turned out to favor the plaintiffs. McMillan called a hearing on the plaintiffs' motion for preliminary relief and notified both parties that the hearing would serve as the final opportunity for either side to present evidence in favor of, or against, the merits of the class action and the claim that plaintiffs were entitled to recovery. This ruling was somewhat alarming to both sides as it allowed for very little time to prepare for such a hearing. However, neither side made any motions to reschedule the hearing and extend the period in which to prepare. Based on McMillan's personal history as a judge, his reputation, and his previous actions in the case at hand, McMillan's action appeared to favor the plaintiffs.

A few days prior to the scheduled hearing, attorneys for the defendants contacted the plaintiffs' attorneys in order to set up a meeting to discuss the possibility of settlement. This was a serious and meaningful gesture on the part of defendants, because it was early in the legal process for defendants to initiate settlement hearings. It is quite likely that the sympathetic voices among the defendants, including Lenore Behar, the head of children's mental health services for the state, were growing louder and more persuasive. It is also possible that the defendants were willing to settle because they believed that the ultimate cost would be minor. Here the state made a gross error in its calculations. According to Behar, the state polled only the training schools to determine how many children would qualify as members of this class of plaintiffs and was given an estimate of only 50 or so children. Little did the state realize that the actual numbers were 20 times greater and that the total cost would skyrocket to hundreds of millions of dollars!

The plaintiffs agreed to meet, and they quickly drafted a proposal from which came Paragraph 9, the most important section of the final settlement. After several settlement meetings and considerable negotiating, the parties came to agreement as to several of the pertinent issues. First, the parties agreed that the court had jurisdiction over the case and that it was properly brought as a class action. These two issues were easier to come to agreement on than the issue of entitlement to recovery. Willie M. resided in the county in which the venue had been selected in the first place, and McMillan had already rejected the defendants' motion for a change of venue. Also, the defendants realized that, with the testimonies of Judges Black and Bason (as well as the deposition testimony of various state officials), it would be difficult to convince the court that there was not an identifiable class for whom to bring formal action. The key

issue that the parties agreed upon was whether plaintiffs were entitled to recovery. The defendants conceded that the plaintiffs did in fact have a right to treatment both under the U.S. Constitution as well as some of the federal and state statutes that had been cited in the original complaint. The settlement of this issue gave the plaintiffs great confidence that a final settlement on all issues would be achieved and that the final settlement proposal would be accepted by the court.

For several reasons, the plaintiffs' litigation team was relieved to settle. They had long realized that because the case law and statutes that they cited did not serve as legal precedent, their chances of success were less than outstanding. The settlement not only ensured a satisfactory remedy, it also meant that they would not have to expend valuable and limited resources any further. Several members of the litigation team were contributing their time and labor pro bono<sup>1</sup> (i.e., without financial compensation) and the settlement allowed several of them to start thinking more about their obligations to other cases and projects. The plaintiffs had avoided the risk of losing the case, had it gone to trial, while simultaneously gaining legal leverage that would allow them to secure the design and implementation of services and facilities in the immediate future. The settlement also alleviated the risk that the named plaintiffs (with the exception of Willie M., who was younger than the others) would be aged out of the class and become ineligible for any services and programs that were court mandated. The settlement further provided for the immediate development of treatments for the four named plaintiffs. This was the beginning of a state-wide intervention program called, of course, the Willie M. Program—a system of care developed to provide education and mental health treatment to youths in North Carolina who were both assaultive and emotionally and behaviorally disturbed.

### **The Heart of the Settlement: The Right to Treatment**

Paragraph 9 of the final settlement defined the right to treatment for class members, and thus was the settlement's most important section. It was the standard by which the defendants' attempts at compliance would be judged. Every individual who was identified as a class member would receive individualized treatment in the least restrictive environment possible. The treatment would be individually tailored to the specific needs of each child and would not be based on other factors, such as availability of services at the time the child was identified as a class member. The settlement guaranteed that these services would be

tailored to each individual child regardless of whether the service previously existed at the time that a class member's personal treatment needs were clarified. If such a scenario were to arise, Paragraph 9 dictated that the child would immediately be provided with the existing services that most closely addressed his or her specific needs while more appropriate services were being designed and implemented in a timely fashion. The plaintiffs did not need to compromise much on this issue, as the parties' agreement mirrored the remedy that had been proposed in the original complaint. This stipulation was a phenomenal victory for children's mental health services not only in North Carolina but nationwide, because it meant that if appropriate services did not exist, the state of North Carolina accepted the responsibility to create them. This stipulation set the stage for unprecedented innovation in children's mental health services and their delivery.

### **An Independent Review Panel Takes Center Stage**

After the parties had agreed on the factual and legal issues of the case, they began to discuss and come to agreement on procedural issues. It was decided that an independent panel of experts would be formed in order to oversee the matter. Stipulated within the settlement proposal was that the panel would be formed in order to monitor all of the state's duties regarding the design, implementation, and continual maintenance of necessary treatments for class members. The parties agreed that a more detailed understanding of the make-up and duties of the review panel would be stipulated after the existing settlement proposal had been adopted by the court.

The settlement proposal was presented to the court on the first day of the hearing that Judge McMillan had scheduled in order to hear final arguments on the merits of the case. McMillan welcomed the settlement document and praised both parties for their expedient and productive work. The judge adopted the stipulations of the settlement proposal as his own findings of fact and conclusions of law. These findings and conclusions were delineated in the final consent decree, which served as the court's formal acceptance of the settlement proposal.

Although the consent decree legally bound both parties to the case, it did not set legal precedent, because the judge's findings and conclusions were based on an accepted settlement proposal and not an adjudicated trial. This fact provided consolation to the defendants, who did not have to face immediate



suits from other parties who could claim the precedent of Willie M. It also rendered ambiguous the implications of this case for children in other states.

Following the hearing, the parties met to discuss further the details of the review panel. The parties quickly came to an agreement as to whom the review panel would include and how the review panel would function. The proposed panel was composed of five individuals, two of whom were to be selected by the plaintiffs, two of whom were to be selected by the defendants, and one of whom was to be jointly selected. The panel needed to consist of at least one mental health expert (either a psychiatrist or psychologist) and one educator. All panel members would need to be independent, paid by the defendants, and given full cooperation by both parties throughout the entire settlement and development of services.

Although the parties agreed on most facets of the structure and function of the review panel, they could not agree as to when the administrative power of the panel would be discontinued. After considering proposals from both parties, McMillan ruled that an annual review of this issue would begin in October 1982. At this time, it would be determined by the court if defendants were satisfactorily meeting their obligations, as delineated in the consent decree, and if the review panel was further needed to oversee defendants' fulfillment of their duties as service providers.

A review panel was quickly formed and panel members began work on overseeing the state's program initiative immediately. The panel recognized that the state's duties included providing relief in the forms of education and mental health treatment for the named plaintiffs, identifying and evaluating potential class members, and developing education and mental health treatment services to treat all class members. The panel began overseeing the state's activity in all three of these areas soon after the panel was formed. Lawyers for the state returned to court for each scheduled review hearing in order to report on the state's progress in developing services. The review panel assessed the reported progress and, as they deemed necessary, set deadlines for future progress.

### **The Review Panel Goes to Work**

Beginning soon after the case settled, the imposing scrutiny of the review panel grew to become an albatross around the neck of state government staff members who were charged with implementing

services. The state made repeated attempts to persuade the court that the review panel was no longer necessary and that the state could develop services without its oversight. The review panel argued vehemently that the state was dragging its feet and not acting in good faith. The good will of the settlement wore thin. Although the state hoped that the court would grant it independence from the review panel, the panel remained heavily involved in the oversight of the Willie M. program for over a decade.

The review panel went to work as quickly as it was formed. It was required to submit quarterly reports and by the beginning of 1982 had submitted three. In the panel's own words, it hoped that its reports would "be useful to the Court and the parties in considering both the current situation of class members and the efforts of the [the State] to comply with the stipulations and the Court's Orders." On January 29, 1982, the panel reported that it had met with Governor Hunt and that the governor had "assured the panel that he would do everything within his capability to ensure that class members receive the services to which they are entitled" and that he would personally seek the necessary funds to meet this necessary end. The governor ordered the DHR to move forward with the certification of a significant number of candidates for Willie M. services. Lastly, the governor promised to increase his personal involvement in overseeing the progress of developing appropriate services for those children who qualified as Willie M. class members.

The astute governor was coming out as head of the reform movement, even though it was his administration that had caused the initial conditions that had forced the lawsuit and it was his administration that floundered in complying with the settlement. Another of the many ironies of this case is that Hunt would leave the office of the governor in 1984 but would return in 1992 to remain as governor when the case was finally closed in 1998. The initiation of the legal case in 1979 and its closure 20 years later were bookends of Governor Hunt's tenure.

In addition to the governor's expressed intent, the panel was further reassured by the state's completion of the certification process for current Willie M. candidates by the close of 1981. The panel diligently monitored the state's Certification Committee in order to make sure that certification criteria were properly and uniformly applied. The panel found relatively few and minor problems with the Certification Committee's actions, and what problems it did find were quickly resolved. As a result of a

timetable proposed by the defendants and agreed to by the plaintiffs and review panel, the state was required to provide appropriate services to at least 25 percent of Willie M. class members by April 1982. In order to help to ensure that the state met this stipulated requirement, the review panel directed the state to develop a plan for the ongoing evaluation of systems of services so that it could be determined whether the services provided met the individual needs of Willie M. class members.

In its report of May 4, 1982, the panel reported to the court that the state had in fact not met the benchmark that 25 percent of Willie M. children be receiving appropriate services by April of that year but rather that only 18 percent of class members were receiving appropriate treatment. The panel noted, though, that the development of systems by which Willie M. class members could receive treatment was significant and that state resources necessary to develop new systems of services were present. The panel acknowledged the state's requirement to have developed service systems, have such systems fully implemented statewide, and provide necessary, appropriate treatments to class members by July 1983. The panel emphasized the need for the state to show that the services provided are actually needed by class members, that such services are being provided in the least restrictive setting, and that provided services are meeting the goal of each individual Willie M. child "to cope as effectively as his own capabilities permit with the demands of his own person and of his environment."

By August 1982, the panel had become discouraged by the state's failure to meet the agreed-upon timetable's benchmarks. The panel expressed regret to the Court that, although the state was required to be appropriately serving 42 percent of Willie M. class members by that time, monitoring visits and the reports of area mental health programs revealed that less than 30 percent of class members were actually receiving appropriate services. The panel acknowledged that the state and local agencies were faced with tasks and activities that were novel to them and that their lack of task familiarity was a cause of the delay. The panel directed the state to develop an overall state plan by which it could anticipate, plan, and develop specific strategies to tackle the various problems and issues that would be likely to arise. The panel was seriously concerned about the state's repeated failure to meet the Paragraph 9 stipulations during the agreed-upon timetable, and as a result, requested a formal meeting with the Governor in October, 1982, in order to make sure that he was aware of the situation.

In July 1983, the panel submitted its sixth report to the court and stated: "Nearly three years have passed since the defendants agreed to provide appropriate services to members of the class, and eighteen months have passed since they agreed to and the Court ordered a timetable of June 30, 1983, by which *all* class members were to be receiving appropriate services in community-based systems of service. *The defendants have failed to meet all of the benchmarks in the timetable, and the statewide implementation of services to meet the needs of individual class members is significantly behind schedule*" (emphasis added). The panel had become increasingly frustrated and reminded the court that the state's compliance must be measured by the actual provision of services to class members based on their individual needs—not by the amount of energy and effort that had been expended by the state in an attempt to meet Paragraph 9 stipulations. Although the state was required to provide appropriate services to all class members by June 30 1983, the panel determined that fewer than half of Willie M. children were receiving the treatment that they needed and deserved. In light of this statistic, the panel reported: "*unavoidable questions arise as to whether the defendants have planned, organized, managed and carried out this task in a manner designed to meet their obligations within what everyone agreed as late as the fall of 1981 to be a reasonable period of time*" (emphasis added).

Despite their considerable disappointment and frustration, panel members were determined to turn things around. The panel informed the court and the state that, due to the state's progress having remained significantly behind schedule, the state would have to take new courses of action in order to ensure that all Willie M. children were receiving appropriate services. The court made this formal recommendation to the defendants. The defendants refused to accept the panel's recommendations.

The state's defiance was a crucial point in the history of the case and program. More crucial was the swift response by the plaintiffs. The plaintiffs filed a motion with the court asking that (a) the defendants be found in contempt of court for failure to comply and (b) the court appoint a "special master" to carry out the panel's recommendation. In December 1983, the state agreed to appoint an administrator, as recommended by the panel, with full authority to plan, organize, and manage in all ways the state's efforts to provide class members with the services to which they were entitled. The favorable effect of this panel recommendation was already observable by January 1984, at which time the administrator completed a work plan by which the state was to proceed. The panel reported that by

January 1984, the state's progress had already had a positive impact on some of the problems previously cited by the panel and that the first six months of 1984 were "*marked by a great deal of activity and some evidence of the type of positive leadership and direction which must be provided by the defendants to ensure their compliance with the stipulations of the parties and Orders of the Court*" (emphasis added).

The year 1984 had seen the first turning point that the panel had been determined to achieve. Although the panel remained hopeful, it continued to stress the need to address several problems that were far from resolved. In particular, the panel cited problems related to (a) the integration of service planning and delivery at state-level and local programs, (b) the lack of adequate information at state and local levels about the entire range of class member needs, (c) the need for services to be provided in the least restrictive, most normal setting appropriate for individual class members, (d) the need for a timely and consistent ongoing certification process to identify all eligible children, and (e) the need for an ongoing evaluation system by which necessary changes in services could be identified and made.

In its September 16, 1985, report, the panel wrote that the state had agreed to a new timetable that would require it to make sure that all class members were receiving appropriate services by the end of that year. However, the panel conceded that by the end of June 1985 less than 70 percent of all class members had been receiving due services. In addition, the panel found it "more disturbing" that even the large, state-level systems of services were still having significant problems abiding by the requirements stipulated in Paragraph 9. Although the panel recognized the potential for immediate improvement in these areas, it was reluctant to express hope that immediate resolutions would be realized due to the four-year history of the state's efforts to meet Paragraph 9 stipulations.

The year to follow was met with both hope and disappointment. In September 1986, the panel reported that, while the year past had caused further frustration, members were feeling encouraged due to the state's new leadership. Although Lenore Behar was the inspirational state leader of many of the innovations in the delivery of services to Willie M. children, the state had not provided her with the administrative support to bolster the office of Child and Family Services. In 1984, she was no longer directly overseeing the state's Willie M. program and a separate section was created to address the needs of Willie M. youth. Mike Pedneau was appointed the section chief of Willie M. Services.

The panel also cited the improvement in the state's ability to monitor and evaluate service systems in an ongoing fashion. The state's evaluation process was expected to be able to determine whether class members' individual conditions were improving as a result of Willie M. services and whether local programs were being effective overall. Further, the panel concluded that the state had developed a system by which disagreements between mental health and social service agencies could be efficiently resolved. The panel acknowledged that plaintiffs' attorneys' continued diligence and commitment to seeing their clients' needs were met had served significantly to help the panel focus on its primary responsibility: to assess and report on compliance. While the panel continued to serve as a check-and-balance system for the state, the plaintiffs' attorneys maintained close watch over the panel's activities and continued fulfillment of its duties.

Although the state had provided favorable evidence of progress, it was accompanied by serious failures, which the panel characterized as "extremely disturbing." In its September 1986 report, the panel noted that, once again, the state had failed to meet its deadline for providing services to all class members. This caused the panel considerable frustration as the December 1985 deadline that the state had failed to meet was the extended deadline outlined by the *second* timetable. As the panel pointed out, the state itself had estimated that by the end of December 1985 less than 70 percent of Willie M. children were receiving the services to which they were entitled. There had been *no* increase in the number or percentage of class members receiving appropriate treatment since the panel's previous report to the court in September 1985.

The panel was equally alarmed by the continued failure of the state to establish positive leadership and direction for meeting class members' educational needs under the responsibility of DPI. In particular, the panel cited the state's abuse of service data, having "relied on information which was obviously incomplete *and* erroneous to contend that they 'are and have been for some time appropriately meeting the educational needs of 95 percent of the class.'" This failure was accentuated by the state's refusal to provide other information that had been requested by the panel regarding the educational needs and status of certain class members. The panel expressed its increasing doubt that the state was dedicated to fulfilling their duty to meet the educational needs of class members as articulated by Paragraph 9 and the second timetable.

The firm message sent by the panel caused the state to submit a response to the court in defense of its efforts and willingness to make progress toward meeting Paragraph 9 stipulations. The state argued that the panel had failed to include in its September 1986 report that DHR representatives had concluded that by the end of May 1986 approximately 80 percent of the class was receiving appropriate services—a marked increase from the “less than 70 percent” statistic provided to the court by the panel. The state emphasized the time-intensive nature of the kinds of systems and services that it was developing and maintaining and the obstacle that was presented to them by the lack of familiarity with services that were needed by certain class members but had previously never been established in North Carolina.

The panel’s next report to the court was submitted in July 1988. Amazingly, although 22 months had passed since its previous review report, the panel reported: “*We do not believe . . . that the defendants are now serving a significantly larger number of class children appropriately than they were at the time of the panel’s last report*” (emphasis added). The panel conceded that the tasks at hand were challenging and that class members have very serious and different treatment and educational needs. However, it was concluded that, over time, the issues had not changed and, although there existed more precise information about the specific problems of class members, the state failed to use this information to increase provision of appropriate services to Willie M. children. In an attempt to get the state’s attention, the panel firmly concluded by stating that “*the opportunities we now see for ultimate success are fragile and must be acted on now or important ground will be lost*” (emphasis added). If that happens, much more drastic responses and interventions would be necessary.” The panel had reached the point of desperation.

### **The 1992 Plan Is Proposed by New Leadership**

It is noteworthy that on January 1, 1992, Marci White replaced Jan Harris who replaced Steve Johnson to become the next chief of the Willie M. section within DHR’s Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS). She had been the administrator for the review panel since early 1981. The state now had as its leader of Willie M. programming the person who had previously been the chief antagonist for the opposition. Furthermore, White’s personal friendship with Sandra Johnson, who had now taken on the role of the plaintiffs’ lead attorney, meant that Johnson

decided to step down from her lead position on behalf of the plaintiffs in order to remove herself from this conflict of interests. So in one fell swoop the state had eliminated its two chief nemeses in its legal battle. Furthermore, it had gained a very savvy leader in White. The decision to appoint White had been made by Pedneau, who had moved on from his former position as director of Willie M. programs to become head of DMH/DD/SAS. Pedneau knew of White's work as the panel administrator and thought that she would be the best person to lead the new section and bring the state into compliance with the court's orders.

In February 1992, the panel submitted its report to the court for the period of September 1, 1988, through January 15, 1992. Eleven years had passed since the Willie M. class action suit had been settled, a consent decree was issued by the court, and the State of North Carolina was ordered to provide all class members with services that met their individual needs. The panel had just completed its eleventh year of monitoring the state's progress toward compliance with the court's orders, eleven years of coping with an imbalance that favored disappointment over hope and frustration over encouragement, eleven years of having to report to the court that the state was *still* not in compliance and *was still* significantly behind the timetables to which it had agreed. On February 28, 1992, the panel stated: "It would be tempting to use this report to focus on our great disappointment and frustration with having to . . . point again to various and specific areas where defendants have failed to meet even their own expectations and time lines for developing, managing, and providing appropriate services to class members. However, such a report would serve only to confirm what everyone already knows: too many class members are not yet receiving appropriate services, and it is long past time to have achieved that goal."

The panel chose to focus its report on re-addressing the respective understandings of the plaintiffs and the defendants of the situation as it currently stood. The panel introduced a plan that had been brought forth by Pedneau and which had been co-written by Charles Davis and Marci White. The plan (which would later become known as the "1992 Plan") was developed by the Willie M. Section and was intended to address the primary goals of the Willie M. services and articulate avenues by which these goals could be met most quickly. The 1992 Plan was not developed in order to clarify routes by which long-term Willie M. objectives could be met but rather as a means by which the state could get back on track toward compliance.



The Plan was a blueprint for state action to get out from under the court. This was a critical point as it was perceived by the plaintiffs as well as the review panel that, as time had passed, the state had slowly moved farther away from maintaining its original trajectory. It is also important to note that the legislature had asked the state to develop a plan for ensuring compliance and evidence of service outcomes—this was a major impetus behind the creation of the 1992 Plan, as it appeared the state was unable to develop a plan independently by which this request could be adequately meet.

The review panel welcomed the 1992 Plan with open arms for a number of reasons, a couple of which are particularly important. First, the panel had become highly frustrated with the state's continued failure to be in compliance and was desperate for possible solutions. This frustration explains why the panel waited four years (from 1988 to 1992) between submitting reports to the court on the state's noncompliance. Second, the panel realized that while it was trying to get the state to focus on the long-term goals of Willie M. services, the need to maintain some focus on short-term objectives had been lost, and ironically this may well have been reason why the state had lost ground in its attempt to be in compliance (a long-term goal, at least by this point in the eleven-year effort).

The objectives outlined in the 1992 Plan were clearly defined, and all focused on the state's role as leader of the design, implementation, and management of the statewide service system for Willie M. class members. In the report, the panel articulated the six main objectives:

1. Revise the certification process to reduce the information and time required for certification of potential class members.
2. Increase the accuracy, completeness, and usefulness to service planners of the diagnostic and evaluative information needed to plan and implement appropriate services.
3. Reduce the time required to plan and implement appropriate services for difficult-to-serve class members by increasing the state's involvement in the diagnostic/evaluation process for these class members, decisions about what will constitute appropriate services, and implementation and monitoring of delivery of those services.

4. Increase the quality of services provided to Willie M. class members by developing guidelines and performance standards for Willie M. services to individuals and for programs.
5. Reduce the number of "conflict cases" involving class members with multi-agency involvement by developing formal interagency agreements to address authority, responsibility, and resolution of conflict cases.
6. Increase and maintain the pool of qualified professional and paraprofessional staff available to work with class members through a variety of recruitment, training, and staff support strategies.

The panel reminded the court that in its previous report (September 1988) it had warned that if the proposed changes were not made by the state in a timely manner, "important ground would be lost." The panel, out of continued frustration, went on to assert: "Unfortunately, the defendants did not take advantage of these opportunities in a consistent and effective way. They, and more importantly, the children in the class have lost ground." The panel expressed its regret at the lack of progress that had been made since its 1988 report. As if to will the state into compliance while convincing itself that there was still reason to have hope, the panel ended the executive summary section of its report by stating: "It is so crucial to move forward now and resolve the problems that are preventing compliance. . . . The panel believes the defendants are capable of doing what needs to be done. Now is the time."

The 1992 Plan included a statement of desired outcomes for Willie M. class members at age 18, which was developed and submitted to the panel for its review. First, the class member needs to attend and participate in educational services appropriate to his or her needs. To the extent that he or she is able, the class member needs to maintain a state of health sufficient for his participation in normal, productive, and rewarding activities. The Willie M. child needs to have a "home," even if it is not his natural home, which provides him or her with a safe, nurturing environment conducive to the achievement of all of his other goals and objectives. The class member needs to have at least one person who is also an advocate, friend, and confidante who maintains a long-term relationship with the child, fostering trust, self-esteem, and social-competence. It must be shown that the class member is engaged in meaningful

employment in a real work setting of his choice, or in activities leading toward that goal. Lastly, the class member needs to develop the social competence and coping skills he needs in order to reduce or ameliorate assaultive and aggressive behaviors.

In addition to key objectives and necessary outcomes, DHR articulated specific underlying assumptions of the 1992 Plan. In general, the objectives of the plan were focused on the ultimate goal of achieving compliance with the consent decree. The degree to which the state is in compliance depends upon the extent to which all class members are receiving appropriate services and *not* on the amount of effort expended by the state. Achieving compliance required the state to take another approach, both administratively and programmatically, toward meeting the service needs of Willie M. children. The department also pointed out that the nature of Willie M. children's disabilities was extensive and that the state would need substantial resources in order to provide appropriate services for them. The 1992 Plan acknowledged that people who were dedicated to and had the necessary expertise to serve such children were few and far between and that the state needed to do everything in its power to recruit and retain qualified and committed personnel. While it was the named state-level defendants (the governor, DHR, etc.) and not local programs who were obligated to fulfill the order of the consent decree, the 1992 Plan clarified that the Willie M. "service system" included all agencies, services and functions under the control of the named defendants. This clarification was of particular importance, as it pointed to the need to utilize resources of the state at all levels while remembering that it was only the named state defendants who were legally responsible for meeting the criteria set out in Paragraph 9.

### **The Willie M. Case Comes to a Close**

Due in part to the 1992 Plan and in part to personnel changes in the governance of the Willie M. system, the period from January 1, 1992, until well into 1993 was marked by the efforts of all parties to reorganize. In July 1992, Eric Vance joined the senior leadership of the Willie M. program as chief psychiatrist. In Vance, the program had found a clinical expert in serious psychopathology and resiliency theory.

The final piece of the leadership puzzle was Gustavo Fernandez, who was responsible for data gathering, analysis, and interpretation. He and Vance developed a computerized system to measure risk and protective factors as well as outcomes that children achieved. Previously, efforts in this area had been

paltry. After 1992, the Willie M. program systematically collected over 300 pieces of information on each child every year. This information was directly linked to services that were delivered and to expenditures of state funds. "It was a live and organic instrument," according to Davis. The information enabled state program directors to compare children across time and those in one region with those in another region of the state. The items covered residential, social, behavioral, educational, and health needs and services of the child. Fernandez and his staff aggregated data across children within 39 regions of the state and produced annual reports for each local region. Their charts enabled local legislators and administrators to know exactly how well (or poorly) their children were faring.

This team also enhanced the program's "unit-cost billing reimbursement system," which had been the first such system in the state and was a national trend-setter. The system sets the financial reimbursement rate to local providers for a specified service, provides documentation of the number of service units received, and provides for reimbursement. This system is now the standard in health care across the nation.

In 1992, in reaction to the new leadership and energy by the Four Musketeers now in power at the Willie M. program, the review panel reported several areas of progress. The state had developed techniques by which it could establish programmatic expectations and outcomes for *individual class* members. It had also prepared and distributed performance expectations for local Willie M. systems of services with the intention of using these expectations for ongoing monitoring of local systems in hopes of ensuring the provision of appropriate services.

Still, reminiscent of reports of years prior, the panel found that many of the class members reviewed were still lacking appropriate services. The absence of a clear clinical picture of the class members' profile, inconsistencies in diagnosis, incomplete supplemental information, and outdated individual class member plans were all cited as likely factors contributing to this latest failure to comply. The panel referred to the 1992 Plan and reminded the court that the state had proposed the development of a clinical resources network in order to provide uniform services to members. The state, however, was not found to have made any significant progress in this area. The panel expressed further hope and claimed to have "a clear sense that the defendants are aware of the many problem areas in the Willie M. system and are knowledgeable about the work that needs to be done." The state continued to accomplish

just enough to satisfy the panel that there was hope for improvement. Still, the panel was forced to recognize that, at the end of the fourteenth year of the Willie M. program, considerable emphasis on the state's part remained on projections of new developments and plans for the future.

In October 1993, the review panel began preparing its next report, documenting the now familiar shortcomings as well as the achievements of the Willie M. effort. This report would be finished and submitted to the court in October 1994, but in the meantime the case changed dramatically. In January 1994, despite recent reports by the panel that the state was still far from meeting compliance standards, the court determined that there was no longer a need for direct court oversight of the Willie M. case. Evidence of the weakening of the plaintiffs' position and the weakening of the power of the review panel was growing. The court ordered both parties (the state and the plaintiffs) to work together to develop a plan that would fulfill the requirements outlined by the settlement but would not require the court to oversee it. Instead of the review panel being given the authority to forge such a plan, the court was now ordering the plaintiffs and the state (and its Willie M. program director, White) to work together.

On January 24, 1995, a plan to remove court oversight had been jointly prepared by defendants and plaintiffs. The 1995 "Plan for Achieving Compliance" was submitted to the court for its review and was quickly approved. This joint effort provided both sides with hope that progress was being made and that the state was approaching compliance at a faster rate than had been realized in the 1980s and early 1990s. In addition, the 1995 General Assembly enacted legislation [N.C.G.S. 122C-3(13a)]<sup>2</sup> that defined who was eligible for Willie M. services in a manner that was consistent with the definition of class members provided in the original class action suit. This provided plaintiffs with some assurance that, although court oversight of the state's progress was coming to an end, children who qualified according to original Willie M. guidelines would receive the services needed.

Although the "Plan for Achieving Compliance" and the newly enacted legislation were signs for hope, the final reports of the review panel continued to be discouraging. In accordance with the court's 1994 orders, the panel continued to monitor the implementation of the plaintiffs' and defendants' proposed plan to remove court oversight. Specifically, the panel reported on its unannounced tour of the Butner Adolescent Treatment Center/Oakview Program on September 29, 1995. The panel toured the facility, talked with staff and class members and found what appeared to be more of a "crime and

punishment” environment than a treatment focused environment. The panel reported that services were unreasonably delayed (e.g., staff had not started developing one class member’s initial treatment plan until eight months after his admission), health conditions were insufficient (e.g., locked bathrooms, no toilet paper) and some medical records lacked dates on significant information.

The panel also reported that an inadequate percentage of class members was receiving appropriate services. In fact, although the state reported that 68 percent of class members were receiving the services they needed, an audit by the panel that was conducted earlier that year led it to conclude that only 38 percent of class members were being served appropriately. The panel correctly pointed out that even in the case that the state’s estimate was more accurate, 68 percent remains significantly less than the 100 percent required by Paragraph 9 for full compliance. The panel reported that the state’s efforts to make progress toward compliance may have stalled or even regressed in the past year. As a result, the panel recommended to the court that its role as monitor of the state’s Willie M. activity be continued.

On March 13, 1996, the panel reported to the court that, although the Statewide System Performance Report was due in the fall of 1995, it had not yet been received by the panel. On August 26, 1996, the panel submitted an update to its March 13th report in which it stated that the state had finished developing a formalized review process by which the appropriate status of class members could be discerned. In addition, the panel reported improvements in other key areas, including the certification process, provision of training opportunities for area program and local system school staff, and interagency collaboration at the state level.

On January 8, 1997, the court ordered the parties to submit a final updated copy of their plan for the court’s approval. The parties were further ordered to submit proposals regarding termination of the Willie M. review panel and the entire case. Attorneys for the defendants responded by filing a motion to terminate the class action.

The panel submitted its final report on July 2, 1997. This marked the completion of its seventeenth year of monitoring the state’s Willie M. activity and progress toward compliance with Paragraph 9 of the court’s consent decree. Once again, the panel expressed serious concerns about major treatment issues and the state’s continued failure to meet compliance criteria. Based on its review of multiple sites, the

panel concluded that there was a lack of clinical information available within the system for class members. An additional concern was that the court was still often forced to send class members off to training school because there were no realistic alternatives.

By 1998, Judge McMillan had passed away. A new federal judge had been appointed, one who was more conservative and unlikely to support the continuation of the case. The court determined that the state had complied with the lawsuit requirements, found the review panel no longer necessary, and ordered the case closed in September 1998. The plaintiffs did not take any legal action to overturn this finding, and the case was thus agreed closed, almost 20 years after Judge Bason's legendary press conference. The defendants had long felt that the Willie M. program was adequately run and that there was no need to expend further valuable resources of the state in order to have the panel review the program only to come to the same conclusion time and again—that the state was acting in accordance with their duties as found by the court.

There are two main reasons why the plaintiffs did not feel it was necessary to oppose the defendants' motion to terminate the class action. First, the plaintiffs' attorneys agreed that the state was adequately running Willie M. services. They believed that the state was in compliance with the settlement order and that there probably was no longer a need for the panel to have direct oversight of the matter. There were occasional complaints made by case workers and other professionals who were representing individual child clients that services were not being adequately provided, however, the plaintiffs' attorneys believed that these complaints were occasional at most and that they were quickly resolved by Willie M. service providers and administrators.

Second, although the settlement order and the case findings of Judge McMillan did not, in themselves, provide legal precedent upon which to fall back on case the state fell out of compliance, the case findings had been codified and class members were now protected by statutory law. The statute marked the ultimate success of the attorneys for the plaintiffs. One of the biggest challenges that had faced them was how to attain a court-mandated remedy for the plaintiffs while setting a legal precedent to protect future class members. Remember that the plaintiffs' attorneys had desired a quick settlement as there was no legal precedent upon which to build their case. However, they knew that while a favorable settlement would protect the named plaintiffs and identified class members, it could not serve as legal

precedent after the case terminated. By codifying the findings of the settlement order into statutory law, the case could terminate, but class members who entered the juvenile justice system would be still be protected, thus eliminating this worry. If the state failed to provide sufficient services and to meet compliance with the settlement order cum statute, legal action could be taken against the state to remedy the situation. Such legal action would not be directly based on the Willie M. class action but rather on the codified findings of the case as they were written into statutory law. As a result, the plaintiffs' attorneys were able to realize not only the short-term successes of the case (e.g., immediate relief for the named plaintiffs) but also the achievement of their long-term goals.

The efforts on the part of the plaintiffs' attorneys were successful in the long term in another sense as well. Because Willie M. services have been shown to be effective in helping to reduce the institutionalization of children with mental health problems and violent and assaultive behavior and to improve the ability of such children to be maintained in their home community, the program has also had the effect of changing some people's perceptions of the kinds of children that can be helped and the types of services that make a difference. The Willie M. case focused a light on a murky and difficult issue: what do conduct-problem children need in order for things to change for the better, both for themselves and their environments? This light has been turned on just as the nation has awakened to the problem of emotionally troubled, violent children. Horrible incidents of school violence in Littleton, Colorado; Atlanta, Georgia; Padukah, Kentucky; and elsewhere have galvanized the federal government to provide unprecedented appropriations for violence prevention programs in 1999. Other states now routinely turn to North Carolina's Willie M. Program for innovations in services and for the leading example of a system of care in children's mental health.



## **Part II:**

### **The System of Services that Is the Willie M. Program**

#### **The Willie M. Treatment Program Forges New Territory**

The Willie M. Program has developed into a statewide network of services that span the worlds of education, residential placement, mental health services, and rehabilitation. The population of children and adolescents served within the Willie M. Program is heterogeneous in many ways. Demographically, they represent both boys and girls, all ages of children and adolescents, and many racial and ethnic groups. In addition, the children differ from one another in their current level of behavioral, emotional, and intellectual functioning. Because of the diversity in the population, a large system of services was developed in order to provide an individualized plan for each certified child or adolescent.

As a result of the out-of-court settlement in September 1980, the state agreed to certain conditions. Each child certified as eligible for Willie M. class membership was to be provided with medical treatment and education to allow for a reasonable chance to gain skills to improve everyday life. Also, each child was guaranteed placement in the least restrictive living conditions that would be appropriate for his or her needs. This guarantee followed from sweeping national reforms that had occurred in the 1970s in education, based on Public Law 94-142 which guaranteed children with disabilities the right to public education in mainstreamed settings with other children, rather than in self-contained classrooms. The extension of this educational philosophy to the Willie M. population was novel and unique, given the violent histories of the class members and previous history of hospitalizing or incarcerating them. Placing a child in the least restrictive setting requires the balancing of two opposing needs, minimizing institutionalization (harm to the child) and minimizing potential harm to society. In addition, after assessment of each certified child, his or her treatment plan was supposed to set recommendations without regard to availability of services. The state was required to develop and to provide services that were actually needed by children in the class, rather than to recommend only those services that were already available in the child's community. Furthermore, the settlement required the state to develop and to implement new services within a reasonable period of time. Of course, legally defining each of these points (What is the

least restrictive setting or a reasonable period of time?) were complicated and somewhat contentious matters.

Administrative changes took place within state government to design an optimal system of care for Willie M. clients, and this program became the first truly comprehensive system of care in the United States. Originally, Willie M. services were housed within the Child Mental Health Section in the Division of Mental Health within DHR under the direction of Lenore Behar. In December 1983, a separate Willie M. Services office was created within DMH/DD/SAS. Likewise, in September 1987, the Department of Public Instruction (DPI) established a separate Office of Willie M. Services within the Division of Exceptional Children. DHR was the designated lead agency that was responsible for coordination and oversight of service delivery, whereas DPI was the lead agency responsible for appropriate delivery of educational services.

The termination of the class action in 1998 brought several important structural changes that continues to threaten the integrity of the Willie M. Program. Organizational changes have occurred within both DHR and DPI. As of October, 1999, the organizational chart of the Division of Mental Health also changed. In particular, the Willie M. section was integrated into the Child and Family Services Section (formerly Children's Mental Health and headed by Behar) within the Division of Mental Health rather than remaining as a free-standing section. The same eligibility procedure and the same system of care, however, were retained.

### **The Willie M. Section Matures within DMH/DD/SAS**

The following five subsections describe the administrative history of the section including the growth and development of the section from 1992 until early fall 1999. Table 1 provides an overview of the persons who have held leadership roles within Mental Health and the Willie M. Section from the beginning of the program until it was dismantled in 1999.

**A compliance plan was developed in 1992.** With the Four Musketeers administration that was brought on board in 1992, both DHR and DPI agencies developed a plan for achieving compliance with the lawsuit. The plan was developed at the request of the General Assembly, and it was requested that the goals of the plan be accomplished with existing resources. It contained specific steps that the state

defendants could take, including time frames, to serve all class members adequately with the goal of the program to become "fully self-regulating and self-monitoring". There were several limitations within the state system at the time the plan had been written that compromised the ability of the state to identify and serve Willie M. clients appropriately. For example, there were not enough qualified personnel in the state to serve these children, and the extensive nature of their problems required a substantial increase in resources. This plan received approval from the state, and the Willie M. Section mobilized a concerted effort to bring the state in compliance.

In summary, the plan contained eight sections, which are described below. First, the legislature needed to provide full funding to implement cost-effective, appropriate services statewide. Second, the Willie M. Section needed to develop and disseminate a clear statement of performance expectations to local programs with a system to monitor client outcomes. Third, given the complexity of problems presented by many Willie M. children and the variability in services across the state, a full continuum of services needed to be developed statewide. Fourth, many tasks concerning the management and organization of the Section, coordination across agencies, and role definitions and responsibilities within DHR needed to be clarified and accomplished. Programmatic changes included the creation of an individual assessment and service planning process, a second secure treatment facility similar to Butner Adolescent Treatment Center, indicators for continued quality improvement of services and performance expectations for local systems and an overall training plan for Willie M. personnel.

In addition, other goals were to conduct credible evaluation studies of the effectiveness of services for class members and to create transition and tracking procedures for aged-out members. The fifth goal was to hire a full-time senior psychologist/clinician and a child psychiatrist at the state level to

Table 1

Willie M. Program History and Participants

Year	Director Division of MH/DD/SA	Willie M. Section				
		Section Chief	Assistant Chief	Clinical Director	Research Evaluation Branch Coordinator	Training Branch Coordinator
1982	Gene Douglass (GD)	Lenore Behar - (LB) chief, Child & Family Services				
1983	GD	LB				
1984	GD	Separate section created; first section chief appointed: Mike Pedneau (MP)				
1985	GD/Paul Kaye (PK)	MP				
1986	PK	MP				
1987	PK	MP				
1988	PK	MP				
1989	Don Taylor (DT)	MP				
1990	DT	Steve Johnson				
1991	DT/Mike Pedneau (MP)	Jan Harris (JH)				
1992	MP	Marci White (MW)	Charles Davis (CD)	Eric Vance (EV)	Gustavo Fernandez (GF)	Joan Kaye (JK)
1993	MP	MW	CD	EV	GF	JK
1994	MP	MW	CD	EV	GF	JK
1995	John Baggett (JB)	MW	CD	EV	GF	JK
1996	JB	MW	CD	EV	GF	JK
1997	JB	MW	CD	EV	GF	JK
1998	JB	Charles Davis	CD	EV	GF	JK
1999	JB	CD	Wayne Smith (WS)	Charles Pryzant (CP)	Shealy Thompson (ST)	JK
10/1999 Reorgan- ization of Division	JB	Lenore Behar	WS (branch head)	CP	ST	Training absorbed into larger division training

assist in providing direct services to the children with the most complex needs as well as to assist in the program consultation and development. The sixth goal was to develop an overall training plan to address the Section's training needs. The seventh goal was to develop an ongoing monitoring system to oversee the services provided to clients and to ensure that the state is in compliance with Paragraph 9. The eighth goal was to evaluate the entire program including conducting credible evaluation studies of the effectiveness of services and outcomes for class members, a cost-effectiveness study, and a study of performance expectations at the local level. In addition, the Section would create a standardized instrument that could be administered at regular intervals to assess individual client progress.

The plan included the creation of a set of desired outcomes for class members. The outcomes were developed to represent desired outcomes in six domain areas. The six areas can be seen in Table 2 and include five areas used by the DMH/DD/SAS in its overall Quality Improvement Plan. These six areas of functioning include education, health, residential placement, social functioning, vocation, and behavior.

**Table 2**  
**1992 Plan: Areas of Desired Outcomes**

<i>Educational</i>	The class member attends and participates in educational services appropriate to his needs.
<i>Health</i>	The class member will, to the extent that he is able, maintain a state of health sufficient to his participation in normal, productive, and rewarding activities.
<i>Housing</i>	The class member has a "home," even if it is not his natural home, which provides him with a safe, nurturing environment conducive to the achievement of all of his other goals and objectives.
<i>Social</i>	The class member has at least one person who is also an advocate, friend, and confidant who maintains a long-term relationship with the child, fostering trust, self-esteem, and social competence.
<i>Vocational</i>	The class member is engaged in meaningful employment in a real work setting of his choice, or in activities leading toward that goal.
<i>Behavioral</i>	The class member develops the social competence and coping skills he needs in order to reduce or ameliorate assaultive and aggressive behaviors.

These desired outcomes are evaluated using seven primary indicators of adjustment listed below and were thought to be appropriate for class members to have reached by their 18th birthday. There are no guarantees that these outcomes will be achieved by each client; however, the defendants were obligated to provide a good faith effort to provide services with these goals in mind. Table 3 presents a description and example of desired outcomes in each of these seven areas. Level of functioning is assessed yearly as part of the Functional Domain Assessment (FDA) which is a section of the AOI. Six of these seven variables were rated on Likert-type rating scales. One item, Recent Arrest, was dichotomously coded as yes or no.

**Table 3**  
**Primary Indicators of Functioning**

<b>Domain</b>	<b>Functional Domain Assessment Item #</b>	<b>Meaning of Score (a higher score indicates)</b>
<b>Educational Progress</b>	FDA 24	Better educational progress
<b>Health Status</b>	FDA 12	Better health
<b>Residential Restrictiveness</b>	FDA 7	A less restrictive residential setting
<b>Assaultive Behavior</b>	FDA 57	A lower frequency of assaultive behavior during the three months prior to the administration of the AOI
<b>Family Support</b>	FDA 11.01	More support from one's family
<b>Mentor Support</b>	FDA 11.03	More support from an adult mentor
<b>Recent Arrest Status</b>	FDA 17	If the client had been arrested in the year prior to administration of the AOI

**The philosophy of the Willie M. service system guides service delivery.** The expectation after the settlement of the lawsuit was that the Willie M. Services section would provide appropriate treatment and education for class members. In fact, the service system that was expected to do this job included all agencies, services, and functions under the control of the defendants in the lawsuit, namely, the governor, DHR, and DPI. The major issue to be resolved was how to evaluate appropriate treatment and education of class members. These standards are described in Table 4.

## Table 4

### Paragraph 9 of the Second Set of Stipulations

In recognition of the above-stated rights, defendants agree and acknowledge their obligation to provide all plaintiffs with appropriate treatment. The scope of the defendants' obligation shall be as follows:

(A) Each plaintiff shall be provided habilitation, including medical treatment, education, training and care, suited to his needs, which affords him a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capabilities permit with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency. Such habilitation shall create a reasonable expectation of progress toward the goal of independent community living. Defendants do not guarantee each plaintiff a "cure," but do guarantee each plaintiff a program of habilitation which is a good faith effort to accomplish the goals set forth herein.

(B) Each plaintiff shall be provided with the least restrictive, i.e., most normal, living conditions appropriate for that person. Among the factors to be considered in determining the least restrictive living conditions appropriate for the individual are the need to minimize the possibility of harm to the individual and society.

(C) The goal of habilitation shall be to enable each plaintiff, as appropriate for that individual, to move from:

- (1) Living and programming segregated from the community to living and programming integrated with the community;
- (2) More structured to less structured living;
- (3) Group residences to individual residences;
- (4) Dependent living to independent living.

(D) Each plaintiff shall be provided such placements and services as are actually needed as determined by an individualized habilitation plan rather than such placements and services as are currently available. If placements and services actually needed are not available, the person shall be entitled to have them developed and implemented within a reasonable period. Prior to development and implementation of needed placement and services, the person shall be entitled to placement and services which meet as nearly as possible his actual needs.

Several features characterize the philosophy behind the Willie M. Program. First, the legal settlement *did not promise a cure* for each child, only that services would be delivered. Most of the children had been exposed to horrific living conditions prior to certification, and one does not quickly reverse the effects of years of abuse or neglect. Many of the children were also faced with the challenges associated with coping with a variety of handicapping conditions from mental retardation, severe learning disabilities, or neurological disorders that are also not readily modifiable. Thus, reduction of symptoms to subclinical levels was not considered to be a realistic goal, whereas reduction of symptoms to allow for less

restrictive living conditions in the child's community provided a more realistic goal. As an aside, critics of the Willie M. Program consider this feature to be one of the mistakes of the settlement on the part of the plaintiffs. That is, if the plaintiffs had been able to get the state to guarantee that positive outcomes would accrue (in addition to services being delivered), then the pressure on the state would have been even greater.

Second, the program had a ***no eject-no reject*** philosophy and did not typically "decertify" children. Once a child was accepted into the program, services were provided until the child reached the age of 18. The program made a commitment to each certified child and created services for a child if they did not already exist. Third, all services were ***individualized*** and individual, realistic goals were developed for each child. Services for each child were based upon the child's actual needs rather than what was available in the community. This point is discussed further below; however, it is notable that given this fact, individual progress can not readily be compared across program participants. Fourth, ***wrap-around services were provided in the community*** of the child with the goal of normalizing the child's experiences. This is a more cost-effective form for the provision of mental health services, and outcome research has demonstrated that it is a relatively effective intervention approach to treatment. Finally, ***case management*** was established in this program as the norm, such that services were integrated across state agencies. In this program, many state agencies were forced to work together as a team, many of whom had never worked together before and many had never even met before.

**The Willie M. Training Branch is created.** Among the many substantial changes that occurred as a result of the 1992 reorganization plan, one was the allocation of specific funds to hire a training coordinator and to create a Willie M. Training Branch. The provision of these extra funds represented an unusual move for the legislature by recognizing the special training needs of Willie M. administrative and direct care staff. The training and support system for staff was crucial not only because of the unique nature of the clientele served, but also due to high rates of staff burnout. The first and only training coordinator of the Branch was Joan Kaye, who was hired in 1993. Kaye came to this position from having been a Willie M. regional service manager. This prior experience put her in a unique position to lead the branch, because she had extensive professional experience in the training needs of the Willie M. staff and affiliated professionals.



One of the greatest challenges in the creation of the Branch was that none of the affiliated professionals, paraprofessionals, or volunteers who worked with Willie M. youth were required to attend training sessions. Thus, the overriding philosophy and strategy of the Branch was to create relevant, interesting, and high quality training experiences that people would elect on their own to attend. Eventually, the goal was to attract attendance through a growing positive reputation that would be obtained from high-quality training experiences. Another hoped-for result was that area mental health centers as well as private mental health facilities would require their staff to attend training in order to be able to serve Willie M. clients appropriately.

The primary goals of the Training Branch included not only the training of all professionals associated with the Willie M. Section, but also to serve as the public information arm of the Section. In these capacities, the Branch was responsible for a wide number of activities including the creation and dissemination of training materials and courses; creating and managing the Willie M. web-site (located at [www.dhhs.state.nc.us/mhddsas/williem](http://www.dhhs.state.nc.us/mhddsas/williem)); handling all requests for information to the Section; planning and scheduling of conferences related to Willie M; and creating information booklets and videos for parents, staff, and the general public. Given that the Branch staff consisted of only the training coordinator, one secretary, and one staff assistant, many activities of the Branch were conducted with the assistance of private contractors as well.

Another high-priority direction for the branch was the creation of a 30-to- 40 hour curriculum for the training of residential direct care staff. One may wonder why such great resources were directed at this topic, but at the time, most of the existing curricula were not designed for the Willie M. population, meaning that they did not deal with children who were multiply and seriously disturbed. This curriculum covered the basic information needed to provide high-quality care to extremely violent children and adolescents who are living away from their home. The curriculum was designed for group-home parents, residential facilities care staff, foster-care parents and others. A careful development process was used for the creation of this curriculum, which included conducting focus groups of what people reported that they actually did in their jobs. The curriculum was developed with an independent contracting agency, Triangle Training and Development (TTAD). TTAD and the Training Branch field-tested the curriculum with existing Willie M. staff, trained trainers, and then provided technical support.

One challenge was how to provide this lengthy curriculum to the direct care staff who serve Willie M. children across the state. Kaye developed a novel and interesting approach to solving this problem by offering the course through the community college system. Unfortunately, though, like the mental health system, each local community college operated as an independent entity, and the North Carolina Department of Community Colleges (DCC) did not have jurisdiction over them. Nonetheless, the DCC assisted Kaye by telling her what the Training Branch needed to do in order to be able to offer a course at a community college. The DCC helped by facilitating the location of the focus groups. In this way, direct-care staff employees in the state could access the course nearest to their home and receive college credit. Currently, four community colleges still offer the course, and the Training Branch maintains a list of instructors who were trained and eligible to teach the course as well as the names of all students who have completed the course of training. Also, the manual which accompanies the training sessions can be found on the web-site.

A third priority for training was to teach crisis intervention skills to all direct-care staff. One reason that this topic was considered to be very important for the staff working with Willie M. clients was that agitated persons have died while in physical restraints. There was also a tremendous public-relations need with this population to prevent the use of physical restraints whenever possible. Also, there was a need to prevent conflict from escalating into crises. A curriculum that was developed by the Crisis Prevention Institute (CPI) in Milwaukee was adopted by the Training Branch to use with training direct-care staff. This curriculum has a focus on prevention of escalation in crisis situations. The goal was to have a coordinated response system in place when crises with Willie M. clients occurred. To date, the CPI has trained about 4,000 people in North Carolina, and approximately 150 professionals have been trained to be trainers. The Training Section provides workbooks for free to all trainees as well as annual certificates indicating receipt of training.

A fourth set of training materials that was developed included a CD-ROM for training administrators on the Willie M. information system and how to use it. The data base and client-tracking systems that were developed by the Willie M. Program under the leadership of Charles Davis and Gustavo Fernandez are considered to be at the cutting-edge in children's mental health service delivery systems. These systems followed directly from the clinical assessment and treatment-planning system that were

developed by Eric Vance. In order for the system to be useful at the local level, training materials needed to be developed so that administrators would use the system.

A fifth training experience sponsored and organized by the Training Branch was the annual clinical conference on aggressive and violent youth held in March of each year in Charlotte, NC. The mental health center in Mecklenberg County has received an annual grant to organize this conference, which is widely attended by several hundred Willie M. direct-care staff and case managers. Nationally prominent guest speakers such as Scott Henggeler (1999) and Patricia Chamberlain (1998) have appeared to expose Willie M. professionals to state-of-the-science intervention programs for violent youth and research findings on aggression in youth.

In addition to traditional training activities, the Branch initiated an important annual event for Willie M. coordinators and leaders in area programs. This Leadership Conference was held for two years and then was postponed in 1999 due to the reorganization of the Section. The provision of this type of conference allowed for important education and networking of staff across the state to discuss successful and innovative programs, to continue to standardize assessment and record-keeping procedures, and to coordinate services across regions. A similar type of Case Management Conference has been held twice a year for case managers.

The Branch has also created an impressive array of video and training materials for parents or guardians, the general public, and professionals who are involved in some way with Willie M. clients. First, a general 20-minute video entitled, "One Kid at a Time" and a public-information video entitled "Vision for the '90's" have been disseminated broadly. Additional training videos and workshops that have been created include "Understanding and Healing the Hurting Child," "Advocacy and the Legal System," "Appropriateness Monitoring in Willie M. Services," "Treatment of Sexually Aggressive Youth," "T/HP Individualized Planning," and "Introduction to the Willie M. Budget Process."

The future goals for the training of staff associated with Willie M. clients have included creating opportunities for distance learning, including the development of training materials on CD-ROMs; updating of existing materials; continued opportunities to provide training using the recently developed curricula by the Branch; and expansion and updating of the Willie M. web-site. With the recent re-organization of the service system, it is unclear which of these activities will remain.

**The Willie M. Nomination Branch is created.** The nomination procedure has been refined continuously over the years of the existence of the program. Ann Baldwin was hired as the head of the Nominations Branch, and she oversaw many changes to the process. Some features of nomination did not change across time, due to the conditions of the lawsuit. For example, anyone could nominate a child for membership in the class. Despite this legal openness in nomination, the procedures for nomination varied dramatically across agencies and localities regarding who typically made the referral (e.g., in some school systems, the director of exceptional children made all the referrals, and in other places the school superintendent made all the referrals). The child must be under 18 years of age, violent or assaultive, involved in the court system, have a handicapping condition, and not currently receive appropriate services.

A board was formed at the state level to oversee the certification process. In addition, there was a state-level appeals process. The application form was changed several times during the 1990s and evolved into an automated, user-friendly form that could be submitted online. Baldwin saw it as her job to make the process and application easier to assist people in making nominations, and most reports confirm that she was successful.

**The Willie M. Program Evaluation Branch is created.** Consistent with the April 1992 Plan, the Program Evaluation Branch (PEB) was created to help the Section comply with the settlement. Although the lawsuit never addressed questions of the efficacy of the program for individual children, the section administrators were keenly interested in evaluating the effectiveness of the Willie M. system. At the time of the settlement, it was sufficient to talk about providing services to children, and no one promised positive outcomes. Pressure from the General Assembly's fiscal research office (especially from Gregory Berns) resulted in a focus on the appropriateness and effectiveness of treatment. These became the mission of the PEB. Berns liked the Willie M. program, in principle, but he did not like that the state spent a great deal of money on it without measuring its outcomes. He suggested that if the Section could not show that the program was affecting the ways the community and public care about these children, then the services would lose support. Prior to 1991, several small evaluation projects had been conducted by contractors or part-time staff. However, there was not sufficient staffing to conduct a detailed and comprehensive evaluation of the overall program. In 1992, Fernandez was hired to work full-time on

evaluation of the Willie M. program. Fernandez developed a working relationship with the Center for Urban Affairs at North Carolina State University, which provided three staff positions to assist the Evaluation Branch in tasks related to day-to-day aggregation of data as well as long-term analyses of data.

In addition, White hired Eric Vance, a child psychiatrist who had been referred to her by Dr. Tom Haislip, the chairman of the Department of Psychiatry at the University of North Carolina at Chapel Hill, to provide a clinical perspective and expertise for the Section. Jim Kirkpatrick, the area director at Wake Mental Health Center, also wanted to hire Vance, so Vance worked out a position that included a combination of outpatient work at Wake County Mental Health, inpatient work at the Butner Adolescent Treatment Center, and research with Fernandez. Additional staff members were hired at this time, and the Section staff grew from four to nine regional members, which allowed for closer monitoring at the local level. Charles Davis also helped to spearhead a new information system for the Section.

In 1995, Fernandez created a dual track for the branch to separate the two functions of the program. The first track addressed issues related to the appropriateness of treatment, and the second addressed issues around the effectiveness of treatment. The appropriateness review was created to allow clinicians to follow standards of practice and to track their activities. The outcome evaluation track evaluated the effectiveness of practices for class members.

Between 1992 and 1999 the Branch developed a system of measures to accomplish the evaluation goals. The development of the outcome instrument took longer than expected, and White needed timely information to report back to the legislature. The "Four Musketeers" group created what they called the "Quick and Dirty" in 1994, which consisted of a simple one-page outcome checklist to provide basic information about outcomes. It could be completed in five minutes and was given to everyone beginning in September of 1994, and then re-administered six to seven times. A report about the findings from this measure was completed by Fernandez in May 1997, and White reported the results to the General Assembly. The information proved to be very powerful. For example, Willie M. clients were found to need increasingly less restrictive settings over time. When the program began, there were about 150 Willie M. clients living in training school, which is an expensive, restrictive, and artificial environment. By the 1990s, only about 25 clients could be found living in training school at any given time.

A longer outcome measure, the AOI, grew from recommendations of the oversight panel in 1992

to examine five desired outcomes (see table 2). White recommended a sixth outcome, and a seventh legal outcome was added later. Fernandez began attending the weekly meetings of the Wake County Mental Health Center's wrap-around multidisciplinary treatment team in 1993 and 1994. He suggested items to examine the seven outcomes and then had the team discuss how to define each indicator operationally, and they developed response scales. Some psychometric work on the AOI measure has been conducted, especially inter-rater reliability assessments. The AOI was piloted in six area program volunteers to test for vagueness, readability, feasibility, and clinical utility, and it includes perspectives of the child client, parent or guardian, teacher, and case manager. In 1995, after a long two years of development, the AOI was administered statewide. Now, there are several hundred Willie M. clients who have received four or more AOIs.

The AOI is administered as a paper-and-pencil measure and takes about two hours to complete for one child. Because of the large time commitment, there was a great deal of resistance from area administrators to having their staff complete it regularly. It is coordinated with the annual review of each case, and the Willie M. program pays 100 percent of a social worker's time to complete each AOI. It took one and one-half years to convince staff in area programs that the completion of the AOI is part of their job.

Davis helped with this campaign in that he graded area programs on their compliance, and the completion of AOIs was part of their grade. A compliance "tickler" mechanism was developed that rated each area program monthly on the number of AOIs completed on time, those late by more than 45 days ("late"), and those later than 90 days ("delinquent"). Each program was given feedback on all the data every two weeks. If a child had two AOIs, then the program received bar charts comparing the child's two scores. By 1997, this system was put online, and area programs could see all of the Brief Psychiatric Rating Scale (BPRS) and all primary and secondary outcome indicators for each domain of functioning. This monitoring and feedback strategy proved to be very effective in that by the time Fernandez left the Willie M. Section, the area programs were in compliance 80 percent of the time.

By the time that Vance joined the Willie M. Section staff, he had completed a psychiatric fellowship at Dartmouth and had been introduced to the risk and resiliency research in developmental psychopathology. Vance suggested the idea of developing a clinical risk assessment tool that included risk

and protective factors. The emphasis on protective factors that were malleable as opposed to more fixed risk factors added a novel perspective to case managers' planning process.

In addition to the development of these new instruments, Greg Berns had written into the appropriations statute that a normed instrument would be used to evaluate the effectiveness of the program. Thus, there was a legal mandate to find a normed instrument. Vance suggested the BPRS, but the language was too complicated, and it did not always apply to the Willie M. population. Vance modified the measure, and the staff assessed its inter-rater reliability. It came to be used as part of the AOI to assess changes in psychiatric symptomatology.

### **The Willie M. System of Care Is Created**

**Service providers played a crucial role.** The legal obligations of the settled Willie M. case required the State of North Carolina to provide services to class members. However, for the most part the state contracted with the 40 local area mental health programs to provide treatment. The state had a separate set-aside pool of funds available to reimburse the area programs for funds spent on Willie M. clients. In some areas, services for Willie M. clients were not readily available. These area programs were allowed to contract with private providers, partner with other area programs, or develop services for clients. The state did develop and administer a few innovative special programs of its own.

**The Willie M. case manager position is created.** Prior to certification as a Willie M. class member, a youth's needs often outstripped the capacities of a local area mental health center, due to limited resources. As an ironic result, many of the Willie M. youth had received more costly services than the program recommended, such as psychiatric hospitalization. Unfortunately, hospitalization for these youths is often ineffective and may have iatrogenic effects. With funds provided by the Willie M. program, each newly certified consumer was assigned a case manager who had access to a range of resources.

**The Individualized Habilitation Planning System is developed.** The Willie M. model used four factors to determine the appropriateness of different services: the child's perspective, an independent assessment of the child's needs, the adequacy of service plans, and actual service provision. These four factors were also used by the case manager and others to create an individualized service plan for each child through a standardized planning approach and format. This plan, called the Individualized

Habilitation Planning (IHP) System, was instituted at all area mental health programs in North Carolina in July 1985 and was revised in 1992.

The case manager was responsible for developing a community team to conduct the IHP meeting and for chairing and coordinating the efforts of the team to make sure that all relevant individuals were involved in the child's care. The team members could include extended family members, neighbors, church members, mental health clinicians, guardians ad litem, substance abuse clinicians, developmental disabilities coordinators, school guidance counselors or vocational education counselors, physicians, psychiatrists, psychologists, and other agency representatives. For example, a social worker had to be present if the local Department of Social Services had legal custody of the child. A court counselor had to be included if the child was adjudicated delinquent. An adult services representative was also invited if the child was almost 18 years of age. As can be seen from the possible membership roster, strong interagency communication and planning was central to the development and maintenance of the IHP, which noted the needs of the child, the goals of the child and family, and the strategies to meet both short- and long-term goals. It was also the job of the case manager to update the IHP (or T/HP, for Treatment and Habilitation Plan, as it was sometimes known) as necessary. The case manager was the point person for the child and family, and it was his or her job to link the child and family with community resources.

The IHP was modeled after the Individualized Education Plan (IEP) from special education and is now used extensively both within North Carolina and nationally. Through the IHP process, the case manager is authorized to move class members among a full-range of services from most to least restrictive. Most importantly, one case manager follows the child across time and settings rather than the child being shuffled from professional to professional without an ongoing advocate. Once the treatment plan has been developed, the case manager contracts for services with other agencies. Many counties created new services because they did not exist within a county prior to the Willie M. program. The creation of services to fit the needs of the child was a novel idea in contrast with the prior strategy of finding children to fit the services that were already available. This shift from agency-centered thinking to child-centered thinking is a key contribution of the Willie M. Program.

Two basic principles guided the development of the IHPs. First, based on the guidelines outlined in Article 9, services were designed for each child based upon that child's individual needs rather than the



availability of services in a geographic area. Second, the plan was required to represent an interagency agreement. For example, an IEP developed by educators and psychologists from the state Department of Public Instruction was integrated into the IHP.

A needs assessment of each child was conducted in the areas of social, behavioral, educational, vocational, housing/residential, and health functioning. This assessment was conducted independent of the availability of services. The orientation of the assessment was twofold. First, there was an assessment of the needs of the child and the risk factors present in the child's environment. At this point in the process, there was explicit consideration of how to protect the child from risk factors. Second, the capabilities and potential of the child were assessed, as well as the presence of protective factors in the child and his or her environment. The strengths of the child and a plan to support these strengths involved an assessment of independent characteristics such as temperament and sociability, as well as the features of the external support system in the neighborhood, school and church. The results of this assessment were prioritized and resources were quickly allocated to address essential needs.

The treatment plan for each child contained both short-term goals and long-term (one-year or longer) objectives. It included provisions for the safety of the child as well as the safety of others. These two issues were balanced in the plan with the goal of placing the child in the most normal, least restrictive environment while attempting to minimize harm to society. Many of the class members were not able to live either independently in the community or with their families, and thus a range of services was utilized. Certain values were evident in the IHP or T/HP; they included taking a broader view of care possibilities than is normally seen in traditional mental health services and refraining from moving the child from residence to residence or treatment program to treatment program arbitrarily.

### **The Willie M. Section Provides a Wide Array of Services**

A broad system of services was developed to address the wide range of needs presented by the Willie M. population. These services, which were tracked monthly, can be described within five broad categories that are outlined in table 5.

The most common types of services included case management (97%), outpatient services (79%), paraprofessional services (55%), group home (25%), and alternative family arrangement (19%) (as

reported in the 1997-98 fiscal year). Even in cases where class members received residential services, these were supplemented with non-residential services, such as day treatment and outpatient therapy. Notably, class members who lived at home received few other services and were the most stable in the placement over a year period. For class members who changed services over time, there was a gradual stepping-down of services from more- to less-restrictive placements in residence.

### **Secure Treatment Facilities Are a Part of the Willie M. Continuum of Care**

As of the beginning of 2000, there were four secure psychiatric facilities utilized by the Willie M. program: Butner Adolescent Treatment Center, Eastern Adolescent Treatment Program (EATP), Whitaker Residential Treatment Center, and Tom Ray Residential Treatment Center. (EATP is the newest facility serving Willie M. children and is not discussed in any detail below.) In addition, some Willie M. participants received services at the five North Carolina state training schools, including C. A. Dillon, Samarkand Manor, Dobbs, Stonewall Jackson, and the Juvenile Evaluation Center (JEC). Table 6 provides an overview of the number of clients served at each of these secure facilities.

From the outset, the Willie M. program has always been responsible for **coordinating** service provision for class members (first known as “wrap-around” services). Later, the section also became involved in **developing** and **providing** services to clients in secure treatment facilities. In 1992, the Willie M. Section began providing services to class members at the BATC. This was a unique departure for the Section, consistent with the effort to develop new and innovative methods of treatment and service delivery in order to treat this complex and challenging population. Below is a description of the population and treatment orientation of each type of secure treatment facility.

**Table 5**

**The Willie M. System of Services**

**Community Services**

- services for children living in their own home, a substitute family home, or a group home
- in-home services can include crisis intervention, parent training, or counseling
- outpatient treatment services: individual, group, or family therapy
- community recreation program
- substance abuse treatment
- professional or paraprofessional mentor
- developmental disability services
- medication monitoring

**Educational Services**

- self-contained classes
- combined day treatment/education
- tutoring
- developmental day care
- in-home or inpatient education
- before- and after-school programs
- summer camp

**Residential Services**

- respite care for family
- group homes (moderate or high management)
- therapeutic home
- professional parenting
- therapeutic foster care
- supervised independent living
- therapeutic camp

**Vocational Services**

- pre-vocational and vocational skills including job interviewing, work values, behavior training, and job skills
- vocational assessment
- job placement
- sheltered workshop placement
- apprenticeship/job coach
- part-time job

**Inpatient or Secure Services**

- short-term hospitalization
- long-term hospitalization
- diagnostic testing
- medical care
- psychiatric treatment
- crisis stabilization
- secure (locked) non-medical setting

**Table 6**

**Capacity of Secure Treatment Facilities Where Willie M. Participants Were Served**

<b>Locked Treatment Facility</b>	<b>Training School (Office of Juvenile Justice)</b>
<b>1. BATC (12 locked; 12 step-down)</b>	<b>1. Stonewall Jackson (134)</b>
<b>2. Tom Ray (24)</b>	<b>2. Samarkand Manor (170)</b>
<b>3. Whitaker (24)</b>	<b>3. Dobbs (162)</b>
	<b>4. C. A. Dillon (121)</b>
	<b>5. Juvenile Evaluation Center (224)</b>
<b>Total (72)</b>	<b>Total (811)</b>

Note: Figures in parentheses denote number of beds at each facility in 1997.

**Butner Adolescent Treatment Center:** The BATC program was created in the late 1980s to serve adolescents between the ages of 13 and 17. Their average length of stay was 12 months. This program was the first new treatment program created and operated by the Willie M. Section and, as such, is an example of the innovations that occurred in the treatment of these adolescents during this period. This program was, perhaps, the type of facility in which several of the initial plaintiffs in the class-action lawsuit (including Thomas H.) might have been appropriately served. A second new program, the Eastern Adolescent Treatment Program, was created later and was modeled after the BATC.

The majority of the adolescents at BATC had previously been in other placements that were found to be unsuitable. Many BATC residents engaged in aggressive behavior that could not be controlled at hospitals or group homes. Approximately 90 percent of the residents had experienced severe abuse or neglect, and most had psychiatric diagnoses of Conduct Disorder, Post-Traumatic Stress Disorder, or an Anxiety Disorder.

The treatment program at BATC was primarily relationship oriented. The philosophy of the program was to increase the presence of protective factors in a child's life rather than to try to decrease risk factors, which often are considered to be immutable. The staff tried to help each adolescent form positive relationships with adults, both at the center and in the community to which the adolescent would be discharged. In addition, BATC used a "positive discipline" approach. This approach aimed to increase

personal responsibility and control rather than focus upon changing behavior through manipulating external controls. For example, the behavioral management system at BATC did not involve levels or long-term behavioral goals (i.e., levels used for providing privileges or restrictions in many institutional settings). Instead, there was a simple day-to-day system in which inductive reasoning was used as the first step in dealing with negative behavior, and brief consequences were used only when reasoning or teaching failed to control the behavior. Individual, group, and family psychotherapy were provided, and many residents entered more independent step-down apartments as a transitional placement after their stay at BATC.

**Tom Ray Residential Treatment Center:** The Tom Ray Residential Treatment Center in Charlotte, North Carolina, served clients with a mean age of 15 years, who had an average length of stay of 9 to 12 months. Similar to residents of BATC, many of the adolescents at Tom Ray had not functioned well in their prior placements at less structured settings, often demonstrating levels of aggressive behavior that the staff was unable to control. In addition, most residents of Tom Ray had experienced trauma or abuse, and most had received psychiatric diagnoses.

Behavioral management at Tom Ray involved a detailed points system in which residents received points for complying with their target behaviors as specified in an individual treatment plan. These points could be saved and used to buy privileges. Negative behavior was met with a "point freeze" in which points could not be accrued for a period of time. When conflicts arose between adolescents, they were encouraged to work together to solve these problems in a "kid's court" where they practiced verbal problem-solving and conflict-resolution skills. Treatment at Tom Ray occurred primarily in group settings, and each resident attended an average of three therapy groups each week on topics such as anger control, criminal thinking, and independent living skills.

**Whitaker Residential Treatment Center:** Whitaker served clients between the ages of 13 and 17 years, who had an average length of stay of 9 months. Eighty percent of Willie M. clients at Whitaker were referred for violent or assaultive behavior, 10 percent were referred for internalizing problems such as depression or social withdrawal, and 10 percent were referred because of thought disorders.

**Training Schools:** The Detention Services Division of the N.C. Office of Juvenile Justice was responsible for overseeing all five training schools in the state and served Willie M. clients with a mean age of 15 years. Their average length of stay was nine months. Training schools were distinct from the other

residential sites described here in that all of their residents had been adjudicated delinquent. Psychological treatment was primarily provided in a group format. However, some participants received individual therapy as well. The treatment focused on mastering five specific competencies: (1) accepting responsibility for criminal behavior, (2) managing anger, (3) preventing relapse, (4) acquiring academic and/or vocational skills, and (5) forming community transition plans. The behavioral system focused on achieving “successful days,” defined as days in which minimal infractions for negative behavior were incurred.

**Comparison of secure treatment facilities:** Table 7 provides an overview of the institutions described in this report. The four types were similar in several ways. For example, they were all locked, secure facilities, and they served clients with similar in the average ages and average durations of stay. In addition, each focused on behavioral management, treatment of aggressive behavior and psychiatric symptoms, and a smooth transition into the community. However, the facilities differed in their specific approaches toward achieving these goals. In addition, the facilities differed in the types of Willie M. class members that they served.

**Table 7**

**Characteristics of Treatment Settings**

	<b>BATC</b>	<b>Tom Ray</b>	<b>Whitaker</b>	<b>Training School</b>
<b>Age (Years)</b>	<b>Range: 13 – 17</b>	<b>Mean: 15</b>	<b>Range: 13 – 17</b>	<b>Mean: 15</b>
<b>Average Stay</b>	<b>12 months</b>	<b>9 months</b>	<b>9 months</b>	<b>9 months</b>
<b>Unique Characteristics</b>	<b>Positive discipline; Relationship-oriented; Generalizable daily behavioral systems</b>	<b>Behavioral system with levels; “Kid’s Court” for conflict resolution</b>	<b>Positive peer culture; Purposeful use of time; Ecological component</b>	<b>Competencies; Successful days</b>
<b>Interviewee (1998)</b>	<b>Ross Ulmer, Ph.D., Chief Psychologist</b>	<b>Dawn O’Malley, Ph.D., Clinical Director</b>	<b>Todd Holtman, Ph.D., Clinical Director</b>	<b>Martin Pharr, Ph.D., Chief Clinical Consultant</b>

## **Epilogue:**

### **The Contributions of the Willie M. Program to Children's Mental Health Services**

Following the closing of the Willie M. legal case in 1998, the Willie M. Section in DMH/DD/SAS of DHR was dismantled in 1999, and Willie M. services became integrated into the rest of the Division. For some optimistic observers, this action marked the final success of the reform effort, because the concepts of the Willie M. program had been mandated to become the fabric of the mainstream. The North Carolina legislature has even codified this mandate and has earmarked resources for the Assaultive and Violent Children's Fund. Others, however, feared this action would be the first step in the demise of the reform. The fear is that without the threat of the court hanging over the head of the legislature and state officials, the reforms will erode gradually over time when new budget crises arise or when new administrators with different philosophies come on board. The jury is still out on the long-term effects of the Willie M. legal case for service delivery to children in North Carolina. That story will depend on many factors, including the future economy of the state for funding purposes, the priorities of a new governor, and new administrators of services to Willie M. children.

Independent of the effects on future North Carolina children, the Willie M. legal case and treatment program have made enormously impressive and important contributions to the mental health care of children in the United States. These contributions have been disseminated concretely through the consultation that has been solicited by other states, including New York, West Virginia, Virginia, and Maryland. A book can be written on these contributions, but they can be summarized in the following paragraphs.

#### **The Willie M. Program Took Ownership of Children That Nobody Else Wanted**

Perhaps the most important contribution is that this case has forced the mental health system to take ownership of these children, the "children that nobody wants." These are the children who generate trouble for others rather than seeming to be the victims of trouble, although the reality is that their

traumatic early lives makes their sympathetic plight obvious. Previously, these children had been expelled from school and rejected by the educational system, turned down by the mental health system as “untreatable,” and labeled by the corrections system as “incorrigible.” With the Willie M. Program, the education, mental health, and corrections systems came to own these children. The remnants of this reform are present in the trend toward alternative schools and similar measures by public school systems to keep wayward children within the system, even if their violent behavior makes it difficult if not impossible to keep them in the regular classroom. The remnants are also seen in the heightened interest in violence prevention among mental health workers and scholars and in the vast amounts of funding that have become available for the prevention and treatment of violent youth through federal efforts such as the Safe Schools Program.

On the other side, there are constant threats to the renewed ownership of these children. In the past decade, 43 states have enacted laws making it easier to turn over juvenile offenders to adult court, where rehabilitation is not a goal and where punishment and warehousing of inmates is commonplace, even applauded. In the past decade, every public school in the nation has adopted a “zero-tolerance” policy for weapon-carrying in public schools. This policy dictates that a child caught bringing a weapon to school is automatically expelled from school for a year, so that the school system rejects its ownership of the wayward child and turns him or her over to the streets. The legacy of Willie M. stands as a shining contrast to the opposing trends.

### **The Willie M. Program Created a New Approach to Treatment, One That Is Child Centered Rather Than Service Centered**

The second major contribution of the Willie M. case is its revolutionary approach to the treatment philosophy for violent youth. This approach is more holistic and less compartmentalized than its predecessors, more developmental and educational and less psychiatric, and oriented more toward building competence and less oriented toward rectifying deficits. The approach is derived from the seminal research by Michael Rutter, which indicates that child psychopathology accrues from multiple heterogeneous risk factors and can be ameliorated by building protective buffers against these risks. The indicators of this new approach are intervention programs that are aimed at building skills in children, skills



that range broadly from social problem-solving to piano playing. The concept is that these skills are necessary to competent behavior and that they fend off the risks that these children constantly face. Nothing defeats the hopelessness that a physically abused child faces every night as he or she goes to sleep like the feeling of self-pride in genuine competence in a particular domain, no matter how obscure. Another indicator of this new approach is the location of the treatment programs that are directed toward children. Treatment occurs less frequently in the psychiatrist's office and more frequently in the home, on the playground, in the school classroom, or among a group of peers.

The essence of this new approach is that it is child centered rather than service centered. Old approaches started with services and then found children to receive them. And, of course, "if you build it [a service], they will come," so these services had been delivered at capacity. The new approach starts with the individual child. As Marcie White has stated, "In Raleigh, we had individual case files, rather than institution files." If one starts with the individual child, new types of services can be envisioned and then developed to meet the needs of that child. The result is a highly individualized set of services for a particular child, aimed precisely at helping that child. The services are molded to meet the requirements of the child, rather than the traditional pattern in which the child would have to be molded *first*, before treatment could begin. The Willie M. program case files are filled with unusual, even humorous, stories of children receiving piano lessons, being transported on dates, and being taught computer skills, all in the name of mental health service delivery.

Once the child is included in treatment planning, it is natural to build a program for that child that is oriented toward enhancing strengths rather than driving away deficits. Once the family is included in treatment planning, it is natural to build a program that includes scaffolding a child with protective factors, such as finding employment for a father, securing family safety by finding a new residence in a less violent neighborhood, enhancing parenting skills, or finding a place in an after-school program.

Yet another consequence of placing the child at the center of treatment planning is that one will readily adopt the "no-eject, no-reject" policy that characterized the Willie M. Program. Previously, treatment programs would reject a child from participation if the child could not behave well enough to maintain order or if the child did not attend sessions regularly. The reason for this rejection practice was that the treatment program, not the child, was the most important entity in the system. The irony of this

practice is that treatment programs were, in effect, saying that a child had to be cured before that child could enter a treatment program. By placing stringent criteria on a child before that child could be eligible to participate, treatment programs were precluding the possibility of change in the most hopeless of child cases. In contrast, the new perspective on treatment is that a child's inability to behave himself in school or her frequent tardiness and absenteeism is actually the phenomenon that needs to be addressed in treatment! The treatment provider needs to find a way to reach that child, in spite of, or even because of, the problematic behavior.

How did the Willie M. Program planners discover this new approach to treatment? According to Eric Vance, they spent hours talking to children and their parents. They took the unusual step: they asked children and parents what they needed! They also asked children who had improved how that improvement had occurred, and they were often told about the importance of competence and relationships. A soccer trophy, a caring school janitor/mentor, these were the recollected reasons that children gave that enabled them to steer in a more fruitful direction. The Willie M. Program planners simply tried to engineer this serendipity through novel programs that involved building skills and providing mentors.

### **The Willie M. Program Created Seminal Concepts in Service Delivery, Such as Wrap-Around Services, Case Management, Continuum of Care, and Treatment in the Least Restrictive Setting**

Cutting-edge concepts in children's mental health service delivery had their origins with the legal mandate that the Willie M. Program afforded. Lenore Behar's vision for a new system of care could be realized with the resources and focus that the Willie M. Program brought. The label of "wrap-around" to describe a method of individualization and linkages to community was first used by Behar in an article in *Children Today* in 1986. This concept is now becoming a best practice in children's mental health services. The essential components of wrap-around services are these:

**1. community base** – The service program is offered within the child's home community.

- 2. individualized treatment, built on strengths, to meet needs across life** – The program is tailored to the child and oriented toward the child's future life.
- 3. cultural competence** – The program must recognize the child's culture and be responsive to that culture. Furthermore, the program must utilize the strengths inherent in that culture, rather than fight against the culture.
- 4. families as full and active partners** – The child lives in a family and will rely on a family throughout life, so the treatment program must include families and strengthen families.
- 5. team-driven process** – Treatment decisions are made through a process of team brainstorming, consensus building, and then team mutual support.
- 6. flexible approaches with adequate and flexible funding** – Because of the high degree of individualization, flexibility is paramount. Funds must also be flexibly utilized, even if the expenditures do not fit a pre-designated category.
- 7. balance of formal and informal services and resources** – The individualized treatment plan most often involves a combination of services, ranging from the structured and pre-set to the informal and highly creative.
- 8. unconditional commitment to serve children** – This policy is known as “no-eject, no-reject.” That is, the treatment team is not allowed to eject a child from the program or reject that child in any way, even when the child tries to reject the program.
- 9. inter-agency, community-neighborhood collaborative process** – Collaboration is essential, given the vast array of resources that will need to be mounted to serve a child effectively. These collaborators must work together rather than at cross-purposes.
- 10. measurable outcomes for each goal** – This concept is so simple that it is usually ignored. Each goal should have a measurable outcome. That outcome should be measured, monitored, and used to guide future treatment.

These concepts have formed the basis for other major reform movements and experiments in children's mental health services, including the Fort Bragg experiment at an army post in Fayetteville, North Carolina. This experiment, funded by the Department of Defense, was the first major attempt to

bring a comprehensive care system to children's mental health for the families of the soldiers stationed at Fort Bragg.

Yet another contribution of the Willie M. Program was the finding that positive outcomes can be reached. Even though the findings are tempered by the lack of a rigorous experimental design, the innovative data tracking system of the program enabled the program administrators to report to the state legislature that assaultive behavior was indeed reduced among those children who could be assessed by the Assessment and Outcome Instrument on more than one occasion over time. Furthermore, these children, whom no one wanted and who were often on the verge of incarceration because of the fear that they would trample their home neighborhoods, were indeed able to be maintained in least restrictive settings. Furthermore, the residential restrictiveness score for children in the program decreased over time, indicating that they were being moved gradually toward less restrictiveness and more freedom over time.

### **The Willie M. Program Demonstrated the Virtue of Focusing on Measurable Goals**

How did the program achieve its positive outcomes? The program administrators claim that they kept it simple. They set goals, measured those goals, and showed the treatment staff and the children their outcome scores. Furthermore, they published group trends so that staff could compare themselves with others. This program demonstrates the tremendous power that comes with focus. The current focus on end-of-grade academic test scores is another example of the outcomes that can occur with a high degree of attention and focus. Of course, one must focus on the right goals, but the contribution of the Willie M. Program is to demonstrate that large statewide initiatives can have an impact.

### **The Willie M. Program Changed the Way That scholars Theorize about the Nature of Child Psychopathology**

The program has shown that trauma-remnant psychopathology, such as serious conduct disorder, can evaporate under certain circumstances. This psychopathology can also return, even after seemingly optimal treatment. Scholars have learned two paradoxical points about child psychopathology. On the one hand, psychopathology is highly plastic and can be controlled; on the other hand, for some children

psychopathology is so severe that it cannot be cured but must be thought of as a chronic disease. As a chronic disease, the goals of treatment are control of the spreading of the disorder and effective coping with the disorder.

### **The Willie M. Program Established a Truly Innovative Cost-Accounting System**

The program was the first in North Carolina and a trend-setter nationally in the use of a unit-cost billing reimbursement system. This system involves the tracking of specific services and the link between those services and financial reimbursement to the service provider. Begun in 1984, this concept was innovative in its time. It is now the standard in health care and health maintenance organizations. Tied to this system is the innovative outcome measurement system that follows from the initial assessment of the child.

### **The Willie M. Program Created and Delivered Many Novel Services to Children**

The child-centeredness of the Willie M. Program fostered innovation in services planning and delivery. One of the innovations was the wide-scale use of paraprofessionals in treatment, as mentors and case managers under the supervision of more experienced and credentialed professionals. This concept is now being used to a greater degree in the current climate of cost containment. The Willie M. Program utilized this concept because those paraprofessionals provided the best treatment. Other innovations include the delivery of services in home and school contexts, the development of novel models of residential care such as small group homes and therapeutic foster care, and the focus on training children in problem-solving skills, especially while they are in the middle of emotion-filled situations. Because the treatment often occurred in the natural setting, staff members were able to help children think more clearly and control their emotions under the "hot" circumstances of real-life problems.

### **The Willie M. Program Demonstrated Innovation and Breadth in Training Its Staff across the State**

The program effectively trained staff members to implement a novel concept, to follow a systematic model that paradoxically called for individualized treatment plans, and to complete novel data collection

procedures. This success in training means that North Carolina now has more than 500 professionals and paraprofessionals trained to intervene with violent youth.

**Finally, the Willie M. Program Demonstrated the Crucial Value of Human Relationships in Mental Health Treatment**

A major focus of the treatment plans was almost always to enhance a child's relationships, with adult caregivers, with peers, and with the community. The importance of relationships is *not* novel to the Willie M. Program; on the contrary, this tenet is very old indeed, but it has been lost in highly technical programs. Political vernacular borrowed from President Clinton's election-year focus on the economy might characterize this point as, "It's the relationship, stupid."

## References

Behar, L. (May-June 1986). Services for families. *Children Today*, 15 (3).

Burns, B. J., & Goldman, S. K. (Eds.) (1999). Promising practices in wrap-around for children with serious emotional disturbance and their families. Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Vol. IV. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Soler, M., & Warboys, L. (1990). Services for violent and severely disturbed children: The *Willie M.* litigation. In S. Dicker (Ed.), Stepping stones: Successful advocacy for children (pp. 61-112). New York: The Foundation for Child Development.

## NOTES

---

1. Plaintiffs' attorneys were ultimately compensated for their work on the case.
2. North Carolina General Statutes 122C-3  
(13a) "Eligible assaultive and violent children" means children who are citizens of North Carolina and:
  - a. Who suffer from emotional, mental, or neurological handicaps that have been accompanied by behavior that is characterized as violent or assaultive; and
  - b. Who are involuntarily institutionalized or otherwise placed in residential programs, including:
    1. Minors who are mentally ill as defined by G.S. 122C-3(21) and who are admitted for evaluation or treatment to a treatment facility under Article 5 of Chapter 122C of the General Statutes or are presented for admission and denied due to their behaviors or handicapping conditions;
    2. Minors who are referred to an area mental health, developmental disabilities, and substance abuse authority pursuant to G.S. 7A-647(3) for whom residential treatment or placement is recommended;
    3. Minors who are placed in residential programs as a condition of probation pursuant to G.S. 7A-649(8);
    4. Minors who are ordered to a professional residential treatment program pursuant to G.S. 7A-649(6); and
    5. Minors committed to the custody of the Division of Youth Services pursuant to G.S. 7A-649(10); and
  - c. For whom the State has not provided appropriate treatment and educational programs.