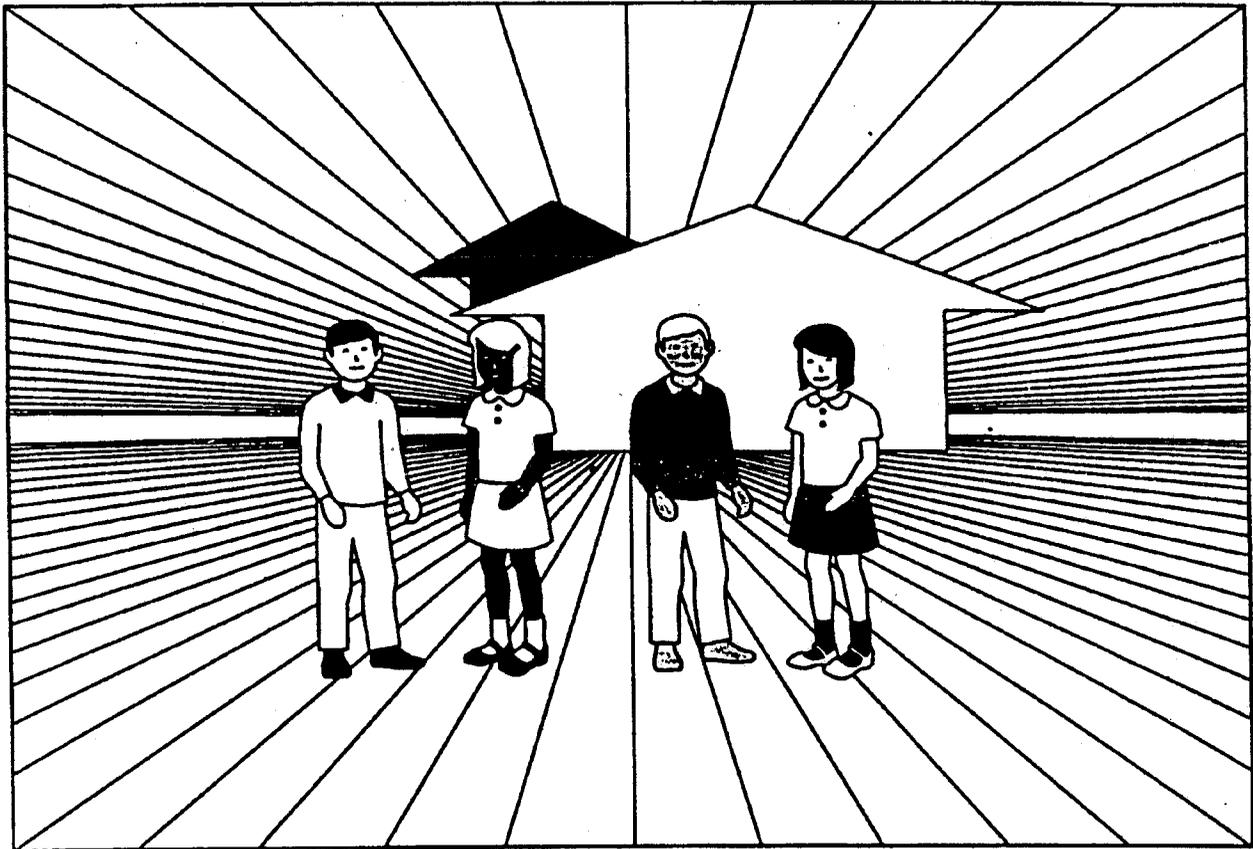


# NYS Residential Services for Children with Emotional Problems: *A Call for Reform*



New York State Commission on Quality of Care  
for the Mentally Disabled

---

# Suggested Principles for Children's Services

---

**Children should live and be raised by their natural or adoptive families whenever possible. It is essential for proper child development that the child have a stable residential environment and consistent relationships with nurturing adults.**

- When it is not possible, despite the provision of reasonable support and training services to natural or adoptive parents, children should be afforded out-of-home placements in family-like settings, close to home, and whenever possible with their siblings.
- Congregate residential and institutional settings should not be used as long-term residential placements for children.
- Adoption into a surrogate family should be a viable and timely opportunity for children who cannot be reunited with their natural families.

**Children should have opportunities to meet, play and study with other children, without regard to their specific handicapping conditions or other problems.**

- Residential programs and other family-based out-of-home placement for children should to the greatest degree possible promote the attendance of children at regular schools.
- Services for families and children should place a heavy emphasis on affording them recreational and educational opportunities that will encourage the formation of informal supports and friendships.

**Comprehensive services should be available in every community to support and assist families and to promote their capabilities and self-esteem.**

- Families at risk of having their children placed out-of-home and families whose children have been temporarily placed out-of-home should be afforded a single case manager who works with the family and coordinates the appropriate provision of needed services, and serves as an advocate for the needs of the child and the

family regardless of the agency from which services are received from time to time.

- All localities should have an accountable model of service delivery which ensures timely, comprehensive services to facilitate reunification of children placed out-of-home and their natural parents.
- Models of service delivery should be "culturally competent" in meeting the needs of the families and children to be served in local communities, and should promote the active participation of families in identifying and selecting the types of services and assistance they need.

**The important principle of family preservation should not overshadow the state's obligation to protect children from harm and to provide them the nurturing of caring adults as they grow from childhood to adult citizens.**

- Children should not be maintained in natural families where there is evidence that they are subject to repeated abuse and severe neglect.
- Repeated out-of-home placements and unsuccessful reunifications are harmful to children. In determining whether parental rights should be terminated, the importance of a safe, stable and nurturing environment for proper child development should be considered.

**Movement of children among out-of-home placements should be discouraged except in such instances where there is clear and convincing evidence that the move is in the best interest of the child.**

- Once successfully placed in an appropriate residential setting, consistent with these principles, a child should not be moved simply to satisfy bureaucratic funding and eligibility requirements. Rather, service systems should accommodate the child's changing needs by providing for such services as required to preserve a successful placement.
-

---

# NYS Residential Services for Children With Emotional Problems: A Call for Reform

---

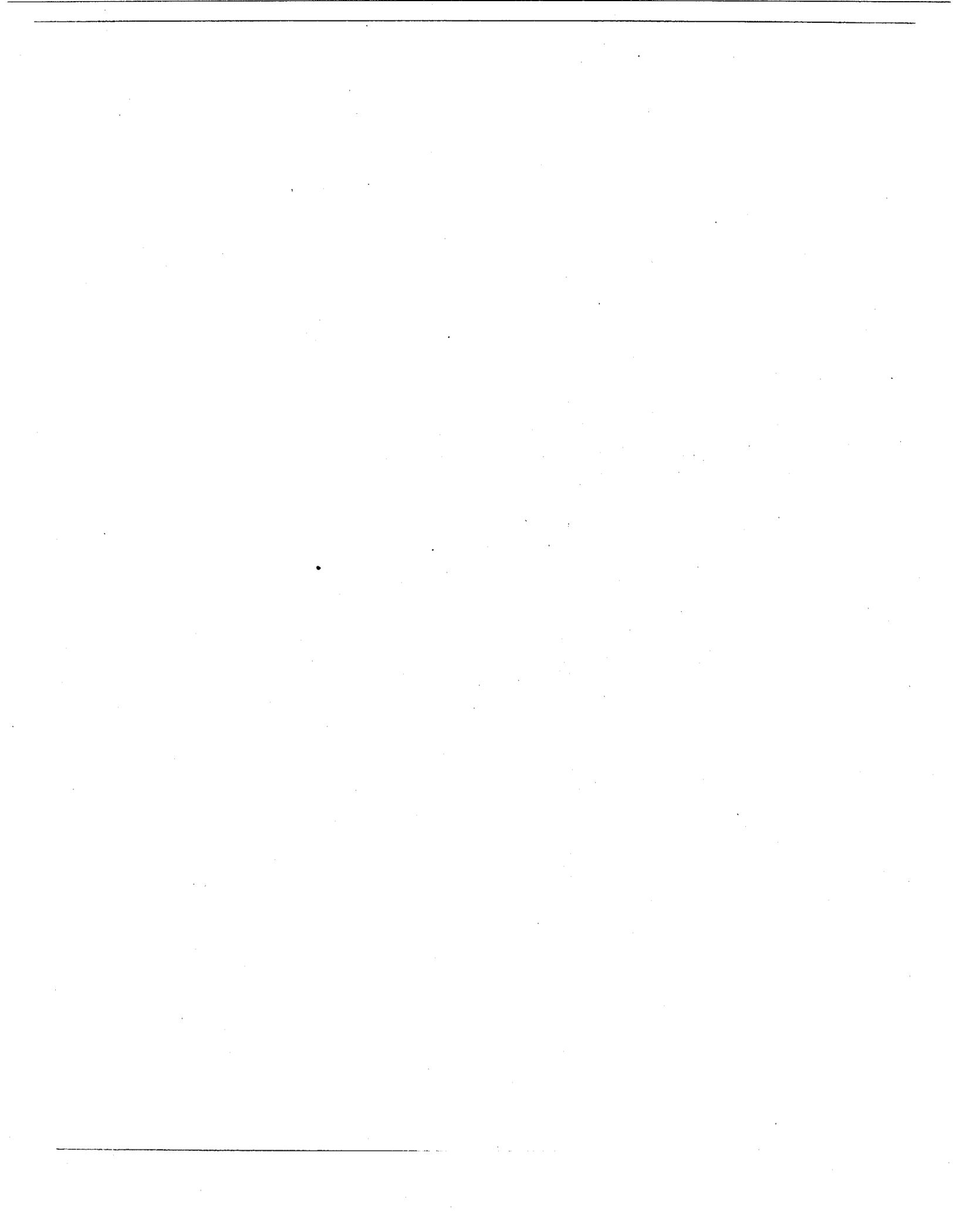
Clarence J. Sundram  
CHAIRMAN

Elizabeth W. Stack  
William P. Benjamin  
COMMISSIONERS

February 1993



NYS COMMISSION  
ON QUALITY OF CARE  
FOR THE MENTALLY DISABLED



---

# Preface

---

We write this report with a sense of urgency. Childhood is brief. The children's world can still be shaped; but the opportunities for individual children, once lost, are lost forever. The decisions that need to be made and implemented are a matter of urgency for a generation of children.

The Commission began this study with a view to examining the quality and costs of a variety of residential programs for children served by the mental health system. Our concerns were prompted, in part, by the fragmentary glimpses we see regularly in the course of investigating allegations of child abuse and neglect emanating from these facilities.

As this report describes, we have learned much about the system of services that calls for significant structural reforms both to serve children and their families most effectively and to make more efficient use of the substantial amounts of public money devoted to this system. Perhaps most importantly, however, this report reinforces the opinion that looking at the mental health system alone is too narrow a view. Many of these children have no symptoms or diagnoses of serious mental illness; they are likely more similar to than different from children served in child care systems operated by the Department of Social Services, Division for Youth, or State Education Department. What most of these children do have in common are catastrophic conditions in their family lives that occasion their removal to a variety of residential programs.

Once removed, the experiences of these children and others much like them are shaped by policies and practices of several service systems, each of which affects some portion of the children's lives for some period of their childhood. Yet, these different service systems appear to work rarely as partners in a common effort to meet the

needs of children and families and to carry out articulated policies to preserve and strengthen families. Instead, they appear to function more like work stations on an assembly line, each narrowly focused on performing its specialized task, with scant regard for the ultimate outcome of their collective efforts upon the future of the child or the family.

In conducting this study and in following the lives of the 100 children in residential programs and the 34 who had been discharged two years ago, the severe consequences of the initial decision to place a child out-of-home were powerfully etched in the life experiences of these children. While the placement out of home into most of the residential programs we reviewed generally provided children with a "safe haven" where their basic needs for food, clothing, shelter, medical care, and educational services were met, it also exchanged the dangers and deficiencies in their family lives for other voids.

Once separated from the family, most of these children began an odyssey through the multiple child care systems—a journey characterized by frequent changes in placement because of: poor adjustment, changed diagnosis, growing up, doing badly or, ironically, doing well. The price of protecting these children from the harmful conditions in their family lives was often depriving them for extended periods of time of many of the attributes of a normal childhood—stable relationships with nurturing adults and opportunities to learn and play with other children who do not carry similar diagnostic labels. In a real sense, these children are often robbed of their childhood, first by the desperate conditions in their family lives that bring them to the attention of the child care systems, and then by the very design of the service systems that keeps them moving from one placement to another.

Once in congregate care settings, in which many children have spent a portion of their journey, the emphasis usually was on controlling their behaviors through "level" systems, psychotropic drugs, restraints, and seclusion. The Commission found inadequate efforts to teach children the skills they would need to negotiate the world they had left behind. And the cost of most of these residential programs was high—an average of \$178,485/year in a children's psychiatric center and \$78,110/year in a residential treatment facility (RTF).

At the same time, the Commission saw a bright silver lining in the newer family-based treatment programs developed by the Office of Mental Health. There, children were placed in a family environment, with surrogate parents who had been intensively trained for their task and who were supported by clinical specialists and case managers in meeting the child's needs in a nurturing and normalized environment. These programs, while serving children who were not significantly different from others in our study, eschewed the use, as behavior controls, of level systems, medications, restraints and seclusion, and concentrated on teaching children the skills they needed to gain control of their lives. At the same time, the programs worked with natural families to help build the capacities they would need to resume their caregiving role. Children attended public schools and had the opportunity to lead more normal lives in school and at play. Significantly, these programs typically cost one-fifth (20%) as much as children's psychiatric centers and one-half (47%) as much as residential treatment facilities. They demonstrate that quality and cost-effectiveness can be compatible companions in meeting the needs of children and families. But, with these programs as well, children faced the prospect of being forced to move in eighteen months to two years or, if they got better, earlier.

The Commission concluded that each of the child care systems needs to be guided by common values and principles. While efforts have been made to articulate these (Chapter 166 of the Laws of 1990), the separate functioning of each system

makes consistent adherence to such values a virtual impossibility.

In this report, we offer our own thoughts about some basic guiding principles for children's services (see *Principles for Children*). Two key values that need to be supported through more flexible practices are family preservation and avoidance of out-of-home placements and assurances for stability and consistency for a child to the maximum extent possible. The first would require localities to marshal local resources in a concerted fashion to avoid out-of-home placements if at all possible and consistent with the best interest of the child, through the provision of whatever services and supports are required by the child and family. This in turn would require giving localities the flexibility to "mix and match" resources from different service systems to meet such needs. Governor Cuomo's State of the State message, in endorsing this approach, provides the state-level leadership and direction for developing such policies and practices.

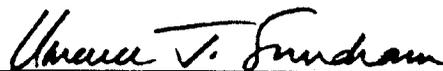
The second would require maintaining a child in a successful placement and allowing for waivers of eligibility and continued stay criteria for such a placement until a more permanent residential setting is available, either through family reunification, adoption, or otherwise. It would also require assigning a single case manager to assist the child and family in obtaining the services and support they require and to be a consistent advocate for the child regardless of where or in which system the child is placed.

The Commission recognizes that the values and principles we propose, and the recommendations we offer, will pose a significant challenge to agencies and services systems. The responses we have received from two of the principal state agencies—the Office of Mental Health and the Department of Social Services—to a draft of this report illustrate how formidable these challenges are. Although there is broad agreement on the general policy directions, there is little consensus on the critical operational issues to be confronted, and the urgent need for an open-minded reexamination of current practices. At the same time, the

agency responses also identify pilot programs, grant-funded projects, and new initiatives that are beginning to implement some of these ideas.

The Commission appreciates that its recommendations will require substantial restructuring of the way in which services for children and families are currently provided. The challenges we collectively face are how to go beyond relying on small grants and pilot projects to implement the values we espouse and how to shift to successful models the large investments we routinely make in supporting programs and services that are inconsistent with these values and inappropriate in meeting the needs of a substantial segment of the children and families served. It is our hope and expectation that the Governor's "call to arms" in the Decade of the Child will supply the energy and the will to meet this challenge on behalf of the generations of children to come.

This report represents the unanimous opinion of the members of the Commission. A draft of this report was sent to several state agencies in the summer of 1992. Responses to that report from the New York State Office of Mental Health, the New York State Department of Social Services, the New York State Education Department, and the New York State Council on Children and Families are attached in Appendix B.



Clarence J. Sundram, Chairman



Elizabeth W. Stack, Commissioner



William P. Benjamin, Commissioner



---

# Table of Contents

---

Chapter I: Overview of the Study .....	1
Chapter II: The Costs of Care .....	9
Chapter III: Who Are the Children? .....	17
Chapter IV: The Services the Children Received .....	29
Chapter V: Progress and Problems: Outcomes of Treatment .....	45
Chapter VI: Nobody's Children: Conclusions and Recommendations .....	59



---

# List of Figures

---

Figure 1:	Sample Residential Facilities .....	2
Figure 2:	Location of Service Provision for Children With Emotional Problems in NYS .....	4
Figure 3:	Number of Children Served in OMH Residential Programs .....	6
Figure 4:	Average Daily Census and Annual Number of Children Served in State Centers/Units .....	8
Figure 5:	Total Costs of Children's OMH Inpatient Residential Services .....	10
Figure 6:	Total Daily Cost Per Child by Program Type .....	11
Figure 7:	Annual Costs Per Occupied Bed by Program Type .....	11
Figure 8:	Total Costs vs Bed Days Provided by State Centers/Units .....	12
Figure 9:	Total Average Daily Costs Per Child at State Centers/Units .....	13
Figure 10:	Total Daily Costs Per Child at State Centers/Units .....	13
Figure 11:	Total Daily Costs Per Child at Residential Treatment Facilities .....	14
Figure 12:	Total Daily Costs Per Child by RTF Program .....	14
Figure 13:	Net Daily State Costs Per Child by Program Type .....	15
Figure 14:	Average Total Staff-to-Child Ratios by Program .....	16
Figure 15:	Children's Characteristics .....	19
Figure 16:	Mental Health Profiles of the Children .....	21
Figure 17:	Family Problems .....	22
Figure 18:	Out-of-Home Placements of the Children .....	23
Figure 19:	Family Relationships .....	24
Figure 20:	Recommendations for Family Placement at Time of Discharge .....	24
Figure 21:	Strengths of the Children .....	26
Figure 22:	Maladaptive Profile of the Children .....	27
Figure 23:	Academic Status of the Children .....	28
Figure 24:	Comprehensive Treatment Plans for Children .....	30
Figure 25:	Average Present, On-Duty Staff-to-Child Ratios by Program .....	31
Figure 26:	Children Receiving Mental Health Interventions .....	32
Figure 27:	Informed Consent/Discussion of Psychotropic Medications .....	35
Figure 28:	Approaches to Behavior Modification/Management .....	36
Figure 29:	Typical "Level/Point Systems" .....	38
Figure 30:	Non-Compliance Citations With State Education Department Regulations .....	40
Figure 31:	Limitations of Special On-Campus Schools .....	41
Figure 32:	Academic Progress of Children With Lengths of Stays 9 Months .....	42
Figure 33:	Teacher Reports of Progress Toward Placement in a Regular Classroom .....	42
Figure 34:	Provision of Support Services to Children .....	43
Figure 35:	Therapists' Reports of Children's Progress and Readiness for Discharge .....	46
Figure 36:	Comparative Profile of Discharged Children vs Children in Original Sample .....	49
Figure 37:	Discharge Dispositions of the 34 Children .....	50
Figure 38:	Adequacy of Records and Discharge Planning .....	51
Figure 39:	"Moves" After Initial Placements During the 2 1/2-Year Follow-Up Period .....	53
Figure 40:	Children Rehospitalized During a 2 1/2-Year Follow-Up Period .....	54
Figure 41:	Receipt of Mental Health Services .....	55
Figure 42:	Adjustment Problems of the Children .....	55
Figure 43:	Initial Placements vs Final Destinations .....	57



---

# Staff Acknowledgements

---

## **Project Director**

Nancy K. Ray, Ed.D.

## **Research and Statistical Analysis**

Mark E. Rappaport, M.S., R.N.

## **Project Coordinators**

Pamela A. Finton, M.A.

Jacqueline García, M.S.W.

Karen J. Myers, M.H.S.A.

Cheryl A. Ouimet, C.S.W.

Victoria L. Rinere, M.S., Ed.

John J. Rybaltowski, M.S.

## **Staff**

Crystal D. Bass

Mindy T. Becker

Barbara A. Beebe, C.S.W.

Peter S. Behm

Nancy D. Bell, A.C.S.W.

Betty Jane Chura

John E. Donohue, B.A.

Craig E. Freis

Thomas Harmon

Randal L. Holloway

Debra J. Johnson

Michael G. Kester

Patricia W. Johnson, J.D.

Mark P. Keegan, C.S.W.

Paul Francis LaFleur

V. Jerome Luhn, Esq.

Kathryn A. McKee, Ph.D.

Harriet Rubenstein, C.S.W.

Natalie J. Russo

Nafsika Socaris

Laurie A. Trojnor

Sylvia H. Wheelless, A.C.S.W.

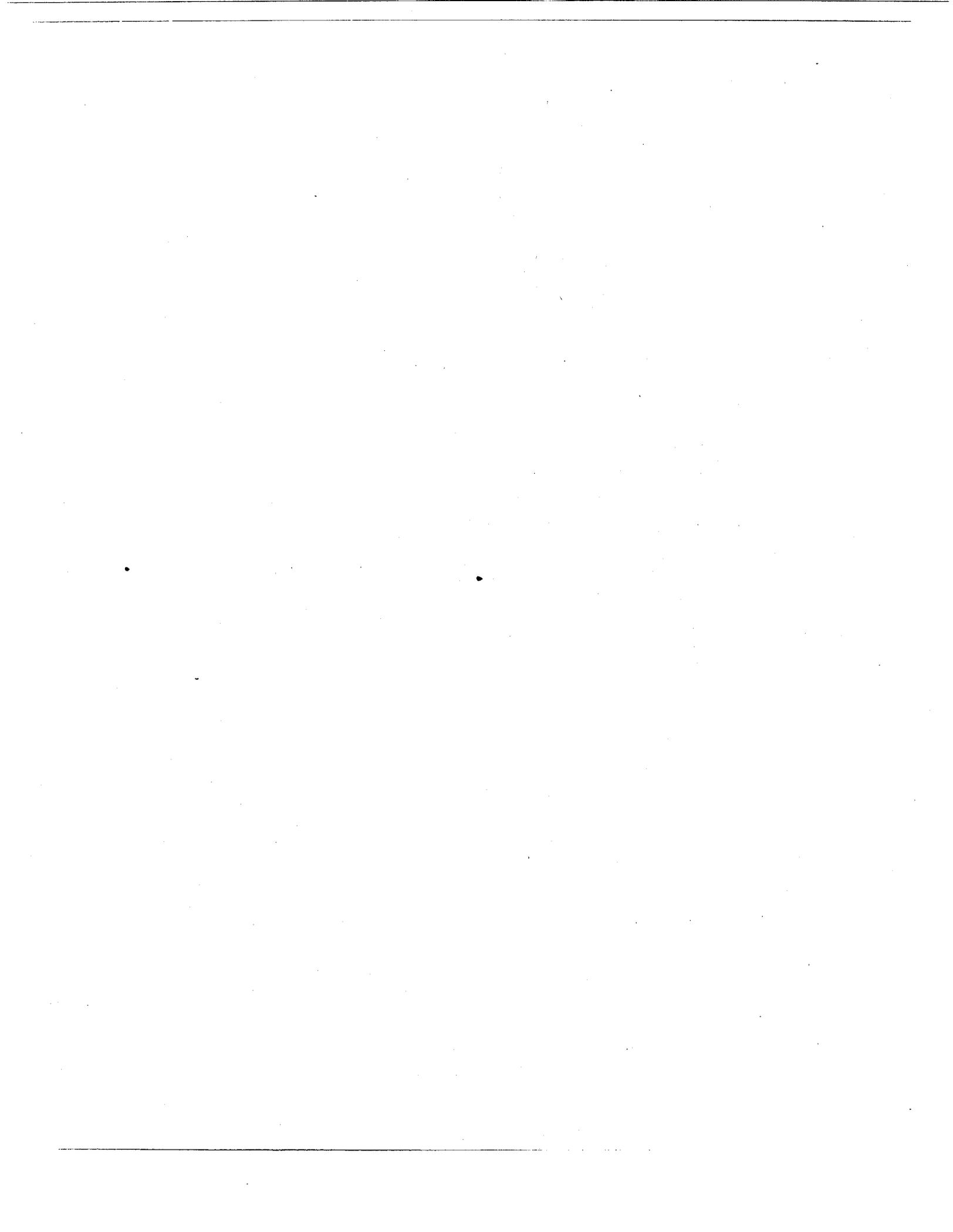
Pamela Williams

## **Production Staff**

Kathleen Runkle

Joyce Salazar

Gail Fetsko



---

# Chapter I

## Overview of the Study

---

This report is about the lives of children who have been classified emotionally disturbed and the residential programs operated or licensed by the Office of Mental Health (OMH) which provided and, in some cases, are still providing for their treatment, care, and supervision. Statewide, as of April 1992, approximately 1,800 children are receiving treatment at any one point in time in psychiatric units in 16 general hospitals and 57 other residential programs operated or licensed by the Office of Mental Health.<sup>1</sup>

The Commission undertook the study of these children and their treatment to understand better the strengths and limitations of the Office of Mental Health's residential system for children who are classified emotionally disturbed. Empirical data were gathered on the children, their daily lives, the treatment and special education services they received, their actual behaviors, and how they fared after leaving the mental health residential program. The study also examined the comparative costs of the residential programs which served the children and the factors which influenced the cost variances across programs.

### Sample of the Study

The Commission visited 18 different OMH residential programs for children, including six state-operated children's psychiatric centers and units, six state-licensed residential treatment facilities (RTFs), four family-based treatment programs, and two community residence programs for children (Figure 1). The sample facilities—which represent approximately one-third of all

OMH-operated or -licensed residential programs for children—were selected to provide a representative geographic sample of existing programs, as well as a sample which assured diversity in the sizes of the programs and the ages of the children served.

A total of 100 children from the 18 programs was selected for careful study. At each of the four family-based treatment programs visited, the Commission selected four children for review; six children were selected from each of the other 14 programs visited. At all programs the Commission attempted to select children who had been at the program for at least three months and to select a set of children who were representative of the age and sex profile of the population served by the program.<sup>2</sup> In achieving this representative sample, all children were randomly drawn.

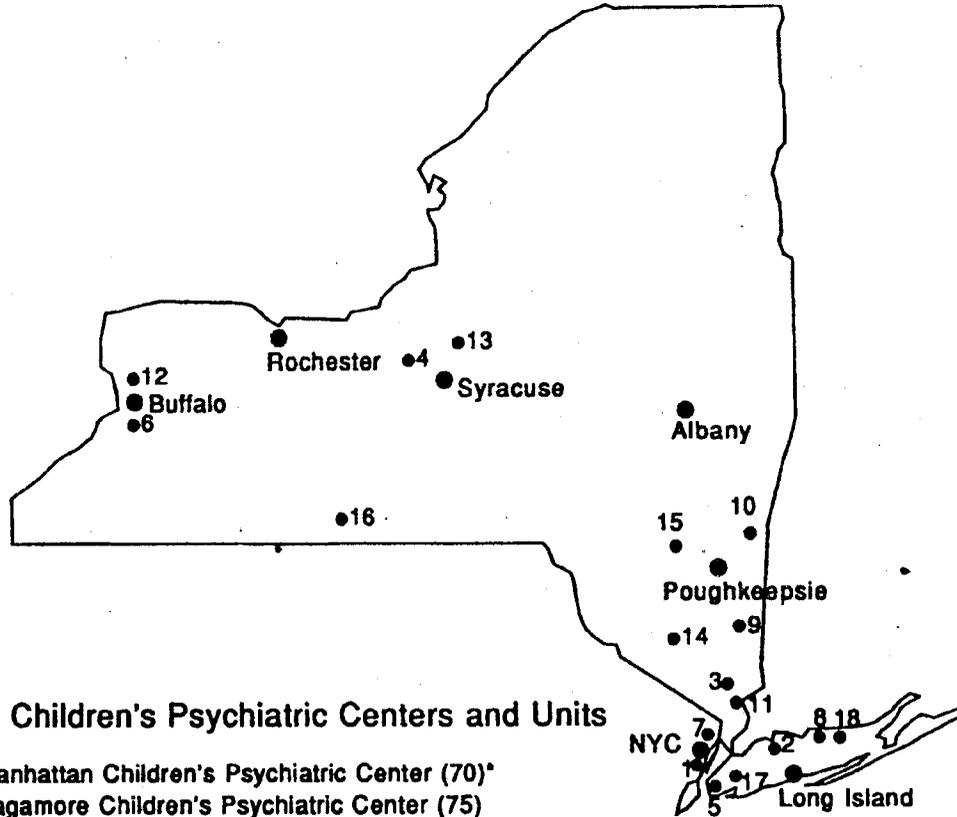
In addition to these 100 children, the Commission also followed up on the lives of 34 children who had been discharged from mental health residential facilities approximately two years previously. The follow-up component focused on children discharged from three of the six state-operated children's centers and units (Rockland, Manhattan, and Western New York) and three of the six state-licensed RTFs (Linden Hill, Madonna Heights, and Astor Home) in the Commission's original sample of 18 facilities. None of the newer family-based treatment programs and community residence programs were included in the follow-up sample, as these programs had not been operational long enough to provide a sample of children discharged two years ago.

---

<sup>1</sup> In the report, the cited number of beds in these programs changes based on the time period cited.

<sup>2</sup> At two of the state-operated children's psychiatric centers and one of the community-based programs, the criteria of a three-month length of stay could not be met for all sample children, as there were not sufficient children at the program who met this criteria. In total, 11 of the 100 children in the sample had lengths of stays of less than three months.

**Figure 1: Sample Residential Facilities  
(N=18)**



**State Children's Psychiatric Centers and Units**

- 1. Manhattan Children's Psychiatric Center (70)\*
- 2. Sagamore Children's Psychiatric Center (75)
- 3. Rockland Children's Psychiatric Center (67)
- 4. Hutchings Children and Youth Unit (10)
- 5. Kingsboro Children and Youth Unit (17)
- 6. Western NY Children's Psychiatric Center (45)

**Residential Treatment Facilities**

- 7. Ittleson RTF (30)
- 8. Madonna Heights RTF (14)
- 9. Green Chimneys RTF (14)
- 10. Astor Home RTF (20)
- 11. Linden Hill RTF (54)
- 12. Baker Hall RTF (45)

**Community-Based Programs**

- 13. Mather Street Community Residence ( 8)
- 14. Hamptonburg Community Residence ( 8)
- 15. Harbour Family-Based Treatment (10)
- 16. Reach Family-Based Treatment ( 9)
- 17. St. Christopher Otille Family-Based Treatment (10)
- 18. Circle Family-Based Treatment ( 8)

\*Average Daily Census

Administrators of each of the six facilities prepared a listing of the children they discharged during the period January-March 1990. If a facility had not discharged ten children during this period, its administrator was asked to list the children discharged in 1989, starting with those discharged in December, until they had a listing of ten children. From each facility listing, the Commission selected a representative sample of five to six boys and girls of different ages who were discharged to various settings (e.g., home, foster home, other residential program, hospital, etc.) for follow-up.

---

*From November 1991 through February 1992, the Commission began what sometimes became a difficult task of tracing the lives of the 34 sample children who had been discharged from six of the programs approximately two years previously.*

---

## Data Collection

A team of two or three Commission reviewers completed most data collection for the study during a two-day visit to each of the 18 programs in the summer of 1991. A second set of field visits was made to the six programs included in the study's follow-up component in November-December 1991. Cost and staffing data were obtained directly from OMH documents.

Specific data collection steps included:

- OMH-provided cost reports, including staffing information, were reviewed and analyzed for all state-operated children's centers and units and all state-licensed RTF programs in the state.
- OMH-provided budgeted cost data, including staffing information, for the newer family-based treatment and community residence programs (for which actual cost

reports were not available) were reviewed and analyzed.

- Senior management and clinical staff at the 18 programs were interviewed to obtain information about the program's philosophy and services and its policies and procedures.
- Quantitative information was obtained at the 18 programs related to the population served, length of stay, and staffing.
- Announced inspections of conditions and activities were conducted on the living units of the six state children's centers and units, the six RTFs, and the two community residences in the sample during late afternoon and early evening hours when the children were present.<sup>3</sup>
- On-site campus school administrators and teachers of the 72 children in the sample residing in state children's centers and units and RTFs were interviewed to obtain general information about the school program and the children's educational status and progress.
- A complete record review and a comprehensive interview with the child's primary therapist were conducted for each of the children in the sample.

From November 1991 through February 1992, the Commission began what sometimes became a difficult task of tracing the lives of the 34 sample children who had been discharged from six of the programs approximately two years previously. Commission staff contacted all residential and outpatient program providers to whom the child had been referred upon discharge, as well as other providers to whom the child had been referred subsequent to his/her discharge. If a child had been rehospitalized, hospital staff were also contacted to obtain information about the hospital stay and the child's discharge arrangements.

---

<sup>3</sup> Although Commission staff did visit several of the foster homes at each of the four family-based treatment programs, formal environmental reviews of these family homes were not conducted.

Finally, in some cases, Commission staff also attempted to contact the child's parent or current guardian to determine how the child was doing.<sup>4</sup>

## Services for Children With Emotional Problems in New York State

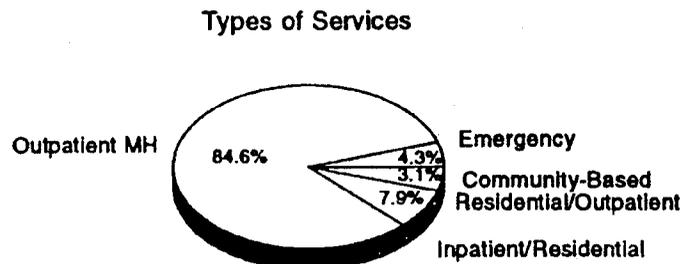
In beginning this report, it is important to clarify that most children with emotional problems in New York State live at home with their families and receive mental health services in their communities from local "prevention and early intervention" programs, mental health clinics, private therapists and social workers, special school-based counselling services, intensive case managers, and/or day treatment programs (Figure 2).<sup>5</sup>

In the past three years, OMH officials have also redoubled efforts to enhance and redesign outpatient services in an effort to reduce the

state's reliance on residential treatment settings for children with serious emotional problems. A new intensive case management program, which currently serves between 760 and 950 children statewide, allows a qualified professional staff person to work with a small caseload of children and families (usually 8 to 10 families) to provide 24-hour crisis support, training, direct assistance, and help in finding appropriate referrals for mental health, medical, educational, and respite services.

The Office of Mental Health has also expanded the number of day treatment programs for children to 86 programs statewide and ensured close liaisons between these programs and local school districts. Finally, the Office has provided funding to eight counties/boroughs to start home-based treatment programs which aim to provide direct assistance, support, and care to the child and family at home, in an effort to divert a hospital admission or residential placement.

**Figure 2: Location of Service Provision for Children With Emotional Problems in NYS (N = 19,708 Children)\***



\* Taken from a 1989 OMH Patient Characteristics Survey which assesses persons served by publicly funded mental health services during a one-week period. Of note, the percentage of children served in community-based services is somewhat underestimated here as few OMH community residences or family-based treatment programs were operational in 1989.

- <sup>4</sup> Parents were initially contacted by letter and asked if they would be willing to speak with Commission staff. Prior to this contact, Commission staff asked the child's most recent primary therapist if he/she had any reservations regarding parent contact. In cases where the therapist had reservations, contact was not made.
- <sup>5</sup> OMH officials reported that they have no reliable estimates of the total number of children served by outpatient mental health programs, although they reported that 43,000 children received Medicaid-reimbursed mental health outpatient services in federal fiscal year 1991.

## Residential Services for Children With Emotional Problems

Only a small percentage of New York's 500,000 children estimated to have emotional problems are placed in residential programs or foster homes, and most of these placements are not made under the auspice of the Office of Mental Health. Exclusive of children treated in psychiatric units of general hospitals, approximately 3,500 of these children are served annually in residential programs operated or licensed by the Office of Mental Health.<sup>6</sup> The majority of children with emotional problems who are placed out of their homes are treated in traditional or therapeutic foster care homes, congregate foster care residential programs, or residential treatment centers (RTCs) certified by the state's Department of Social Services. Other children classified as emotionally disturbed are placed in residential facilities sponsored by the state's Division for Youth or in one of the 86 special residential schools for children approved by the State Education Department.

Reflective of the multiple agencies sponsoring these residential programs and placements, as well as the concomitant physical and cognitive disabilities of many of these children, no one in government has an accurate count of the total number of children with emotional problems in out-of-home placements. Estimates from the involved state agencies (Department of Social Services, State Education Department, Division for Youth) suggest that, at any one point in time, approximately 9,000 children with emotional problems reside in out-of-home placements or residential programs *not* operated or funded by the Office of Mental Health.

## OMH Long-Term Residential Services for Children

This report focuses on the residential facilities operated and funded by the Office of Mental

Health providing care and treatment for children with serious emotional problems (Figure 3). These programs include 6 state-operated children's psychiatric centers, 9 state-operated children and adolescent psychiatric units affiliated with state adult psychiatric centers, and 16 residential treatment facilities.

---

*Reflective of the multiple agencies sponsoring these residential programs and placements, no one in government has an accurate count of the total number of children with emotional problems in out-of-home placements.*

---

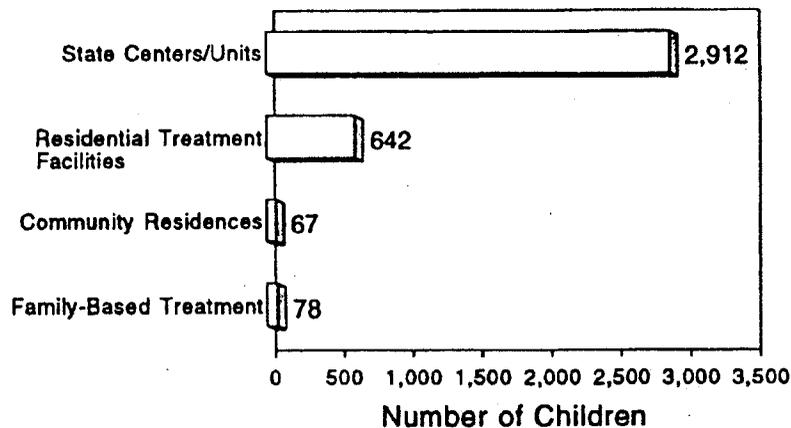
In addition to these modalities, the Office of Mental Health sponsors two smaller community-based residential programs for children with emotional problems: small (4-8 beds) community residence programs and family-based treatment programs. These programs are new and, at any one point in time, they serve approximately 250 children.<sup>7</sup>

The small community residences are similar in structure and services to community residence programs for adults with mental illness. The family-based treatment programs are modeled after traditional foster care programs, but allow for additional clinical, training and case management support through the provision of a "family-based specialist" who is assigned to a small caseload of just five "professional" foster families. The program also provides a modestly enhanced stipend for the "professional" foster families. Both of these new models respond to a concern that New York's other residential models are too institutional and deprive children of many of the normal experiences of childhood within a family or family-like setting in the community.

<sup>6</sup> Data were provided by the Office of Mental Health.

<sup>7</sup> The Office of Mental Health reports that there are seven traditional foster care beds certified for children.

**Figure 3: Number of Children Served in OMH Residential Programs\* (CY 1991)**



\* Based on data provided by OMH. The number of children served in the state children's centers and units may be overestimated as OMH officials reported that readmissions of the same child during the calendar year may be counted more than once.

Notwithstanding its newer community-based residential models, the vast majority of children served in OMH residential programs continue to be served in more traditional congregate psychiatric centers or units and residential treatment facilities. As shown in Figure 3, less than 4% of the children served in OMH residential programs in 1991 were served in community-based options of small group homes or family-based treatment programs. Of note, however, in the FY 1992-93 and 1993-94 Executive Budgets, the Office of Mental Health projects substantial expansion of its community-based residential programs. By June 30, 1992, there will be 180 family-based treatment beds and 150 community residence beds. By June 30, 1993 there will be 220 family-based treatment beds and 182 community residence beds.

In addition, while not yet funded for operation, funding has been authorized to begin devel-

opment of a new residential model—the teaching family community residence, a four-bed community residence staffed by a married couple and one or two child care staff.

Within New York State, approximately 4,500 children with emotional problems also receive inpatient psychiatric care each year in acute psychiatric units of approximately 16 general (Article 28) hospitals and 5 private psychiatric (Article 31) hospitals. In total, these units have approximately 500 beds reserved for inpatient psychiatric care for children.<sup>1</sup>

Of note, however, these acute psychiatric beds in general and private psychiatric hospitals are not available in most communities of New York State. Almost all of these beds (75%) are located in the five boroughs of New York City (194 beds) and Westchester County (177 beds).

<sup>1</sup> The Office of Mental Health does not issue special certifications for acute psychiatric units of either general hospitals or private psychiatric hospitals which serve children, and precise data on bed capacity in these sectors for children are not available. The OMH data presented reflect children discharged with a psychiatric diagnosis, and include some children admitted to medical units, as well as a duplicated count of children with more than one admission.

Additionally, acute psychiatric beds in private psychiatric hospitals are not usually easily accessible to children and adolescents whose families do not have health insurance coverage or other means to pay privately the relatively high daily fees of these facilities.

Although this report focuses on the Office of Mental Health's longer-term residential models for children, the importance of these acute treatment settings in influencing the patterns of service provision in the longer-term models of care should not be overlooked. Most importantly, many have alleged that the limited accessibility for children to acute psychiatric beds in general and private hospitals has contributed to the over-reliance on state children's psychiatric centers and units.

## Shifting Roles of OMH Residential Programs

In the past few years, OMH officials have also struggled to define the mission and respective roles of each of its residential modalities for children. In particular, OMH has tried to differentiate the roles of its state-operated centers and units and its state-licensed RTFs by defining the former facilities as providers of intermediate care of 30 to 180 days and the latter programs as longer-term care facilities. OMH has also tried to discourage direct admissions to its state-operated children's psychiatric centers and units, and instead to rely increasingly on psychiatric units of general (Article 28) hospitals to accommodate all direct acute psychiatric admissions of children and adolescents.

In accordance with this scheme, it was anticipated that state centers and units would admit children who needed ongoing intensive psychiatric treatment beyond the usual three- to six-week stay in an acute psychiatric unit of a general hospital and that these children would receive care for one to six months at state centers or units. In instances where, after a six-month stay, children admitted to state centers and units could not be discharged home, to a foster home, or to a less

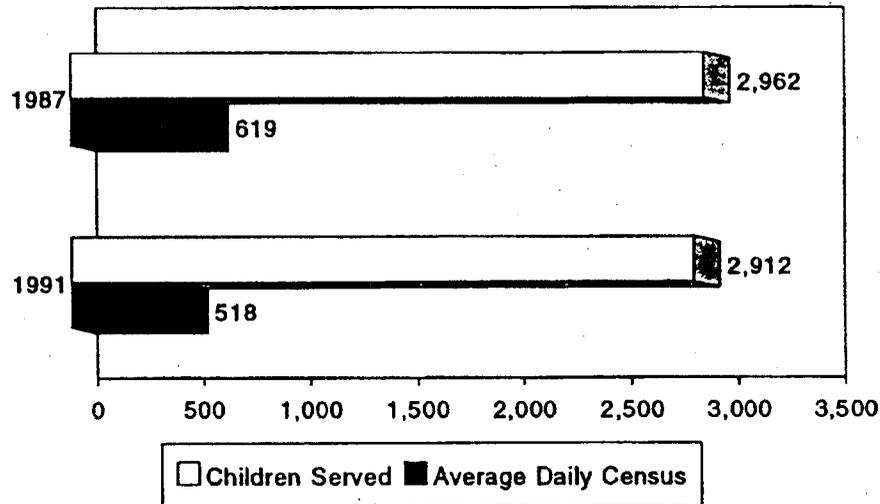
restrictive level of care, transfers to an RTF for longer-term care were to be arranged.

It was also anticipated that these changes in roles, as well as the development of the newer OMH community-based models of residential care, would reduce that state's reliance on state children's psychiatric centers and units. This anticipated outcome has become a reality, as the daily census in these state-operated facilities has decreased 16% from 619 in Fiscal Year 1987-88 to 518 in Fiscal Year 1990-91 (Figure 4).

Also, as intended, many of the state children's centers and units have become more short-term treatment facilities. Presently, more than three-fourths of the children at half of the state children's centers and units have lengths of stays of less than six months. Statewide, however, approximately one-third (32%) of the children in residence at these programs at any one point in time have lengths of stays over six months. At four state centers and units (Kingsboro, Manhattan, Queens, and Rochester), between one-half (47%) and three-fourths (73%) of the children in care have lengths of stays greater than six months. The shorter lengths of stays have ensured that, despite the above census reductions, the number of individual children served annually in these institutional programs has hardly changed. In 1987, a total of 2,962 children were served in state-operated children's centers and units; in 1991, 2,912 children were served.

Many have applauded this redefinition and clarity of the roles of OMH's residential modalities for children, but some experts in the field of children's mental health have argued that the proposed continuum encourages the movement of children from one treatment setting to another as a benchmark of their "progress," and impairs the system's ability to provide children with permanency and lasting relationships with clinicians, staff, and other children. Still others have decried the loss of residential psychiatric service capacity within the state system, without sufficient development of accessible and available community alternatives.

**Figure 4: Average Daily Census and Annual Number of Children Served in State Centers/Units**



\* Data provided by OMH. Census numbers are based on fiscal years and numbers of children served are based on calendar years.

Meeting the stated objectives for newly defined roles has also not been smooth sailing statewide. In many communities, the limited capacity of local general hospitals to provide acute inpatient psychiatric care for children and youth has left a heavy acute care role with state children's centers and units. In our sample, 44% of the children from these programs had been admitted directly from their homes, and another 13% from foster care homes.

Additionally, state children's centers and units have also not found it easy to discharge children when they no longer need inpatient care. RTFs also do not have the capacity to accept children who no longer need care in state centers in a timely manner, as RTFs, too, have great difficulty finding less restrictive placements for children who, subsequent to treatment, cannot return home.

There has been at least one silver lining to these dilemmas. Without access to RTF beds, some state children's centers and units have reached out directly to the newer community-based residential options as placement settings for children who, just a few years ago, would have continued treatment on a congregate care mental health residential campus. OMH also reports that it has been successful in incorporating families in the planning, service delivery, and quality review of its newer community residential programs for children. The Commission staff had an opportunity to meet some of these children in the course of this study and they, like most of their peers who were offered these opportunities, are doing remarkably well in their new community settings. The experiences of these children are causing many to again rethink the appropriate role of congregate residential treatment programs.

---

## Chapter II

# The Costs of Care

---

An initial focus of the study was to examine the costs of the Office of Mental Health's residential treatment programs for children. In its examination, the Commission reviewed the costs of children's psychiatric units in general (Article 28) hospitals and private psychiatric (Article 31) hospitals, state children's psychiatric centers and units, residential treatment facilities (RTFs), and the two newer OMH community-based models, community residences for children and family-based treatment programs.

Summary cost data for three recent fiscal years were obtained from the Office of Mental Health to conduct the review.<sup>9</sup> These data included the total cost of providing residential services in the various programs. For state children's centers and units and RTFs, which provide a fully integrated residential and clinical program, these costs reflected the full range of these provided services. For the newer community-based programs, which typically refer children to outside providers for clinical mental health and medical services, the Commission attempted to obtain an estimate of the additional costs of medical and clinical care from Medicaid files. Of note, the costs associated with providing educational services for the children are *excluded* from this profile.

General (Article 28) hospitals and private psychiatric (Article 31) hospitals are not required to maintain discrete cost information for inpatient psychiatric services provided to children and youth. The Commission contacted the general and pri-

vate psychiatric hospitals with a children's psychiatric unit(s) to request discrete cost data for their inpatient children's psychiatric units. Ten (10) of the 16 general hospitals responded to the Commission's request, while the other six reported that their cost reporting systems would not allow such discrete reporting of cost data. Cost data in this report for children's psychiatric beds in general hospitals were estimated from the data provided by these ten hospitals. Of note, these ten hospitals accounted for 65% of the acute children's psychiatric beds in general hospitals in New York State.

The Commission was less successful in obtaining cost data for children's psychiatric beds in private psychiatric hospitals, and ultimately determined not to include these costs in the report, both because they were so incomplete, and because available data suggested that the five private hospitals were generally accessible only to children whose families could privately pay or who had liberal insurance plans. Two of these five hospitals reported no Medicaid revenue in their 1990 cost reports and, for the other three, Medicaid reimbursement accounted for only 13% of their total revenues.

Finally, due to their recent development, actual cost information for community residences for children and the family-based treatment programs was either incomplete or non-existent. Consequently, the Commission had to rely on OMH "budgeted" cost data rather than actual expenditure reports for these programs.

---

<sup>9</sup> Fiscal years for the state-operated children's psychiatric centers and units, the community residences, and the family-based programs started on April 1, 1988 and ended on March 31, 1991. Fiscal years for RTFs started on July 1, 1987 and ended on June 30, 1990. Cost data for the children's psychiatric units of general hospitals were available only for calendar year 1990.

## Overview

For FY 1989-90, the Office of Mental Health reports 1,444 beds for children with emotional problems, excluding the approximately 150 beds in private psychiatric hospitals discussed above. The total annual cost of these beds was about \$210 million or about \$145,000 per bed (Figure 5).

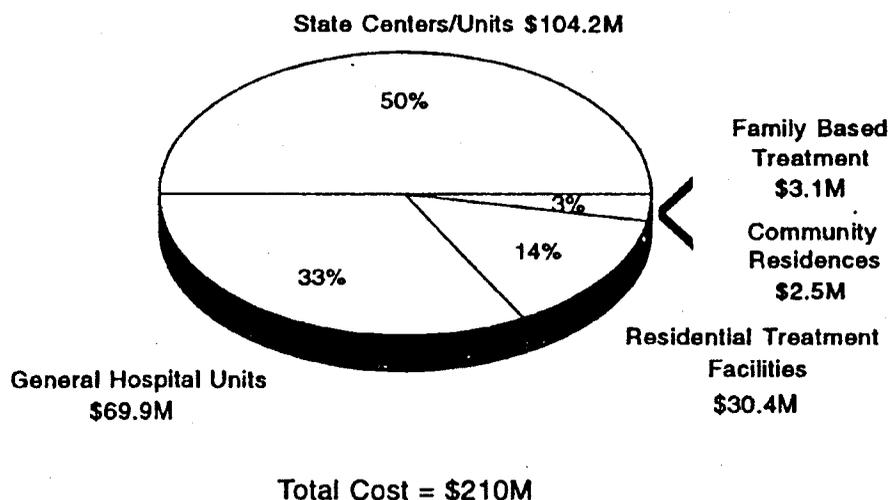
Approximately two-thirds of the 1,444 beds (63%) are in hospital-based or institutional settings. Reflective of the higher average costs of these beds versus beds in the newer community-based programs, they account for approximately 83% of the total annual cost of children's residential beds in FY 1989-90.

Almost one-half of the total expenditures (\$104 million of the \$210 million) was for the 584 beds at state children's psychiatric centers and units. The approximately 332 children's psychiatric beds in general (Article 28) hospitals account for another one-third of the total expenditures or \$70 million. Residential treatment facili-

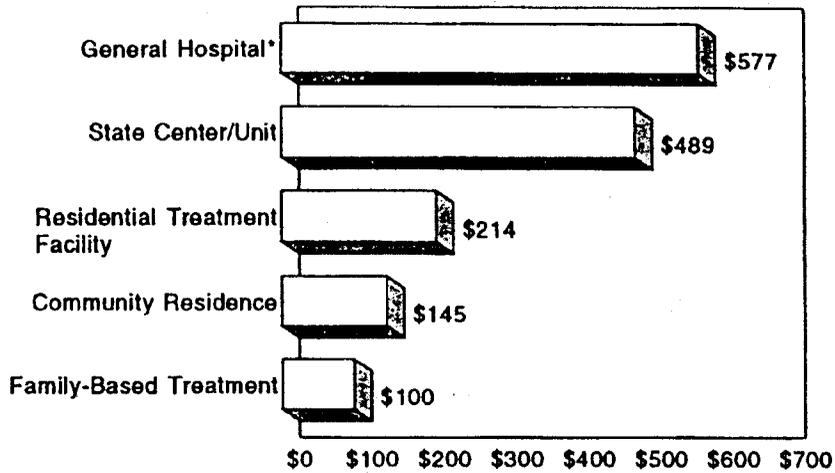
ties (RTFs), which provide a level of care between psychiatric hospitalization and less intensive treatment in community residences, and which serve about 396 children and youth at any one point in time, account for approximately 14% of the total expenditures or \$30 million. In sharp contrast, the costs of the newer community-based programs represented only 3% of the total expenditures or \$5.6 million.

When viewing program costs on a per day basis, the review found that hospital-based beds and beds in state children's centers and units were more than twice as expensive as the next most costly treatment modality. In FY 1989-90, hospital-based children's psychiatric beds were the most expensive, costing on average about \$577 per day. State children's centers and units were slightly less expensive, averaging \$489 per day, followed by RTFs at \$214 per day, and community residences and family-based treatment programs at \$145 and \$100 per day, respectively (Figure 6).

**Figure 5: Total Costs of Children's OMH Inpatient Residential Services (FY 1989 - 1990)**

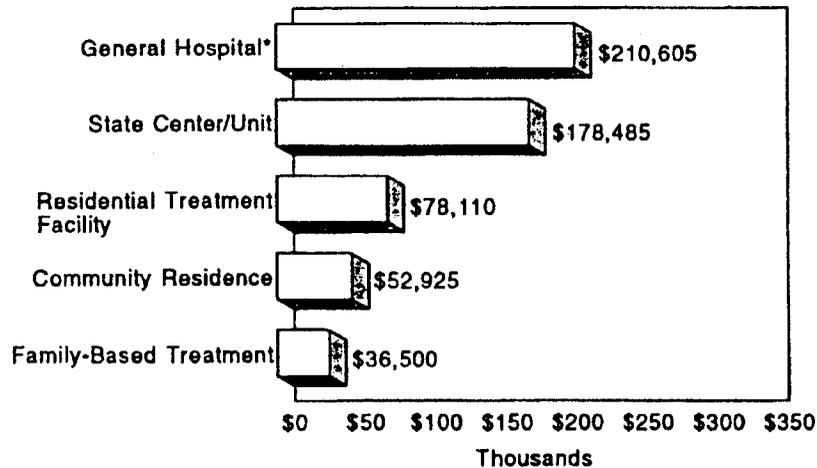


**Figure 6: Total Daily Cost Per Child  
by Program Type  
(FY 1989 - 90)**



\* Estimated based on 10 hospitals' costs which accounted for 65% of all days of inpatient psychiatric services provided to children in Article 28 hospitals.

**Figure 7: Annual Costs Per Occupied Bed  
by Program Type  
(FY 1989 - 90)**



\* Estimated based on 10 hospitals' costs which accounted for 65% of all days of inpatient psychiatric services provided to children in Article 28 hospitals.

On an annual basis, the costs for the different treatment modalities ranged from a low of \$36,500 per bed for family-based treatment programs to a high of \$210,605 per bed for children's psychiatric beds in general (Article 28) hospitals (Figure 7).

### Children's Psychiatric Centers

In FY 1989-1990, state children's psychiatric centers and units had total expenditures of approximately \$104 million or about \$178,000 per occupied bed per year. These program costs are funded primarily (90%) by Medicaid funds (a 50% federal share and a 50% state share).

Over the past three years, total costs at these centers have increased by about 42% (Figure 8). The largest increase occurred between FY 1987-1988 and FY 1988-1989 when costs increased by

about 20%. Additionally, while total costs at these programs have continued to increase, patient days have steadily declined, causing the cost per patient day to increase even more substantially. In FY 1987-1988, the average cost to take care of a child at a state children's center or unit was about \$336 per day. By FY 1990-1991, that cost had increased by 56% to about \$524 per day (Figure 9).

Clinical support functions, including relatively highly paid clinical staff such as psychiatrists, psychologists, nurses, physical therapists, etc., account for 55% of the total costs at state children's centers and units. Virtually equal amounts were spent in three areas—administrative costs (12%), fringe benefits (12%), and residential support (i.e., housekeeping, dietary, laundry/linen services) (11%). Finally, about 10% of the total costs was spent on maintenance, utilities, and capital cost items.

**Figure 8: Total Costs vs Bed Days Provided by State Centers/Units (FY 1987-88 - FY 1990-91)**

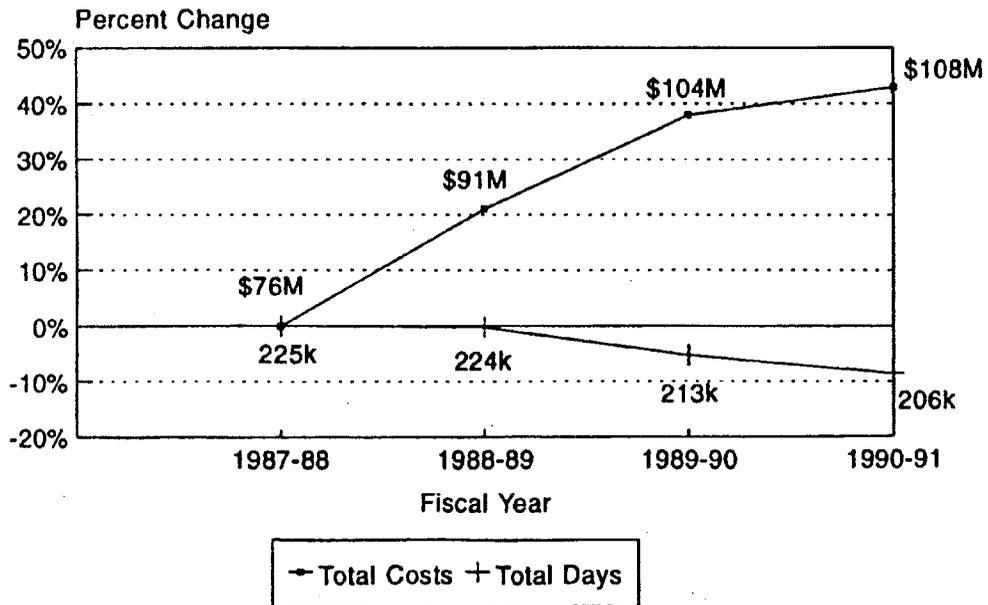
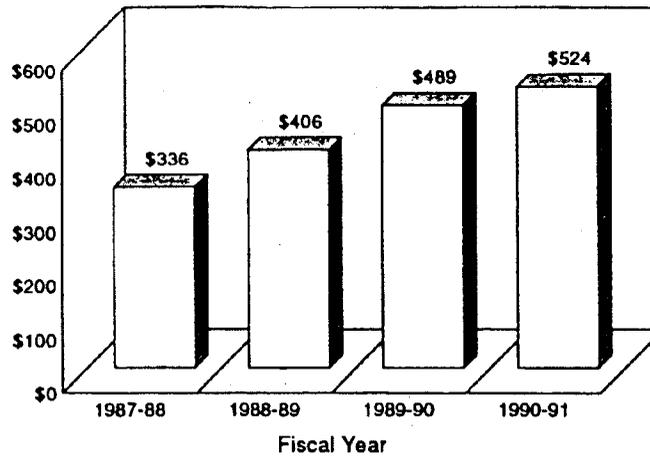


Figure 9: Total Average Daily Costs Per Child at State Centers/Units



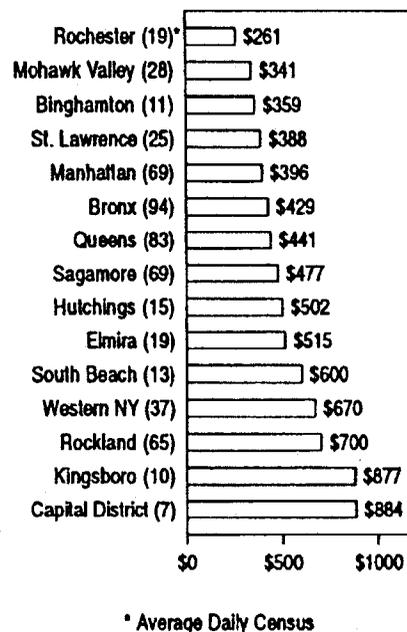
The data also showed that costs among the 15 state children's centers and units varied by 239% (Figure 10). Per child costs ranged from a low of about \$261 per day at the Children and Youth Unit at Rochester Psychiatric Center to a high of \$884 per day at the Children and Youth Unit at Capital District Psychiatric Center.<sup>10</sup> On an annual basis, costs per occupied bed ranged from \$95,265 to over \$322,000 per year.

### Residential Treatment Facilities

As of June 30, 1990, there were 15 residential treatment facilities (RTFs) with a total capacity of 412 beds. In FY 1989-1990, RTF costs totaled about \$30.4 million, and the average per child cost in an RTF was about \$214 a day or about \$78,110 a year.<sup>11</sup>

Like state children's centers and units, RTFs receive the vast majority of their revenue from Medicaid. In FY 1989-90, about 97% of RTFs' revenue came from Medicaid, with the remaining 3% coming from government grants, program development grants or contributions.

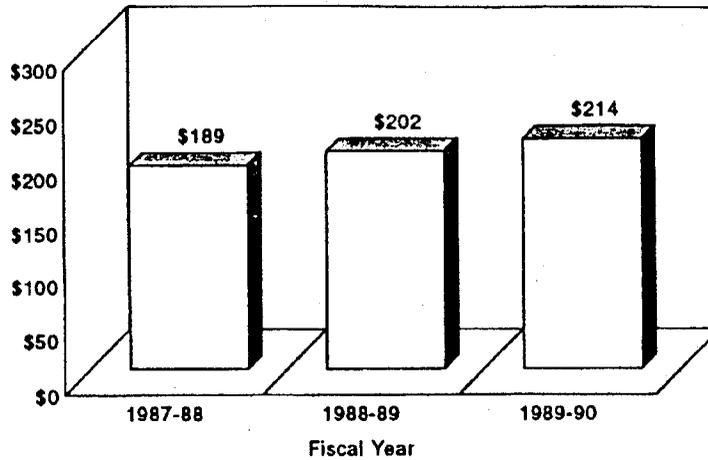
Figure 10: Total Daily Costs Per Child at State Centers/Units (FY 1989 - 90)



<sup>10</sup> In 1990-91, there was a variance of a low of \$353 at Rochester Psychiatric Center and a high of \$1,132 per day at Capital District Psychiatric Center.

<sup>11</sup> RTF cost reports are based on a July 1 to June 30 fiscal year. Cost reports for the three-year period, July 1, 1987 to June 30, 1990, were reviewed.

**Figure 11: Total Daily Costs Per Child at Residential Treatment Facilities (FY 1987-88 - FY 1990-91)**



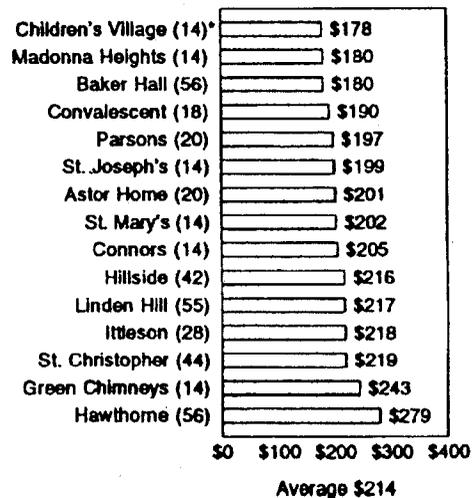
Over the period FY 1987-88 through FY 1989-90, total RTF costs increased from \$25.2 million to \$30.4 million or about 21%. Unlike state children's centers and units where patient days were decreasing as total costs were increasing, however, the number of patient days at RTFs statewide actually increased about 7% over the same three-year period. Because of this increase, the average cost per day for RTFs increased less dramatically than the total cost (13% versus 21%) (Figure 11).

Individual RTF costs, like those of state children's centers and units, also varied significantly, although somewhat less so (57% versus 239%) (Figure 12). RTFs' costs ranged from a low of \$178 per child per day at Children's Village RTF to a high of \$279 at Hawthorne Cedar Knolls RTF.

### Community Residences and Family-Based Treatment Programs

As stated earlier, OMH's community-based residential program modalities are new additions to the Office's continuum of residential

**Figure 12: Total Daily Costs Per Child by RTF Program (FY 1989 - 90)**



\* Number of Certified Beds

care. As of December 1990, these programs had a total daily capacity of only 132 children. Due to their recent development, actual cost information for these programs was either incomplete or non-existent. Consequently, the Commission relied on OMH "budgeted" rather than actual cost figures for these programs.

Additionally, unlike the other programs studied, both the community residence program and the family-based treatment program rely on outpatient mental health and medical providers to ensure clinical services for children enrolled. As these costs are not included in OMH "budgeted" costs for these modalities, the Commission estimated average ancillary service costs for these programs at \$20 a day per child, by reviewing Medicaid claims for the 28 children in the Commission's sample enrolled in these programs. These ancillary cost per diems were added to the budgeted costs of these programs.

This analysis found community residences and family-based treatment programs markedly less costly than state centers or units or RTFs. In FY 1989-1990, an average community residence

and ancillary service had an estimated cost of approximately \$165 a day, and an average family-based treatment program placement with an ancillary service cost of approximately \$120 per day. Annual per child costs of these programs of about \$60,225 and \$43,800, respectively, were much lower than the actual annual costs of state children's centers and units (\$178,500) and RTFs (\$78,110).

Unlike RTFs and state children's centers and units, however, the costs of operating community residences for children and family-based treatment programs are not presently offset by federal Medicaid funding. Instead, these programs are funded primarily through state funds, with minimal revenue offsets coming from the federal portion of the children's Supplemental Security Income (SSI) benefits. Although OMH officials report that they are seeking Medicaid reimbursement for certain portions of residential services (e.g., clinical and personal care) for both of these programs in the forthcoming budget year, presently net state costs for these programs, while still substantially lower than state children's centers and units, are comparable to net state costs for RTFs (Figure 13). Net state costs for family-

Figure 13: Net Daily State Costs Per Child by Program Type (FY 1989 - 90)

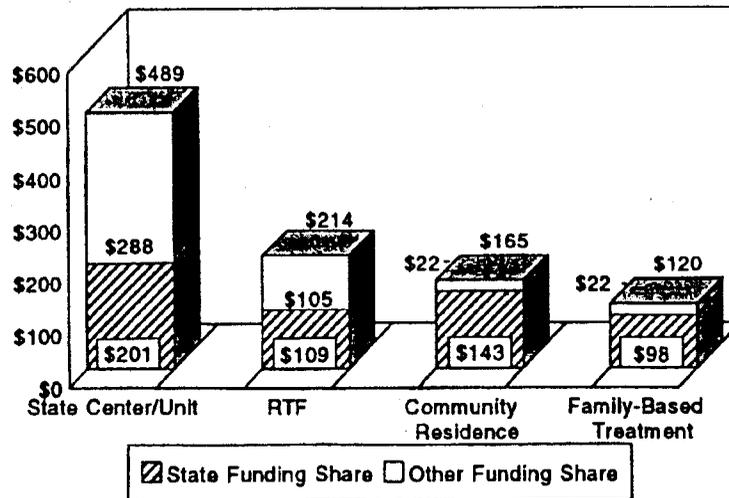
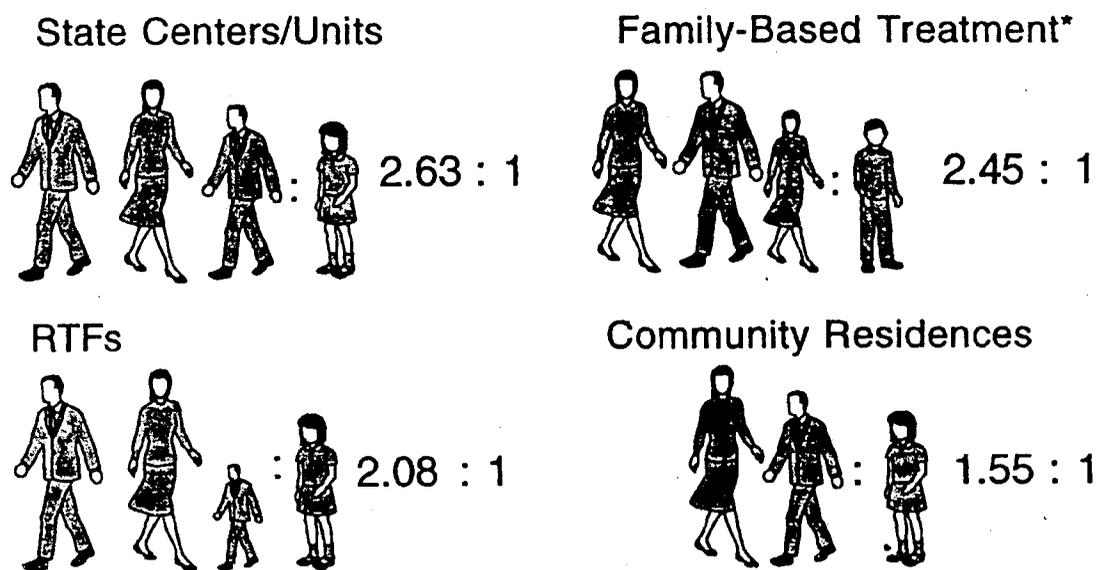


Figure 14: Average Total Staff-to-Child Ratios by Program (FY 1989-90)\*



\*Note: Family-based treatment programs require two foster parents per child placed, but in many instances foster parents also have one or more children of their own.

based programs are \$98 a day and, for community residences, these costs are \$143 a day. These net state costs compare to \$201 a day in state centers and units and \$109 a day in RTFs.

## Staffing Comparisons

Reflective of the wide cost variations among the program modalities, cost reports and budgeted cost models indicated significant differences in the staffing of the programs (Figure 14).<sup>12</sup> Overall, state children's centers and units had the highest average staff-to-child ratio of 2.63 staff for every 1 child in FY 1989-90. By comparison, staff ratios for RTFs averaged 2.08 staff for every 1 child, and staff ratios for community residences averaged 1.55 for every 1 child.

In family-based treatment programs, there was an average of .45 "professional" staff for every 1 child, and these programs also provide two foster parents for each child placed in the home.

The analysis also showed that although staffing costs accounted for a significant percentage of every program's total costs, variations in staffing ratios did not fully account for cost variations among the program modalities. For example, state centers and units were more than 100% more costly than RTFs, but they provided a staffing ratio of only about 26% greater than RTFs. Family-based programs, which offer each child a family-based home with two foster parents and a half of a professional staff person, come in at about 25% of the total per diem costs of state centers and units and at about 56% of the total per diem costs of RTFs.

<sup>12</sup> Discrete staffing data were not available for children's psychiatric units of general (Article 28) hospitals, and, therefore, these programs are not referenced in this analysis.

---

## Chapter III

# Who Are the Children?

---

This chapter describes 100 of the approximately 1,200 children who were residing in OMH residential programs during the summer of 1991. These 100 children included 36 children living in six state-operated children's psychiatric centers or units, 36 children living in six RTF programs, and 28 children living in four family-based treatment programs and two community residence programs for children located across New York State.

Although this profile is based on a relatively small sample of children, it is noteworthy that, where comparable data were available, the Commission's profile closely matched an OMH 1988 profile, based on its Needs Assessment Survey of a larger sample of children in its residential programs.

### Overview

The Commission found that most of the children in care were boys, over the age of 12, who had their first contact with mental health services before the age of 10 and who were not succeeding in school.

Despite their early initial contact with mental health services, less than one-fourth of these children had a major psychiatric diagnosis. Most had found their way to residential treatment largely due to violent, aggressive, and impulsive behaviors, and nearly half of the children (45%) had a recent history of self-injurious behavior or suicidal ideation.

The role of family problems and difficulties in the behavioral histories of these children also could not be overlooked. Approximately 80% of these children had some indication or documented evidence of prior familial abuse or neglect. One or both parents of 86% of the children had a mental

### Steven

*By the age of 2, Steven had already suffered two skull fractures. At 3, he was placed out of his parents' home and, by age 7, he was permanently removed from his parents' custody due to physical and sexual abuse. Over the next five years, Steven was placed in ten foster homes. Finally, at age 12, a family adopted Steven.*

*Adoption did not resolve all of Steven's childhood traumas, however. Three years later, at age 15, Steven was living in a state children's center, where he had been admitted four months previously due to depression, sexually acting out behavior with his younger adoptive brother, and cutting his arms and wrists. This was Steven's third psychiatric admission in the past year.*

*As of June 1991, Steven's total treatment costs at the state children's center were approximately \$80,400, exclusive of education costs. At the state children's center, he receives approximately 50 hours/month of various verbal therapies which focus on his sex abuse history, and he is enrolled in an intensive (ten hours/week) drug/alcohol abuse program. He receives Mellaril, a psychotropic drug, for an attention deficit hyperactivity disorder and borderline pathology, and Ativan as a STAT medication for aggression.*

*Steven attends the center's on-campus special education school program, where he is more than two years below grade level in reading and math. His teacher commented that Steven's academic skills have regressed since his admission. At the state children's center, Steven does not participate in a sex education or vocational training program, although he appears to need both.*

illness/emotional problem, an alcohol or drug abuse problem, or were mentally retarded. One or both parents of 25% of the children had been incarcerated, and 36% of the parents had lost or surrendered custody of their children to the Department of Social Services.

Half of the children had also not lived at "home" for the past two years, and 44% had spent a total of at least three years in out-of-home placements. A striking one-fifth of the children had experienced their first out-of-home placement before the age of 5.

Finally, for many of the children, returning home to live did not appear to be a realistic option. For over half of the children (58%), therapists did not recommend their placement back home when they were ready for discharge and, for an additional 12% of the children, therapists would make such a recommendation only with "many reservations." More than two-thirds of the children had entered their current mental health residential program on a transfer from another out-of-home placement. Many of these children were "on the shuffle" from one placement to the next, with little hope of ever finding a "home."

*It is also important to note that, in general, there were few significant differences in the profiles of the children living in the different types of residential programs. The only thematic difference that did surface was that the children in community-based programs appeared to have suffered greater degrees of family upheaval and dysfunction than the children in other settings.*

## Demographics of the Children

Boys outnumbered girls almost two to one (65% boys and 35% girls), and nearly half of the children (47%) were non-white.<sup>13</sup> Older children were also more prevalent, with children over 12 accounting for 63% of the children in the sample. One-fifth of the children (21%) were 10 or younger, while 24% of the children were 16 or older (Figure 15).

<sup>13</sup> Of note, 1990 New York State census data indicate that, statewide, approximately 51% of the state's children are boys and approximately 32% of the state's children are non-white.

### Anthony

*Anthony was first placed in a foster home at age 10. In the next two years, Anthony was sent to a state children's center, a group home, and then returned to his family. His return home lasted two months; he was then sent to an RTF. DSS assumed custody of him in 1990 because of serious physical and sexual abuse and neglect by his parents. His mother has a developmental disability; his father has mental health and alcohol/drug problems; and, both have been incarcerated.*

*When the Commission visited the RTF in June 1991, Anthony, now 16, had been there for four years. At a total cost of approximately \$263,000, it appears that Anthony has made minimal progress. He has a diagnosis of conduct disorder, and receives 13 hours of various verbal therapies and one hour of sex education each month. There is no specific therapy to address his abuse history. Anthony also has been diagnosed with a developmental reading disorder and is more than two years below grade level; however, the only remedial help he receives for this is homework assistance for about one hour each week.*

*His therapist noted that Anthony only does what he has to do to stay at the RTF and is not especially motivated to move on to a community residence. He does volunteer work at a nursing home and Meals on Wheels, but he still needs 1:1 for job coaching/vocational skills.*

*According to Anthony's therapist, Anthony's only unmet need is case management to coordinate his discharge and referrals; however, he is not yet ready for discharge. His therapist believes when Anthony is 18 (in another two years), he'll be ready for a small, enriched family-like community residence.*

**Figure 15: Children's Characteristics  
(N=100)**



**Boys  
65%**



**Girls  
35%**



**16+  
Years  
24%**



**13-15  
Years  
39%**



**11-12  
Years  
16%**



**≤10  
Years  
21%**



**White  
53%**



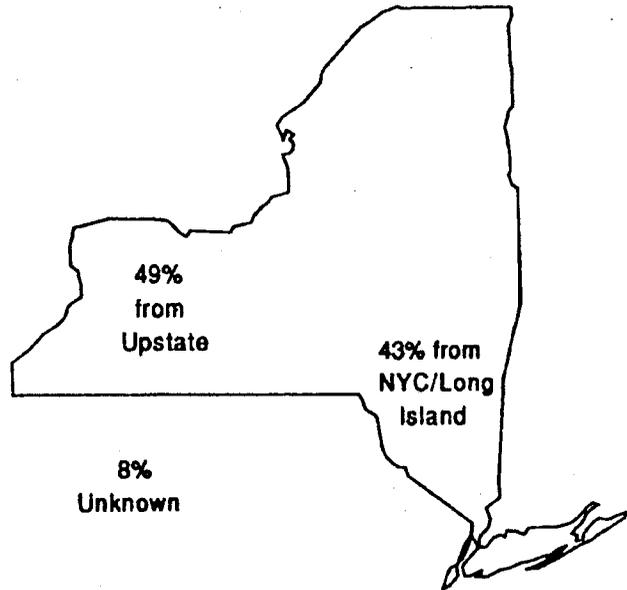
**Black  
23%**



**Hispanic  
18%**



**Other  
6%**



For approximately half of the children (49%), upstate counties were listed as their counties of fiscal responsibility; for 43% of the children, one of the five boroughs of New York City or Nassau or Suffolk Counties in Long Island was listed; and for 8% of the children, their counties of fiscal responsibility were not listed in the records. Although 67% of the children were reportedly being treated in a facility within one hour's travel time of their family home, 45% of the children were *not* receiving residential services from a facility located in their county of fiscal responsibility.

## Diagnostic Profiles of the Children

Disruptive behavior disorders (41%) and mood disorders (23%) were the most common primary psychiatric diagnoses given to the children (Figure 16). Other diagnoses were assigned less frequently, and only two other diagnostic categories were assigned to at least 5% of the children—psychotic disorders (10%) and adjustment disorders (9%).

Half of the children (53%) were also diagnosed as having another concomitant disability or chronic health problem. Over one-fourth of the children (29%) had an ongoing medical condition requiring treatment; 11% were diagnosed as mentally retarded or developmentally disabled; 11% had a specific physical disability; and 10% were diagnosed as having a learning disability. Drug and alcohol abuse disorders were diagnosed in only 6% and 5% of the children, respectively.

Although the diagnostic profiles of the children in different modalities generally did not differ significantly, the data did show that a higher percentage of the children in community-based programs were diagnosed with disruptive behavior disorders (64% versus 32% of all other children in the sample), and a slightly lower percentage of these children were diagnosed with mood disorders (14% versus 26%) or psychotic disorders (0% versus 14%).<sup>14</sup> Concomitant disabilities,

### *Antoinette*

*Antoinette's first encounter with the mental health system happened at age 11 when she was admitted to a state children's center. She had tried to strangle herself, after writing a suicide note; she appeared depressed; and she expressed fears that a stranger would attack her.*

*By all reports, Antoinette had a hard family life. Two reports of physical abuse have been filed against her mother, who keeps 47 stray cats and 2 dogs and who says that her pets are her first priority. Although Antoinette denies any sexual abuse, her mother admitted that her two older daughters had been sexually abused by her nephew.*

*Diagnosed with major depression, Antoinette's treatment focuses on her interpersonal problems with her mother—who reportedly is distracted, disorganized and sees kids as "demanding." Antoinette receives approximately eight hours of individual and family therapy each month. She continues to voice suicidal thoughts and intentions that her therapist attributes to her reluctance to return home.*

*Despite all the upheaval in her childhood, she (at age 12), is reading at the 12th grade level. Antoinette does excellently in the on-campus school program.*

*Her therapist feels that if Antoinette's mother had fewer doubts about handling the stress of having Antoinette return home, and if Antoinette were to receive individual and family therapy, she could and should go home. Antoinette, however, does not agree. She has found a safe haven at the state children's center which she does not want to give up.*

*As of June 1991, Antoinette has lived at the state children's center for three months, at an approximate cost of \$63,000. Plans for her discharge are on hold.*

<sup>14</sup> Caution should be exercised in interpreting these few differences in the diagnostic profiles of the children in community programs, as nearly half of these children (43%) had resided in state centers and units or RTFs immediately prior to their admission to the community programs. It appears that changing diagnoses may simply be a by-product of the children's shift to community psychiatrists.

**Figure 16: Mental Health Profiles  
of the Children  
(N = 100)**

<b>Primary Diagnoses</b>	
Disruptive Behavior Disorders .....	41%
Mood Disorders .....	23%
Psychotic Disorders .....	10%
Adjustment Disorders .....	9%
Developmental Disorders .....	4%
Impulse Disorders .....	4%
Other .....	9%

<b>Age at Initial Receipt of Mental Health Services</b>	
≤ 6 Years .....	36%
7 - 12 Years .....	42%
13+ Years .....	22%

<b>Prior Psychiatric Hospitalization</b>	
None .....	25%
1 .....	34%
2 .....	15%
3+ .....	26%

however, were more common among children in community-based programs (68%). These children were particularly more likely to have a chronic medical condition (39% versus 22% of the other children).

## Mental Health Histories of the Children

Most of the children had initial contact with mental health services early in their childhood. Over three-fourths of the children (78%) had their first contact with a mental health service provider by the age of 12, and over one-third (36%) had their first contact by the age of 6. Only 10% of the children had their first contact with mental health services after the age of 15.

## Shane

*At age 14, Shane, who is developmentally delayed, became one of the first children admitted to the Office of Mental Health's new family-based treatment program.*

*Shane's early childhood was marked by abuse and neglect. He was regularly left at home all day and into the early evenings to care for his four younger half-siblings. Things were not going well for Shane, and he reacted by running away, setting small fires and, reportedly, trying to strangle his youngest sibling, a brother of one year.*

*At 9, Shane's situation was discovered by authorities, and he was placed in a kinship foster care home for approximately two years. For reasons that are unclear, at age 11, Shane was removed from this home and placed in a state children's psychiatric center, where he remained for two years before enrolling in the family-based treatment program.*

*Shane had been living with his foster family and new foster brother for almost two and a half years when the Commission visited his new home. All agree that Shane has done very well since his move. He attends a special education class in a regular public school, participates in programs at a local community center where he also has a part-time job, and he has made a few friends.*

*Although he still carries the diagnosis of conduct disorder, solitary aggressive, he no longer takes any psychotropic medications. Shane still tends to suck his thumb when nervous and he can be overaggressive toward his younger peers, but he works well with his family-based specialist who spends at least three hours a week with Shane and his foster family.*

*Shane's foster family wants to make him a permanent member of their family but, unfortunately, despite his long history of out-of-home placements, Shane has not been freed for adoption.*

*The cost of Shane's care for two and a half years in family-based treatment has been approximately \$90,000, a fraction of the cost of his two-year stay in a state children's center of approximately \$357,000.*

Reflective of the fact that a stay in an acute psychiatric unit of a general hospital is a typical starting-off point for many children transferred to one of OMH's residential programs, three-fourths of the children (75%) had at least one prior psychiatric hospitalization, and nearly one-fourth (26%) had three or more prior hospitalizations. Prior hospitalizations were especially common among children served in RTFs. All but 8% of these children had at least one prior hospitalization, and 34% had three or more prior hospitalizations.

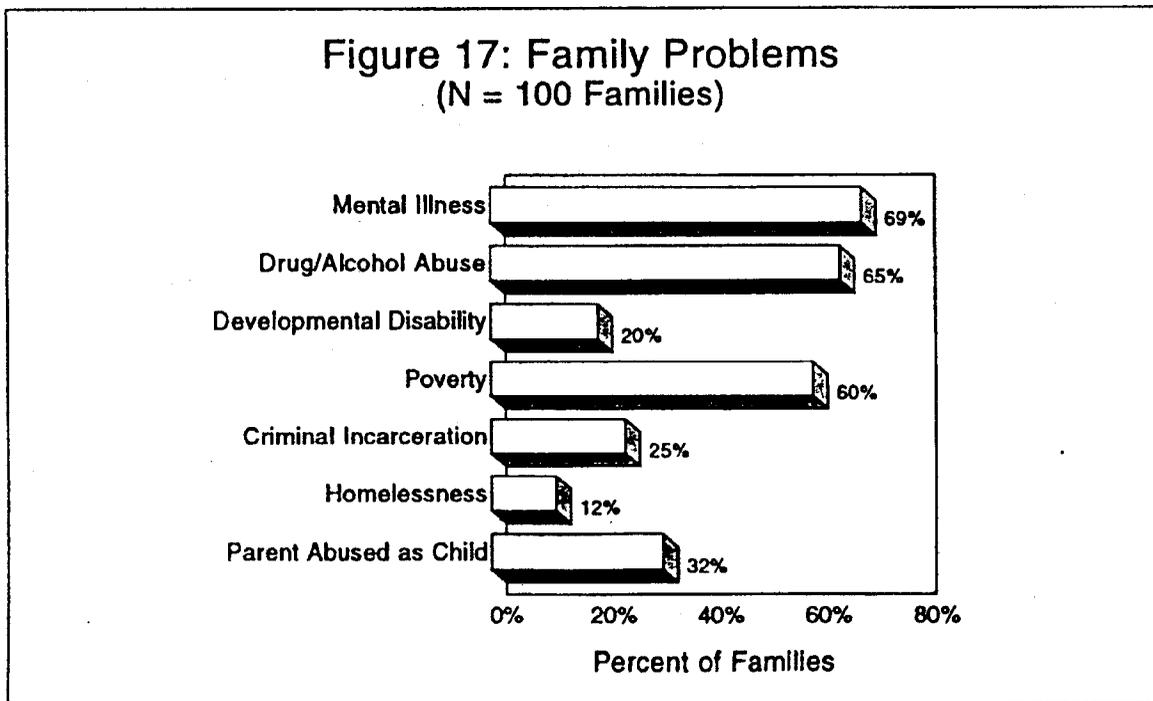
### Family Profiles of the Children

Troubled families, with one or both parents suffering from a significant and chronic disability, were the hallmark of the children in the Commission's study (Figure 17). More than two-thirds of the children's biological parents had emotional problems (69%) and/or a current drug or alcohol abuse problem (65%); and parents of 20% of the children were mentally retarded or developmentally disabled.<sup>15</sup> In total, 86% of the

children's parents currently suffered from one or more of the above mental disabilities and/or a substance abuse problem. Physical disabilities or severe chronic medical problems were present among the parents of 23% of the children.

According to the children's therapists, biological parents of 60% of the children were living in poverty with unstable incomes, and 12% of the families had at one point been homeless. Histories of criminal incarceration were common to parents of 25% of the children. Marital or "significant other" relationships of biological parents of 80% of the children were characterized by the children's therapists as "unstable." Parents of one-third of the children (32%) were identified by primary therapists as having been abused themselves as children.

Documented histories of prior child abuse and neglect were reported by the therapists of nearly half of the children (47%). For an additional 35% of the children, therapists reported some evidence, although not necessarily written documentation, of prior abuse and neglect.



<sup>15</sup> Throughout this discussion, a positive response indicates that the indicator was present for one or both of the child's parents.

On almost all of the above indicators, the data further showed greater problems in the families of children in community-based programs. All but 6 of these 28 children (79%) had a parent with a current drug or alcohol abuse problem; 71% of these children's families were characterized as poor; and 47% of these children had a parent who had been incarcerated. Additionally, familial abuse histories were significantly more common among the children in community programs (89% versus 59%).

### Placement Histories of the Children

Reflective of the problems of their parents, nearly three-fourths of the children (71%) had their first out-of-home placement by the age of 12. One-fifth of the children (19%) had their first out-of-home placement before the age of 5; and another 38% of the children had their first out-of-home placement by the age of 10 (Figure 18).

Half of the children (53%) had not lived with their biological or adoptive parents for the past two years, and 31% of the children had not lived with their parents for the past five years. Almost half of the children (44%) had spent a total of three or more years in out-of-home placements, and 18% of the children had spent a total of six or more years in out-of-home placements.

More than two-thirds of the children in the sample came to their current residential mental health program from an out-of-home placement. Only 32% of the children had been living at home with their own parents prior to their current placement. Of the children who came from an out-of-home placement, 15% had been living in a foster care home. Half of the children (53%) were admitted from acute psychiatric units of general hospitals (18%), state children's psychiatric centers or units (18%), RTFs (6%), or congregate residential programs sponsored by another state agency (11%).

Differences in the prior placement profiles of children in the different program types were also noted. For example, almost half of the children in

state-operated centers and units (44%) were admitted directly from home, compared to only 30% and 17% of the children in RTFs and community-based programs, respectively. And, 32% of the children in community-based programs were placed from a foster care home, compared to only 13% and 2% of the children in state children's centers and units and RTFs, respectively.

### Family Relationships

Despite their troubled families, a majority (57%) of the children were in the legal custody of their biological parents (50%) or adoptive parents (7%). Six (6) percent of the children were in the legal custody of another family member or individual, and 36% were in the custody of the Department of Social Services.<sup>16</sup>

**Figure 18: Out-of-Home Placements of the Children**  
(N = 100)

**Initial Placement Out-of-Home**

- By Age 5 ..... 19%
- Ages 6 to 10 Years ..... 38%
- Ages 11 to 12 Years ..... 14%

**Total Years in Out-of-Home Placements**

- Less than 2 Years ..... 37%
- 2-3 Years ..... 24%
- 4-5 Years ..... 17%
- More than 5 Years ..... 22%

**Move From an Out-of-Home Placement to Current MH Residential Placement**

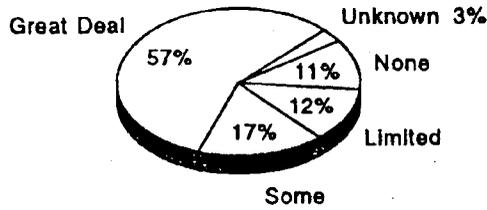
- No ..... 32%
- Yes ..... 68%

<sup>16</sup> One child's custody status was unknown to the facility.

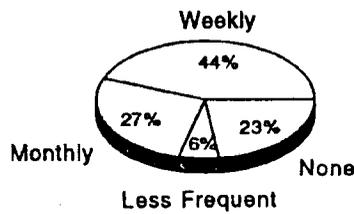
**Figure 19: Family Relationships**

(N = 100)

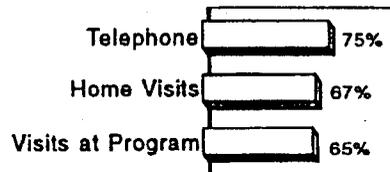
**Child's Interest in Family Contact\***



**Actual Family Contact**



**Contact Methods**

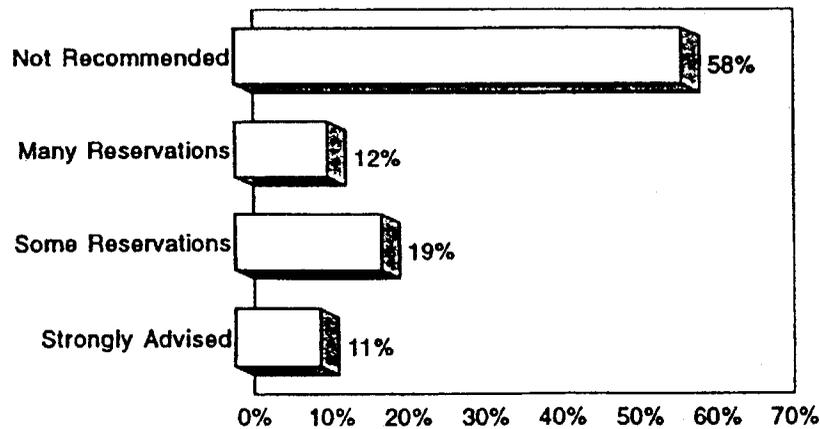


\* As reported by primary therapists

**Figure 20: Recommendations for Family Placement at Time of Discharge**

(N = 100)

**Discharge to Family . . .**



Notwithstanding custody arrangements, however, therapists reported that 77% of the children have some contact with their biological or adoptive parents (Figure 19). Seventy-one percent (71%) of the children reportedly had contact at least monthly, including 44% who had contact at least weekly. Contact was most frequently made by telephone (75% of the children), but many children also had home visits (67%) and/or family visits to the facility (65%). Therapists reported that there were court orders limiting or restricting family visits for 33% of the children.<sup>17</sup>

Corresponding to the level of family contact, therapists reported that approximately three-fourths of the children (74%) showed some interest in seeing their biological or adoptive parents, with 57% of the children reportedly showing "a great deal of interest" in seeing their parents. In sharp contrast to this finding, however, *even if all appropriate clinical and support services were available*, therapists of only 24% of the children believed that the children would be better served living at home with their families.

Therapists of most of the children (58%) also did not recommend placement of the child back with his/her biological or adoptive family, even at the point of discharge (Figure 20). Such a placement was "strongly advised" by therapists of only 11% of the children; it was "advised with some reservations" for 19% of the children; and it was "advised with many reservations" for 12% of the children.

Notably, however, despite these reservations over returning children to their biological or adoptive families, most of these children were also not available for adoption into another family.

### *Emmanuel*

*Little is known of Emmanuel's first two years of life, but by age 2, he was removed from his parents' home and placed in foster care. Between the ages of 2 and 11, Emmanuel lived in five different foster care homes. Some time in this period, both of Emmanuel's parents were murdered, and he was placed in permanent DSS custody.*

*At age 11, Emmanuel was moved to a congregate child care facility, where he stayed only three months, until he was moved to another program. He stayed in this program for three years, but then aged out and, at age 14, Emmanuel was placed for the first time in a residential mental health facility (RTF).*

*Over this time period, Emmanuel's early childhood diagnosis of attention deficit hyperactivity disorder gradually changed as he became more socially isolated and "subject" to visual and auditory hallucinations. When the Commission staff met Emmanuel, at age 15 in his RTF, he carried the diagnoses of schizophrenia, chronic, undifferentiated with borderline intellectual functioning.*

*Emmanuel has lived at the RTF for a year and a half, at an approximate cost of \$137,000. At the RTF he is treated with the psychotropic medication Mellaril, and he receives about 16 hours of individual and group therapy each month.*

*Although there are notations of Emmanuel's speech problem throughout his record, he is not receiving speech therapy. Emmanuel's teacher also noted that his school program does not provide the one-to-one assistance that Emmanuel requires and that, at age 15, he should be enrolled in vocational opportunities.*

<sup>17</sup> Of note, these 33 children were not exclusively children in the custody of the Department of Social Services; 19 of the children were in the custody of the Department; 11 were in the legal custody of their biological parents; and 3 were in the custody of another family legal guardian.

Figure 21: Strengths of the Children

(N = 100)

Child . . .	Usually*	Rarely*
<input type="checkbox"/> independently completes personal hygiene tasks	70%	4%
<input type="checkbox"/> completes assigned chores	66%	4%
<input type="checkbox"/> agreeably attends therapist appointments	87%	0%
<input type="checkbox"/> seeks staff help when angry/upset	34%	13%
<input type="checkbox"/> abides by program rules	56%	1%
<input type="checkbox"/> completes homework assignments*	51%	5%
<input type="checkbox"/> displays good table manners	62%	4%
<input type="checkbox"/> attends to structured play activity/30 minutes	58%	19%
<input type="checkbox"/> participates in group activities	44%	7%
<input type="checkbox"/> develops and maintains friendships with other children	32%	23%
<input type="checkbox"/> develops and maintains a relationship with an adult	70%	2%
<input type="checkbox"/> gets along with adults charged with care and supervision	70%	0%

\* Difference between the sum of "usually" and "rarely" responses and 100% equals "sometimes" responses, except for homework, where 28% of the children received "not applicable" responses.

## Current Strengths and Problems of the Children

A brief adaptive and maladaptive behavior survey was completed by the primary therapist of each of the 100 children. This survey asked the therapists to indicate if the child had demonstrated approximately two dozen basic adaptive or maladaptive behaviors in the past three months. In addition, to obtain a benchmark of seriousness for maladaptive behaviors, the therapist was also asked if present maladaptive behaviors had occurred more than three times in the past three months.

Although primary therapists had been fairly consistent with their overall assessments of the children as "very troubled" or "disturbed," it was surprising that the survey results indicated that most children scored well both on the adaptive and maladaptive subscores. As shown in Figure 21, at least half of the children were rated as "usually" achieving most of the assessed adaptive behaviors.

### Martin

*Martin grew up with neglect, abuse and a history of medical problems. His first contact with the mental health system was at age 6, his first hospitalization at 10, and then he was transferred to an RTF.*

*When the Commission visited in June 1991, Martin had been at the RTF for 6 months with a diagnosis of a psychotic disorder for which he receives 2 psychotropic medications daily (Thorazine and lithium). His major problems center around sexual and physical acting out.*

*Even with his multiple problems, Martin gets limited clinical services, including 7 hours of verbal therapy and 12 hours of art therapy monthly. Although his academic performance is 1-2 years below grade level, he does not receive homework or 1:1 assistance. He receives no sex education, nor are his sexual problems addressed in therapy. At this time, Martin's therapist indicates that he is not ready for discharge.*

*The approximate cost of his stay (6 months) at the RTF, exclusive of his education, was \$39,000.*

Figure 22: Maladaptive Profile of the Children  
(N=100)

During the preceding 3 months the child has . . .

	At Least One Time	Three or More Times
<input type="checkbox"/> hit another child	51%	26%
<input type="checkbox"/> hit an adult	31%	12%
<input type="checkbox"/> voiced suicidal thoughts	31%	16%
<input type="checkbox"/> attempted suicide	4%	1%
<input type="checkbox"/> used drugs/alcohol	6%	2%
<input type="checkbox"/> set fires	3%	0%
<input type="checkbox"/> been found with weapons	12%	4%
<input type="checkbox"/> resisted taking medications	25%	13%
<input type="checkbox"/> engaged in self-injurious behavior	35%	17%
<input type="checkbox"/> left the program without consent	13%	3%
<input type="checkbox"/> been involved with police	4%	0%

The children not achieving a “usually” rating on specific adaptive behaviors were most often rated as “sometimes” demonstrating the behavior. For only two specific adaptive behaviors—both relating to social interaction skills with peers—did therapists rate *more than 15%* of the children as “rarely” demonstrating these behaviors. Twenty-three (23) percent of the children were rated as “rarely” maintaining friendships with other children, and 19% of the children were rated as “rarely” being able to be attentive in a structured leisure or play activity for 30 minutes.

Consistent with their adaptive behavior profiles, less than 15% of the children had evidenced the most serious specific maladaptive behaviors (e.g., attempted suicide, set fires, used drugs/alcohol, possessed a weapon, or ran away) in the past three months (Figure 22). More common maladaptive behaviors, but behaviors still limited

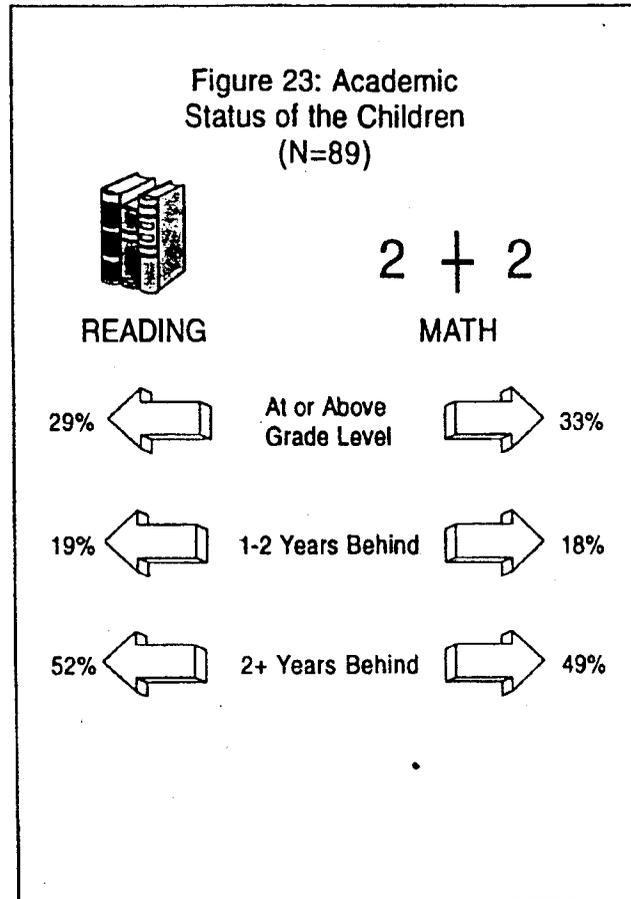
to approximately one-third of the children, included: engaged in self-injurious behaviors and activities (35%), hit an adult (31%), voiced suicidal thoughts or ideation (31%), and resisted taking prescribed medications (25%).

Even for these more common maladaptive behaviors, about half of the children who displayed these behaviors did so *less than three times in the past three months*. For example, only 17% of the children had displayed self-injurious behaviors and only 16% expressed suicidal ideation three or more times in the past three months. Similarly, only 12% of the children had hit an adult three or more times in the past three months, and only 13% had resisted taking medications three or more times. The only maladaptive behavior attributed to at least half of the children (51%) included one common to most children and adolescents—hit another child.

## Academic Status of the Children

Although many of the children scored reasonably well on scales of basic adaptive and maladaptive behaviors, they did not score well on measures of academic performance.<sup>18</sup> Interviews with teachers and primary therapists revealed that, although relatively few children were classified as mentally retarded (11%) or learning disabled (10%), most of the children suffered from significant academic delays and problems (Figure 23).

More than two-thirds of the 89 children, for whom data were available, were performing at least one year below grade level in reading and math, and half of the children were performing *two or more years* below grade level in reading and math.<sup>19</sup> Teachers of the children at the on-campus schools at state centers and RTFs further clarified that poor attitudes toward school, low motivation, and school-resistive behaviors characterized about half of the children, while approximately one-fifth of the children were described as needing one-to-one instruction.



<sup>18</sup> Classroom teachers of the 72 children in the sample who were receiving educational services from on-campus special schools at state centers or units or RTFs were interviewed. Although classroom teachers of children enrolled in community-based programs were not interviewed, in many instances (17 of the 28 children), primary therapists could provide some basic schooling information. The Commission decided not to interview teachers of the 28 children in the community-based programs, as many of these children for the first time in many years were attending integrated community schools, and the Commission was concerned that teacher interviews would be stigmatizing for the children.

<sup>19</sup> Seven (7) of the 11 children for whom academic data were unavailable were residing in community-based programs. In total, academic "progress" data were available for nearly half of the 15 children who had been enrolled in community-based programs for the last six months.

---

# Chapter IV

## The Services the Children Received

---

A major objective of the Commission's study was to understand more fully the treatment and services provided to the 100 children by the mental health residential programs. Data for this section of the report were obtained from interviews with the children's primary therapists and teachers, reviews of the children's clinical records, observations on the residential units, and informal interviews with the children themselves. Additionally, for the children enrolled in the Office of Mental Health's new family-based treatment program, Commission staff visited the foster parents and the children in their homes.

### Overview

The Commission found that the children's basic needs for custodial care, supervision, medical and dental care, as well as mental health therapy, were addressed by the programs. Most of the children also attended richly staffed special education programs, but actual curriculum offerings of these programs were often less adequate than the typical public school program.

Behavior management was also a central theme in most of the children's treatment but, with the exception of the family-based treatment programs, most programs relied minimally on individually tailored behavior modification plans. Instead, the Commission found a heavy dependence across most programs on generic behavioral level and point systems, psychotropic medications, "time-out," and physical interventions by staff.

The Commission found that nearly three-fourths of the children were regularly prescribed psychotropic medications, often in the absence of carefully monitored individualized behavioral

### *Juanita*

*Very little is known about Juanita except that, at age 12, she was raped and had her first encounter with the mental health system. Then from 1986 to 1990 she had six hospital stays, two RTF placements, and a two-month stay at Covenant House. She has a history of self-destructive behavior, hallucinations, and bulimia.*

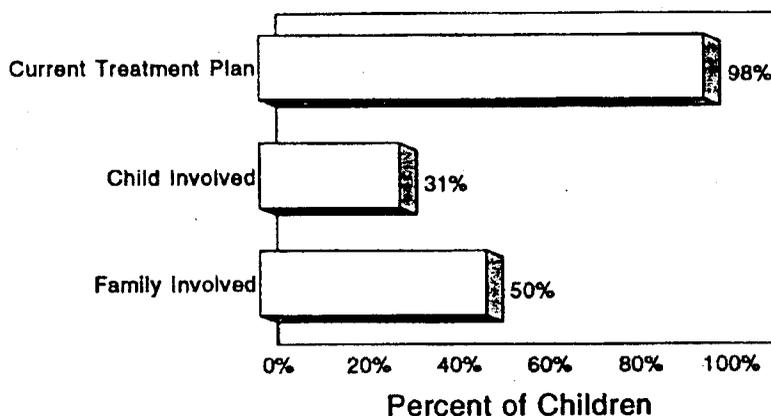
*Her parents could no longer manage Juanita so, at age 17, she was admitted to an all-girls' RTF with diagnoses of a bipolar disorder and bulimia nervosa, both reportedly "in remission;" she does not receive any psychotropic medications.*

*Juanita meets with her therapist eight hours each month; however, there is no mention of addressing her past rape. She only receives two hours of sex education each month, but no specific therapy for her eating disorder. Her therapist specified that Juanita needed help from an expert in eating disorders.*

*Although Juanita is 17 and has expressed an interest in nursing, she receives no vocational/career training and limited opportunities for community outings. Her therapist and teacher agree that Juanita would benefit from vocational training, more integration with boys to help facilitate a "normalizing" perspective on how the two genders should interact, and more "hands-on" life experiences that a girl in the general population would encounter.*

*The cost of Juanita's most recent RTF placement after 15 months, exclusive of education costs, has been \$81,000.*

**Figure 24: Comprehensive Treatment Plans for Children**  
(N = 100)



programs and often without evidencing the conditions and symptomatology for which drug manufacturers recommend the use of the medications.

With the exception of the community-based programs, the weakest point of most of the programs was their inability to provide the children with many of the normal opportunities and experiences of childhood or with specific skill training that would help them to live in the community or make the transition to adulthood. Very few of the children had any opportunities in school or in the program to meet, play, or study with children who did not carry the label of "emotionally disturbed." Organized sports, musical performances, clubs, and student governments were also typically not available. Additionally, only half of the children 12 and older were participating in a sex education program, and only half of the children 16 and older participated in a job training program, a supportive work program, or a real job.

The Commission also found that, although virtually all children (98%) had a current compre-

hensive treatment plan, involvement of children and their families in developing treatment plan goals was not common (Figure 24). Only 31% of the records documented child involvement, and only 50% of the records documented family involvement in identifying treatment plan goals. On both of these indicators, however, community-based programs performed substantially better:

- 61% of the children in community-based programs participated in the development of their treatment goals compared to 25% of the children in state-operated centers and units and 14% of the children in RTF programs; and,
- 79% of the families or foster families of the children in community-based programs participated in the development of the children's treatment goals compared to 36% of the families/foster families of the children in state-operated centers and units and 31% of the families/foster families in RTFs.

## A Safe Respite

Comments from virtually all primary therapists—regardless of modality—emphasized that a primary service of the programs was a respite for the child from troubled relationships with parents and other family members and, in many cases, from extremely dysfunctional family settings. In this regard, Commission staff found the facilities visited, with few exceptions, to be generally clean, safe, and adequately furnished. Although, with the exception of the community-based programs, few facilities offered environments which could be described as “home-like,” program staff universally assured Commission staff that the facilities were far better environments than most of the children had experienced at home. With the exception of one facility, meals and dining services at the programs, if somewhat institutional, also appeared appropriate.

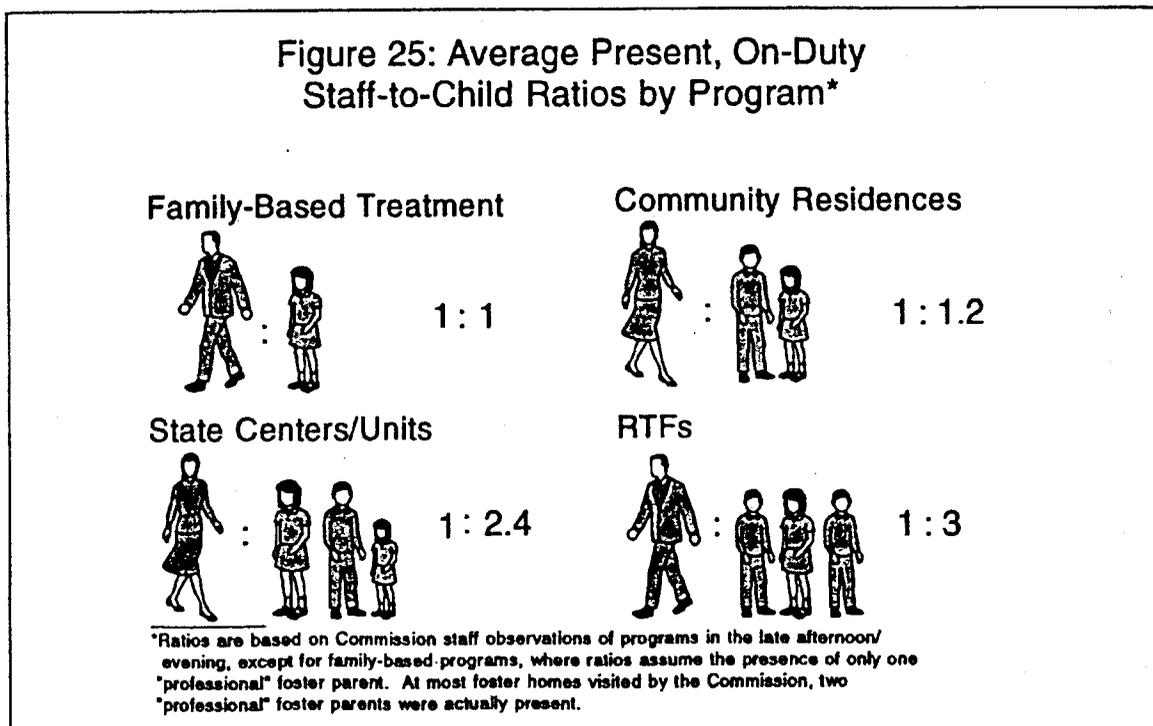
Additionally, an added benefit of placement for almost all of the children was regular access to medical and dental care. Almost all of the children (93%) had a current annual physical exam, and record reviews indicated that ongoing medical care needs of all children were being addressed.

Records also showed that 86% of the children had a dental exam within the past year.

Finally, virtually all of the children in the sample reportedly participated in some recreational activities for about 10 hours each week. These activities varied from program to program, but, with the exception of the community-based programs, the “off-campus” community trips and activities were often less frequent than weekly. With the exception of the community-based programs, most programs offered their children no *routine* opportunities to play with children without handicapping conditions. For many programs, the safe respite offered was also a very isolated and segregated respite, which limited the children’s opportunities for normal childhood developmental experiences on the way to adulthood.

## Staff Supervision

During its on-site *announced* visits, the Commission was also generally impressed with the relatively rich present, on-duty staffing ratios. Across all programs, there was usually at least one staff person present for every three children (Figure 25).



The richest present, on-duty “staffing” was clearly in the family-based treatment programs, where each child had the benefit of “professional” foster parents, as well as at least twice weekly substantial contact (and 24-hour crisis availability) with his/her family-based specialist, who functioned as a combination of support structure for the foster parents, a crisis worker, a case manager, and a friend to both the child and the family. The two community residence programs visited were also richly staffed on the days of our visit, with one present, on-duty staff person for almost every two children. By comparison, present, on-duty staffing ratios at the six state centers and units and at the six RTFs visited averaged 1:2.4 and 1:3.0, respectively.

Despite these relatively rich staffing ratios, however, clinical staff presence was not always assured, especially during the late afternoon and early evening hours when most children were on the living units. At four of the six state centers and units visited and, at three of the six RTFs visited, clinical staff were *not present*—or scheduled to be present—on half of the living units reviewed. Also, even where clinical staff were present, it was often the case that they were not scheduled to be present, but rather had “dropped in.”

In contrast, clinical professional staff were present, and scheduled to be present at these times, at both of the community residences visited. Additionally, professional foster parents at all four of the family-based treatment programs uniformly complimented the program for the ready accessibility of family-based specialists, both for regularly scheduled visits, and promptly at any time of the night or day when they had an emergency.

## Mental Health Therapy Services

Reflective of the mental health sponsorship of the programs, it was not surprising that various therapy services were commonly received by almost all of the children (Figure 26). Nearly all of the children (96%) reportedly received individual therapy; 77% participated in group therapy; and 66% participated in family therapy.

Figure 26: Children Receiving Mental Health Interventions

(N = 100)

### Basic Therapies

Individual Therapy .....	96%*
Group Therapy .....	77%*
Family Therapy .....	66%*

### Psychotropic Medications

One Regular Medication .....	44%
Two or More Regular Medications ...	26%
PRN/STAT Orders .....	34%
Placed in Restraint/Seclusion .....	14%

(in preceding 3 months)

### Adjunct Therapies

Art Therapy .....	28%
Speech Therapy .....	17%
Alcohol Abuse Counseling .....	15%
Drug Abuse Counseling .....	8%

\* In total, the average child received about 5 hours/week of these basic therapies.

Despite the rich provision of therapy to the children, however, the Commission noted that, for many children, their past histories of familial physical or sexual abuse were not specifically addressed in their treatment plans. Nearly three-fourths of the children (72%) were identified as being victims of past familial physical or sexual abuse, but only 28% of these children received specialized therapies or services.

The actual provision of family therapy was also generally very limited, with 28 of the 66 children (42%) receiving only one-two hours of this service monthly and only 11 of the 66 children (17%) receiving more than 4 hours of this service monthly. In many programs, and especially RTF programs where the children’s families lived an hour or more away, provisions for family therapy were limited by travel arrangements.

### *Caroline*

*Caroline was placed out of her parents' home when she was 6 due to confirmed physical abuse and suspected sexual abuse. One year later, Caroline, who was described as very aggressive and prone to 45-minute tantrums and head banging, was placed in a long-term mental health residential facility (RTF).*

*Commission staff met Caroline, at age 8, approximately nine months after her admission to the RTF. Caroline's treatment regimen at the RTF includes 8 hours of individual and family therapy each month, recreational services, and Thorazine, a psychotropic medication.*

*Reflective of her early childhood abuse history, Caroline's diagnosis is "post-traumatic stress syndrome," but her records do not indicate that her therapy sessions or other treatment activities are addressing her abuse history.*

*Caroline's therapist stated that she would benefit from more services, increased and stable staffing, and more family therapy for her parents. Her teacher agreed with this assessment, adding that Caroline should be mainstreamed in some non-academic activities and have the opportunity to participate in more non-academic subjects like cooking classes and other daily living skills programs. Unfortunately, these opportunities are not available to Caroline at the RTF.*

*As of June 1991, Caroline's total treatment costs at the RTF, exclusive of special education costs, were approximately \$65,400.*

In contrast, the average child received 16 hours of individual and group therapy each month, with the average child in a state-operated children's center or unit who received these services (and all did) receiving 19 hours of these services a month. By comparison, the average child in RTF programs received 15 hours of these services each month, and the average child in community-based programs received 10 hours of these services each month.

The Commission also found that primary therapists at the programs generally had small caseloads, ranging from 4 to 8 children. Average caseloads for primary therapists ranged from 7.5 children per full-time therapist at RTFs visited, to 5.7 children per full-time therapist at state centers and units visited, to 4 children per full-time therapist in community residences and family-based treatment programs visited.

## Adjunct Clinical Therapies

With the exception of art therapy, which was provided to 28 of the 100 children (including 21 of the 36 RTF children), no other adjunct clinical therapy was provided to more than 20% of the children. Fifteen (15) percent of the children were receiving alcohol abuse services; and 8% of the children were receiving drug abuse services. Approximately 17% of the children were also receiving speech therapy.

Among the children receiving these adjunct therapies, the average child received a total of only 5 hours of services each month (across all adjunct therapies), but again, the children in state-operated centers and units reportedly received more of these clinical services than the children in other modalities (an average of 8 hours each month compared to 5 hours a month in RTF programs and 2 hours a month in community-based programs).

## Psychotropic Medications

In addition to these clinical services, 70% of the children had a standing order for at least one psychotropic medication, and one-fourth of the children (26%) had standing orders for two or more psychotropic medications.<sup>20</sup> Additionally, 34% of the children (including five children with no standing orders for psychotropic medications) had a PRN (as needed) order for a psychotropic medication. Two of these children had PRN orders for two different psychotropic medications.

<sup>20</sup> In this discussion, the term "psychotropic medication" is used to mean a medication used to address psychiatric symptoms or emotional or behavioral problems. Anticonvulsant medications used to address seizure disorders of children are excluded. Additionally, medications which may be used both for psychiatric and medical conditions, like certain antihistamines, Inderal, and Clonidine, are included only if they were being used for psychiatric purposes. "Standing orders" are orders for medications to be administered daily.

### *Daniel*

*Daniel lived at home until he was 3 and was placed in foster care. At age 7, Daniel returned to live with his natural family. This arrangement lasted only one year, and once again he was placed in foster care. Four years later, and after spending 8 of his young 12 years in foster care placements, Daniel was adopted.*

*At age 10, Daniel began receiving outpatient mental health services, but problems persisted. At age 14, Daniel was admitted to a state children's center due to suicidal ideation and threatening to kill his younger brother for "telling on him" to their father.*

*We met Daniel at the state children's center where he had been a patient for nine months. As of June 1991, Daniel's nine-month stay at the center had cost approximately \$129,000.*

*At the center, Daniel receives approximately 14 hours of verbal therapy and about 8 hours of structured recreational activities monthly. He also participates in the on-campus special education school program. Diagnosed by his therapist with both an adjustment disorder and a conduct disorder, Daniel is receiving Vistaril daily, and over the past three months he has been administered several PRN doses of Taractan to control his behavior. His therapist also reports that Daniel has been sexually active at the center.*

*Daniel's therapist and his special education teacher both noted that he would be better off at home. His therapist stated that he no longer meets the center's continued stay criteria, and that the center cannot meet Daniel's need for a structured program in vocational and daily living skills or sex education.*

*Daniel's teacher spoke positively about his above-grade-level performance in math, but she lamented the absence of a strong school sports program for Daniel, who is very athletic. She also noted that he would also benefit from a good science lab program of a public high school.*

*As of June 1991, Daniel's discharge was on hold, pending arrangements for day treatment services, an appropriate school program, and support services for his adoptive family.*

Of note, standing and especially PRN psychotropic medication orders were less common for children in community programs. PRN orders for psychotropic medications were on file for only 11% of the children in community-based programs, compared to 58% of the children in state centers and units and 28% of the children in RTFs. Less significant, but noteworthy, differences were noted among programs in the provision of standing orders for psychotropic medications. Eighty-one (81) percent of the children in state centers and units had at least one standing order for psychotropic medications, compared to 75% of the children in RTFs and 68% of the children in community-based treatment programs.

Most children's records (77%) provided a rationale for standing orders for psychotropic medications, although rationales were not present in the records of 16 of the 70 children regularly receiving these drugs. Rationales were more uniformly present (90%) for STAT and PRN orders for psychotropic medications.

It should also be noted that although one-fourth of the children (26%) were regularly receiving two or more psychotropic medications, only one child's medication regimen (which included standing orders for two antidepressant medications) reflected classic polypharmacy as defined by professional standards. Of note, however, 57% of the children receiving psychotropic medications were receiving at least one medication which is not recommended for children with their diagnoses by the drug manufacturer or FDA guidelines. Fifteen children (22%) were receiving psychotropic medications not recommended for children of their ages by drug manufacturers or FDA guidelines.

For example, cross-referencing medication orders with the children's diagnoses revealed that:

- Only one-third (33%) of the 33 children with a standing order for an antipsychotic medication had a diagnosed psychotic disorder;

- Only 3 of the 15 children (20%) receiving lithium had a diagnosed bipolar disorder; and,
- Only 8 of the 21 children (38%) with a standing order for an antidepressant medication had a diagnosed depressive disorder.

Two-thirds of the children (67%) who were prescribed stimulant drugs did have a diagnosis of attention deficit hyperactivity disorder, the primary indication for this class of medications with children.

Recognizing that rationales for psychotropic medications often referenced some form of behavior management, the Commission also attempted to discern if the children in the sample who had orders for psychotropic medications were significantly different in terms of maladaptive behaviors than the remaining 25 children in the sample. In general, this analysis *did not* indicate significant between-group differences.

Although the children receiving psychotropic medications were somewhat more likely to have evidenced many of the maladaptive behaviors which were assessed, only one of these between-group differences was statistically significant. Specifically, children on psychotropic medications were significantly more likely to have hit another child in the past three months ( $p < .05$ ). Of note, however, children on psychotropic medications were not significantly more likely than the other children to have assaulted another child three or more times in the past three months.

The Commission also noted that, although general medical treatment informed consent forms were present in almost all of the children's records, specific informed consent forms related to psychotropic medications were not present in the records of approximately half of the children (51%). Additionally, in many of the cases where informed consent forms for medications were present, these forms amounted to "generic" consent for psychotropic medication treatment or they did not list the child's current medication regimen accurately (Figure 27).

**Figure 27: Informed Consent/Discussion of Psychotropic Medications**  
(N = 75 children on psychotropic medication)

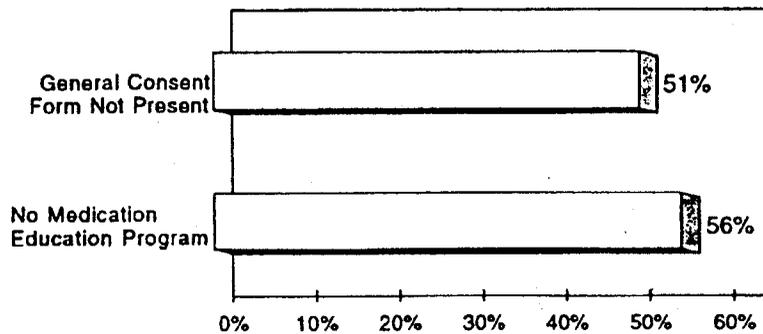
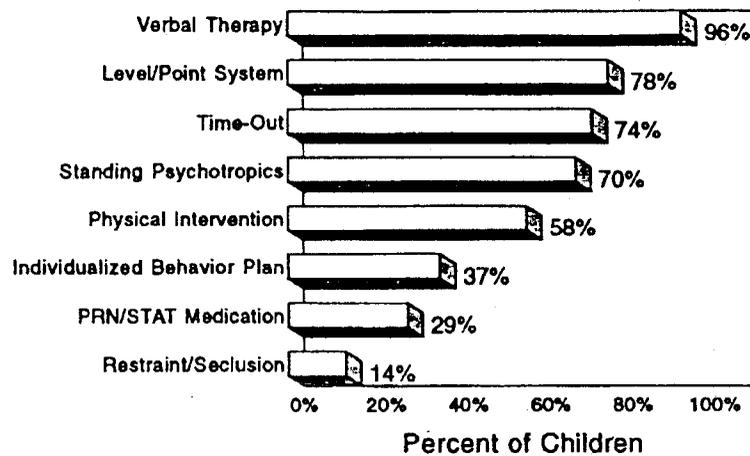


Figure 28: Approaches to Behavior Modification/Management  
(N = 100)



Commission staff also found little documentation of clinician discussions with parents of guardians regarding the children's psychotropic medications, their intended effects, and their possible adverse side effects, as required by Office of Mental Health regulations (14 NYCRR §527.8). Interviews with the children's primary therapists also indicated that medication education services were being provided to *less than half* (44%) of the children who were receiving psychotropic medications.

## Approaches to Behavior Management

As noted above, central issues in almost all of the children's treatment plans included socially inappropriate, self-injurious, dangerous, oppositional, and/or impulsive behaviors. Senior staff, as well as primary therapists at all of the programs, spoke of these problems and, most critically, the children themselves seemed well aware that their "way out" was through "good behavior."

As the Commission looked more closely at the behavioral management strategies of the pro-

grams, it was clear that these issues were regularly discussed in individual, group, and family therapy sessions, and that, as discussed above, many clinicians had placed considerable faith in the ongoing use of psychotropic medications to help the children modify their behaviors (Figure 28).

The study also found that "time-out" and physical staff interventions were commonly used to address the children's behaviors. Overall, 74% of the children had been placed in "time-out" in the three months prior to the Commission's visit. Staff had physically intervened to address behaviors of 58% of the children in the same time period; 34% of the children had been subject to three or more incidents of staff physical interventions in this three-month period.

In the three months prior to the Commission's site visit, PRN or STAT doses of psychotropic medications were received by 29% of the children. During the same period, 11% of the children were placed in seclusion, meaning placement alone in a room, often locked, which the child was physically blocked from exiting, and 3% of the children were placed in mechanical restraints.

Although these more restrictive interventions are often employed in adult psychiatric institutions and hospitals, the Commission noted that both mechanical restraints and seclusion are "forbidden" in most programs for children with developmental disabilities, as well as in a number of programs for children with emotional problems. The Commission also noted that, unlike in mental retardation programs where the use of psychotropic medications for behavior management must be accompanied by employment of an individually tailored and carefully monitored behavioral management plan, such plans were not in place for most children subject to these interventions in the study's sample.

Only one-third of the children on psychotropic medications (33%) had an individualized behavioral plan which targeted specific aggressive, dangerous, or self-injurious behaviors and ensured regular, daily notes of progress and incidence of the dangerous behaviors. From another perspective, only 45% of the children ( $n = 73$ ) whose treatment plans identified aggressive, assaultive, or self-injurious behaviors had an individualized behavioral plan addressing these problem behaviors.

Only the family-based treatment programs usually ensured individualized behavioral plans. All of the four family-based treatment programs visited had individualized behavioral plans for at least 75% of the children with aggressive, assaultive, or self-injurious behaviors. Less than one-third of the state-operated centers and units, RTFs, or community residences scored as well on this performance indicator, and many of these programs (42%) provided individualized behavioral plans to less than one-third of their children in the sample with aggressive or dangerous behaviors.

## "Level Systems" and "Point Systems"

Notwithstanding the presence or absence of individualized behavioral plans, however, the

predominant strategy for behavioral management, especially from the children's point of view, appeared to be the standardized behavioral management "level or point systems." Although the four family-based programs did not rely on these systems, all but 1 of the other 14 programs visited by the Commission (Ittleson RTF) had a "standardized level or point system," or some combination of the two in place.

In "level systems," children who meet various expectations progress from level to level—where each succeeding level typically awards a child more freedom of movement and privileges. "Point systems" are similar, but, instead of progressing from level to level, children earn and lose points<sup>21</sup> which they can "cash-in" for certain privileges or specific rewards.

Although at many of the programs visited, these systems and their labyrinth of expectations, rewards, and punishments seemed inordinately complex and difficult to implement, it was impressive that, in almost all cases, the children (notwithstanding their reported learning difficulties) had a good understanding of "how to work the system." Overall, these systems did also work as effective tools for helping program staff in managing the children *while they were at the program*.

The design and implementation of these systems, however, seemed less helpful in teaching children to maintain control over their behavior once discharged from the program. Most systems were simply too complex and externally directed to be transported to a family home. And, there was too much variability across systems in different programs for them to transport easily as the child moved from one program to another.

In most programs the children also played a minimal role in developing and evaluating "level and point systems" and, as a result, they did not personally invest in or internalize the values of these systems. Additionally, although approximately half of the programs' written policies

<sup>21</sup> Some policies for "point systems" emphasize that children cannot lose points for bad behavior, but they can earn "negative points." This euphemistic distinction was generally lost on the children, program staff, and Commission staff alike.

reportedly allowed for the incorporation of some individualized expectations for children in their “level and point systems,” in most of the programs visited, this individualization remained largely a theoretical construct.

Policy descriptions of all systems also emphasized positive reinforcements, and the Commission’s observations confirmed a positive orientation at several of the programs visited (Astor Home RTF, Sagamore and Hutchings Children and Youth Units). At many programs, however, the emphasis on positive behaviors seemed less clear in practice. For example, at two programs, the descriptions of “level/point systems” only listed consequences for negative behaviors and, at another program, children could earn points only for “not doing” negative behaviors.

Commission staff also noted that, in some of the systems, losing points and levels seemed to be much easier than earning them. For example, at one state children’s center, children could earn between 250 and 500 points for good behaviors,

but they could lose between 500 and 10,000 points for bad behaviors.<sup>22</sup> At another program, a child could drop precipitously to the lowest level of the level system from any one of ten behaviors, from smoking to going AWOL.

The Commission also noted that many of the systems seemed to rely heavily on punishments which deprived children of valuable and essential family and social contact (Figure 29). In other cases, the “rewards” offered to the children (e.g., bedtime stories, back rubs, trips to town with a staff person) seemed to be some of the few vestiges of home-like nurturing, and one would have hoped that they were there for all kids, as a matter of course, rather than as a privilege that must be earned.

### The “ABC” Approach

In contrast to these systems, by OMH mandate, all of the newer family-based programs rely on a strictly individualized behavior management

**Figure 29: Typical “Level/Point Systems”**

**Positive Consequences/Rewards**

- Later Bedtimes
- Bedtime Stories
- Bedtime Back Rubs
- Movies
- Writing Paper, Pens, Crayons, Books, Magazines
- Trips, Community Outings
- Quiet, Private Time

**Negative Consequences/Restrictions**

- Loss of Home/Weekend Pass
- Restrictions on Phone Use
- Restrictions on Visitors
- Restrictions on Grounds Privileges
- Restricted to Certain Living Unit Areas

<sup>22</sup> Administrators at this program emphasized that children did not “lose” points for bad behaviors, but instead they earned “negative” points.

program called "ABC" for "antecedent, behavior, and consequence." In this system, a unique and individualized limited set of behavioral expectations is established for each child, and data are maintained on a child's weekly progress.

Although children may earn tangible rewards, the emphasis of the program is catching the children being good and strongly reinforcing good behavior with immediate verbal praise. Unlike the "level and point systems" reviewed, the "ABC" system has a specific warning about too many negative consequences—which in and of themselves must trigger a review and revision of the plan. Also, importantly, the child, the foster parents, and the family-based specialist work together to identify the targeted behavioral expectations.

As suggested above, the Commission found much to be emulated in the more individualized, positively oriented, and child-focused "ABC" system employed by the family-based programs. In part, this system just seemed more closely allied with generally accepted good parenting methods, but it was also apparent that this system—which focused on the individual child, and not on unit management or general behavioral control—worked better for the children and the foster parents.

Most fundamentally, the "ABC" system was simpler. Plans tended to focus on only a few specific behaviors most relevant to individual children. Additionally, while children in congregate programs viewed "level and point systems" as the facility's systems and as systems "to be worked," children in family-based programs—even the very youngest children—had a personal investment in their own "ABC" plans.

Finally, perhaps the best evidence of the "success" of the "ABC" system was that many of the foster parents Commission staff visited had begun to use the system with their own children. No staff of the congregate facilities reported taking the program's "level or point system" home to their own kids!

### *Hilary*

*Hilary was admitted to one of the Office of Mental Health's new community residences for children in July of 1990 when she was 14. In the two years prior to this placement, Hilary had had three admissions to a state children's psychiatric center, which were all justified based on her explosive temper and "rages."*

*Hilary's homelife has been troubled. Her father is a recovering alcoholic, who acknowledges having great difficulty responding appropriately to Hilary's rages, and at least once in the past, he has himself called Child Protective Services for help. Hilary's mother has a long history of serious mental illness, with several hospitalizations and suicide attempts. One of Hilary's sisters has also been placed out of home in a DSS group home.*

*Hilary's first year in the community residence was marked by many positive achievements, and she was considered a model resident. She was successfully attending a community school; she participated in group activities at the community residence; and she had made some friends.*

*Then, on Memorial Day weekend, almost one year after she came to live in the community residence, Hilary ran away with another girl and got drunk. She was found and returned to the residence within 48 hours of her departure, but since this incident she has been increasingly withdrawn, and she has frequently expressed her desire to return home. Hilary has also engaged in some self-injurious behaviors, which her counselor believes are her way of expressing her disappointment at not being able to return home.*

*Despite these behaviors, however, the community residence staff believe that they can meet Hilary's needs and that she does not require placement in a more restrictive setting. Hilary continues to attend the community school, and she is receiving group and individual therapy. The long-term goal is for Hilary to return home, but community residence staff and Hilary's father acknowledge that, for now, the community residence is the best place for her.*

At the same time, however, the Commission is not naive to the reality that it would be difficult to implement truly individualized behavioral management plans in many of the larger treatment programs it visited. In many respects the drawbacks of the standardized "level and point systems" seemed to be by-products of the larger, less personal congregate settings themselves.

## School Services

As noted above, 72 of the 100 children attended special on-campus schools at the state centers and units and RTFs, which operated on a 12-month calendar year. All of the 28 children in the community-based programs, in contrast, attended local public schools, and 11 of these children were enrolled in regular integrated classes most of their school day.

Almost all of the 72 children (86%) attending the special on-campus schools at state centers or units and RTFs enjoyed small classes of 8 or fewer students, with a teacher-to-pupil ratio of 1:8 or better. In addition, teacher aide-to-pupil ratios in 70% of the children's classrooms were also 1:8 or better, resulting in an overall teaching staff-to-child ratio of at least 1:4 for the vast majority of the children.

Notwithstanding these advantages, however, many of the schools' actual program offerings were limited. None of the special on-campus schools provided any opportunities for their pupils to interact in academic or recreational activities with children who were not handicapped; in fact, at all of the schools, 100% of the enrolled children had a Committee on Special Education designation of "emotionally disturbed." Only two of the schools served any community children; and, at both of these schools, less than 5% of the enrolled children came from the community.

Figure 30: Non-Compliance Citations With State Education Department Regulations\* (N = 12 Schools)

Minimum Instructional Time .....	42%
Development of Individualized Educational Plans .....	67%
Composition of Committees on Special Education .....	50%
Class Size/Composition .....	67%
Provision of Related Services .....	58%
Staff Ratios .....	42%
Alternate Testing Options .....	33%

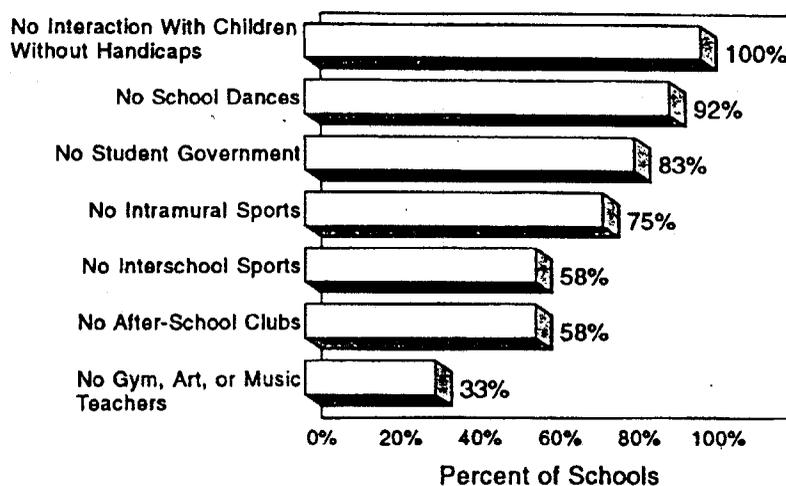
\* All data are based on the schools' most recent SED tri-annual reports for the school programs, except minimum instructional time where findings were based on instructional hours at the time of the Commission's summer 1991 site visit.

At 42% of the programs, on-campus schools were not in compliance with the State Education Department's mandated number of hours of instructional time (Figure 30). Most of these deficient schools were offering only 80-90% of the mandated 5 to 5.5 hours of instruction.<sup>23</sup>

The limitation on instructional time at these schools was compounded by the fact that the State Education Department allows the provision of "related services" to count as instructional time. More than half of the children (57%) attending the special on-campus schools were receiving "counselling" as a related service. In practice, most of these children were being "pulled" regularly from their school program (and their mandated instructional time) to see their residential program therapists—whose regular 8:00 am to 4:00 pm hours made seeing children during the school day an imperative.

<sup>23</sup> The State Education Department requires that schools serving elementary age students provide 5 hours of instruction daily and that schools serving middle school and high school age students provide 5.5 hours of instruction daily. Schools not providing the mandated hours were generally providing 80-90% of this minimum.

Figure 31: Limitations of Special On-Campus Schools  
(N = 12 Schools)



On the non-academic side, despite their staffing ratios, one-third of the special school programs had no gym, art, or music teachers, and regular classroom teachers assumed these duties. In part because most of the schools were small, with less than 75 enrolled students, these schools also had limited after-school options. Over half of the 12 schools had no school dances (92%), no student government (83%), no intramural sports (75%), no after-school clubs (58%), and no interscholastic sports (58%) (Figure 31).

The Commission also reviewed State Education Department assessments of the 12 special on-campus schools. These assessments, conducted every three years, further indicated that most of the schools were not complying with several key mandates of state regulations for the provision of a free and appropriate public education for children with handicapping conditions. More than half of the programs were cited for deficiencies related to development of individualized educational plans (67%), composition of the Committee on Special Education (50%), class size or composition (67%), and the provision of related services (58%).

## Poor Academic Progress

Perhaps the most significant indicator of the limitations of the special on-campus schools was that most of the children were not making significant academic progress in these special settings, and many were losing ground academically (Figure 32). Of the 72 children attending the special on-campus schools, 40 had been enrolled in the residential program prior to October 1990, or for at least nine months of the academic year prior to the Commission's June 1991 visits. Teachers of these longer-stay children were asked to assess the children's academic progress in reading and/or math for the 1990-1991 academic year. In almost all cases, these reports were supported by the comparison of end-year achievement test score results for the current and past academic school years.

Nearly three-fourths of these children (74%) had progressed *less than one year* in reading achievement, and 60% had progressed *less than one year* in math achievement. Approximately one-third of these children had achieved *less than a half-year's progress or no progress* in reading (26%) and/or in math (35%).

Most critically, teachers reported that almost two-thirds of the 72 children (63%) in the special on-campus schools had made limited or no progress in improving or gaining skills which would facilitate their placement in a regular classroom (Figure 33). Teachers reported that 38% of these children had made limited progress, that 19% of these children had made no progress, and that 6% of these children had actually regressed in skills that would facilitate their placement in a regular classroom.

### Other Rehabilitation and Support Services

Aside from the above services, therapists reported that almost all of the children (85%) also received other rehabilitative and support services from their residential program (Figure 34). The average child reportedly received about 30 hours of these services—which included training in basic living skills, help with homework, case management services, sex education, and vocational services—each month.

Figure 32: Academic Progress of Children With Lengths of Stays 9 Months (N=40)

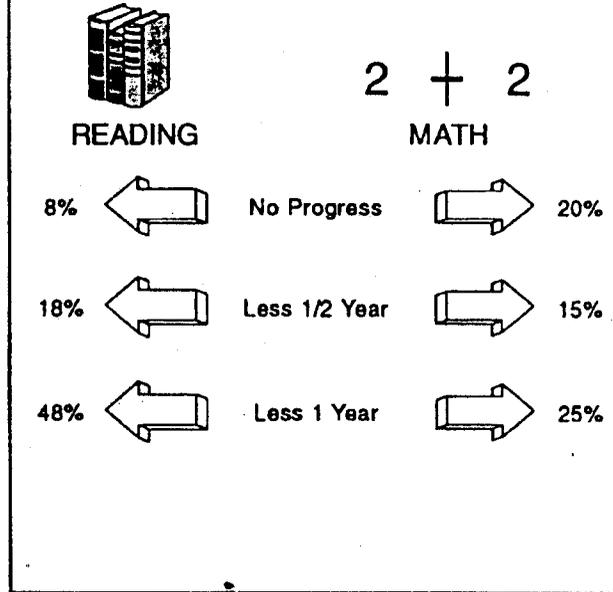
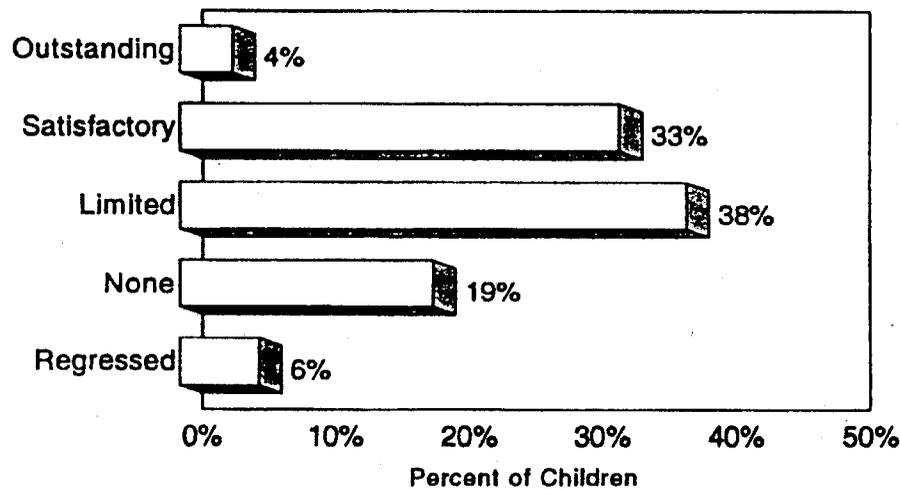
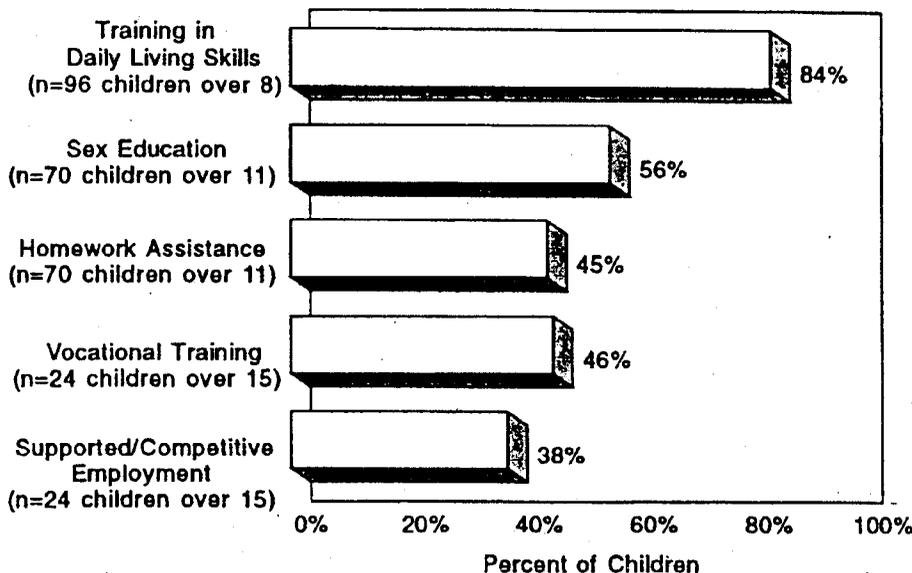


Figure 33: Teacher Reports of Progress Toward Placement in a Regular Classroom (N = 72)\*



\* Teacher reports were available only for the 72 children in state children's centers/units and RTFs.

Figure 34: Provision of Support Services to Children



Training in daily living skills, including cooking, cleaning, shopping, and budgeting, was clearly the most frequently rendered rehabilitative service, with 84% of the children over age 8 reportedly receiving this service, and the average child receiving (according to reports of primary therapists) about 25 hours of training each month, or about 5.5 hours a week.

The nature of these basic skills programs, however, varied widely across programs. A few congregate programs, like Baker Hall RTF and Green Chimney's RTF, offered a very structured course of instruction; more typically, basic skill training amounted to children completing some chores on the living unit, rather than teaching the children (especially older adolescents) to be sufficiently independent to maintain themselves in the community as young adults.

The marked exceptions to this general rule were the community residence programs and the

family-based treatment foster homes that the Commission visited. In both of these settings, children had the regular opportunity not only to learn and practice daily living skills in a real home, but also to observe home staff and foster parents carrying out these responsibilities of daily family living.

Only half of the children (45%) across all programs reportedly received assistance with their homework from residential staff. Unfortunately, for most of the other children, there was no homework expectation from the school program. When the Commission looked at these data more closely for the 70 children in the sample who were middle school age or older, the findings did not improve. Over half of these children (55%) received no homework assistance; and, of the 31 children who did receive assistance, 10 received 5 or fewer hours a month, or less than 15 minutes each school night. Ten (10) others received between 6 and 10 hours of assistance a month, or only about 30 minutes each school night.

### **Renee**

*Renee had her first contact with the mental health system when she was 16 and was hospitalized for a month at a local general hospital, and then transferred to a state children's center. At the time we met Renee, she had been at the state center for nearly a year.*

*On admission to the state center, Renee was described as depressed and suicidal. She had razor blades and a meat cleaver, wrote suicide notes and poems, and reportedly planned to buy a gun. Four months into her stay, Renee also disclosed being sexually abused by a family friend when she was 5 and, at age 11, by a man in her neighborhood.*

*Renee's current stay at the state children's center has cost approximately \$221,000, exclusive of special education costs. At the center, she receives approximately six hours of individual therapy each month, but there is no documentation that she receives any therapy/education that specifically addresses her sexual abuse. She receives Ativan as a PRN medication for agitation.*

*Renee's primary therapist was candid in stating that she would be better off at home, enrolled in a community school program, participating in more community activities, and receiving clinical and social supports from an intensive case manager. Her therapist also reported that Renee, who is extremely bright, is unchallenged and bored in the center's on-campus special education school program. According to Renee's teacher, she has regressed in reading, and she has dropped from Math III to Business Math to GED Math.*

Again, however, opportunities were much greater than average for the children in community residence and family-based treatment programs. Three-fourths of these children (75%), compared to only 36% of the other children in the sample, benefited from regular homework assistance.

Sex education and vocational services were also not "expected fare" at most of the programs visited. Therapists reported that only 56% of the children 12 or older ( $n = 70$ ) participated in a sex education program, and that only 50% of the children 16 or older ( $n = 24$ ) were receiving some vocational training (46%) and/or participating in supported work or had a real job (38%).<sup>24</sup>

Even among the relatively few adolescents who were participating in work-related activities, time spent in these activities was usually limited. With the exception of one child who was reportedly receiving 60 hours of vocational training a month, the average child received only 8 hours of service a month—or less than two hours a week. Similarly, with the exception of one child who reportedly was participating in a supported work program for 100 hours a month, the average child enrolled in these programs participated only 11 hours a month—or about 2.5 hours a week.

<sup>24</sup> Vocational training and supported work participation includes participation in these activities by the adolescent in the school and/or in the residential program.

---

# Chapter V

## Progress and Problems: Outcomes of Treatment

---

Gaining an understanding of the progress of the children served by the mental health residential programs visited was a final, important objective of the study. The Commission approached this objective from two perspectives:

- Commission staff asked the primary therapists/family-based specialists of the 100 children in the main study sample to assess their progress and readiness for discharge.
- Commission staff attempted to trace the lives of 34 additional children discharged from 6 of the 18 residential programs in the study's original sample for approximately two and a half years after their discharge.<sup>25</sup>

### Overview

As related in this chapter, these assessments tended to confirm the informal opinions of program administrators that most children in mental health residential placements, especially state centers and RTFs, are not making optimal progress toward their treatment objectives. The data also showed that many of the children, upon discharge, will simply be shuffled on to another residential placement, and that most will encounter many problems with the discharge transition.

Although the Commission discovered some "success" stories among the 34 children it fol-

lowed, most of the children, at best, had a very difficult transition year. Many of the children moved on to another residential program or foster care home, and from there to one or more other residential programs over the 2 1/2-year follow-up period. For some children, the "safe respite" of the residential program simply could not be matched on the outside. Of note, both the Commission and their service providers had lost track of one-fourth of the 34 children before the end of the 2 1/2-year follow-up period. Another one-fourth of the children had moved five or more times since their discharge.

### Therapists' Reports of Progress

By sampling design, over two-thirds of the children in the Commission's initial sample of 100 children (68%) had a length of stay at their residential program at the time of the Commission's visit of at least six months, and approximately one-third of the children (32%) had a length of stay of over one year. Only 11% of the children had a length of stay of less than three months.

Despite the children's relatively long lengths of stays, however, therapists' reports indicated that most of the children, and especially the children in state centers and RTFs, were making less than optimal progress in meeting their treatment plan objectives, and that nearly one-fifth of the children were judged as making "limited or no progress."

---

<sup>25</sup> These six facilities included three state children's psychiatric centers, Manhattan Children's Psychiatric Center, Rockland Children's Psychiatric Center, and Western New York Children's Psychiatric Center, and three RTFs, Madonna Heights RTF, Linden Hill RTF, and Astor Home RTF. As noted in Chapter 1, the Commission did not track discharge dispositions of children served by the more recently established community-based programs (community residences and family-based treatment) because only a small number of children had been discharged from these programs at least two years prior to the initiation of the review.

Therapists rated only 37% of the children as having made "a great deal of progress" toward their stated treatment plan objectives (Figure 35). Therapists rated 45% of the children as having made "some progress," and 17% of the children were rated as having made "limited progress." Only one child was rated as having made "no progress."

Although therapists' progress reports for children in state-operated centers and units and children in RTFs were similar, despite their generally shorter lengths of stays, the children in the community-based programs were more likely to be rated as having made a "great deal of progress" (46% versus 33% of the children in the other modalities) and less likely to be rated as having made "limited or no progress" (11% versus 21% of the children in the other modalities).

### Readiness for Discharge

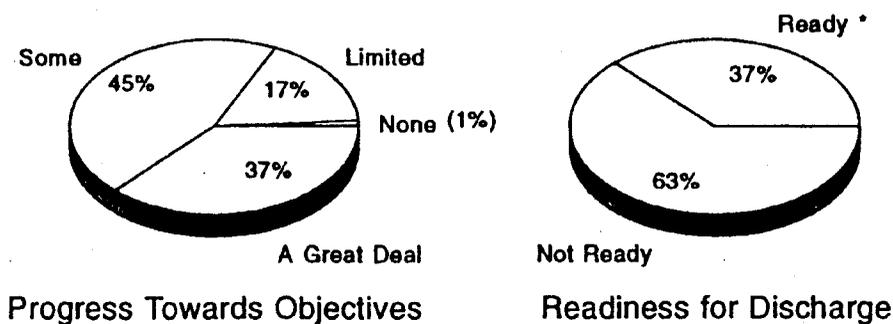
Corresponding to their progress ratings for the children, therapists indicated that most of the

children (63%) were not ready for discharge to a less restrictive setting. Over one-third of the children (37%), however, were judged by their therapists as being ready for discharge and, for 22 of these 37 children, therapists stated that continued placement at the facility would do the child "more harm than good."

Twenty-two (22) of the 37 children judged as ready for discharge were currently residing in state-operated children's centers or units. Of note, these 22 children represented 61% of the 36 sample children who resided in state-operated children's centers and units. Additionally, for 11 of these 22 children, therapists also stated that continued stay would do the child "more harm than good."

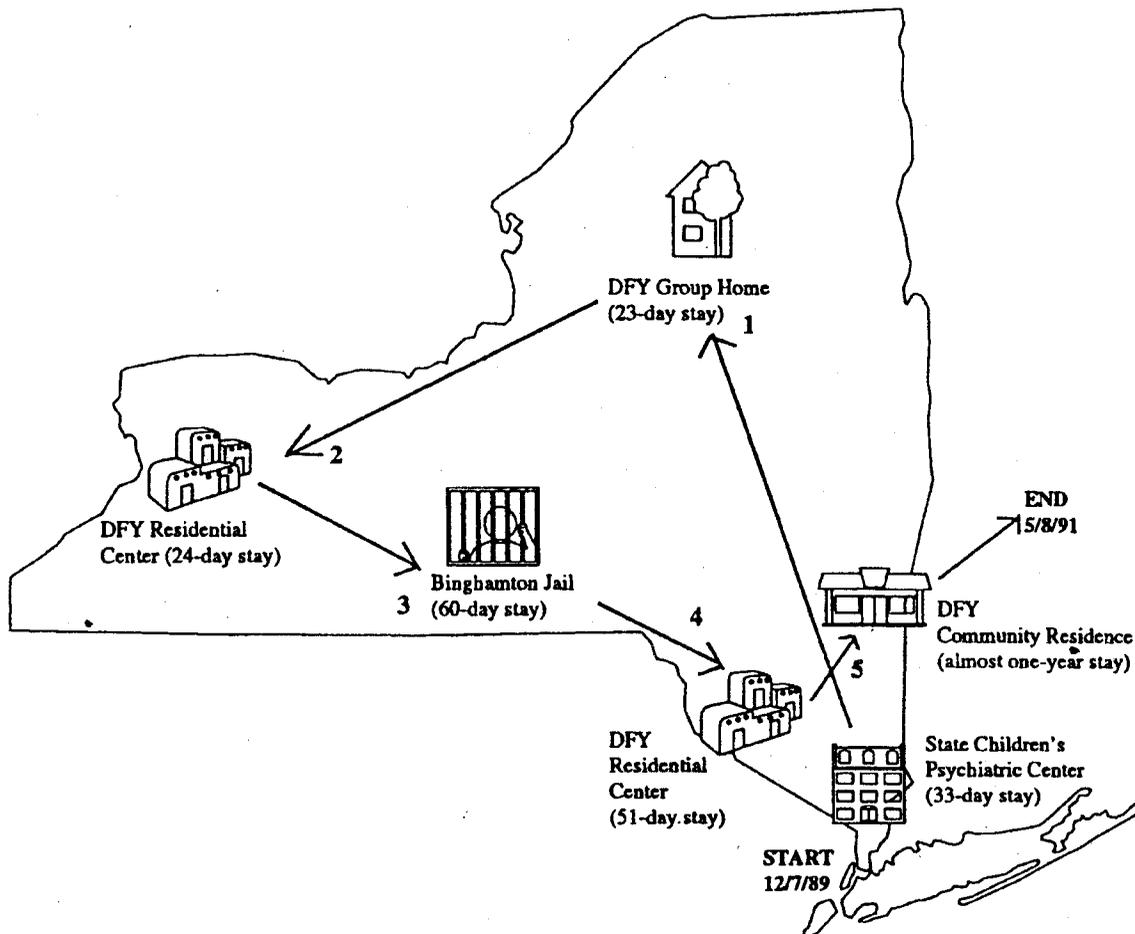
For most of these children (26 of the 37) judged to be ready for discharge, finding an appropriate, less restrictive program was holding up their discharge. For the remaining children, either the child or the family was resisting the discharge option recommended by the facility.

**Figure 35: Therapists' Reports of Children's Progress and Readiness for Discharge**  
(N = 100)



\* For 22 of the 37 children considered ready for discharge, therapists also felt that their continued stay would cause "more harm than good."

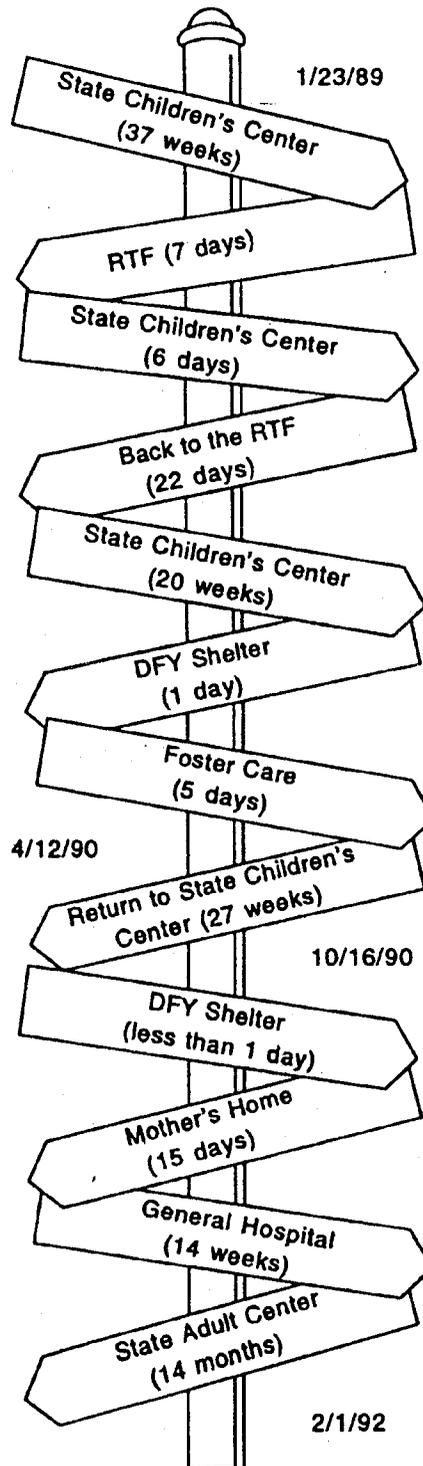
# Andy: On the Road Again



- At age 16, Andy was admitted to a state children's center for 33 days with the diagnosis of conduct disorder. The original plan was for his discharge to an RTC/RTF, but it was changed due to his aggressiveness.
- Upon discharge, Andy went upstate to a DFY group home. He was evaluated by a mobile crisis unit and diagnosed as a paranoid schizophrenic and a sex offender who was inappropriate for the setting and needed psychiatric care.
- After 23 days, Andy moved across the state to Buffalo to a more secure DFY residential center. He went AWOL, stole a car, was arrested, and placed in jail.
- Andy stayed in jail for two months and then moved downstate to another DFY center. During his stay of less than two months, Andy was re-evaluated. He was found to be socially sophisticated and only to have parent-child problems. The diagnosis of sex offender was totally refuted.
- Andy once again moved, this time to the Mid-Hudson region, where he resided at a DFY group home for almost a year.
- Andy was discharged in May 1991; at his 18th birthday in June, he would have aged out of the program anyway.
- Since Andy's discharge in May 1991, he reportedly went to live with a friend. His whereabouts at the present time are unknown.

# Anita: Which Program Will Work?

At age 16, Anita was admitted to a state children's center where she made significant progress, and then she was transferred to an RTF. This transfer was to begin her 17-month odyssey to 11 other placements.



During these 17 months, Anita attempted suicide several times; she alleged being raped by a fellow patient and later by a homeless man; she passed through a foster care home, and 5 other types of settings; finally, as she turned 18, Anita was admitted to a state adult psychiatric center for long-term care.

As of February 1992, one year after her admission, Anita was still at the state adult center and was beginning to show some improvement.

## The 34 Discharged Children . . .

The Commission attempted to follow the lives of 34 children who had been discharged from three state children's psychiatric centers and three RTFs included in its original sample of 18 programs for approximately two and a half years after they left the residential program. As shown in Figure 36, these 34 children were similar on most demographic and family history variables to the children in the Commission's main sample of 100 children. The discharged sample children were, however, significantly more likely to be 15 or older (79% versus 40%), reflecting the general tendency of many programs to activate discharge efforts as the child approached 18 years of age.

Figure 36: Comparative Profile of Discharged Children vs Children in Original Sample

"100" Children in Original Sample		"34" Discharged Children
40%	15 Years of Age or Older	79%
53%	White	50%
80%	Evidence of Prior Abuse/ Neglect	79%
41%	First Placed Out-of-Home at Age 8 or Younger	39%
47%	Spent 3 or More Years in Out-of-Home Placement	56%
50%	First Sought Mental Health Services at Age 8 or Younger	33%

## Initial Placements

Discharge dispositions of the 34 children included 4 children discharged subsequent to their running away (AWOL), 3 children discharged against medical advice (AMA), 5 children discharged to *more* restrictive/treatment intensive settings, and 22 children discharged to *less or equally* restrictive/treatment intensive settings

(Figure 37). The five children discharged to more restrictive/treatment intensive settings all had resided in RTFs, and they were all discharged to a state children's psychiatric center or unit.

In contrast, the 22 children with planned discharges to *less or equally* restrictive settings went to many different types of residential settings. Only 6 of these children went home to live with their natural or adoptive parents, and 5 others went to regular or enhanced foster care homes. Ten (10) of these children were discharged to one of six different types of residential treatment program, including residential treatment centers (3 children), RTFs (2 children), out-of-state facilities (2 children), a special residential school (1 child), a private psychiatric facility (1 child), and a Division for Youth group home (1 child). One other child was discharged to jail.

Four (4) of the 7 children discharged AWOL or AMA reportedly also went home to live with their families. One of the other children discharged AWOL was ultimately picked up by a local social services worker and placed in a foster home; another child discharged AWOL was readmitted to a state children's psychiatric center within a week or two of *his* AWOL.

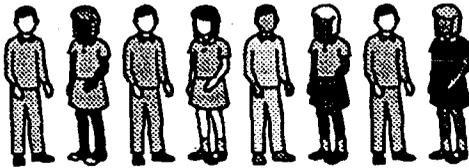
The last child, a 14-year-old girl, was discharged AWOL from an RTF, and she ran to a nearby homeless shelter. Over the next few months she wandered, living sometimes with a relative and sometimes on the street. In August 1990, seven months after her AWOL, she died as a passenger in a car crash. The driver was another young girl of no relation. Little is known of this young girl's final months. DSS had "lost" track of her five months after discharge, when her caseworker went on medical leave.

## Discharge Planning

As a general rule, the Commission found discharge plans (85%) and discharge summaries (88%) in the records of the 34 children (Figure 38). All of the children's records also included assessments, admission summaries, comprehensive treatment plans, and regular daily or weekly progress notes.

# Figure 37: Discharge Dispositions of the 34 Children

## Less/Equally Restrictive



22 Children

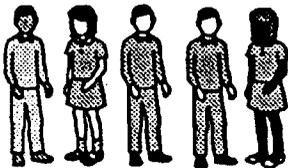
6 children to natural family

5 children to foster care/  
enhanced foster care

10 children to various  
residential facilities

1 child to jail, then to home

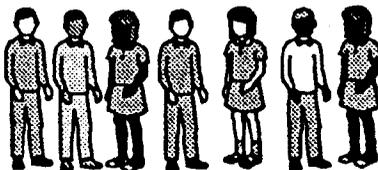
## More Restrictive



5 Children

All discharged from RTFs  
to state children's centers

## AWOL/AMA Discharges



7 Children

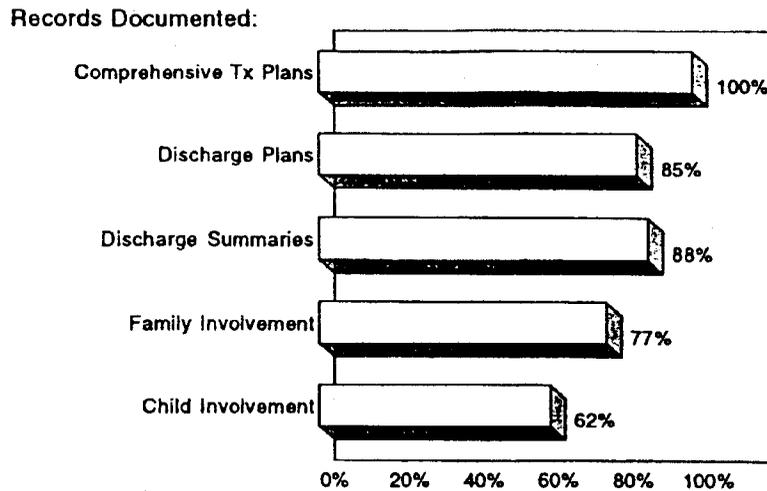
4 children to natural family

1 child to emergency foster  
home

1 child to the streets, then  
to state children's center

1 child to shelter

Figure 38: Adequacy of Records and Discharge Planning  
(N = 34)



Records of 77% of the children, including 11 out of the 15 children discharged home or to a foster home, also referenced family or foster family involvement in discharge planning. Notation of the child's involvement in discharge planning was present, however, in only 21 of the 34 cases (62%). The 13 children whose records did not document their participation in discharge planning included 4 children who left the facility AWOL or AMA, 5 children with planned discharges to a *more* restrictive setting, and 4 children with planned discharges to a *less* or equally restrictive setting.

### On the Move Again . . .

In tracing the post-discharge lives of these 34 children, the Commission soon discovered that many were "on the move" during the 2 1/2-year follow-up period, and that most had dropped in and out of various outpatient programs over the same period. These children were not easy to find or to keep tabs on.

In total, the Commission was able to trace the whereabouts of 24 of the 34 children for the entire 2 1/2-year follow-up period. For four of the "lost" children, the Commission knew the child's initial "reported" place of residence subsequent to discharge, but was unable to make contact with any service provider or family member who knew where the child was or had been after the first few weeks or months of his/her discharge. The Commission lost track of another five children prior to December 31, 1991, the close of the follow-up period. One other child, as mentioned above, died in a car accident approximately seven months after her discharge.<sup>26</sup>

Only one-third of the 24 children (33%) whom the Commission was able to trace through the close of the follow-up period had remained in their initial placement for the entire period (Figure 39). Nearly half of these children (46%), however, were known to have moved at least two times after their initial placements in the 2 1/2-year follow-up period, including seven children (29%) who were known to have moved five or more times.

<sup>26</sup> Descriptions of the circumstances of the ten "lost" children are provided in Appendix A.

# Helena: AWOL and Missing

1990

January	February AWOL 2/26	March Discharged from State Children's Center on 3/5	April ?
May 5/30 May be pregnant	June ?	July ?	August ?
September ?	October 10/16 Seen in ER from car accident	November ?	December ?

□ At 14, Helena is brought to a state children's center on 1/26/88, and she stays for over two years. On admission, Helena's mother states, "I don't like or care for Helena. Do what you want with her." Helena makes little progress at the center and goes AWOL a number of times. On 3/5/90 Helena is discharged while AWOL. Reportedly, she is living with her aunt.

1991

January ?	February ?	March ?	April ?
May ?	June ?	July ?	August ?
September ?	October ?	November 11/27 Seen at CPBH for PAP smear	December ?

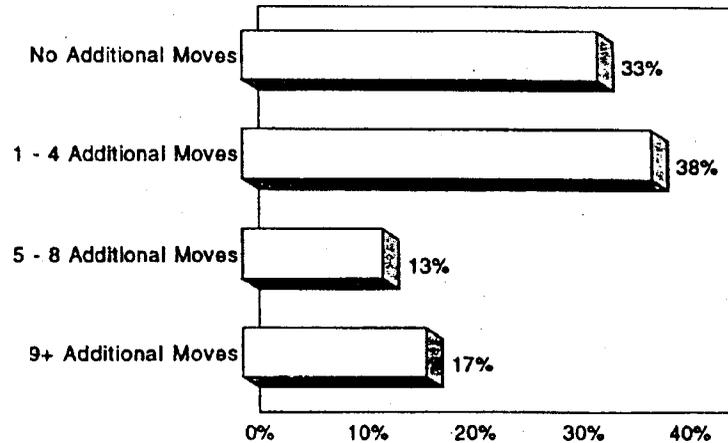
□ On 5/30/90, staff from the state center try to persuade Helena's mother to take Helena to a local hospital's outpatient department as she may be pregnant. There is no further contact with Helena or her family until October 1990, when Helena is brought to the local hospital's ER for medical attention. An evaluation by a psychiatric intern finds Helena stable, but recommends follow-up by the Mobile Crisis Unit. This unit's evaluation finds Helena agitated, irritable, and hostile, but not in need of services they offer.

1992

January ?	February ?	March Mother dying of AIDS	April
May	June	July	August
September	October	November	December

□ A year goes by before Helena has contact with the local hospital in November 1991, again for medical attention. She still has not received any mental health services in over a year and a half. Four months later, in March 1992, Helena's mother's social worker calls the local hospital to inform them that Helena's mother is dying of AIDS, that Helena is living with her on and off, and that someone needs to follow-up on Helena because she refuses to go to a mental health provider.

Figure 39: "Moves" After Initial Placements During the 2 1/2-Year Follow-Up Period (N = 24)\*



\* Data provided for 24 of 34 children whom the Commission was able to track for the full 2 1/2-year follow-up period. Total percentage exceeds 100% due to rounding.

As illustrated by the pictorial vignettes in this chapter, some children literally moved all around the state; others moved into and out of many different child care modalities over a brief period of time; and, still others seemed to bounce back and forth between two facilities, like "unwanted" people.

Reflective of the number of children who moved several times in the 2 1/2-year follow-up period, many had not stayed long in any one residential setting. Four (4) of the 24 children (17%) followed through the full 2 1/2-year period had never spent longer than six months in any one residential setting; and another 5 (21%) had never spent longer than one year in any one residential setting.

## Rehospitalizations

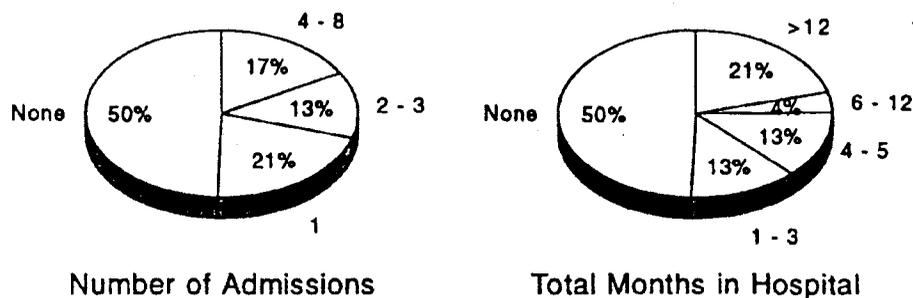
For half of the 24 children (50%), some of their residential placements included "rehospitalizations" at state psychiatric centers (11 children), and/or on psychiatric wards of general hospitals or private psychiatric hospitals (6 children) (Figure 40). In total, 5 of the 24 children were rehospitalized once

in the 2 1/2-year follow-up period; 3 were rehospitalized two-three times; and 4 of the children were rehospitalized four-eight times.

Perhaps even more telling, many of the rehospitalized children had relatively long inpatient stays. In total, 25% of the 24 children spent *more than six months* on psychiatric wards of general hospitals or state psychiatric centers in the 2 1/2 years subsequent to their discharge. Five of these six children spent more than a year as a psychiatric inpatient in this 2 1/2-year period.

Reflective of the overall incidence of rehospitalizations among the children in the sample, in the 2 1/2-year follow-up period, half of the 24 children (50%) had required mental health crisis services; 50% had expressed suicidal ideation, and 14% had attempted suicide. Despite these findings, however, relatively few of the 24 children had evidenced other serious psychiatric symptomatology. Only 9% of the children had experienced visual or auditory hallucinations, and only 18% had reportedly manifested delusional thinking.

**Figure 40: Children Rehospitalized During a 2 1/2-Year Follow-Up Period**  
(N = 24)\*



\* Data provided for 24 of 34 children whom the Commission was able to track for the full 2 1/2-year follow-up period. Total percentage exceeds 100% due to rounding.

## Services Received/Needed

The vast majority of the 24 children (92%) followed through the close of the 2 1/2-year follow-up period received some mental health services during this time, and, at the close of the follow-up period, 79% were receiving these services either through a comprehensive residential program (50%), an outpatient mental health clinic (21%), or a continuing treatment program (8%). As shown in Figure 41, of the children receiving outpatient mental health services, most received services from clinics, but approximately one of every two of these children was attending a more service-intensive continuing treatment program.

Additionally, although 13 of the 24 children had a DSS case worker during some part of the follow-up period,<sup>27</sup> the Commission generally found that these workers had relatively large caseloads (e.g., 20-35) and were not in regular contact with the children. Ironically, even when case managers seemed to know the children well,

few seemed to see it as their job to plan comprehensive services for the children or to critically evaluate permanency issues. For many case managers, just keeping track of where the child was currently living, if he/she was making it, or searching out another program that would take the child, seemed to define their primary activities.

Perhaps reflective of the relatively low level of outpatient/ancillary services that the children were receiving, nearly half of the 24 children (46%) were identified by their current therapists or caregivers as having one or more unmet service needs. Notably, for many of these children, their unmet needs related to basic skills for daily living.

- Unmet service needs listed for the children included: a more structured and supervised living environment (3 children), more family contact and nurturance (2 children), vocational or work opportunities (3 children), daily living and coping skills training (2 children), and more individual or family therapy (3 children).

<sup>27</sup> Only 1 of the 24 children currently had an intensive case manager, and only 2 had an intensive case manager for some part of the follow-up period.

Figure 41: Receipt of Mental Health Services

	At the close of the 2 1/2-year follow-up period... (N = 24)	At some point during the follow-up period... (N = 24)
Comprehensive Residential Treatment Program	12 (50%)	15 (63%)
Mental Health Clinic	5 (21%)	10 (42%)
Continuing Treatment Program	2 ( 8%)	6 (25%)

- Other identified unmet needs for individual children included: money management training, basic academic skill training, routine medical care, and help in working out social relationships with peers.

moving about. During this period, 8 of the original 34 children also aged into adulthood.

For 22 of the 24 children followed through the entire period, the Commission was also able to interview the child's current primary therapist or caregiver using a structured survey tool which assessed his/her adjustment. As shown in Figure 42, these assessments indicated that most of the children had social adjustment problems and appeared distrustful of adults.

### Significant Events in the Children's Lives

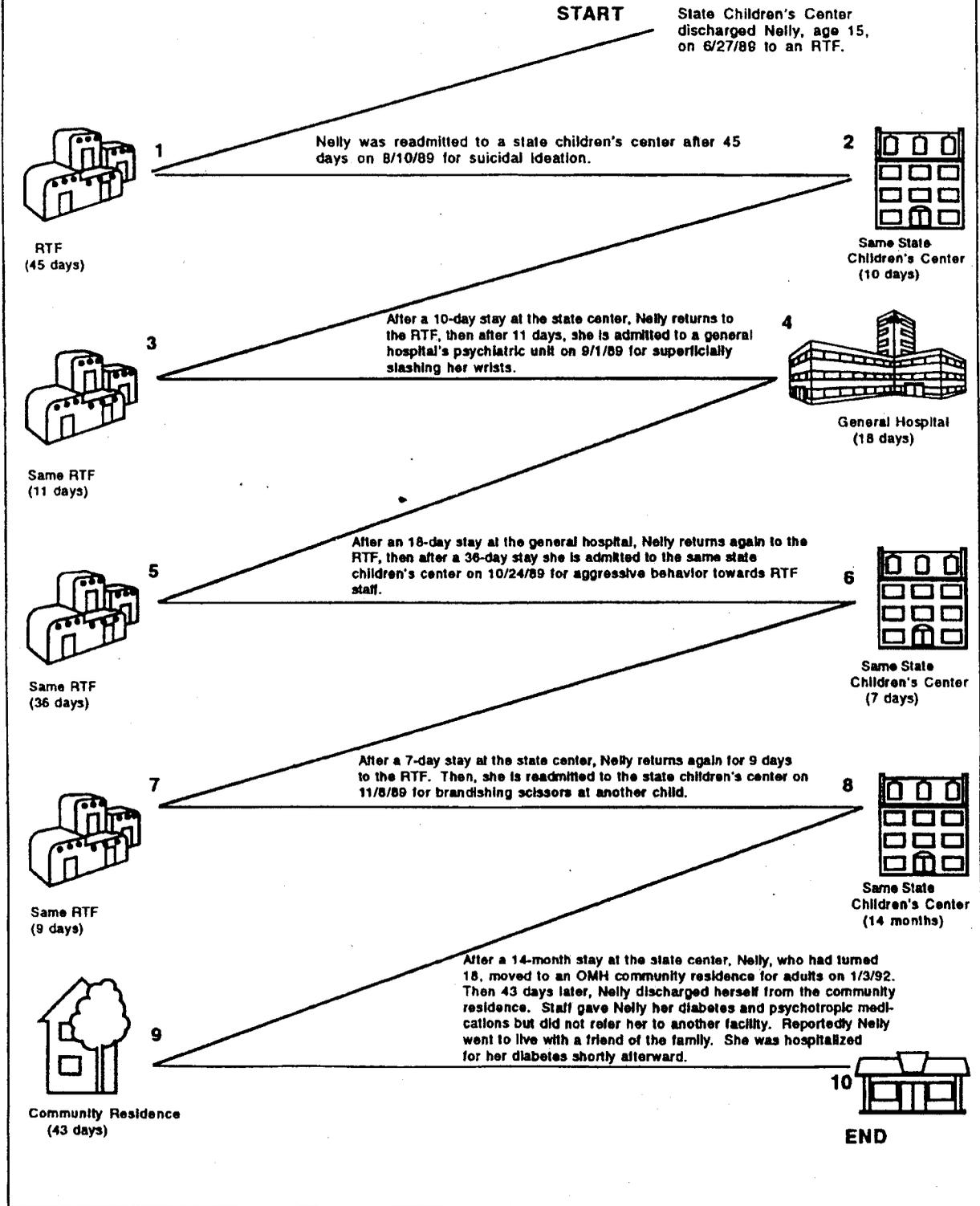
Over the 2 1/2-year follow-up period, the children's lives were marked by more than just

Figure 42: Adjustment Problems of the Children  
(N = 22)\*

Not usually trusting of other children .....	86%
Not usually trusting of adults .....	82%
Usually or sometimes displaying oppositional behavior to most adults and children .....	73%
Usually or sometimes unwilling to relate to adults .....	50%
Victimized in a crime .....	55%
Suspended or expelled from school at least once during the 2 1/2-year follow-up period .....	36%
Regularly gets into trouble at school .....	30%

\* Data provided for 22 of the 24 children followed through the entire 2 1/2-year follow-up period for whom the Commission was able to interview the child's current primary therapist or caregiver on the child's adjustment.

# Nelly: Same Places but Never for Long



These assessments also indicated that over the 2 1/2-year follow-up period, a significant minority of the 22 children had engaged in unlawful activities or had been victims of crimes, including physical and sexual assaults.

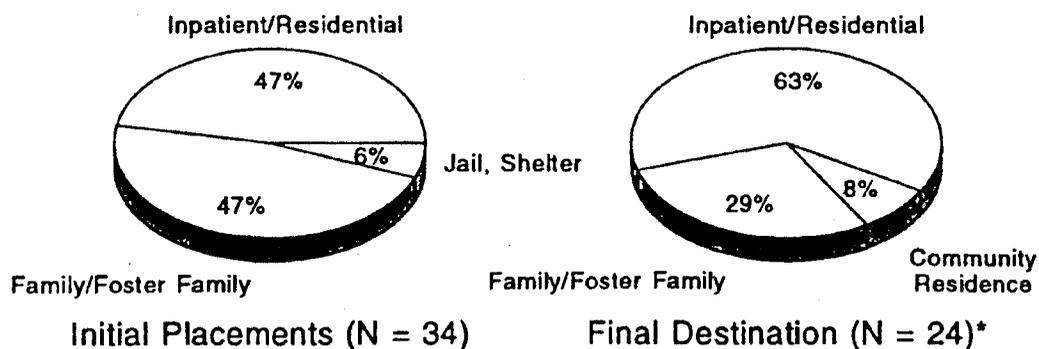
- Seven (7) of the 22 children, or 32%, had some contact with law enforcement. Three children (14%) had been arrested and charged with a crime, and one child (5%) had been placed on probation.
- More of the children, 12 of the 22 (55%), had themselves been victims. Seven (7) of the 22 children (32%) had been physically threatened or harmed; six of the 22 children (27%) had been sexually threatened or harmed; and two of the children (9%) had been a victim of another crime. Three other children had been seriously injured or hurt in an accident.

## Final Destinations

As noted above, the Commission was not able to determine where 9 of the 34 children were living at the end of the follow-up period, and one other child died. For the remaining 24 children, the data indicated a general trend of movement away from community-based and family-like settings and toward more institutional-like settings (Figure 43).

At the close of the follow-up period, 15 of these 24 children (63%) were living in a congregate residential setting compared to 47% of the total 34 children at the time of discharge. Of the 15 children residing in congregate settings at the close of the follow-up period, 4 were in congregate residential placements out-of-state; 2 were in a state children's center or unit and 2 were in an adult psychiatric center. Three (3) others were in an RTF; 3 were in a residential treatment center; and, 1 child had been placed in a residential school for the deaf.

Figure 43: Initial Placements vs Final Destinations



\* Data provided for 24 of 34 children whom the Commission was able to track for the full 2 1/2-year follow-up period.

Five (5) of the 24 children followed through the close of the follow-up period had initially been discharged home to their families, but only 3 remained at home. At the close of the period, one of the children resided at a state children's center and the other had moved to an RTF.

Additionally, only 1 of the 5 children initially discharged to foster care or enhanced foster care (the child discharged to a family-based treatment program) remained with his foster family through the close of the 2 1/2-year follow-up period.

---

# Chapter VI

## Nobody's Children:

### Conclusions and Recommendations

---

This study was designed to focus on children classified as emotionally disturbed who were served by residential programs operated or licensed by the Office of Mental Health, but we soon discovered that these children migrated among the state's child care systems.

---

*Over two-thirds of the children in the Commission's sample had moved to their current mental health residential placement from another out-of-home placement.*

---

To focus exclusively on the mental health system's performance in thinking about the future of these children is too limited a view. Children are not that easily compartmentalized. Their lives are affected by the adults around them—by families and foster families; by the educational system which must help prepare them for adulthood; by a variety of social services and financial assistance programs needed by them and their families; and, occasionally, by the juvenile justice system.

Indeed, as illustrated in the study's findings, many of these children were caught up in a shuffle from one out-of-home placement to another. Over two-thirds of the children in the Commission's sample had moved to their current mental health residential placement from another out-of-home placement, and data findings indicated that most would leave their mental health residential placement to enter yet another out-of-home placement.

Frequently described as the most "difficult children" by their congregate child care providers, these children were really "Nobody's Children." Once placed out of their family homes,

these children often were treated apart from their natural family—as family therapy and support services became both an impractical and conceptually incongruent service for residential programs often located some distance away.

Notwithstanding the very limited support services to help parents reunite with their children, efforts to promote permanency planning for many of the children in the sample also seemed stalled. Decisions to move toward termination of parental rights, even in the most extreme cases, were put on hold while the child was in residential placement. At best, these efforts seemed to be reactivated only periodically as the "system" considered where to move the child next.

Despite lip service to "permanency planning," rationales for moving children among out-of-home placements were changeable. Children could be abruptly moved for getting into trouble, for evidencing signs of more serious problems, for getting too old, or ironically for doing well.

---

*Notwithstanding the very limited support services to help parents reunite with their children, efforts to promote permanency planning for many of the children also seemed stalled.*

---

Stalling year after year in making these admittedly difficult decisions had effectively deprived many of the children in the Commission's sample of a stable family throughout most of their childhood. Over half of the children (57%) had been placed out of their homes by the age of 10, and nearly half (44%) had already spent a total of three or more years of their childhood in congregate child care settings.

Permanency planning problems even surfaced in the community-based options. Commission staff visited several foster families enrolled in family-based treatment programs who were willing and eager to adopt the children in their care. In each of these cases, there was substantial evidence that the child's natural parents could not or would not be able to resume full-time parenting. However, their unwillingness to acknowledge this and surrender a child for adoption often led officials to conclude that efforts to sever parental rights would be futile.

---

*What was notable for the vast majority of the children in the Commission's sample was not their mental health conditions or diagnoses, but their often harrowing and bitter histories of family dysfunction and abuse and neglect.*

---

## The Search for a Family

What was notable for the vast majority of the children in the Commission's sample was not their mental health conditions or diagnoses, but their often harrowing and bitter histories of family dysfunction and abuse and neglect. Admission notes for many of the children seemed to focus more on these family problems and the child's need for protective, long-term placement than their psychiatric needs.

It seemed that what these children usually needed most was a nurturing family. Unfortunately, except for the children enrolled in family-based treatment programs, it seemed that this need may never be met. And even for children in family-based programs, their nurturing and comfortable families were secure only as long as they stayed "mentally ill." Once cured or improved, these children had to give up their new families.

Traditional foster care families had failed to meet the needs of many of these children one or more times in the past and, as this track record of failures mounted, the children were relegated to congregate child care facilities, which provided

even less semblance of a nurturing family life. Once a child entered the congregate child care system, he/she was also at very high risk of more moves in the future, often to wholly new communities or regions of the state.

In following the odyssey of these children through various child care programs, the Commission was struck by the apparent absence of value placed on assuring *stability* for them through their developmental period, as well as a seeming lack of active recognition that childhood is brief and, once lost, is irretrievable.

## The State's Promising, but Fragmented Response

At the same time, as one notes these failures of the child care system in addressing the needs of many of these children, the Office of Mental Health and other state agencies must be credited with their recent independent initiatives to address these problems. In many respects, new initiatives of the Office of Mental Health, both in enriching its children's outpatient service system and in expanding its community-based residential options for children, have been the first significant efforts in years to address these fundamental issues in children's mental health services. The Commission is likewise aware that the Department of Social Services has simultaneously attempted to develop parallel services for children in its system.

---

*In following the odyssey of these children through various child care programs, the Commission was struck by the apparent absence of value placed on assuring stability for them through their developmental period.*

---

The Department of Social Services sponsors a "Homebuilders Program" which provides intensive short-term, in-home support and assistance to families where children are at risk of out-of-home placement. Likewise, the Office of Men-

tal Health sponsors a very similar "Home-Based Treatment Program" to try to divert children who may be admitted to acute hospitals or residential mental health settings. And, both the Department of Social Services and the Office of Mental Health sponsor comparable enriched foster care programs, which are differentiated chiefly by their unique names ("Therapeutic Foster Care" versus "Family-Based Treatment"), and different paperwork and other administrative requirements, as well as minor differences in reimbursement and admission eligibility requirements.

The Commission is also aware that the Division for Youth and the Office of Mental Retardation and Developmental Disabilities are attempting to pursue similar initiatives. All of these initiatives hold some promise for a brighter future for children classified as emotionally disturbed. What seems unfortunate is that, as in the past, each of these state agencies is on its own separate highway to reform. Indeed, these new programs, each with its own funding stream and eligibility and administrative requirements, appear poised to fashion yet another level of tangled and uncoordinated child care services at the local level.

---

*All of these state initiatives hold some promise for a brighter future for children classified as emotionally disturbed, but what seems unfortunate is that, as in the past, each of these state agencies is on its own separate highway to reform.*

---

The dilemmas posed by this web of new home-based and family-based service initiatives for children and their families, as well as for local government officials and service providers, are easy to spot.

Take the little six year old in our sample who was enrolled in an OMH family-based treatment program. He was doing so well that his treating clinician was not sure he should really have a mental health diagnosis any longer. According to the rules, however, once "cured," or stripped of

his mental health diagnosis, this young boy will no longer be eligible for his family-based program placement, but his foster parents belong to that program. OMH rules restrict their programs from recruiting foster parents who have qualified in any other state agency program. If this youngster transfers to regular foster care or therapeutic foster care, he loses his foster parents who have made such a difference in his life. It is hardly surprising, given these options, that the young boy's therapist decided to keep him labeled with his ambiguous mental health diagnosis a little longer.

The difficulties of maintaining siblings together can be compounded by this array of different agencies' categorical community-based services. For example, if two siblings must be placed out-of-home due to abuse and concomitant problems, they may be separated due to availability of placement or their diagnoses.

## Toward Solutions

Fully addressing the problem of fragmented services for children classified as emotionally disturbed, as well as other children at risk of or in out-of-home placements, will require that New York take a fresh look at its entire multiagency-sponsored array of child care services. In the interim, however, New York should take immediate steps to ensure that it does not replicate the worst failings of its splintered congregate care residential system for children in creating an equally fragmented system of family support and community-based services for children.

It is tempting to recommend what logically flows from these observations—that New York State avoid continuing on the path of existing separate, but similar, categorical family support and family-based programs in each of its separate child care systems, with the predictable problems of continuing to ping pong children between programs as their labels change, and that the state avoid developing separate, overlapping, and duplicative administrative and regulatory structures for such programs. That such a course is counter-

productive, expensive and wasteful appears to have been widely recognized.<sup>28</sup> Yet, concrete steps to change the existing fragmentation, duplication, overlap, and redundancy have been slow in coming.

---

*We believe it is essential that each such child be assigned a case manager/advocate in his/her local community who would remain actively involved for as long as the child remains in an out-of-home placement, regardless of which agency is operating or certifying the placement.*

---

Candidly, the Commission fears that the most likely immediate outcome of such a recommendation might be to prompt a halt in the development of successful, much-needed, and preferable models of community services, while the bureaucratic, political, and other barriers that have thus far stymied progress remain fully entrenched. Therefore, while we recognize and support the need for such structural changes, and for the development of a more flexible and integrated approach to meeting the needs of children and families in the community, we also believe there are *immediate* steps that must be taken while longer range restructuring is planned. One of the critical steps is to address the needs of children who are now in out-of-home placements.

We believe it is essential that each such child be assigned a case manager/advocate in his/her local community who would remain actively involved for as long as the child remains in an out-of-home placement, regardless of which agency is operating or certifying the program. The role of the case manager/advocate should be to advocate for achieving the ultimate goal of the state's intervention—reunification with the family, where that is possible or desirable, or freeing up the child for adoption or more stable long-term residence with a surrogate family.

For this type of child and family-focused approach to be successful, case management needs to be viewed as a generic service to children, rather than as specific to each child care system, and as fragmented in its approach as the services themselves.

One means of implementing a different, more integrated model of services would be to "block grant" to localities the various categorical funds now provided and give both guidance and incentives to tailor a more flexible child- and family-centered approach to service delivery, driven by children's and families' needs rather than their labels and eligibility.

An interim step towards achieving such a goal might be the adoption of a liberal waiver of admission/continued-stay criteria to allow children to receive the services they need without having to change a successful residential placement just to get them. Thus, if a child was doing well in a program and a continued stay would benefit the child in achieving the ultimate goals of the intervention, the case manager/advocate should seek a waiver of the program rules that would require the child to move.

---

*An interim step towards achieving such a goal might be the adoption of a liberal waiver of admission/continued stay criteria to allow children to receive the services they need without having to change a successful residential placement just to get them.*

---

The Commission also strongly endorses other interagency efforts which promote the use of financial incentives to localities in engineering creative service options and packages that prove themselves in helping families to overcome their difficulties and to stay together and, where this is

---

<sup>28</sup> *Report of the Workgroup on Regulation of NYS Children's Services*, Governor's Work Group on Regulation of Children's Services, December 1990; *New Directions in Accountability for NYS Children's Services*, Governor's Task Force on Children and Youth, November 1988; *Putting the Pieces Together: Survey of State Systems for Children in Crisis*, National Conference of State Legislatures, July 1990.

not possible, in ensuring children permanence and quality lives in surrogate family situations in their own communities. To this end, the Commission urges the Office of Mental Health and all state agencies serving children at risk of or in out-of-home placements to take affirmative steps, including sponsoring selective interagency demonstration block grants, which assist local governments in moving ahead with such endeavors.

---

*While institutional programs generally perform a "safety net" function reasonably well, providing a safe haven for children who had been in environments of abuse and neglect, and attending to their basic custodial and medical needs, these benefits came at a high price, both fiscally and otherwise.*

---

## Buying Less for More

Other study findings clarified the high costs of New York's largely institutionally based children's residential system to the New York taxpayer. Placing a single child in a state children's psychiatric center or unit currently costs almost \$200,000 a year. While per diem costs in RTFs are lower, they still stack up to a hefty bill of \$214 a day, or almost \$80,000 a year.

And, despite their high costs, our review found these programs failed to provide for many of the children's essential needs. While these programs generally perform a "safety net" function reasonably well, providing a safe haven for children who had been in environments of abuse and neglect and attending to their basic custodial and medical needs, these benefits came at a high price, both fiscally and otherwise.

In both settings, children are largely isolated from any semblance of a normal community or family life, or the social responsibilities inherent in these experiences, nor are they learning to accept these responsibilities. Children in these programs also have no opportunities, from the

time they wake up in the morning until they go to sleep at night, to play or study with children who are not, like them, classified as "emotionally disturbed."

Additionally, as documented in this report, these programs do not provide strong academic programs to help the children compensate for academic deficits; they do not typically offer well-structured programs to teach daily living and home management skills; and they offer few adolescents substantial vocational training or supported work programs. And, although verbal therapies and relatively small primary therapist case-loads tended to characterize all of the programs visited, even primary issues of prior familial abuse and neglect were often not explicitly addressed in the children's treatment plans.

Finally, and perhaps most basically, clinical records suggested that family and child involvement in treatment planning was not a fundamental principle of many of the state children's centers and units and RTFs visited. Although families were in regular contact with 71% of the children in these programs, records indicated that only 50% of the families had been involved in developing their children's treatment plans. Just as disappointing, records of only 31% of the children noted that they had been consulted in the development of their own treatment plans.

## Community Programs Offered More for Less Cost

By almost all yardsticks, the community-based programs visited, and especially the family-based programs, offered the children they served significantly more than the institutional programs at a significantly lower cost. Five children could be served in family-based treatment programs for approximately the same total cost as the cost for caring for a single child in a state children's center or unit. As OMH moves to provide Medicaid reimbursement for both the family-based treatment programs and community residences for children, the net State costs of these programs will also be reduced substantially.

More important, the children in the community-based programs not only had many more day-to-day opportunities to be with other children in their communities not classified emotionally disturbed, they were also much more likely to attend community schools and even to be in regular classrooms. These children also had more opportunities to learn daily living skills; they were more likely to get after-school help with their homework; and their behavior problems were considerably less likely to be addressed with psychotropic medications or other intrusive physical interventions or restraint.

Notably, by the design of the program, children in family-based treatment and community residence programs met the same admission criteria as children in RTFs. Yet, despite comparable, if more involved, clinical and family histories and shorter lengths of stays, more children in the community-based options were also likely to be making "a great deal" of progress toward their treatment objectives (46% versus 33%), and less likely to be stalled in making any significant progress (11% versus 21%).

## Psychotropic Medications

The Commission also observed treatment practices in many of the residential programs visited—especially many of the state centers and units and RTFs—that simply seemed wrong.

The liberal administration of psychotropic medications to three-fourths of the children, most of whom had no serious psychiatric symptomatology or no major psychiatric diagnoses, was striking. Noting the very limited empirical studies substantiating the benefits of psychotropic medications to children with these diagnostic profiles, virtually all experts advise the limited and cautious use of these medications with children.

In contrast with this advice, however, almost all the programs visited—and especially state centers and units and RTFs—viewed psychotropic medications as a routine component of the treatment regimens of the vast majority of the

children they served. Psychotropic medications were usually started virtually concurrently with the child's admission, and drug-free periods to assess whether the medications should be continued were not standard practice in any of the programs visited. In almost all programs, clinicians and living unit staff also were not systematically collecting data monitoring the impact of psychotropic medications on the children's behaviors.

Half of the parents and guardians of children in the sample receiving psychotropic medications had also signed no consent form for the administration of these drugs to their children, and documentation that parents and guardians had been fully apprised of the intended effects and the known adverse side effects of the medications their children were taking was universally absent.

---

*The liberal administration of psychotropic medications to three-fourths of the children, most of whom had no serious psychiatric symptomatology or no major psychiatric diagnoses, was striking.*

---

## Managing, Not Teaching Children

Almost all programs, except the family-based treatment programs, also relied extensively on "level or point systems" to manage children during their stays in the residential programs. The Commission found these systems to be wanting in many respects, from their lack of individualization, to their heavy emphasis on negative rather than positive reinforcement, to the limited transferability of their "benefits" upon a child's discharge in assisting the child in learning self-control.

Almost all of the "level and point systems" the Commission observed also routinely exacted consequences, like restrictions on visitors, family contact, and telephone use, that violated the children's basic rights. In other situations, these systems compelled children to earn as "rewards"

activities and experiences, like bedtime stories, which one would expect to be found as basic elements of a nurturing program for children separated from their families.

---

*Almost all of the "level and point systems" the Commission observed also routinely exacted consequences, like restrictions on visitors, family contact, and telephone use, that violated the children's basic rights.*

---

Perhaps the most serious aftermath of the programs' heavy reliance on "level and point systems," however, was that these systems tended to obscure the need and benefits of more individualized behavioral plans, developed with individual children, to teach and to invest the children personally in desired goals. Despite the fact that almost three-fourths of the children were reportedly placed out-of-home due to aggressive behaviors, only 33 of the 100 children in the sample had any semblance of an individualized behavior plan targeted at their problem behaviors. And, even among these 33 children, according to their records, only 42% had been involved in the development of the plan.

## Imprudent Use of Chemical and Physical Restraints

The Commission also found that when "level or point systems" failed to keep order, the tendency to resort to more intrusive and restrictive practices was common, especially in the congregate residential programs. Almost all of the children's records also provided limited documentation that program staff had tried less restrictive methods, before these more intrusive and potentially dangerous techniques were used.

In the three months prior to the Commission's visits, a significant 40% of the children in state children's centers and units and RTFs had been subject to chemical restraint in the form of a PRN or STAT psychotropic medication. Additionally, while mechanical restraints and seclusion were

used with only 14% of the children in the sample, the exceptional use of these interventions by relatively few of the programs visited raised questions about whether such interventions should be permitted at all in children's residential programs. Of note, *none* of the children in the community-based programs visited were subject to either chemical restraints, mechanical restraints, or seclusion in the three-month period reviewed.

Here, again, it is worth noting that these children's diagnostic profiles and histories were substantially similar to those of the other children in the larger congregate settings.

## Other Restrictive Interventions Also Common

Other physical interventions and "time-outs" were also frequently employed by many of the programs visited. Overall, 81% of the children in the sample were subject to one or both of these interventions in the three months prior to the Commission's review.

---

*None of the children in the community-based programs visited were subject to either chemical restraints, mechanical restraints, or seclusion in the three-month period reviewed.*

---

As the Commission analyzed these data, it was also apparent that the descriptive phrases "physical interventions" and "time-out" do not adequately communicate the wide variety of practices they cover. For example, physical interventions of staff varied from a staff person gently holding a child who was upset, to violent "take-down" procedures where a child was held down by several staff. Similarly, "time-out" in some programs meant sending a child to his or her bedroom for a short time, giving both the staff person and the child a respite to cool off; in other programs "time-out" was placement in a stark room, where only the absence of a locked door differentiated the intervention from seclusion.

Again, as with the use of PRN or STAT psychotropic medications, records often did not document that less restrictive techniques had been employed by staff before intervening physically with a child. Not inconsequentially, the Commission's investigation of child abuse reports in these residential programs has also repeatedly revealed that physical intervention techniques place both children and staff at high risk of harm. Of note, 22% of the 850 child abuse and neglect reports investigated by the Commission in its first three years implementing the Child Abuse and Prevention Act centered on the use of physical interventions or mechanical restraints with children by residential facility staff.<sup>29</sup>

---

*Few programs provided sufficient follow-up with the youngsters who left their programs, although follow-up on children for a year or two subsequent to their discharge seemed a very reasonable clinical expectation of these high-priced programs.*

---

## Too Little Quality Assurance

Perhaps most critically, the Commission found very deficient internal quality assurance systems at almost all of the programs reviewed. In general, the programs visited did not critically examine their practices, nor did they follow up on children when they leave their programs to find out if their programs did successfully help them.

Program-wide reviews of the effectiveness of "level and point systems," psychotropic medication regimens, physical interventions and restraints, and "time-outs" were also not standard in any of the programs. Even on an individual basis, few programs maintained sufficiently detailed and uniform documentation of children's behaviors to provide reliable and valid assessments of the efficacy of these interventions. Most

critically, in the absence of these reviews, programs had little objective data to evaluate their performance or to assess whether their most frequently employed behavioral interventions were in fact working.

Few programs provided sufficient follow-up with the youngsters who left their programs to evaluate the child's long-term adjustment or success. This was particularly notable given the relatively small caseloads of primary therapists (five to eight children) and that follow-up on children for a year or two subsequent to their discharge seemed a very reasonable clinical expectation of these high-priced programs.

## Recommendations:

1. The Office of Mental Health and other agencies serving children with emotional problems in out-of-home placements or at risk of such placements should promptly take steps to ensure an accountable and coordinated system of locally based generic case management services which will oversee the care, services, and placements of these children; the support, counselling, and educational services provided to their families; and accountability for family preference and permanency planning.

In the evolution of this locally based coordinated system of case management, the Office of Mental Health and other agencies are encouraged to pool existing funding which is supporting discrete agency-sponsored case management programs for children into consolidated local county block grants for this purpose. Of importance, these local case management advocate services should guide the child through the service system, and from program to program, when change is in the youngster's best interest, even in instances when these transfers move the child outside his/her county of financial responsibility.

---

<sup>29</sup> See *Child Abuse and Neglect in New York State Office of Mental Health and Office of Mental Retardation and Developmental Disabilities Residential Programs*, NYS Commission on Quality of Care, February 1992.

2. The Office of Mental Health and other agencies serving children should establish, at the local governmental level, a single point of entry for all children being considered for an out-of-home placement. A major mission of this single point of entry should be to prevent inappropriate placements by facilitating the provision of services necessary to meet the needs of the child and family and, where placement is the only reasonable alternative, to ensure that the child is placed as close as possible to his/her family and in a stable setting which offers optimal opportunities for the child to reunite with his/her family, and to enjoy the normal activities of childhood in an integrated setting.
3. The State should ensure that, in every county/borough, a locally appointed independent review and oversight panel of child development and family specialist professionals reviews the locality's overall track record for out-of-home placements and permanency planning to ascertain the adequacy and appropriateness of current efforts to assist children in reuniting with their natural families and/or to assure children a stable surrogate family living arrangement with an adoptive or foster care family.

---

*The Office of Mental Health and other agencies serving children should establish, at the local governmental level, a single point of entry for all children being considered for an out-of-home placement.*

---

Such locally appointed review and oversight panels should also assume certain quality assurance responsibilities, including the review and approval of all "moves" of children from one out-of-home placement to another and oversight of the performance of local social services departments in ensuring regular assessments and reasonable decision-

making for children who have been in out-of-home placements two or more years, but who have not been freed for adoption, and the costs of caring for children in such placements.

4. In the coming year, the Office of Mental Health and other agencies serving children in out-of-home placements and at risk of such placements should sponsor interagency block grants which encourage several local governments to consider creative, integrated, and comprehensive service delivery models in their local communities to serve these children and their families.

These block grants should encourage local governments to provide comprehensive and intensive early intervention support services to families to prevent and limit the length of out-of-home placements; to establish services which promote permanency for children living in out-of-home placements who cannot return home, by ensuring timeliness in freeing children for adoption, and for keeping children out of congregate care and institutional living arrangements.

5. The Office of Mental Health should work with other state agencies providing community-based residential services for children in ensuring needed waivers of eligibility and continued-stay criteria which will promote permanency planning for children and placement of siblings together in these programs.

In the interim, as planning for these waivers proceeds, OMH should take immediate steps to ensure that children in its family-based programs are not separated from successful family placements to be moved to another out-of-home placement simply because they no longer carry a mental health diagnosis.

6. To facilitate the increased reliance on community-based services for children classified as emotionally disturbed, the Office of Mental Health should develop a long-term plan for the appropriate, more limited role of its state centers and units in serving only those

children who cannot be treated in less restrictive community-based settings.

As an initial step in this effort, each state children's center and unit should be required to aggressively pursue less restrictive placements of children in these centers and units currently judged by their therapists as no longer requiring institutional placement.

Simultaneously, the Office of Mental Health should carefully evaluate all direct acute admissions of children to state centers and units to identify the gaps in available community-based crisis and inpatient psychiatric services which are contributing to these admissions.

Most critically, OMH should prioritize the continued development of family-based and community-based outpatient and residential services with a goal of ensuring the accessibility of these services in each county of the state by 1995.

---

*The Office of Mental Health should consider a moratorium on the planned development of additional RTF beds for at least two years, while the merits and capacity of these newer less restrictive community-based residential models can be more fully understood.*

---

7. Given the positive track record of the family-based treatment programs and community residences in meeting the needs of many children previously believed to require placement in a larger congregate campus setting, the Office of Mental Health should consider a moratorium on the planned development of additional RTF beds for at least two years, while the merits and capacities of these newer less restrictive residential models can be more fully understood.

---

*The Office of Mental Health should ensure that the on-campus school programs of these residential facilities take full advantage of the children's presence on-campus 24 hours a day.*

---

8. The Office of Mental Health should take immediate steps to strengthen the treatment programs of its state-operated children's centers and units and its state-licensed RTFs by:
  - ensuring that children and parents and legal guardians are meaningful partners in the development and evaluation of individualized treatment plans;
  - ensuring that the on-campus school programs of these residential facilities take full advantage of the children's presence on-campus 24 hours a day, by insisting that all programs fully meet and, where appropriate, exceed the State Education Department's requirements for instructional time, and that all programs build in a structured homework time each school night on all living units;
  - ensuring that individualized treatment plans of all children who are not performing at grade level in reading and math address these issues, or provide a documented rationale explaining their omission;
  - ensuring that all programs have a structured educational component for teaching children independence in daily living skills (e.g., planning and cooking nutritional meals, basic housekeeping, money management, parenting skills, comparative shopping, etc.) tailored to the skills and abilities of individual children which are incorporated into each child's individualized treatment plan;

- ensuring that all programs provide comprehensive vocational assessments and vocational training and supported work programs for children 14 years or older who are likely to reside at the program for at least three months, and who are unlikely to be college-bound. As with daily living skills, vocational goals and objectives should also be integrated in these children's treatment plans; and,

---

*The Office of Mental Health should institute more explicit guidelines regulating the appropriate cautious use of psychotropic medications and chemical restraints in its state children's centers and units and RTF programs.*

---

- ensuring that all programs provide a comprehensive sex education program that can be tailored to the needs and abilities of individual children. Individualized treatment plans should include appropriate goals and objectives which correspond to individual children's participation in these programs.
9. The Office of Mental Health should institute more explicit guidelines regulating the appropriate, cautious use of psychotropic medications and chemical restraints in all residential programs serving children. These guidelines should ensure that:
    - programs carefully assess and try less intrusive or less potentially dangerous treatment interventions before resorting to psychotropic medications;
    - programs implement regular drug-free periods to assess the continued need for psychotropic medications;
    - children are well-informed of the intended effects and likely side effects of any medications they are prescribed;
  10. The Office of Mental Health should allocate more research funding in its research institute budgets to develop and carry out empirical studies of the effectiveness of specific psychotropic medications currently used in treating children in its state-operated, state-licensed, and state-funded residential programs. Special efforts should also be made in existing OMH publications to inform providers of ongoing research and to disseminate brief findings reports.
  11. The Office of Mental Health should establish clear guidelines for the operation of "level or point systems" in its children's residential programs. These guidelines should ensure that:
    - parents or legal guardians of children are well-informed of all the medications being administered to their children and that they have signed specific informed consent forms for these medications;
    - children and parents/legal guardians for whom English is not their primary language are provided information about medications in a language that they understand;
    - psychotropic medications are administered on a PRN or STAT basis, as a form of chemical restraint, only when there is clear and recent evidence that such restraint is warranted by behaviors which present a substantial threat of harm to the child or others and that clinical staff have tried other less restrictive interventions—which must be identified in the PRN/STAT order—prior to the administration of the medications; and,
    - all programs provide regular systemic quality assurance reviews of psychotropic medication use which ensure the carefully clinically monitored use of these medications in the lowest effective dosages and for the shortest possible time periods, in conjunction with individualized behavior plans.

- ❑ such systems are not “generic” and that, to the greatest extent possible, they are based on behavioral objectives for individual children;
- ❑ such systems focus on “teaching” children appropriate behaviors, not on convenient methods for managing or controlling children;

---

*The Office of Mental Health should convene a group of independent child care experts to draft explicit guidelines for the more restricted and carefully monitored use of mechanical restraints, seclusion, “time-out” and other physical interventions in all state-operated and -licensed children’s residential programs.*

---

- ❑ such systems truly provide an emphasis on catching children “doing right,” and do not instead focus most concretely on issuing negative consequences for “bad” behaviors;

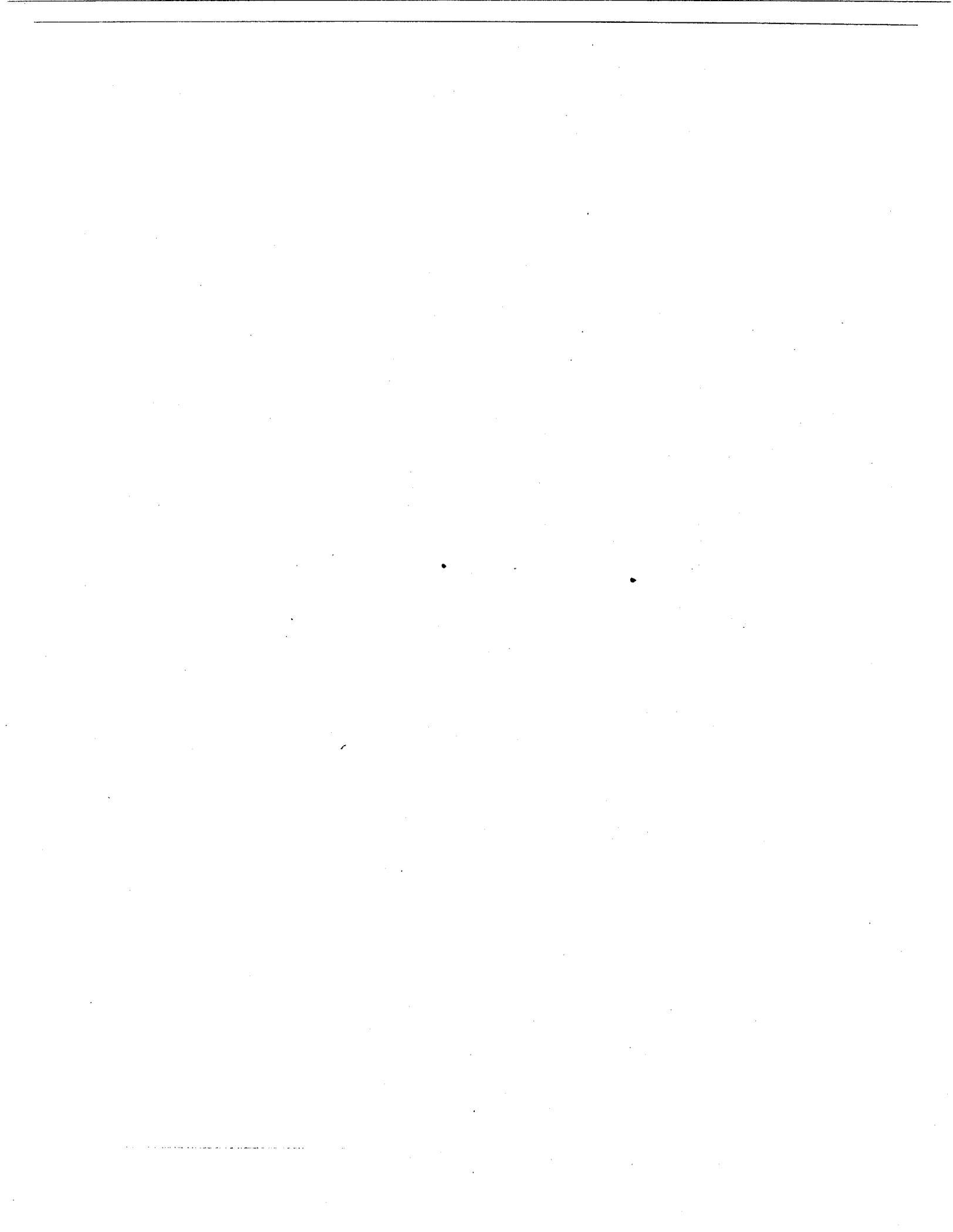
- ❑ such systems, especially as tailored for individual children, are as simple as possible and are fully explained and shared with the child’s parents and legal guardians in the hopes that some of their benefits may “transfer” when the child is discharged home; and,
- ❑ that rewards and consequences of such systems are consistent with sound child-rearing practices, and that consequences do not deny children the basic rights to communicate and visit with families and friends and to have some opportunity to play outdoors and exercise regularly.

12. The Office of Mental Health should convene a group of independent child care experts to draft explicit guidelines for the more restricted and carefully monitored use of mechanical restraints, seclusion, “time-out” and other physical interventions in all state-operated and -licensed children’s residential programs. This workgroup should specifically consider whether mechanical restraints and seclusion are warranted in children’s residential programs.

---

# Appendix A

---



## The Ten "Lost" Children

- K.H., at age 14, was discharged from an RTF following her elopement in January 1990. The Commission was able to determine that, through the early summer, K.H. had moved through two DFY shelters, a DSS foster care home, several short attempts at living at home, and several short stays at homes of friends. Local DSS officials reported that they had lost track of K.H. in early summer, after her caseworker went on extended medical leave. Unfortunately, further research revealed that later that year in August of 1990, approximately seven months after her discharge, K.H. had died in a car accident.
- M.A., now 18 years old, was discharged home to her mother from a state children's psychiatric center in March 1990 at the age of 16, after an approximately one-year stay and a recent elopement from the center for 36 days. During her elopement, she had become pregnant. In May 1990, M.A. left her mother's home and reportedly was living with an aunt. When the Commission contacted the mental health clinic to which M.A. was referred, the staff had no record of her. The prenatal clinic where M.A. was also referred, declined to provide any information to the Commission on the basis of client confidentiality. The Commission was unsuccessful in contacting M.A., her mother, or her aunt.
- C.D., now 19 years old, was discharged from an RTF in January 1990, after an elopement at the age of 17. She sought help from her DSS caseworker who contacted her adoptive parents, and they refused involvement. C.D. was then placed in an emergency foster care home, but she soon ran away, reportedly to reunite with her biological family. Subsequently, the Commission followed C.D. through three emergency shelter placements until August 1991, when it lost all leads on her whereabouts.
- L.D., a young woman now 22 years old, was discharged home to her parents from an RTF in January 1990, at the age of 20, after an approximately 2 1/2-year stay. Upon discharge, she refused service referrals, but the Commission found she later attended a mental health clinic from March until July 1990, a day treatment program from October 1990 to April of 1991, and another day treatment program from May to September 1991. Upon leaving the second day program, L.D. was referred to another program, but she never showed up. The Commission was unable to find further information about L.D.
- A.U., now 19 years old, was discharged from a state children's psychiatric center in January 1990, at the age of 17, to a Division for Youth facility. The Commission was able to track A.U. through a series of three additional DFY placements scattered across the state in the five months after his discharge and a brief stay in a local jail. A.U. was discharged from a fourth DFY facility in May 1991, just before his 18th birthday. Reportedly, he went to live with the family of a friend, having refused placement, with no service referrals.
- F.M., now 18 years old, was discharged from an RTF in February 1989, at the age of 15, to live with her family and to attend a day treatment program. During the seven months F.M. was home, her parents separated, and she was picked up by the police and subsequently offered an emergency foster care placement. She was later returned to her father's custody for 24-48 hours pending her placement with her grandmother in Florida. This was the last available information that local DSS had regarding the whereabouts of F.M.
- K.R., now 21 years old, was discharged from an RTF, against medical advice, in December 1989, at the age of 18. Although the RTF staff referred K.R. back to her local mental health clinic, neither she nor her mother made any contact with the clinic. The Commission was unable to obtain any information about K.R. from the point of her discharge.
- C.D., now 16 years old, was discharged from an RTF, against medical advice, after an 11-month stay in March 1990, at the age of 14, at his adoptive mother's request. Reportedly, his mother, concerned about C.D.'s lack of school progress in the RTF, arranged for C.D. to attend special education classes and a local outpatient mental health clinic. Upon follow-up, however, the clinic had no information about C.D.
- K.A., now 21 years old, was discharged from an RTF in June 1989, at the age of 18, to her family with a referral to a local mental health clinic. She received services from August 1989 through October 1990, at which time she requested termination. Her parents agreed. The Commission's attempt to contact K.A. by mail was unsuccessful. Now an adult, K.A. was reportedly, not receiving mental health services.
- F.B., now 17 years old, was discharged from one state children's psychiatric center in March 1990, after a 2 1/2-year stay, to another state children's center. In November 1990, F.B., at the age of 15, was discharged home from the second state center, with a referral to special education, but no mental health services. The Commission was unable to follow up on what happened to F.B., as it has no legal access to schools, and F.B.'s therapist at the state center advised against family contact due to family objection to mental health services.



---

---

# Appendix B

---





RICHARD C. SURLS, Ph.D., Commissioner

January 27, 1993

Mr. Clarence J. Sundram  
Chairman  
NYS Commission on Quality of Care  
for the Mentally Disabled  
99 Washington Avenue, Suite 2001  
Albany, New York 12224

Dear Mr. Sundram:

Thank you for the opportunity to respond to the draft report on the Commission's review of children's residential programs sponsored by the Office of Mental Health.

As we have discussed, the development of a community based system of care for children with serious emotional disturbances is an OMH priority. We welcome the Commission's endorsement of the residential component of this endeavor and commend the thoroughness of your review.

Our commitment to a community based system of care highlights several principles as essential in working with children and adolescents with serious emotional disturbances and their families. OMH was pleased to find some of these same principles stressed throughout the Commission's draft report, particularly in the Recommendations section.

OMH concurs with many of the recommendations outlined by the Commission. Although the specifics of some of the recommendations may be difficult to implement, the attached response provides an overview of current and planned OMH initiatives supporting our commitment to a community based system of care.

Should you have any questions regarding the response, please contact Dr. Sandra Forquer, Deputy Commissioner for Quality Assurance and Information Systems.

Sincerely,

Richard C. Surles, Ph.D.  
Commissioner

attachment

cc: Sandra L. Forquer, Ph.D.  
Gloria Newton-Logsdon

59 FEB -1 11 59 37  
COMMUNICATIONS SECTION  
FEB 1 1993

**OMH Response to CQC Draft Report on  
Residential Services for Children with  
Serious Emotional Disturbances**

The Commission's draft report emphasizes the need for children to have a stable family or family-like environment throughout their childhood. OMH strongly supports this principle and has used it as the cornerstone for all new children's initiatives. In 1985, OMH received one of the first Child and Adolescent Service System Program (CASSP) grants issued by the National Institute of Mental Health. The focus of the grant was to ensure that children are raised in a stable family or family-like setting. The CASSP grant was a catalyst for OMH to move from an institutionally based to a community based system of care for children with serious emotional disturbances. This movement has gathered momentum in the past few years as OMH and other state agencies have implemented initiatives which emphasize families and communities caring for their own children at home and in the community.

Consistent with this theme, the goal of a stable family environment is an underlying principle in the 1992 NYS Plan for Children and Families Mental Health Services, "At the Crossroads: Expanding Community-Based Care for Children and Families." Input to this plan was provided by parents, provider agencies, and experts in the field of permanency planning. OMH believes that this plan, combined with other initiatives in progress, address the majority of recommendations in the Commission's report.

The following input to the draft report is divided into two sections: A) General comments & recommended changes and B) Response to specific recommendations.

**A. General Comments and Recommended Changes**

1. Since the draft report identifies several shortcomings within the State Department of Social Services (DSS) child care system, OMH requested that it be shared with DSS. We are pleased to note that the Commission has provided DSS with an opportunity to respond to the report.
2. It is a guiding principle of OMH to support families, recognize their strengths, be sensitive to their needs, and include them in all aspects of planning and service delivery. The draft report contains no reference to family input into the evaluation of residential services.

OMH recommends that the Commission acknowledge the important role of families in planning, service delivery and quality review. This focus should be included as a principle in the report.

3. OMH finds it inappropriate to use individual vignettes and has shared with the Commission on previous occasions the opinion that this practice can violate confidentiality. The report includes no vignettes of children whose hospitalization was successful and none of children from Family Based Treatment or Community Residence Programs. OMH recommends that vignettes not be used and that Appendix A be deleted from the report.

4. Corrections

**Page 6**

Each Teaching Family Community Residence will be staffed by a married couple and one or two child care staff. [There will be no weekend relief staff; rather, the program will provide an additional amount of staff time to ensure awake night staff when needed.]

**Page 7**

The expected length of stay in state-operated intermediate inpatient programs is 30-180 days.

**B. Response to Specific Recommendations**

**Overall Goal For Recommendations 1, 2, 3 and 4:**

Ensure children have a stable family or family-like environment throughout their childhood.

**OMH Response:**

OMH is in full agreement with the Commission's goal of ensuring a stable environment for all of New York State's children. This goal is in accordance with a number of current OMH initiatives delineated in the NYS Plan for Children and Families Mental Health Services, sent to the Commission earlier this year. A summary of three current projects supporting this goal is attached as Appendix A. These include: (1) a recently funded grant proposal to the National Institute of Mental Health for a Demonstration Child and Adolescent Service System Program project; (2) the All States Budget Request - Implementing a Coordinated Children's Service Delivery System; and (3) a draft grant proposal to the Robert Wood Johnson Foundation.

As the summary indicates, parts of each of the Commission's first four recommendations are addressed in these three projects. For instance, the combination of Tier I from the All States Budget Request and the use of the Intensive Case Manager through the CASSP grant address the case management recommendation spelled out in the first recommendation. Tiers II and III of the All States Budget Request will serve the function of oversight spelled out in Recommendation #3.

As the draft report acknowledges, realization of the Commission's recommendations requires the cooperation of all state agencies serving children and families. It must also be noted that OMH is dependent on existing resources and approval of specific budget requests and grants to achieve the goals outlined.

A number of other OMH initiatives with other state agencies have already been implemented at the state-wide, regional, and local levels. These also incorporate many of the strategies outlined in the Commission's first four recommendations. OMH would welcome the opportunity to review these currently operating initiatives in detail, as well as the progress of the three projects mentioned above, with the Commission.

**Overall Goal for Recommendation 5:**

Promote permanency planning and placement of siblings together in residential programs.

**OMH Response:**

OMH concurs with these goals. OMH will ensure that this goal is placed as a priority in implementing the All States Budget Request and in the staff training provided through the CASSP grant (see Appendix A).

To the extent that siblings require the same level of care and it is deemed clinically appropriate to place them together, we will attempt to do so. OMH will also review the design and operation of its residential programs to address the inappropriate movement of youngsters from one placement to another.

**Overall Goal for Recommendation 6:**

Aggressively pursue less restrictive placements for children.

**OMH Response:**

OMH concurs with this goal and is pleased to note the Commission's endorsement of our policy direction. A number of projects are in process that directly impact this goal:

1. This is a priority area in OMH's 93-94 budget request.
2. A state-wide work group on emergency services has been convened to review existing emergency and admission diversion programs and to assess needs in this area.
3. OMH used the 1992 Satellite Training Program to initiate a training program for clinical staff on "Integrating the Family in the Treatment of Children and Adolescents". An affiliation with the Family Studies Center and Salvador Minuchin, M.D. has been developed to carry out the training program. Objectives include enhancing the skills of our clinical staff in diverting unnecessary admissions, reducing lengths of stay in inpatient programs, identifying local service gaps, and creating new flexible services to support children and their families in the community.
4. Recently, OMH allocated a number of inpatient personnel items (gained through bed reductions) to Intensive Case Management positions for children/adolescents. Positions were also re-deployed for clinical staff to provide admission diversion services from children's state-operated inpatient programs.

**Overall Goal for Recommendation 7:**

Place a moratorium on the planned development of RTF beds.

**OMH Response:**

Consistent with the Governor's recent announcement of a moratorium on the development or expansion of institutions for children with special needs, OMH is in the process of reviewing the status of all RTF projects that are currently in development or planned. No new Program Development Grants will be awarded for RTFs. RTF projects that are in the early stages of development will be carefully reviewed to determine if it is feasible to discontinue development. When the review process is complete, OMH will seek to convert the unused portion of the 600 bed

RTF authorization to less restrictive residential alternatives in areas of the state where additional RTF beds would have been developed.

**Overall Goal for Recommendation 8:**

Strengthen the educational components of children's state-operated inpatient programs and RTF's.

**OMH Response:**

The Bureau of Children and Families has recently hired two staff whose responsibilities include addressing the needs of educational programs at children's facilities/units and RTF programs. As part of their initial tasks, they will develop an assessment protocol of the educational programs at all of the above programs. The areas outlined in Recommendation #8 by the Commission will be included in the assessment protocol. After the implementation of the assessment process, OMH intends to summarize the results into both system-wide and program-specific recommendations.

**Overall Goal for Recommendation 9:**

Ensure careful and proper use of all psychotropic medication.

**OMH Response:**

The majority of recommendations outlined in this area are congruent with current practices at our children's programs. Additionally, the Commission recently wrote a report commending OMH for following safe practices in the administration of psychotropic medications in its children's programs. A number of the recommendations made in this draft report on residential services are addressed in OMH's response to the draft report on psychotropic medication.

In 1993, OMH will reconvene a workgroup for state-operated inpatient programs. This group, interfacing with the OMH Clinical Sub-Cabinet, will review the use of psychotropic medications and chemical restraints in children's state-operated inpatient programs. This review will be followed by a set of recommendations for all children's residential programs.

**Overall Goal for Recommendation 10:**

Allocate research funding for studies on the effectiveness of specific psychotropic medications for children.

**OMH Response:**

There are currently a number of medication research protocols active in the Department of Child Psychiatry at Psychiatric Institute:

Tricyclic Treatment of Adolescent Depression

Dr. Klein

Drug - Desipramine

Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder Adult Manifestations

Dr. Greenhill

Drug - Ritalin

Biological and Treatment Studies in Outpatient Adolescents at Risk for Suicide

Dr. Greenhill

Drug - Fluoxetine

Biological and Treatment Studies in Inpatient Adolescents - Rockland

Dr. Greenhill

Drug - Fluoxetine, Fenfluramine

Biological and Treatment Studies in Inpatient Adolescents at Risk for Suicide: A Controlled Study

Dr. Greenhill

Drug - Fluoxetine, Fenfluramine

A Neuropsychiatric Study of Adolescent Schizophrenia

Dr. Whitaker

Drug - Haldol, Artane

Fluoxetine in the Treatment of Anxiety Disorders in Children

Dr. Klein

Drug - Fluoxetine

Fluoxetine Treatment of Adolescent Depression

Dr. Tancer

Drug - Fluoxetine

Methylphenidate in Childhood Behavior Disorders II Long Term Methylphenidate Treatment

Dr. Klein

Drug - Methylphenidate

In addition to this work, we will be encouraging our researchers specializing in children and adolescents to apply for additional grants in the area of psychotropic medications.

**Overall Goal for Recommendation 11:**

Ensure individualized, teaching focused, and positive level systems for children in all residential programs.

**OMH Response:**

OMH has been pleased with the results of the psychoeducational model initiated at Western New York Children's Psychiatric Center. This model has now been implemented on units of two other state-operated programs (Rockland Children's Psychiatric Center and Mohawk Valley Psychiatric Center Children and Youth Unit), with similar results. Appendix B explains this model and outlines the goals, most of which have been attained on the units which use this model at WNYCPC. OMH plans to continue to expand this model to other state-operated programs, as fiscal resources allow.

A workgroup has been established which meets quarterly to review, adapt and improve the psychoeducational model, as well as to consult on expansion plans. Some of the recommendations from this workgroup will be shared with all OMH state-operated inpatient children's programs and residential treatment facility programs.

**Overall Goal for Recommendation 12:**

Study the use of restrictive interventions in children's programs.

**OMH Response:**

OMH convened the first meeting of its Seclusion and Restraint Task Force on March 18, 1992. This work group has been meeting regularly and will be developing systemwide recommendations. A subgroup has been formed to study and make recommendations regarding special restraint/seclusion issues related to children and adolescents. This subgroup is chaired by Dr. Harvey Kranzler, Clinical Director of Bronx Children's Psychiatric Center.

NEW YORK STATE

DEPARTMENT OF SOCIAL SERVICES

40 NORTH PEARL STREET, ALBANY, NEW YORK 12243-0001

MARY JO BANE  
Commissioner



(518) 474-9475

November 5, 1992

Mr. Clarence J. Sundram  
Chairman  
State of New York  
Commission on Quality of Care  
for the Mentally Disabled  
99 Washington Avenue, Suite 1002  
Albany, NY 12210

Re: Your Draft Report: NYS  
Residential Services for  
Children with Emotional  
Problems: A Call for Reform  
(92-038)

Dear Mr. Sundram:

The following comments to the subject report address those issues affecting children served under the Foster Care Program.

While the report raises some important and troubling questions about the needs of children with emotional difficulties, the conclusions the report reached are too general and, we believe, oversimplified. In its strong criticism of the whole social services system, the report relies on a very small sample of 134 children of which only a small fraction involved children in the foster care system. We do not believe this is a representative sample of the 65,000 children presently in foster care. While we recognize that even if one child in our care is adversely affected, it is one too many, the report's caustic criticism and the condemnation of the whole system is not justified.

Given the fact that there are DSS-custody children represented in the sample, we are troubled about the report's references to a lack of permanency planning and family reunification or termination proceedings for the children studied. Apparently the writers of the report have not reviewed social services records so it is questionable whether they gained the full understanding of the scope of services provided to the children and their families.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

Similarly, the report speaks to the strong medical model shaping many of the interventions in the Office of Mental Health programs. Again, there is no discussion of whether workers from the child welfare system were involved in providing additional resources or advocacy. We agree that the level of abuse/neglect in the backgrounds of these young people requires close collaboration within case planning, particularly in terms of permanency planning. However, the assertion that 80% of the children having some "indication" or documented evidence of prior abuse or neglect is highly questionable. The reader is not provided any definition of what exactly an "indication" might entail. We strongly object to the assertion made in Chapter VI that children who are served by the social services system should be labeled as "Nobody's Children". If a child is in foster care, the goal is always to provide care in the least restrictive, most homelike setting conducive to meeting the needs of the child. The report did not appropriately acknowledge the case recording, case management and quality assurance standards promulgated by the Department and complied with by social services districts in relation to children in foster care (see 18 NYCRR Parts 428 and 430). The report is critical of the failure to achieve permanency through adoption, but fails to recognize the strict constitutional and statutory standards applied to the termination of parental rights (see Section 384-b of the Social Services Law).

With these general comments, we will now address the report's recommendations.

#### Case Management

The report recommends the pooling of financial resources, ignoring the fact that its implementation would create a serious cost allocation problem under Title IV-E of the Social Security Act. Federal Title IV-E funds cannot be used for the cost of care or administration of children not in foster care. The report is not clear how the proposed case management system would work where a child is in foster care. The case management of a foster child must be done by the agency which has legal custody; it is not clear if the report suggests that a different agency be given that responsibility.

The report fails to mention the recently passed legislation and the Memorandum of Understanding (MOU) between OMH and the Department to expedite cross-system utilization of specialized community-based beds for foster care children in need of mental health services. This MOU introduces into the system Federal Title IV-E funding to underwrite the care and maintenance costs of foster care children in these highly acclaimed models. By acknowledging that the licensure of these programs meet Title IV-E criteria, we have reduced bureaucratic barriers and the need for joint or duplicative licensure. Equally important, we have offset State funding for these programs by introducing Federal reimbursement. On this and other projects of mutual interest, our close and cooperative efforts with OMH refute the report's contention that "once again all of the state agencies are proceeding independently". On the contrary, the present system proves that State agencies are fully cooperating to achieve mutually desired results.