

**RESIDENTIAL TREATMENT FACILITIES:
THE EXPERIENCES OF 60 YOUTHS**

June 2007



**NYS Commission on Quality of Care and
Advocacy for Persons with Disabilities**

RESIDENTIAL TREATMENT FACILITIES: THE EXPERIENCES OF 60 YOUTHS

EXECUTIVE SUMMARY June 2007

The Commission's decision to study the experience of 60 youths who had been discharged from 13 Office of Mental Health (OMH) licensed Residential Treatment Facilities (RTFs) between January 1, 2004 and June 30, 2005 was made, in part, to determine the impact of recent OMH initiatives in expanding appropriate and timely access to the type of mental health care each child requires – both as an inpatient in the RTF and after discharge. The Commission's study was predicated on the understanding of mental health literature that supports the goal of family-centered, community-based systems of care for children, citing the harm done to a child's ability to form caring relationships throughout life when the child and parent contact is severely limited. This study identified barriers to reducing youths lengths of stay in RTFs and to get children home more quickly where appropriate, and purposed strategies to reduce these barriers in the future.

This study of a sample of youths was designed to provide the Commission with information related to who is being served, the length of stay and conditions of stay (therapies offered, use of restrictive techniques, privilege systems); the admission and discharge process, particularly as it relates to the SPOA initiative; discharge options and supports available to youths; the involvement of birth/adoptive and foster families; and the efforts of programs to engage families in the treatment of their child/adolescent.

Commission staff reviewed the clinical records of all 60 sample youth, examining each youth's individual strengths and needs, treatment objectives and the assessment of progress upon discharge, prior out-of-home residential placements, inpatient mental health hospitalizations, familial information, restrictive restraint measures used with each youth and life skills training. Interviews were also conducted with the strategic players in the RTF referral and discharge process. Administrators were asked to identify barriers to the effective delivery of services to youths with serious emotional disturbances and the resources needed to overcome the barriers. Discharged youths and their families/care providers were asked about their experiences during the admission process, and their views on the quality of the RTF stay and the challenges faced during discharge planning and after discharge. Six single point of accountability (SPOA) entities set up by local governments utilizing OMH funding to develop a "clinical coordination infrastructure" that manages children in their own communities with appropriate mental health strategies were interviewed, as were all the Preadmission Certification Committees (PACC) which control admissions to RTFs.

The major findings of the study were that youths in the sample were, indeed, seriously emotionally disturbed. Few children came to the RTF directly from their homes. The single largest group of youngsters (27) came to the RTF from OMH certified or operated inpatient beds. There also was a high level of disruption of family life experienced by the children, their siblings and parents prior to the child's admission to the RTF, with 87 percent of the sample children

having already experienced a mental health inpatient stay or other out-of-home placement. Twenty-three had a documented history of sexual abuse, 26 had a documented history of physical abuse, 41 of 60 had a documented history of neglect. Forty-five of the 60 youths had been in out-of-home placements other than inpatient mental health hospital stays prior to their RTF admission.

Families were also dealing with other serious issues. One or more parents in 29 families had a documented history of mental illness, and 43 families had a documented history of alcohol or substance abuse. Of the 40 families for which family therapy would have been appropriate, only 22 participated, despite efforts of the RTF to engage them.

Nevertheless, both the adult and youth respondents indicated that particular aspects of the RTF stay had been significant. They cited the relationship they formed with particular staff at the RTF, as well as the structure – knowing what was expected and the consequences. Not surprisingly, adults were concerned about the frequent turn-over of direct support staff and the inadequate training provided to them.

Despite the general approval ratings given to the children's education, upon discharge from an RTF, many youths leave lacking basic age-appropriate skills. Discharge options, including residences where adolescents can learn community survival skills under adult guidance and supervision, are insufficient for adolescents leaving the RTF who have no family to accept their return.

Further findings showed that the effectiveness of the working relationship between the SPOAs and the PACCs varied among the counties visited. In some counties the collaboration was strong and all involved believed that the children in the county with serious emotional disturbance were appropriately placed and served. In other counties PACCs accepted referrals without the knowledge of the SPOA and the question of whether the child could have been served with community services remained unanswered.

Finally, there were differences of opinions among RTF administrators, PACC and SPOA interviewees on the place of the RTF in the mental health system of care for children and adolescents. Some said the problem was simply an insufficient number of RTF beds. Others said it was the limited number of specialty beds; still others said the RTF was an anachronistic model and should be replaced with smaller, community-based services (both treatment and residential).

Commission Recommendations

Based on our review, the Commission made the following recommendations to OMH:

- With regard to the role of the SPOA and the PACCs, the Commission recommends that OMH issue clear and uniform guidelines addressing:
 - ✓ OMH's expectations regarding the working relationship between the SPOA and the PACC to ensure consistency across counties and then monitor against the guidelines;

- ✓ the need for SPOAs to actively reach out to providers of children's services, such as OMRDD, SED, OASAS and family court so that these agencies will be more responsive when their assistance/cooperation is required. To facilitate this wider cooperation, OMH should engage its sister agencies with the goal of developing agreement that they (sister agencies) will encourage their providers to actively participate in the SPOA process;
 - ✓ the need for the SPOA and /or PACC to advise parents when the application packet is complete and when they can expect to hear the PACCs decision; and,
 - ✓ the responsibility of the SPOA to consider the needs of the entire family in fashioning a support plan for a child. This might include mental health and/or substance abuse treatment for parents, support groups for parents and siblings, parenting education, and recreational and social activities for the child, for example.
- ❑ With universal recognition that work with families in appropriate situations improves the likelihood of a successful discharge, the Commission recommends that OMH identify, promulgate and to the extent possible provide training opportunities for RTF clinicians on best practices for conducting comprehensive family and home assessments, providing family therapy and for engaging families in therapy.
 - ❑ OMH should take steps to encourage RTFs to build on their work with families to improve discharge planning to:
 - ✓ develop realistic reward systems that accommodate the family's resources and other responsibilities;
 - ✓ document efforts to enroll youths in activities to reduce the amount of unsupervised down time that parents' work schedules require; and,
 - ✓ ensure the educational and mental health programs are in place at the time of discharge.
 - ❑ To enable transition coordinators to finalize educational placements for youths prior to discharge, OMH and SED should identify obstacles to successful placements and work to eliminate the barriers identified.
 - ❑ OMH should require RTFs to review their curricula, daily procedures and activities to identify additional opportunities to teach functional skills.
 - ❑ Finally, the Commission commends the attention to the needs of young adults for safe, supervised housing that is part of the NY/NY III agreement. NY/NY III provides for the development of housing for two categories of young persons: 200 congregate care beds are allocated for young adults in State psychiatric centers or other mental health care settings. Also, 100 congregate beds and 100 scattered site beds are allotted to young adults who have left or are leaving foster care and are at risk of homelessness. In looking beyond New York City, the Commission recommends that OMH, in consultation with local mental hygiene providers and recipients, review the distribution of mental health services and supervised housing for children, adolescents and young adults in other areas of the state, particularly in under-served areas, to identify needs and allocate resources as appropriate.

OMH Response

OMH responded to the Commission's findings, in part, by describing the recently issued (April 4, 2007) *SPOA Guidance Document of Core Elements and Performance Expectations for 2007*. OMH will rely on this document to specify the role of SPOA and various "core elements" that each SPOA should have in place, and has required a *SPOA Core Element Work Plan*.

In brief, OMH will hold regional meetings with SPOA coordinators, RTF specialists (PACC representatives in OMH field offices), and RTF Transition Coordinators to discuss implementation of these core principles, to clarify roles and responsibilities and to develop networks that promote collaboration and comprehensive planning. Under the core element "Collaboration and Coordination," a performance target has been set for September 2007 whereby there will be regular and consistent representation from participating child- serving agencies (i.e., Department of Social Services, Probation, Schools, Developmental Disabilities, Substance Abuse Treatment, and others) and families in the SPOA process. The Commission believes OMH has taken a positive step by requiring that each SPOA identify what stakeholders are currently involved in the SPOA process, and for those not currently involved, further requiring a plan including dates for engagement of other missing stakeholders.

Additionally, the Commission believes the core element of "Family Support" availability, requiring a plan for how each SPOA will ensure that each family has access to family support by September 2007, is a positive step toward assuring the availability of services including mental health or substance abuse treatment for parents, support groups for families and siblings etc. Although OMH is also requiring each SPOA to develop a process to remain in contact with children admitted to the RTF at all points of treatment, including discharge planning from the RTF under the core element "Supporting Children and Families Through Transitions To and From Placement (to be implemented by September 2007), this provision should be strengthened by including the Commission recommendation for the SPOA and PACC to advise parents when the application packet is complete and when they can expect to hear the PACC decision.

OMH will also be issuing a Request for Proposals later this year to strengthen both family engagement and family supports in residential programs including RTFs. OMH has made available \$850,000 to residential providers for training and consultation on evidence-based engagement strategies, parenting skills and direct support services to families via family therapy and work in the home and community.

OMH has taken a positive approach by convening a short-term workgroup composed of Parent Advocates, RTF representatives, SPOA coordinators, the Statewide Youth Advocate and OMH staff to develop policy frameworks in the areas of reward systems and discharge planning. Equally positive was OMH's stated intent to strengthen the expectation and accountability of Transition Coordinators.

OMH will also establish a team comprised of representatives from the State Education Department, OMH, RTF providers, and school districts to identify and resolve educational obstacles for children served by RTFs. OMH also stated it will ensure that the review of treatment plan protocols is conducted to make sure individualized assessments of strengths and

needs relate to the establishment of treatment and support goals across the life domains, including developmentally appropriate living and recreation skills. Finally, OMH has described residential development allocations for children and adolescents.

The Commission looks forward to working with OMH to assure the effective implementation of these critical initiatives.

RESIDENTIAL TREATMENT FACILITIES: THE EXPERIENCES OF 60 YOUTHS

COMMISSION STUDY OBJECTIVES AND SCOPE

In response to concerns expressed by parents who believed their children with serious emotional disturbances waited too long for residential treatment, parents whose children had not had successful discharges from residential treatment, and advocates who cited the dearth of residential options for young adults leaving Residential Treatment Facilities (RTFs), the Commission undertook a study of 60 youths who had been discharged from Office of Mental Health (OMH) licensed RTFs between January 1, 2004 and June 30, 2005. This sample represents nearly 20 percent (19.48 percent) of the youths discharged from the study facilities during the study time period. The objectives of the study were four-fold:

- Understand and, if warranted, make appropriate recommendations to improve procedures governing the admission and discharge of youths from RTFs.
- Follow as many of the 60 youths as possible to learn, first-hand, their thoughts about their stay at the RTF, identifying those aspects of care and treatment that were most helpful to them and those that they believed did not support their recovery.
- Talk to the parents and guardians of the youths in the sample to learn and report their perspective on their youth's stay at the RTF and how it impacted on the youth's development and ability to function outside of the institution.
- Learn from RTF administrators the challenges they are facing and their thoughts on how to improve the treatment of the youths in their care.

As these limited objectives indicate, this study has a narrow focus – to relate the experiences of 60 children¹ who were treated in an RTF and the adults who were active in their lives and to make recommendations to improve this experience for other youths. The needs of children with serious emotional disturbances and their families often cross not only providers but service systems. Schools, individual and family therapy services, crisis and respite services, case management, parenting education, and assistance with maintaining a household may be enlisted to support a child and his/her family. This study and the recommendations address only a limited number of the complex issues of creating sufficient services and then coordinating the services and funding streams to design a package of services that fits the individualized needs of each child and his/her family. However, it is our hope that some study findings and recommendations may be helpful to state agencies providing services to children, the Coordinated Children's Services Initiative, the Children's Mental Health Coalition, Families Together and others who are working on these issues.

Commission staff visited the 13 RTFs that served the youths in the sample, toured the facilities, reviewed the records of the sample youths, and conducted a structured interview with the director or administrator. We were able to follow 54 of the 60 youths and to interview 44.

¹ The words "children," "youth" and "youngster" are used interchangeably in this report to identify the subjects of this study. "Adolescent" is used to distinguish that group of individuals from younger children.

Additionally, we were able to interview 20 parents, family members, foster parents or family-based treatment parents who were active with the youth during his/her stay in the RTF. Eight representatives of local social services departments (DSS), one therapist and two case managers were interviewed. To the degree possible, Commission staff used a structured interview with all participants.

Following this phase of the review, Commission staff met with the OMH Deputy Commissioner for Children and Families to gain an understanding of the Office’s perspective on the operation of the SPOA (Single Point of Accountability), as it relates to the admission and discharge of youths from RTFs. SPOAs aim to identify children at highest risk of mental health placement and develop strategies to serve them in their home communities. We followed the OMH meeting with interviews of six SPOA coordinators and all of the PACC (Pre-admission Certification Committee) coordinators. The latter are the regional bodies which formally review and approve a youngster for RTF level of care.

The table below identifies the RTFs in the Commission study and provides census and sample size information. Our sample represents almost three-quarters of the RTFs in the state and about 12 percent of the RTF population. The youths in the sample were selected anonymously, based on their age and the type of residential setting to which they were discharged, in order to include in the sample all discharge settings. Children and adolescents with longer lengths of stay were generally chosen over those with briefer stays, as we believed that studying these children would help the Commission identify and describe barriers to discharge. The sample selection was based on data received from the RTFs in response to our written request for information on the youths discharged during the study period. The youths were identified by initials only.

RTF/LOCATION	RTF CAPACITY	SAMPLE SIZE	POPULATION SERVED
August Aichhorn/Manhattan	32	6	Coed adolescents
Astor Home/Rhinebeck	20	4	Male children
Children’s Home/Chenango Forks	18	4	Coed children and adolescents
Children’s Village/Dobbs Ferry	14	4	Male children
Crestwood Children’s Center/Rochester	18	4	Co-ed children
Green Chimney/Brewster	14	4	Male adolescents
Goldsmith Center/Hawthorne	49	6	Male adolescents
Henry Ittleson/Bronx	32	6	Coed children
Hillside Children’s Center/Rochester	14	4	Coed adolescents, plus a specialized program for hearing-impaired children and adolescents.
House of Good Shepherd/Utica	18	4	Co-ed adolescents
Madonna Heights/Dix Hills	14	4	Females adolescents
St. Christopher Ottilie/Jamaica	61	6	Co-ed adolescents with mild MR and serious emotional disturbance
St. Joseph’s Villa/Rochester	14	4	Male adolescents

RTF CARE AND TREATMENT

Residential Treatment Facilities were established in 1981 to provide comprehensive mental health services under the supervision of a physician to children and youth who need long-term active treatment in a residential setting. The OMH website expands this description, stating:

Residential Treatment Facilities are designed to provide individualized, active mental health treatment to children and adolescents with a severe emotional disturbance within an intensively staffed residential setting. Residential Treatment Facilities are less restrictive and less intensively staffed than hospital-based programs, but more intensively staffed and provide a wider range of services than community residences. The objective of the program is to help a child improve his or her daily functioning, develop coping skills, support the family and ensure appropriate community linkages and supports to ensure successful transition to the community. Residential Treatment Facilities range in size from 14-56 beds and serve an average of 760 children per year between the ages of 5 and 21 years.

Operated by not-for-profit corporations, RTFs are issued operating certificates by the Office of Mental Health for a maximum of two years. The 18 RTFs in New York State have a total capacity of approximately 539 beds, with 78 beds in OMH's Central NY region; 175 beds in the Hudson River Region; 133 in Western NY; 125 in NYC; and 28 located on Long Island. OMH reports approximately two-thirds of the RTF beds located in the Hudson River region are accessed by New York City children.

The Commission heard an array of opinions about the role of RTFs in the service system for children with severe emotional disturbance. Whether the present number of RTFs should be expanded to accommodate more youngsters depends on who is speaking. Parents, several RTF administrators, and some PACC members shared their concern that there are an insufficient number of RTF beds available for the youngsters who need them. They particularly mentioned the need for beds for females (data for March 20, 2006 indicates that 21 females were waiting for RTF beds as compared with 14 males) and "specialty" beds for youths with severe acting out behavior and those with a medical or developmental disability along with their mental health problems. Beds are filled quickly. OMH data for 2004 and 2005 indicated that, with rare exception, all beds in the RTFs across the state were filled. At all data collection points during this 24-month period, RTFs were at 99.25% of capacity or greater.

The interviewees who favored the expansion of RTFs spoke to the positive social development of the youths as they learn the give-and-take required to build and nurture positive relationships necessary to succeed in school and elsewhere. They explained that this is particularly crucial because many youth in RTFs do not have families to support them or have families who are unable at the time to provide guidance and modeling on how to succeed in the community.

In contrast, others interviewed expressed the view that with proper supports all youths who do not require acute inpatient care can and should be cared for in their communities. They cited the need for more trained "professional" families, small community residences for children whose parents cannot support them, school-centered mental health services. Some interviewees went so

far as to say that RTFs were ill-prepared to care for the youths who are presently being admitted, particularly those who set fires or who have been traumatized by sexual abuse, suggesting that RTFs are an out-dated model of care.

YOUTHS IN THE STUDY

Where They Came From and How Long They Stayed

The heart of the Commission study was its focus on the children and adolescents in the sample. Our sample children and adolescents were a diverse group. Boys outnumbered girls almost 3:1, with 44 males in the sample and 16 females. At the time of admission, the youngest child was 7 and the oldest, 17. More than half of the youths in the sample (58.3 percent) entered the RTF between the ages of 10 and 14. Eleven youths (18 percent) were admitted to the RTF at age 16 or 17. The average age of the sample children on admission was 9.1 years and for adolescents, 13.9 years. The oldest youth in the sample was 19 at discharge, and the youngest was discharged at age 9. While the overall average length of stay was 25 months, the chart below shows the wide range in lengths of stay for the sample youths. Two youths were in an RTF for short stays of 4 and 5 months respectively, and at the far other end of the range, the two longest lengths of stay were 60 and 62 months. The largest percentage of youths (38 percent) lived at the RTF for between 12 and 23 months. There was no significant difference in the length of stay between children in DSS custody and those in parental custody. The average length of stay for the children in our study was 4.5 months longer than for the adolescents.

LOS	# youth	% of sample
< 6 mos.	2	3
6-11 mos.	7	12
12-23 mos.	23	38
24-35 mos.	14	23
36-47 mos.	8	13
48-59 mos.	4	7
60 mos. and greater	2	3

OMH data for the first two quarters of calendar year 2005 indicates that statewide the average length of stay for youths discharged from an RTF was 19.7 months. This was an increase from 2004 when the average length of stay was 17.8 months. The five month difference in average length of stay between the statewide figure and the study sample reflects the bias of the Commission sample in favor of youths who had had longer lengths of stay.

As presented in the table below, few children in the Commission's study came to the RTF directly from their homes. The single largest group of youngsters (27) came to the RTF from OMH certified or operated inpatient beds, indicative of the level of disability of the children.

Immediate Prior Placement	# of Sample Youths	% of Sample
Parents'/Guardians' Home	8	13
Foster Family (DSS)	1	2
Family Based Treatment (OMH)	2	3
RTF (OMH)	1	2
Residential Treatment Center (OCFS)	14	23
OMH Inpatient	27	45
Other	7	12

These figures also suggest the high level of disruption of family life experienced by the children, their siblings and parents prior to the child's admission to the RTF, with 87 percent of the sample children having already experienced a mental health inpatient stay or other out-of-home placement. Out-of-home placements and inpatient stays were only one measure of the care needs of the children in the study. Diagnoses, physical and emotional trauma, severe behaviors, and family pathology – all discussed later in this report – provided further evidence that the children in the study had multiple, extensive treatment needs.

For the youths admitted from an inpatient hospital, the move to the RTF represented progress in being able to function in a less restrictive setting. For the youths coming from other settings, the RTF move reflected their need for more intensive clinical services and the continuous support of a therapeutic treatment setting. The Commission's finding that the greatest proportion of sample youth were admitted from inpatient hospital settings is consistent with OMH data that indicates that 54 percent of the youths waiting for a RTF bed during the week of March 20, 2006 were in a State psychiatric center or on the mental health unit of a hospital.

Family and Adult Involvement

Forty-four (73 percent) of the youths in the sample had an adult active in their lives during their stay in the RTF. In most instances this was one or both parents; for four children the interested adult was a grandparent, for two children, a pre-adoptive parent, and in two instances, a foster parent. A DSS worker or contract agency worker was the adult active in the lives of four children, although 24 children in the study were under DSS custody. We determined that a paid staff (DSS or contract agency) was an active adult in a child's life when no family member or other person assuming a parental role had been active with the child and when the staff member had been in regular contact with the child and had participated in treatment planning. In one rural county, for example, where distance was an issue, DSS workers were required to see a child in an RTF only once each quarter. In these circumstances, the worker would not be considered an adult active in the life of the child, for purposes of this study.

While the finding that nearly three-fourths of the youths had an adult active in their life during their stay at the RTF is a positive one, the number of children whose families engaged in therapy with them was far less positive. Of the 40 children with an active adult for whom family therapy would have been appropriate, as suggested by the case record notes, only 22 had a family member who engaged in family therapy with them. The failure of nearly half of the relevant

families to engage in family therapy had broad clinical implications and restricted the youths' discharge options.

The lack of engagement in family therapy, the serious abuse and neglect histories of many of the children in the study and the clinical issues identified in many families, as depicted below, suggest that a number of children leave the RTFs with serious unresolved issues.

From the Sample of 60 Children	From the Sample of 60 Families
23 children had a documented history of sexual abuse 5 children had a suspected history of sexual abuse	29 families had a documented history of mental illness
26 children had a documented history of physical abuse 6 children had a suspected history of physical abuse	1 family had a suspected history of mental illness
41 children had a documented history of neglect 5 children had a suspected history of neglect	43 families had documented alcohol or substance abuse
	1 family was suspected of alcohol or substance abuse

Without exception, the RTF administrators interviewed explained that family support and involvement are vital aspects of treatment. This long-standing priority for RTFs was reinforced in the final report of the President's New Freedom Commission on Mental Health, which challenged the nation to transform mental health services, making them evidence-based, recovery focused and consumer and family driven. Programs described various techniques used to engage and support families to participate in family therapy. Most facilities reported providing transportation assistance, usually in the form of bus or subway fares or gas money, funds to cover lodging, weekend and evening therapy sessions and sessions by telephone. Some programs offered therapy in the child's home, meaning the facility would bring the child to the parent's home for therapy sessions. Nonetheless, the number of families taking advantage of these initiatives, according to administrators, was less than they would like to see. One grandmother who did take advantage of the facility's outreach told Commission staff, "They did everything in their power to help me visit and stay connected with my grandson. It helped him and me. I can't think of a thing I would have done differently."

The combination of children hurt by abuse and neglect and families unable to cope clearly manifested its impact in the numbers of out-of-home placements experienced by the children in the Commission sample. As

One downstate RTF provided a single mom with two other children, who lived 60 miles from the RTF, money for tolls, lodging, phone cards, and home therapy sessions. When her son was ready for discharge, the facility used \$1800 of wrap-around funds to make repairs to the family car to ensure that mom would have transportation for therapy appointments.

mentioned previously, more children came to the RTF directly from an OMH operated or certified inpatient bed than from any other site. Looking further at inpatient stays prior to the RTF admission, only 3 children in the sample had not had an inpatient mental health stay. One child had had 10 admissions. Nearly one-third of the children (18) had had four admissions. The average number of inpatient stays per youth was 3.5.

Forty-five of the 60 children had experienced out-of-home placements other than inpatient mental health stays prior to their RTF admission. Thirty-one children experienced one or two out-of-home stays, and the remainder experienced more. In the most extreme case, one child experienced more than 10 out-of-home placements. The children lived in the homes of family members, with foster families (sometimes several different foster families), in Residential Treatment Centers licensed by the Office of Children and Families Services (OCFS), in juvenile detention centers, and in assessment centers.

Inpatient stays and out-of-home placements separated children from brothers and sisters, as well as from parents. However, in the Commission's limited study, the work of families and the RTFs in maintaining contact between siblings was fruitful. Fifty-seven of the 60 youths in the sample had siblings, and 43 (75 percent) were able to maintain contact with them. Several positive stories stand out:

- A DSS caseworker and a foster family mother collaborated to reunite three siblings. Michael had always believed that he, along with five siblings, had been abandoned by his mother. When he was 15, he learned that he had two siblings, not five – an older brother and an older sister, who lived together with a foster family. The DSS case worker and the foster mom initiated visits where the three youngsters grew to know and enjoy each other. The hope of family was the incentive Michael needed to work hard on his discharge goals. A year later he was discharged to the same foster family that had taken in his brother and sister. Although Michael moved from this foster placement after a while, he maintains contact with his brother and sister.
- Meredith was 10-years old when she found out that she had a baby sister. Through the persistent work of the RTF with the girls' mom, Meredith has established a positive relationship with her younger sister.
- David, his sister and his twin brother were separated when they were taken away from their mother to protect them from further abuse and neglect. David's RTF worked, in cooperation with the agencies caring for the other two siblings, to ensure that David had a visit with his brother twice a month and with his sister once a month.

Not all sibling stories were heart-warming. Tom looked forward to visits from his two sisters, until their adoptive parents decided it was in the girls' best interest to cut off contact. Chris also had grown close to his much younger adoptive sister, but this relationship was broken when the adoptive parents decided that they could not care for Chris and surrendered custody of him.

The Perspective of Adults Involved in the Lives of the Study Youths

In informal conversations and structured interviews, parents and other adults² involved with the child during his/her RTF stay shared information that was particularly useful in identifying those aspects of their child's RTF care and treatment that were most helpful to them and their families. In all, Commission staff interviewed or received completed questionnaires from 31 adults involved with 31 children. Several reasons accounted for our inability to reach an adult for each child in the study: the DSS caseworker who was responsible for the child during his/her RTF study was not reachable; some youths who were part of the study sample had become adults by the time we were interviewing, and we did not contact their parents; Commission staff could not locate six parents/ family members (letters were returned undeliverable); and 11 families did not respond to letters or phone calls asking for their cooperation. In total, eight DSS workers, two foster parents, two grandparents, one family-based treatment parent, two contract case managers, one therapist, and 15 parents were interviewed or returned an interview form in the mail. Not all respondents expressed an opinion on all of the statements.

The adults were asked to grade their level of agreement with nine statements on a questionnaire. Not all respondents expressed an opinion on all of the statements. The results for four statements follow:

Questionnaire Statement	# adults responding	# / % positive response
Prior to admission, you and your child toured the unit.	25	21 / 84
Policies and procedures were explained to you.	24	21 / 88
The treatment team/therapist was receptive to information and concerns you shared with them.	28	26 / 93
You were invited to participate in your child's treatment planning.	26	24 / 92

The responses cited above, where adults gave highest marks to those areas which implied a partnership with RTF staff in planning treatment and sharing information and concerns, were consistent with conversations Commission staff had with adults who had assumed parenting or advocacy roles. The relationship that the adult had with the child's therapist, social worker or other staff person was often mentioned as a positive aspect of care. Transition coordinators were cited as particularly helpful. Eleven respondents said they talked to their child's therapist or facility contact at least once a week. Seven said they spoke to their facility contact person bi-weekly, and nine said they spoke at least monthly. In total, 87 percent of the respondents in our survey met or spoke with their facility contact persons at least monthly, and two-thirds had contact more often.

² In an effort to hear from as many adults as possible, we attempted to contact DSS workers and therapists when we could not reach family members.

“They [treatment team] were very receptive to suggestions. I could call the caseworker whenever I needed to.” – one child’s grandmother

“Family therapy and the therapist helped us retain custody of [our son]. They were so helpful.” – a parent

“Staff were available and very caring and bonded with the children.” – a DSS caseworker

Even when parents had not lived up to their commitments during their child’s stay, e.g., failure to visit as often as promised, some still mentioned the relationship with a staff member as important to their peace of mind.

In contrast, five respondents cited negative issues related to staff. Clinical staff were criticized for not sharing information or not sharing it in a timely manner. Specifically, respondents cited the failure to call them when a child had been hospitalized and the lack of adequate information regarding medications – side effects were not explained sufficiently and parents were not advised when medications were changed. Several respondents cited problems with direct support staff. These included high turn-over, inadequate training of direct support staff in de-escalating tension-filled situations, and direct support staff who did not provide a model of adult behavior that the respondent approved of, e.g., wearing their pants too low and using vulgar language. Personal items that were lost or “disappeared” and incompatible roommates were also cited as problematic aspects of the child’s RTF stay.

Second to mentioning the importance to them of relationships they had made with therapists and other staff members at the RTF, parents and other respondents mentioned the structure and consistent routine and expectations as particularly helpful to their children. All adults staying “on message” was cited by a DSS worker as essential to one adolescent’s successful transition to a foster family. Some adults mentioned the level systems that provided graduated rewards for good behavior as helpful to their child. Conversely, one parent noted that the level system in the RTF had such rich rewards for good behavior, e.g., a community outing for miniature golf, that the family could not compete when the child returned home. This left the youth annoyed and bored and the parents feeling inadequate. A second parent made a similar observation and mentioned the need for the RTF to develop, collaboratively with the family, a level system that works within the family unit, particularly when there are other children in the home.

Seven respondents cited counseling and frank discussions at the RTF as essential to their ability to engage with their child or foster child. A family-based treatment parent lauded the effective strategy of combining directed therapy with them and the child and the free private time given them by the RTF to get to know the child.

In response to the fifth item on the questionnaire, 22 of 24 respondents indicated that they were satisfied with the education that their child received at the RTF. One foster parent cited the improvement in reading that her foster child made during his stay, while a DSS worker spoke

about the general academic advance that a child made in the five months he was at the RTF. One of the two respondents who was not satisfied said that her child was given just “busy work.”

In contrast to the general approval ratings given to the children’s education, several respondents stated that the children had not learned life skills at the RTF. A family-based treatment parent asked, “Is [he] going to be dependent on the system for the rest of his life?” At 15 years-old, the youth did not know how to operate a washing machine or fold his clothes. One parent, who adopted a 10 year-old boy after he left the RTF, expressed his frustration with his son’s lack of life skills, despite years of institutional living – three of them in an RTF. His son had never learned right from left, never learned his middle name, could not tell time, could not swim or ride a bike.

Other study findings also suggest that some adolescents leave the RTF lacking basic skills necessary for community living. As an example, only one of the 23 adolescents – 16-years old or older – had a goal to improve his/her money management skills, yet the records of eight additional adolescents indicated that they were not able to budget or keep a checkbook. Only two of the 23 adolescents had a goal related to working, job training, or volunteer work.

The final four statements on the questionnaire related to discharge and the respondent’s overall opinion of the benefit to the child of his/her RTF stay. The responses are identified below.

Questionnaire Statement	# adults responding	# / % positive response
You were invited to participate in discharge planning for your child.	29	24 / 82
You were satisfied with the discharge arrangements made for your child.	26	23 / 88
Your child was ready for discharge when he/she was discharged from the RTF.	28	19 / 68
Your child benefited from the treatment he/she received at the RTF.	28	22 / 79

One respondent who believed that her child was not ready for discharge and yet indicated satisfaction with the discharge arrangements recognized her child was not ready for discharge

“I wanted her home, but she wasn’t ready.”

“I wanted him home, but he probably wasn’t ready. I pushed the issue.”

“I didn’t think he was ready for discharge. The RTF felt he was. It has not been going well.”

“Being institutionalized as long as he was, was not helpful. The RTF was slow in letting him go.”

only with hindsight. Another parent was discouraged because her son was discharged to a more secure facility and perhaps believed that had his stay in the RTF been longer, this would not have been necessary. Nonetheless, it is clear from the answers to the questionnaire and from interviews that along with problems gaining admission to the RTF (discussed in the next section), discharge presented the most difficulty. Some respondents cited premature discharges and others cited tardy discharges following stays that they believed were too long. As described later in this report, inadequate community resources and plans where

services were still being arranged were commonly cited as reasons for problematic or failed discharges.

Nearly four of every five respondents indicated that the youth had benefited from his/her stay at the RTF. Some of the positive responses were enthusiastic: “The RTF did a great job. He has turned his life around.” “I couldn’t say enough good things about the RTF.” “Staff attitude was great. They were always there for us.” Others responded citing specific assistance the RTF provided. For example, “They taught me how to manage his behaviors.” Families mentioned the efforts made to facilitate their maintaining contact with their children--assistance with travel expenses, for example. Family counseling and “frank discussions” about a child’s diagnosis and how it impacted on the family were also cited.

Several respondents who were critical of their child’s RTF stay noted their disappointment that the child had not learned to interact in a more socially appropriate way which would have made fitting back into the family and the community less stressful. One respondent who did not believe that the RTF stay benefited her daughter indicated that the facility was never up-front about her daughter’s mental illness, and hence she did not understand the seriousness of her daughter’s condition. She learned this when the discharge to home failed and her daughter was admitted to a children’s psychiatric center.

Among the Commission’s study sample of the 44 youths with an active adult in their lives, 36 of the adults (82 percent) actively participated in discharge planning.

THE ROAD TO THE RTF – GAINING ADMISSION

To be admitted to an RTF, the child’s application must be approved by a Preadmission Certification Committee (PACC), which operates in each OMH region. This procedure, established in regulation, is designed to provide a level playing field – ensuring uniform access to RTFs for children and adolescents regardless of their current placement or the source of the referral. Information supplied by the family, school, treating clinicians, and mental health providers, as well as the use of an assessment tool that considers both the youth’s profile and the caregiver’s capacity to care for the youth (often the CANS-MH, Child and Adolescent Needs and Strengths) form the basis for the PACC’s decision whether RTF admission is the best option for the youth. Regulations define the PACC members as psychiatrists, physicians, nurses, psychologists or social workers who have experience in the assessment and treatment of mental illness, preferably in children and adolescents.

In many counties, but not all, the application for services passes through the SPOA committee (Single Point of Accountability) before submission to the PACC. SPOA, an OMH initiative based in each county, is intended to facilitate the review of a youth’s application packet to determine whether sufficient community-based services can be marshaled to meet the youngster’s and family’s needs, without resorting to residential care. A family, hospital, community mental health provider, school or other entity may refer a child to SPOA, recognizing that SPOA serves children with high-end mental health service needs. The SPOA may package a mix of community-based services, such as Home and Community Based Waiver services,

Intensive or Supportive Case Management or other family support services to support the child in the community. If the SPOA determines that community-based services are not sufficient to meet the child's needs, it may determine that residential care is needed and refer the child to the PACC for consideration for RTF placement. The operation of the SPOA committees is governed by OMH guidelines, but not regulation.

Persons we interviewed criticized the RTF admission process on three fronts: 1) it is not consistent across the state, as in some regions the SPOA plays a far more active role in convening children's service providers than in others; 2) the process may require redundant evaluations of the youth because of the lack of implementation of standard procedures governing the relationship of the SPOA and the PACC; and, 3) the process simply takes too long and children and families wait without adequate mental health and other supports or youths spend too long in acute psychiatric care beds. This latter criticism may place some unmerited blame on the process, when the problem, at least according to some, is an insufficient and unevenly distributed number of beds.³

Because all case records did not contain the information necessary for the calculations, the Commission was able to determine the length of time from approval for RTF care to admission for 55 of the sample children. Thirty-four of the 55 children (61 percent) for whom the information was available waited more than 90 days from the time their RTF application was approved by the PACC until they were admitted to the facility. Six children and their families waited over 270 days for admission. In those instances where the delay occurred in admitting the youth after the application was approved, the absence of an opening in an appropriate RTF would seem to figure prominently. The application and admission process for some children in the study occurred in 2003.

In our study sample, older youths were admitted slightly more quickly on average than the younger children (186 days as compared to 232 days). The percentage of girls with long waiting times to receive RTF services was not larger than for boys (50 percent for girls versus 68 percent for boys), a finding not consistent with the information provided in interviews nor with OMH data for March 2006, showing more girls than boys waiting for RTF placement. It may be that the need for RTF beds for girls continues to grow and was not as evident in 2003-2004 when the females in our study would have been being evaluated for admission, or the Commission sample of females may not be representative in this respect.

All parties agreed that effective communication between the SPOA and the PACC reduces waiting time during which the child and his family may be in difficult straits, with insufficient mental health and other services to meet their needs. In those instances when the SPOA has reviewed a packet and passed it on to the PACC, the referral information is usually complete and can be acted upon at the very next meeting. In those instances where the referral packet to the PACC is lacking a piece of information, instead of deferring discussion until the next month's meeting, SPOA representatives suggested that the SPOA be contacted by phone to get a quick answer. Additionally, all SPOA respondents explained that the wider the representation on the SPOA committee, e.g., the addition of school personnel, law enforcement, OCFS specialized

³ 2004 OMH data indicates that there were RTF beds in 14 of NY's 62 counties.

services, family court, etc., the greater the chance of creating the right mix of services for the child and family.

Not all referrals for RTF services go through the SPOA in all counties, although this is the ideal process that OMH envisions⁴. OMH officials suggested that this is due, in part, to the design and procurement process and consequently the limited operation of the SPOA, the absence of regulations around the operation of SPOAs, and the fact that PACCs were operating well before SPOAs were created. There can be unintended consequences when children's applications are referred directly to the PACC, but the SPOA has not been informed. There is no assurance in these cases that community mental health supports would be insufficient to support the child and family. There is also the dreaded possibility, as explained by one SPOA representative, that should the PACC determine that the child does not need an RTF placement and recommends instead placement in a Residential Treatment Center (RTC), under the auspice of the Office of Children and Family Services, the parents are forced to decide if they are willing to give up custody of the child in order to have him/her admitted to the RTC.⁵ In short, the referral they made to the PACC for mental health services for their child boomerangs into a heart-wrenching decision to give up custody. One SPOA Coordinator suggested that problems resulting from a failure to communicate could be handled by having a SPOA member attend PACC meetings.

The disconnect that sometimes occurs between the SPOA and PACC is not the rule, according to most persons interviewed by Commission staff. In some counties the cooperation is exemplary, and both bodies are sure that no child is inadequately served in the community or prematurely placed into an out-of-home setting. This appraisal, not surprisingly, comes from those areas of the state with the richest array of community-based services.

Common Themes from SPOAs, PACCs and RTF Administrators

In discussions with Commission staff, the PACC Coordinators, SPOA representatives and RTF administrators echoed some common themes. Overarching many of the specific concerns was the expressed perception that the youth currently residing in and being referred to RTFs are more seriously emotionally disturbed than in the past. Several reasons were given to support this perception:

- Community resources are supporting the youths with less serious disabilities in their home communities;
- Acute care stays are shorter, and children coming from these settings are less stable;

⁴ During the time of our study, SPOA was not fully operational in New York City. All five boroughs currently have a functioning SPOA where RTF referrals are reviewed. OMH has advised the Commission that while SPOAs are strongly encouraged to screen all referrals for RTFs, families have a right to make a referral directly to the PACC if they choose to do so.

⁵ RTF services are paid for by Medicaid as a sub-category of inpatient hospital services. There is no requirement that a parent or guardian relinquish custody in order for a child to receive RTF services. RTCs are foster care programs operated by voluntary authorized agencies. RTC services are paid for by federal, state and local foster care funds. In order to receive services in an RTC, the child must be placed in the custody of the local commissioner of social services by the Family Court pursuant to a child protective, person in need of supervision or juvenile delinquency proceeding or placed voluntarily by the parent into the custody of the local DSS.

- Because every effort is made to wrap services around a child and family to prevent an out-of-home placement, when it is determined that these services are not sufficient, the child is very ill; and,
- The mental health and substance abuse problems of parents are often serious and persistent and must be addressed if the parents are to be expected to support their child.

Conversations around the acuity level of the children in RTFs led to discussions of the need for specialized services. Some interviewees stated their belief that there are simply an insufficient number of RTF beds to fill the need. This belief was not universal, however. Several respondents nuanced this perception stating that there are an insufficient number of specialized RTF beds for children with developmental disabilities, those with violent behaviors, children who have set fires, and children with behaviors that constitute sexual offenses. These children are often sent to programs out-of-state, according to one interviewee, particularly if they are residing in an RTC and need specialized care. Over half of the SPOA and PACC respondents cited the insufficient number of RTF beds for girls. Traditionally, far fewer girls were referred for RTF level of care. These numbers have increased, and the insufficient number of beds has meant that girls wait substantially longer for a bed than do boys. One Coordinator explained that it currently takes 8 to 10 months to place a girl and a week to two months to place a boy.

The need for more discharge options for youths leaving the RTF, both in terms of residential settings and mental health services and supports, was an almost universal observation. Interviewees spoke passionately about the need to develop appropriate residential options for late adolescents who leave the RTF but cannot go home. In the absence of appropriate settings, adolescents move into community residences and other settings designed for adults or they are placed into independent living situations without the skills necessary to succeed – skills such as how to write a check, how to find a job, they explained. Transition apartments where the adolescents can learn these skills in real-life situations under the guidance of staff were on the wish-list of several coordinators. Moving mental health services into schools was identified as an essential component to any successful community-based mental health service system for children. Fast-tracking these services was cited as a priority.

Clinical supports for discharged children of all ages are also in short supply, according to the study respondents. Long waits for evaluations and for day services and in some cases educational placements were cited. This places the discharged RTF children in jeopardy of needing to return to the RTF or to an even higher level of care. In rural counties, the lack of choice because of the dearth of providers was cited. The need to strengthen the role of families and of the youths themselves in not only planning treatment for a specific individual, but in establishing priorities for the development of local and regional mental health services, was mentioned by representatives of the more successful SPOAs.

MEETING THE NEEDS OF THE CHILDREN AT THE RTF

The 60 children in the Commission study, as reported earlier, had significant trauma histories, with over two-thirds having a documented history of neglect and 70 percent having a documented history of either physical or sexual abuse – sometimes in their birth or adopted

families and other times in foster care or while in institutional care. The severity of the abuse suffered by some children is heart-wrenching and the resilience of these children is breathtaking.

At age 3, Kathy’s mom poured hot coffee on her straight from the coffee pot. At age 4, she was sexually abused by mom’s boyfriend. At age 6 she was removed from her home to foster care, following several instances of severe neglect. She was adopted two years later, but the adoption failed because of Kathy’s out-of-control behavior. She was again moved into foster care. This placement was not successful, and Kathy moved into a respite bed in a community residence until she was admitted to the RTF.

Sam, who has a developmental disability, was 15 when we met him in an RTF for adolescents. At age 5, he was sexually abused by his mom’s boyfriend. His mother physically abused and neglected him. His father beat his mother and Sam was made to watch. His father went to prison, and Sam went into an RTF for children shortly thereafter. Later he was discharged to an RTF for adolescents. He has lost contact with his brothers and sisters.

The trauma, broken emotional ties, and the lack of strong personal supports often presented in extreme behaviors in the sample children: hair-trigger tempers, aggression against themselves (particularly girls cutting themselves) and others, sexually promiscuous and sexually offending behavior, sometimes fire-setting and running away behaviors. These factors also often contributed to youngsters’ experiencing significant developmental delays that impacted negatively on their ability to process information and problem solve. The behaviors at admission most frequently cited in the sample children’s records (with the number and percentage of the sample children) were:

Physical aggression	51 (85%)
Psychotic symptoms	41 (68%)
Rage (without physical aggression)	39 (65%)
Disruptive at school	38 (63%)
Sexual acting out	26 (43%)
Property destruction	24 (40%)
Self-injurious behavior	23 (38%)

Children admitted to an RTF must, by regulation, be identified as having a serious and persistent psychopathology, an IQ equal to or greater than 51, and present no likelihood of serious harm to others. Consequently, it is not surprising that the children in the sample carried serious diagnoses and, with rare exception, multiple mental health diagnoses, as presented below in rank order. Fourteen of the sample children carried a diagnosis of mild mental retardation or pervasive developmental disorder.

Diagnosis upon discharge	# youths
ADHD	24
Post traumatic stress disorder (PTSD)	15
Bi-polar D/O	11
Schizophrenia/Schizoaffective D/O	11
Depression	10
Oppositional Defiant D/O	10
Psychotic D/O NOS	9
Intermittent Explosive D/O	6
Anxiety D/O	5
Conduct D/O	4
Other	4

Most of the 13 RTF administrators interviewed indicated that more children with special needs were being referred to their program. Eight administrators cited the challenge presented by youths with developmental disabilities in addition to mental health problems. One administrator stated that finding discharge options for children with multiple disabilities is difficult and often results in their remaining in the RTF for long stays. She noted that often these children “graduate” to an RTC. The, RTC, she noted, is not the type of program they need, but rather they should be served in residential programs under the auspice of OMRDD, where program staff are skilled in dealing with issues related to impaired intellectual functioning.

A second administrator noted that children with developmental disabilities require “constant reinforcement for pro-social behaviors” and such systems are difficult to duplicate in an RTF. Another administrator noted that children with developmental disabilities require a “qualitatively different treatment milieu.” In response to the question asking administrators how children in RTFs differed from children in RTCs, in addition to differentiating the two groups on the basis of their mental health symptoms and treatment needs, five administrators specifically noted that RTF children have more cognitive and/or developmental impairments.

Children who set fires, children with eating disorders, and children who are sexually aggressive or have hyper-sexualized behaviors were also identified as difficult to treat. Generally, administrators said they were able to meet the needs of these children, but also suggested that they could use some help. Building treatment expertise to meet the needs of these children was mentioned by several administrators. One administrator cited the need for training opportunities to develop the professional skills of clinical staff to treat these youths. Similarly, another administrator stated that the use of outside resources to provide some services for these children is very helpful and that such opportunities should be expanded.

Defining and Reaching Treatment Goals

The record review completed by Commission staff for each youth in the sample included review of the treatment objectives in the last treatment plan and the assessment of progress at discharge. The most common treatment objectives and the number and percent of children and adolescents making progress is presented below.

Goals and Progress	Children < 11 (N=18) Goal Present # / %	Children < 11 Made Progress # / %	Adolescents ≥ 11 (N=42) Goal Present # / %	Adolescents ≥ 11 Made Progress # / %
Use Coping Skills in Symptom Management	16 / 89	14 / 87.5	29 / 69	27 / 93
Improve Social Skills/Family Relationships	15 / 83	12 / 80	32 / 76	32 / 100
Limit Aggressive Behavior	12 / 67	10 / 83	26 / 62	24 / 92
Follow School Rules-Homework/Classroom	12 / 67	10 / 83	26 / 62	25 / 96
Limit Disruptive Behavior	9 / 50*	7 / 78	21 / 50	20 / 95
Accept Responsibility for Actions	7 / 39	7 / 100	-	-
Improve ADLs	7 / 39	6 / 86	11 / 26	10 / 91
Limit Self-Injurious Behavior	1 / 6	1 / 100	6 / 14	5 / 83
Limit Sexual Inappropriate Behavior	5 / 28	4 / 80	6 / 14	3 / 50
Limit Psychotic Symptoms/Behaviors	5 / 28	4 / 80	2 / 5	2 / 100
Medication/Treatment Compliance	3 / 17	3 / 100	18 / 43	17 / 94
Limit Sexual Offending Behavior	0	-	1 / 1	1 / 100

* One sample youth's progress could not be determined from the treatment record.

The final set of treatment goals for the sample youths directly addressed four of the seven most common behaviors exhibited by the children on admission: physical aggression, psychotic symptoms, disruptive behavior at school and sexual acting-out behavior. The only treatment goal where the children showed success rates of less than 80 percent was in limiting destructive behavior.

The Use of Restraining Techniques

All of the RTFs in the sample stated that they use physical interventions to protect the child and others when a youth's behavior is considered out-of-control. The practices used differ between children and adolescents, but in its most intrusive form, youths are held on the floor until they calm down. Forty-four (73 percent) of the youths in the study were physically restrained at some point during their RTF stay. Because of the long lengths of stay of the sample children, Commission staff determined the number of physical interventions used on the sample youths in the three months prior to discharge with the following results. In total, slightly more than half (23) of the 44 youths (or 38 percent of the total sample) required physical interventions in the three months leading up to their discharge. Two youths required more than five restraint

interventions, six youths required three to five restraint interventions, five required two, and ten youths required a single restraint intervention.

Information on the use of manual restraining interventions provided by OMH for a portion of the study period, the fourth quarter of 2004, indicates variable rates of use among RTFs. When calculated on client days to offset differences in census, 4 of the 18 RTFs had rates that exceeded 4 holds per 100 client days. This was double the rate of the 10 RTFs with rates of less than 2 holds per 100 client days.

At the time of the Commission study, state agencies and providers were engaged in a controversy over the proper technique when it is necessary to hold a youth on the floor. The Office of Mental Health strongly advised RTF providers to avoid prone restraint for safety reasons, citing asphyxiation deaths that have occurred in facilities across the country as staff applied pressure to a struggling individual's back, cutting off his/her ability to take in oxygen. The Commission, based on its own investigations, a review of the pertinent literature and the recommendations of its Medical Review Board, endorses the position adopted by OMH with regard to the avoidance of prone restraint and further encourages the elimination of all restraints whenever possible.

Some RTF providers countered that supine (face up) restraints are more traumatic for youths, particularly those who have been sexually abused. Providers also took issue with the OMH advisory on practical reasons, first stating that their staff had been trained in prone restraint and there were no funds provided for retraining. Second, they argued that many RTFs are co-located on campuses with RTCs, where staff are trained to use prone restraints. These providers pointed out the problems that will likely occur when students who share facilities require different restraining techniques, including allegations of abuse for failure to use the proper restraining technique. In response, legislation was adopted in 2006 to establish a restraint and crisis intervention committee to develop coordinated standards to address the problem. The Commission will be participating in this committee.

The Youths' Perspectives on their RTF Stay

The Commission used two interview forms to solicit information from the youths in the study: one for adolescents (completed by 31 youths) and one for children and those adolescents whose cognitive ability suggested this would be the more appropriate tool (13 youths used this form). In total, we have responses from 44 youths who either spoke to us directly or mailed in the questionnaires. Included in each of the interview forms were two open-ended questions asking each youth what was most helpful and least helpful during his/her RTF stay.⁶ Additionally, several yes/no questions were asked of the children, and the adolescents were asked to use a five-point scale to indicate their agreement with statements.

Consistent with the replies of parents and other adults active in their lives, over one-third of the 44 youths responding identified staff, sometimes citing a staff member by name, as most helpful to them during their stay. Several youths made statements like "Staff talking to me and helping me with homework was helpful." Next most frequently cited, nearly one-third of the youths

⁶ We were hoping to have each youth give three factors each for helpful and not helpful. Some were able to provide only one or two.

identified therapy as most useful to them. These respondents spoke about the help they received from their psychiatrist or therapist. One youth offered, “primarily the one-on-one treatment” was helpful. Thirteen youths (30 percent) named recreational activities as most helpful, and nine identified playing/socializing with their peers. Several youths identified the level system or, more generally, the structure of the RTF as very helpful. “Knowing what I am supposed to do and what will happen if I don’t [was helpful].” In a surprising finding, only one youth named visits from family and friends as helpful.

In response to the question asking what was least helpful, an equal number of youths (13) cited their own or peers’ problem behaviors and staff who were not understanding, would not listen or were intimidating or verbally abusive. Ten youths specifically stated that the use of physical interventions was not helpful to them. Six respondents stated the food was bad, and two cited poor environmental conditions. These youngsters mentioned bathrooms that were “dirty and nasty,” moldy ceilings, and “leaky pipes that dripped onto my hair.” No one named visits from family and friends as “not helpful” to them.

The responses to the yes/no questions and statements scored for agreement/disagreement are presented below.

Statement/Question	Number / % positive responses	Number / % negative responses
You toured the unit before admission	28 / 93	2 / 6
Policies/procedures/rules were explained to you	31 / 100	0 / 0
You helped plan your treatment	26 / 90	3 / 10
You helped plan your discharge	23 / 82	5 / 18
You visited your new home before discharge* **	7 / 88	1 / 13
You were happy with the discharge arrangements*	27 / 93	2 / 7
When you were discharged, you felt ready.	27 / 96	1 / 4
You could have visitors	44 / 100	0 / 0
You could make phone calls	43 / 100	0 / 0

* These questions were not asked of youths discharged to an inpatient facility.

** Many children said they could not remember the answer to this question.

Several questions/statements elicited particularly revealing comments:

Did the school you attended at the RTF provide a good learning experience?

Total responding: 30

Positive responses: 22

Negative responses: 8

“The school was way cool.”

“[I liked] the classes because I like to read.”

“They were more focused on my behavior than on my education.”

“I was placed with kids below my grade level.”

“It wasn’t a school setting; it was chaotic, little structure, hard to learn.”

“Class got into fights.”

Did staff listen to you when you wanted to talk?

Total responding: 44

Positive responses: 37

Negative responses: 6

“[Staff] are the main reason I loved the RTF.”

“Staff helped me to focus.”

“Staff say, ‘Get out of my face.’ Sometimes it is funny and sometimes, not.”

LEAVING THE RTF

It would seem that the question one most wants answered in looking at the discharges of the 60 youths is whether they benefited from the RTF stay sufficiently to be able to resume their lives in the community with enough supports to keep them safe and able to enjoy a quality of life. Commission staff assessed the discharges of the sample youths and determined whether the youths met these criteria, based on the interviews with the youths, the adults involved with them, and the RTF staff with whom they had kept in touch. We were able to gather sufficient current information on 54 youths to make a judgment about the success of their discharge.

At the time of our contact, 30 of the 54 youths had been discharged to a less restrictive setting and were doing well. Thirteen youths were home with family, five were in therapeutic foster care, six were living in community residences, three in supported housing, two in Family-based Treatment, and one youngster was in pre-adoptive foster care.

Labeling a discharge “unsuccessful” can be tricky. The discharge of a youngster to an inpatient unit because he needs that level of care to be safe is not a bad discharge. Acknowledging this, but still maintaining the less restrictive setting criteria, we determined that 15 youths did not meet our successful discharge criteria because they were discharged to inpatient settings, to a more secure RTF, or from one RTF to another. The discharges of the remaining nine youths

were determined to be unsuccessful for a variety of reasons: one young man was in jail and another was living at home, accepting no services and having been arrested twice; two young people were living in supported housing but refusing education, a job or job training; one young man was living at home receiving tutoring because he was expelled from school for fighting; one youth was placed in an RTC, but reportedly was not doing well, showing increased mental health problems. One youth had moved through several foster care families and was still not stable, and finally two young women were living at home, pregnant, and we have no information to indicate that they were in a stable relationship or financially self-sufficient.

We do not mean to suggest that unsuccessful discharges are necessarily the result of inadequate treatment or poor discharge planning, although records would indicate that in some instances this was the case. Sometimes, factors beyond the control of the RTF doomed a discharge, despite the RTF's efforts to advocate on behalf of the youngster.

Arthur's RTF discharge plan called for him to attend the 8:1:1 class at the local public school. Despite many contacts by the RTF transition coordinator and education supervisor, his home school district would offer only home tutoring. The RTF education supervisor contacted the State Education Dept., OMH, BOCES and the local DSS to secure a more appropriate school placement. Two successive school placements failed. The final plan was for Arthur to attend an ARC program.

In several instances, while the youth may have been ready for discharge, the family clearly was not. Elizabeth was one of those youths.

Elizabeth lived at the RTF for over four years. As discharge planning began in earnest, it became apparent that her grandmother was too old to care for and supervise Elizabeth. Five residential programs determined that they could not care for her. The RTF engaged Elizabeth's mother in treatment planning, but she would not participate in therapy with her daughter. A few months after discharge, Elizabeth was admitted to a psychiatric facility due to increased symptoms brought on, in part, by a lack of medication, which Elizabeth's mom believed she did not need and refused to let her take.

In reviewing the services offered to children at discharge, it became apparent that services identified as necessary were in place, as documented in the treatment record, approximately 75-80 percent of the time. Several administrators explained that delays in determining eligibility for county Medicaid were a factor in some instances. At discharge, 32 youths were determined to need case management services, the records of 24 (75 percent) indicated that services had been set up. For seven youths, case management services were not in place, and we were not able to determine if services for one child were finalized. Forty-four youths were determined to need clinic or day services, the records of 32 of them indicated that the service had been set up prior to discharge. In six instances, the service was not in place at discharge, and for the six remaining

children, we were not able to determine if the services had been secured. Forty-five of the sample youths were 18 or younger when they were discharged to community, not institutional, settings. Twenty percent did not have a school placement finalized at the time discharge. Michael is a case in point.

Michael's mother was in drug rehab from the time he was six until he was eight. During this time, he stayed with his grandmother. Michael had several hospitalizations in the succeeding years for aggression and command hallucinations to hurt himself. He was admitted to an RTF and his mother was active with him during his stay and participated in family therapy. Weekend visits and a two week trial discharge before the actual discharge were described as successful. Upon discharge at age 15, Michael was linked with clinic services and case management. He did not have a school placement. Three months after discharge he was re-hospitalized, returned to the RTF and was subsequently readmitted to the hospital.

CONCLUSIONS AND RECOMMENDATIONS

An RTF fills several roles that are not always in harmony and which compete for resources, staff attention, time, and the commitment of the youths themselves. An RTF is, by regulation, an inpatient psychiatric facility, with attention to medication and verbal therapies, teaching coping skills and symptom management. It is also, by virtue of the lengths of stay of many youths, their home for several years and the last place, for some, to learn the skills they will need before they live independently. The Commission's study of 60 youths discharged from an RTF between January 2004 and June 2005 identifies some of the tensions in filling these multiple roles. We also believe the study findings provide the groundwork for recommendations that acknowledge the multiple tasks of the RTF, will improve admission and discharge procedures, and will enhance the quality of care provided in these settings.

- ❑ With regard to the role of the SPOA and the PACCs the Commission recommends that OMH issue clear and uniform guidelines addressing:
 - OMHs expectations regarding the working relationship between the SPOA and the PACC to ensure consistency across the counties and then monitor performance against the guidelines;
 - the need for SPOAs to actively reach out to providers of children's services, such as OMRDD, SED, OASAS and family court so that these agencies will be more responsive when their assistance/cooperation is required. To facilitate this wider cooperation, OMH should engage its sister agencies with the goal of developing agreement that they (sister agencies) will encourage their providers to actively participate in the SPOA process;
 - the need for the SPOA and/or PACC to advise parents when the application packet is complete and when they can expect to hear the PACCs decision; and,

- the responsibility of the SPOA to consider the needs of the entire family in fashioning a support plan for a child. This might include mental health and/or substance abuse treatment for parents, support groups for parents and siblings, parenting education, and recreational and social activities for the child, for example.
- ❑ With the universal recognition that work with families in appropriate situations improves the likelihood of a successful discharge, the Commission recommends that OMH identify, promulgate and to the extent possible provide training opportunities for RTF clinicians on best practices for conducting comprehensive family and home assessments, providing family therapy and for engaging families in therapy.
 - ❑ OMH should take steps to encourage RTFs to build on their work with families to improve discharge planning to:
 - develop realistic reward systems that accommodate the family’s resources and other responsibilities;
 - document efforts to enroll youths in activities to reduce the amount of unsupervised down time that parents’ work schedules require; and,
 - ensure that educational and mental health programs are in place at the time of discharge.
 - ❑ To enable transition coordinators to finalize educational placements for youths prior to discharge, OMH and SED should identify obstacles to successful placements and work to eliminate the barriers identified.
 - ❑ OMH should require RTFs to review their curricula, daily procedures and activities to identify additional opportunities to teach functional living skills.
 - ❑ The Commission commends the attention to the needs of young adults for safe, supervised housing that is part of the NY/NY III agreement. NY/NY III provides for the development of housing for two categories of young persons: 200 congregate beds are allocated for young adults in State psychiatric centers or other mental health care settings. Also, 100 congregate beds and 100 scattered site beds are allotted to young adults who have left or are leaving foster care and are at risk of homelessness. In looking beyond New York City, the Commission recommends that OMH, in consultation with local mental hygiene providers and recipients, review the distribution of mental health services and supervised housing for children, adolescents and young adults in other areas of the state, particularly in under-served areas, to identify needs and allocate resources as appropriate.