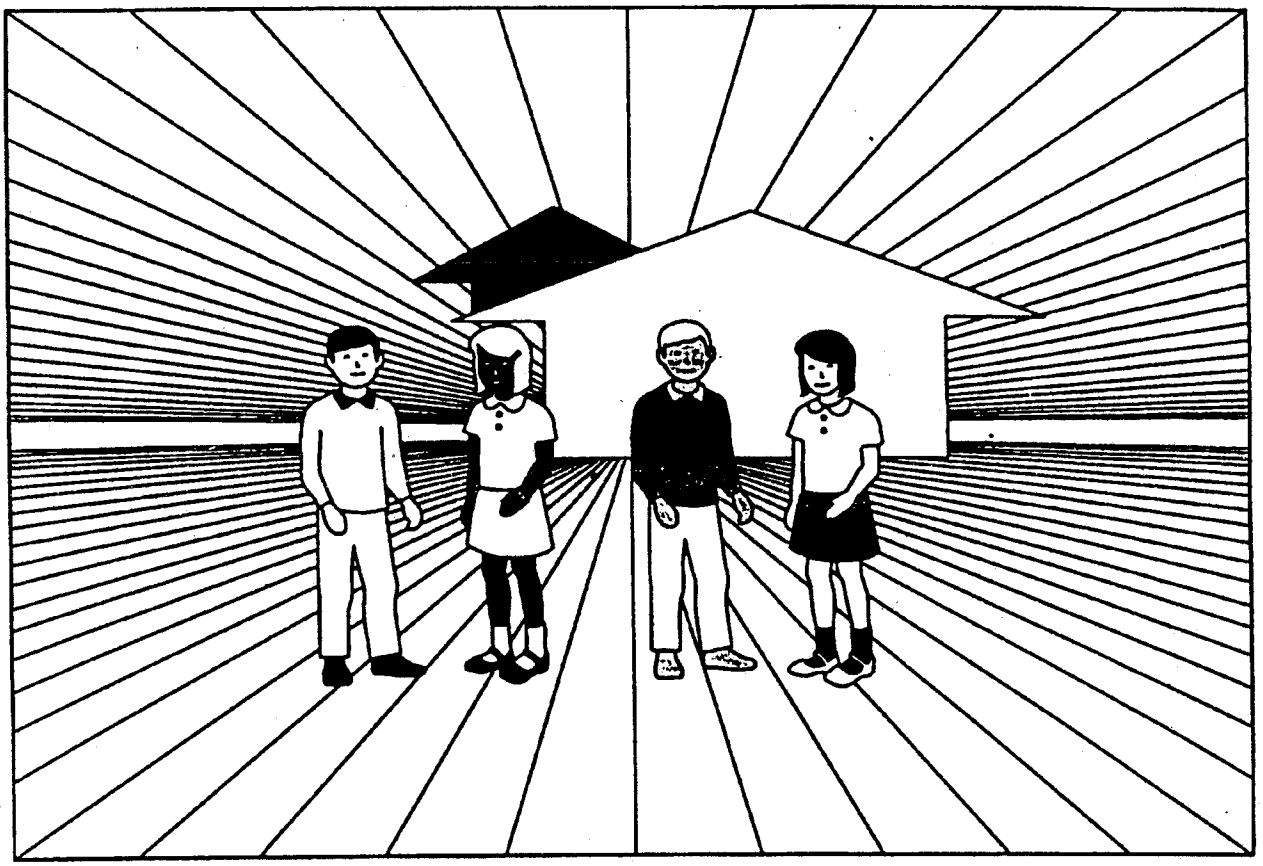
NYS Residential Services for Children with Emotional Problems: *A Call for Reform*



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

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Elizabeth W. Stack
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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.

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Elizabeth W. Stack, Commissioner

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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.[1]

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.

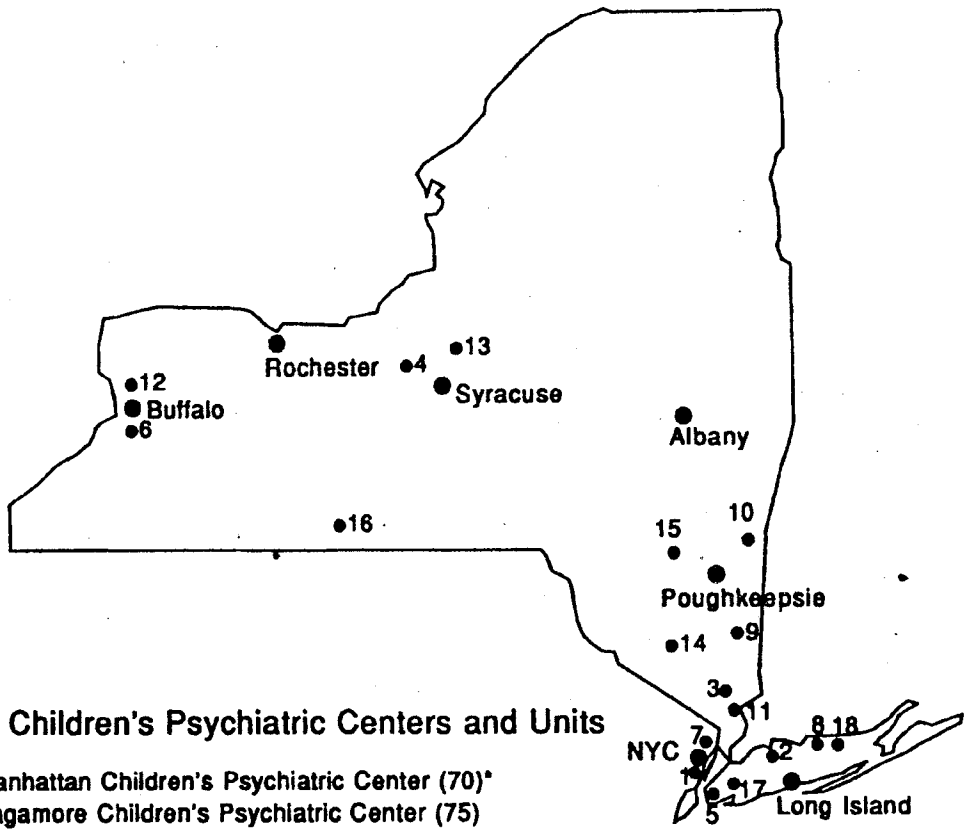
A total of 100 children from the 18 programs was selected for careful study. At each of the four family-based treatment programs visited, the Commission selected four children for review; six children were selected from each of the other 14 programs visited. At all programs the Commission attempted to 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.[2] 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.

[1] In the report, the cited number of beds in these programs changes based on the time period cited.

[2] 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. Chistopher Ottilie 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.[3]
- 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.

[3] 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.[4]

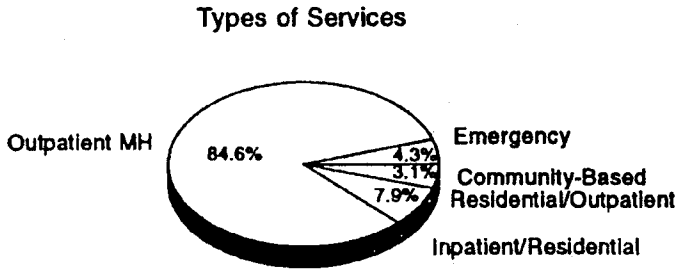
Services for Children With Emotional Problems in New York State

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).[5]

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.

[4] 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.

[5] 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.[6] 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.

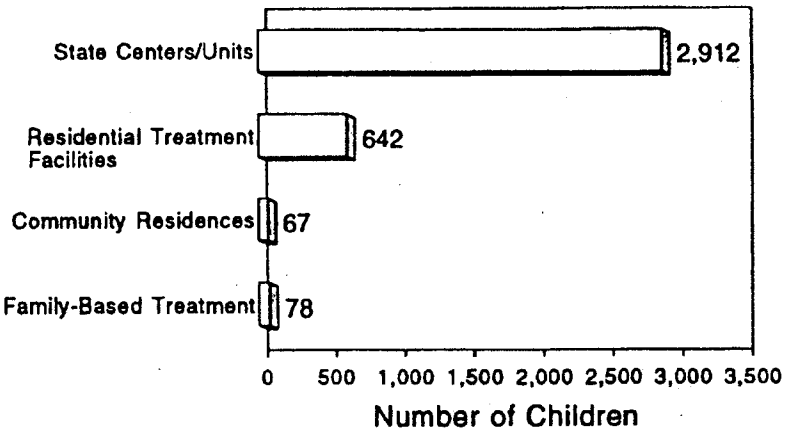
In addition to these modalities, the Office of Mental Health sponsors two smaller community-based residential programs for children with emotional problems: small (4-8 beds) community residence programs and family-based treatment programs. These programs are new and, at any one point in time, they serve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

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.

[6] Data were provided by the Office of Mental Health.

[7] 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 development 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.[8]

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).

[8] 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.

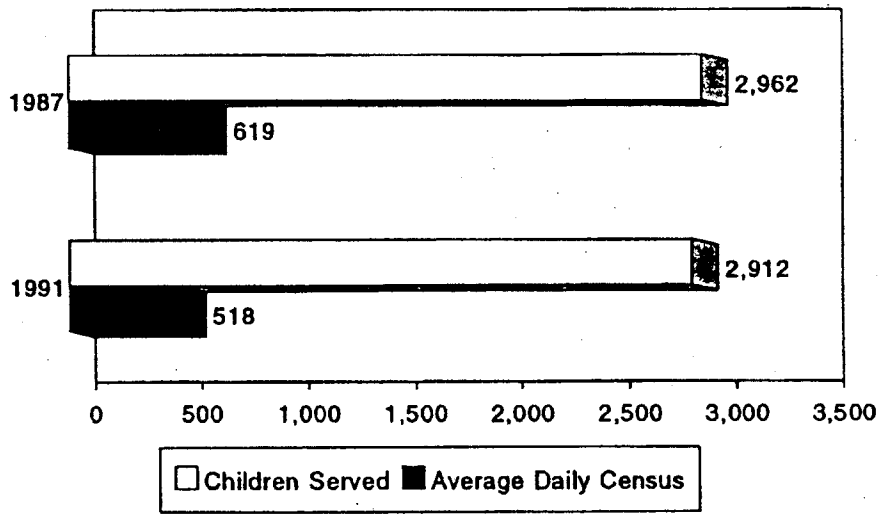
In accordance with this scheme, it was anticipated that state centers and units would admit children who needed ongoing intensive psychiatric treatment beyond the usual three- to six-week stay in an acute psychiatric unit of a general hospital and that these children would receive care for one to six 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.[9] 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 private 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.

[9] 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.