

# **Evaluation Of Residential Resources For Children In Maryland**

## **Final Report**

### **Submitted To:**



**Maryland Governor's Office For Children, Youth And Families**  
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## EXECUTIVE SUMMARY

In response to the 2001 Joint Chairmen's Report, the Governor's Office for Children, Youth, and Families (GOCYF) contracted with REDA International Inc. (REDA) in November 2002 to provide information to aid Maryland's Subcabinet for Children, Youth, and Families in preparing a statewide resource development plan for the provision of adequate community-based resources to serve children with special needs.

The major research questions to be addressed in the study are:

- ◆ With regard to residential resources in the state of Maryland, how does the service delivery system operate for children with special needs?
- ◆ Are there any gaps between service provision and the needs for services? If so, where do the gaps exist?
- ◆ What are the major factors that have created the need for residential resources?

Due to the scope of work for the contract, the study was directed to the needs and services for children already identified as being in need of residential placement. It did not address the needs and services associated with other children who may have special needs, those whose needs are less intensive, and those who have not yet been considered by a public agency for residential placement.

### **Study Methodology**

Information about the service delivery system for children with special needs for residential services was gathered at the resident level, the provider level, the local referral level, and the state level.

To obtain information about the resident children, the evaluation team employed both case record reviews and parent focus groups. The study team visited each RTC and reviewed a designated number of randomly selected individual case records. The record reviewers recorded information about the child's demographic characteristics, diagnoses, services received, length of stay, discharge plans, educational disability and other things. Four focus groups were conducted with parents from different regions of the state.

To obtain information at the service provider level, two separate mail surveys were conducted. The first survey successfully gathered information from all of the 14 RTC directors in the state. In addition to the mail surveys, licensed psychologists and social workers interviewed the facility's designated administrative personnel to collect data on the operations of the facilities. The second mail survey solicited information from organizations licensed to run residential programs other than RTCs for children or youth under age 22 in the state. These were

referred to as Other Residential Programs (ORPs). There were 57 ORPs that responded to this survey.

To obtain information at the local referral level, REDA conducted interviews with each of the Local Coordinating Council chairs from each county. To obtain information at the state level, REDA's evaluation team conducted five, semi-structured, in-depth interviews with key state agency representatives.

### **Highlights of Findings about the RTCs from the Surveys and Record Reviews**

The total capacity at RTCs in Maryland on May 15, 2003 was 756 beds whereas enrollment was 703 residents on that date. On average, Maryland's RTCs operate at more than 90 percent of capacity. At least one RTC is generally at 100 percent capacity. Six of the 14 RTCs have children on a formal waitlist. Forty-two percent of eligible applicants with complete paperwork were placed on a waiting list, whereas 58 percent were immediately offered placement. Some RTCs have programs that serve specialized populations including children who have displayed sexually offending behaviors. These programs have high utilization rates. Two of the specialty units (specialized treatment and intensive treatment) were operating at 100 percent capacity on May 15, 2003. The adolescent male sex offender units also had a relatively high occupancy rate (97%). The existence and apparent high demand of these units explains why there may be children on a waiting list in spite of an RTC not operating at 100 percent capacity.

Nine of the 14 RTCs reported having delays in discharge. They reported that nearly half (46%) of these delays were due to the inability to find a more appropriate, less restrictive placement. For another 12 percent of the youth whose discharge was delayed, lack of funding for a more appropriate, less restrictive placement was reported by RTCs as the reason. About another one-eighth of the delays were reported to be related to parents' disagreement with the recommended placement. Finally, almost one third (30%) of the discharge delays were reported to be due to other reasons, including agency-related issues such as case workers neglecting to follow through on necessary paperwork. Inadequate community resources was also one of the most commonly reported "other" reasons for delayed discharges.

A record review of RTC residents indicated that 15 percent of the current residents continued to stay in an RTC though their estimated discharge date had passed. Thirty-two percent of the records of discharged residents indicated that their actual discharge date was after their estimated discharge date. These records revealed that deterioration or instability in mental state was a major reason for delayed discharges. It was mentioned in nearly three-quarters (74%) of the relevant cases. However, in more than one third (36%) of the cases for which reasons for the delay were provided, difficulty in finding a less restrictive place for the resident to transition to was also named as the barrier to discharge. For example, concerns about the resident's ability to function within the family environment or the family's willingness to accept them were presented in nearly a quarter of the cases (23%). Waiting for a placement to a less restrictive facility was indicated in 14 percent of the cases.

None of the RTCs accept children below the age of five. Thirteen of the 14 RTCs indicated that they do not accept youth with a diagnosis of profound mental retardation. Twelve reported that they did not admit youth with severe or moderate mental retardation. Six of the 14 reported that they did not admit youth with mild mental retardation. With regards to legal criteria, half of the RTCs (n=7) do not accept adjudicated or non-adjudicated sex offenders, and eight of the RTCs reported that they do not accept fire setters.

RTCs reported that 12 percent of their residents had a history of fire setting and that 12% of the RTC residents were adjudicated sex offenders. RTC providers were asked, "How many residents at your facility on May 15, 2003 were court-ordered youth?" In response to this question, the RTC providers reported that slightly more than two-fifths (41%) of the residents were court-ordered youth. Overall, the RTCs indicated that they are able to provide appropriate treatment for 97 percent of the court-ordered youth. In the 3 percent of cases in which the RTCs reported being unable to provide appropriate treatment, the youth were characterized by sex offending behaviors, severe aggression, lack of parental participation or parental agreement with placement, or low IQ/mental retardation impeding the RTCs' ability to meet the child's educational needs.

Of the cases reviewed for the RTC record abstraction analysis, 51 percent indicated that the youth had a substance abuse issue, but only 35 percent of the youth had their substance abuse disorders indicated in their DSM-IV diagnostic picture. The RTC directors' reported through their surveys that in 11 percent of the cases sexual abuse was indicated. Yet, 38 percent of the records reviewed at the RTCs revealed that the residents were survivors of sexually abusive experiences. Further investigation of these discrepancies might be warranted.

The percentage of RTC residents using aftercare services was three-fifths (60%) for general RTC units, as well as Specialized Treatment. A quarter of the court evaluation unit residents utilized aftercare services. Some of the types of aftercare services reportedly offered were education-related services, transitioning to other programs offered by the organization (e.g., therapeutic group home, day treatment, etc.), and individual and family therapy.

None of the secured RTC units or Adolescent Male Sex Offender RTC units reported providing aftercare or follow-up services to youth after discharge. Key state representatives, RTC providers, and LCC representatives each reported that after-care and step-down services for children leaving RTCs was of primary importance. RTC providers expressly emphasized the need for aftercare programs and group homes for the adjudicated sex offender population.

### **Highlights of Findings from the Survey of Other Residential Programs (ORPs)**

Based on unweighted data from a mail survey of ORP providers, ORP programs in which children receive mental health/psychiatric services either on or off-site (e.g., hospital-based respites, diagnostic centers, therapeutic group homes, intermediate care, and treatment foster care) only made up 22 percent of the total ORP capacity and served 21 percent of the children/youth currently enrolled in these ORP programs. Moreover, excluding the treatment

foster care programs which provide access to outpatient counseling services to the children in individual foster homes, the conventional ORP programs that serve children/youth with psychiatric conditions (i.e., hospital-based respites, diagnostic centers, and therapeutic group homes) made up only seven percent of the total ORP capacity and served 10 percent of the ORP residents.

A majority of the ORP providers reported that they would not accept an applicant who is an adjudicated sex offender (71%), or younger than age five (67%), or has severe or profound mental retardation (both 65%, or with a history of fire-setting (64%). About half of the service providers would not accept an applicant who has a major illness or serious medical condition (52%), or who has a moderate mental retardation (50%).

The ORP survey respondents reported that a total of 407 of their slots were either vacant or not filled by the target children/youth group. However, most of these “vacancies” were located in treatment foster care homes (27%), small group homes (22%), emergency shelter group homes (12%), alternative living units (9%), and “other” types of programs (e.g., residential schools). Very few vacancies could be found in community based respites (0.2%), diagnostic centers (0%), hospital based/psychiatric respites (3%), and therapeutic group homes (1%).

Over one third (39%) of the ORP providers indicated that they had plans to change the capacity of existing youth-serving residential programs and nearly two fifths (39%) of the ORP providers had plans to start a new residential program. Based on the survey data, it is estimated that the capacity to serve youth among the responding ORP providers might increase by a total of approximately 410 beds. The capacity of existing programs is slated to increase by 203 beds and new programs are expected to add another 207 beds to the overall OPR capacity. However, nearly two thirds (62%) of the planned capacity increase in the existing programs was reported by one residential school whereas the beds in the planned new programs would be more evenly distributed across programs with and without a therapeutic component. The populations slated to be served by the new programs included drug exposed/drug affected infants to two year olds, adolescent females, and transitionally aged youth (ages 18-21).

Nearly three quarters (70%) of the youth residents in the ORPs had mental health or psychiatric issues. Specifically, nearly one-quarter (22%) of the ORP residents had two or more psychiatric conditions; nearly one fifth (18%) had both a substance abuse/dependence disorder and a psychiatric condition, and 10 percent had a co-existing developmental disability and psychiatric condition.

Over one quarter (29%) of the youth residents had been diagnosed with mental retardation. However, only 13 percent of them lived in programs that either provided or provided access to mental health or psychiatric services (e.g., hospital-based respites, diagnostic centers, intermediate care, therapeutic group homes, and treatment foster care). The vast majority (83%) lived in small group homes, ALUs, and residential schools, which usually do not provide extensive mental health or psychiatric services.

Based on unweighted data collected from the ORP providers, the geographical distribution of ORP residents in the survey was not consistent with the state-wide population distribution of youth under age 21 with regard to the most populous jurisdictions in the state of

Maryland. Baltimore City was over represented among the ORP residents (34%) as compared to its proportion (13%) in the state population of youth under age 21. On the other hand, however, some major suburban counties were under represented. These included Montgomery County (6% in survey vs. 16% in population), Prince George's County (9% in survey vs. 16% in population), Anne Arundel County (4% in survey vs. 9% population), and Howard County (2% in survey vs. 5% in population).

The 57 responding ORP providers reported a total of 148 delayed discharges in the 12 months prior to the survey. Over one third of the delays were in the small group homes (20%) and the diagnostic centers (17%). Another one third were in emergency shelter group homes (10%), large group homes (10%), and 90-day structured shelter care homes (10%). The most commonly reported barriers to discharge included finding a more appropriate place for residents to transition to upon leaving the facility. Primarily, being rejected or waiting for a bed was mentioned, followed closely by the inability to return to their parents.

### **Highlights of Findings from the Focus Groups and Interviews**

Every key state agency representative explained that there is a need for more mental health training for new and existing direct care staff and professionals in the system. A high turnover rate for these workers was attributed to the "very poor pay and benefits for people who work with special needs children." Every key state agency respondent maintained that there were not enough community-based programs, particularly specialized programs that would address the needs of more distinct populations. Children with more complicated diagnoses represented hard-to-place children in community programs. These children's conditions were reported to oftentimes deteriorate due to a lack of community-based services, thus resulting in increased emergency crises that may or may not require more restrictive levels of care.

Some of the key state agency representatives explained that one of the main reasons that a child stays in an RTC longer than necessary is because there is such a scarcity of less restrictive, community-based options available to them. Every respondent explained that the issue of parental custody relinquishment in exchange for services represented one of the most sobering dilemmas in the service delivery system. They also expressed their belief that because the service needs at one level are contingent upon and are related to the needs at another level, the overall failure to meet the needs of some children can create problems throughout the system.

The dually diagnosed population was also identified as most in need of residential services. This finding was reported both in the RTC directors' survey and by key state agency representatives. LCC representatives specifically noted that dually diagnosed children are one of the populations that are hard to place.

LCC respondents' responses appeared to reflect a general consensus that the current RTC placement system is "inefficient" and "overburdened" with a large number of children requiring placement. Representatives explained that streamlining the referral and placement system would enhance the quality of services provided to children and could be done through (1) ensuring speedier fund disbursement, (2) pooling funds so that the burden of providing money for a child's services is shared, and (3) revising policies, procedures, and regulations so that they

provide a helpful and guiding framework that does not put lead agencies in a position to have to work around them rather than with them.

In focus groups, parents articulated some of the barriers to attaining appropriate services. These were (1) knowledge of services, (2) a service delivery system that lacked standardization, (3) funding issues, and (4) geographic location of available services.

In these groups parents explained that one could “self-educate” in order to get information, but that the time required engaging in this process is a luxury that most of the parents could not afford. Strained communication between facility staff and parents was reported to be another problem for parents who wanted to stay informed about their child’s treatment. Overall, the responses that parents made seemed to reflect a desire to shift away from a reactive system that is more responsive to parents once crisis has set in, toward a preventative system that addresses the needs of children before they develop conditions necessitating RTC placement.

## **Summary**

In summary, the needs for residential resources are two-fold. First, there is a considerable need for residential treatment centers (RTCs). The overall occupancy rate of RTC beds was 93 percent on May 15, 2003. According to data reported by the six RTCs that maintain a formal waiting list, in the 12 months prior to the survey, a total of 80 applications, or two fifths (42%) of all the eligible applications<sup>1</sup> with complete paperwork, had to be put on a waiting list due to a lack of vacancy. The length of waiting ranged from 30 days to seven months. Secondly, there is also a big need for step-down services in the communities. The needs on both sides of the aisle reinforce each other. Data abstracted from a random sample of individual case records of RTC residents revealed that 26 percent of the admissions between September 1, 2001 and August 27, 2003 had a delay in discharge and more than one third (36%) of the delays were related to difficulty finding a less restrictive placement. While a resident is awaiting discharge, the resident often de-compensates, further delaying discharge, creating a catch 22 situation.

There are some populations that are underserved in the residential programs captured in this study. One of the groups that all data sources noted as being underserved is the dually diagnosed population, particularly those with developmental disabilities and psychiatric conditions. Previous literature indicates that oftentimes, dually diagnosed youth’s behavioral and emotional problems are inappropriately attributed to their developmental disability as opposed to a psychiatric disorder (Tonge & Einfeld, 2000). Moreover, individuals with developmental disabilities are at least four times more likely to also have a psychiatric disorder when compared with the general population. (Bongiorno, 1996; Tonge & Einfeld, 1999). However, 12 RTCs reported that they will not accept youth with moderate or severe developmental delays, and 13 RTCs exclude youth with profound developmental delays from admission. Sixty-five percent of ORPs reported that they will not accept youth with severe or

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<sup>1</sup> The unit of analysis here is in terms of each application rather than each individual applicant because one person may apply to more than one RTC concurrently.

profound mental retardation, and 50 percent of ORPs reported that will not accept youth with moderate mental retardation. Even so, only 22 percent of the ORPs beds are in facilities in which children receive mental health/psychiatric services either on or off-site (e.g., hospital-based respite, diagnostic centers, therapeutic group homes, intermediate care, and treatment foster care). Moreover, only 13 percent of the ORP residents with developmental disabilities were being served in these programs.

Another population that was consistently reported as being underserved is youth who have committed sexual offenses. Half of the RTCs (n=7) do not accept adjudicated or non-adjudicated sex offenders. Nearly three quarters (71%) of ORPs indicated that they would not accept an applicant who is an adjudicated sex offender. This population was noted as one most in need of aftercare and step down services, as well as group homes. This sentiment was expressed by the RTC providers in the interviews and mail survey, key agency representatives, and LCC representatives. Although some RTCs do not provide aftercare, DJS continues to track and follow up with the children.

Additionally, youth with a history of firesetting represent an underserved group. LCC representatives noted the difficulty in finding appropriate placements for these youth, and the need for services for the populations with a history of firesetting and/or sex offenses were echoed throughout the course of the study. RTC survey data also indicated that these youth are one of the populations most in need of residential services. Eight of the 14 RTCs reported that they do not accept fire setters. Sixty-four percent of ORPs generally reported that they do not accept firesetters. A further investigation of the admission policy regarding fire setters revealed that whether the fire setting episode was dangerous or not was a key factor in determining whether an applicant with a history of fire setting could be admitted. For example, none of the ORP providers that responded to the survey would consider accepting an applicant with a history of a recent and dangerous fire setting episode, though over half (59%) would be willing to consider accepting an applicant whose history of fire-setting was not recent or frequent and not dangerous.

Though some populations are underserved due to a limited number of available placements to treat their specific diagnostic issues, some residents may be in need of additional or more specialized services. Specifically, there appears to be a need to address substance abuse and sexual abuse survivor issues in more comprehensive ways at RTCs. Record abstraction analyses revealed that 51 percent of the cases reviewed were of youth that had substance abuse as an issue. However, only 35 percent have substance abuse disorders as part of their diagnostic picture. With regard to sexual abuse, the RTC directors' survey and the diagnoses listed in the record indicated sexual abuse 11 percent and 8 percent of the time, respectively. Yet, 38 percent of the records reviewed at the RTCs revealed that the residents were survivors of sexually abusive experiences. Therefore more focused attention to these issues is warranted given that they are accentuated by the high relationship between addiction and sexual abuse survivor issues (Swanston, Plunkett, O'Toole, Shrimpton, Parkinson & Oates, 2003).

Aftercare and step-down services were also reported as major needs for RTC residents, in general. Key state representatives, RTC providers, and LCC representatives each reported that after-care and step-down services for children leaving RTCs was of primary importance. RTC

providers expressly emphasized the need for aftercare programs and group homes for the adjudicated sex offender population. The percentage of RTC residents using aftercare services was three-fifths (60%) for general RTC units, as well as specialized treatment. A quarter of the court evaluation unit residents utilized aftercare services. None of the secured units or adolescent male sex offender RTC units reported providing aftercare or follow-up services to youth after discharge. For ORPs, less than two fifths (39%) of the respondents reported providing aftercare or follow-up care to their youth residents after discharge from their program.

**EVALUATION OF RESIDENTIAL RESOURCES FOR CHILDREN  
IN MARYLAND**

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### List of Abbreviations

Adolescent Sex Offender Program	ASOP
Alternative Living Unit	ALU
Americans with Disabilities Act	ADA
Certificate of Need	CON
Community Services Initiative	CSI
Core Service Agency	CSA
Court Appointed Special Advocate	CASA
Department of Health and Mental Hygiene	DHMH
Department of Human Resources	DHR
Department of Juvenile Services	DHS
Department of Rehabilitative Services	DORS
Department of Social Services	DSS
Developmental Disabilities Administration	DDA
Didactic Behavior Therapy	DBT
Early & Periodic Screening, Diagnosis & Treatment	EPSDT
Extended School Year	ESY
Governor's Office for Children, Youth and Families	GOCYF
House Bill	HB
Independent Living Preparation Program	ILPP
Individual Family Service Plan	IFSP
Individualized Education Plan	IEP
Individuals with Disabilities Education Act	IDEA
Local Coordinating Council	LCC
Local Departments of Social Services	LDSS
Local Education Agency	LEA
Local Management Board	LMB
Maryland Association of Resourced for Families and Youth	MARFY
Maryland Disabilities Law Center	MDLC

Maryland Health Partners	MHP
Maryland State Department of Education	MSDE
Mental Health Administration	MHA
Multi-Agency Review Team	MART
Multi-Disciplinary Team	MDT
National Center on Institutions and Alternatives	NCIA
Office of Health Care Quality	OHCQ
Other Residential Program	ORP
Program Review Committee	PRC
Psychiatric Rehabilitation Program	PRP
Regional Institutes for Children and Adolescents	RICA
Residential Treatment Center	RTC
Senate Bill	SB
State Coordinating Council	SCC
Subcabinet Child, Youth and Family Information System	SCYFIS
System Reform Initiative	SRI
United States Department of Health and Human Services	USDHHS

## CHAPTER 1

### INTRODUCTION

The Governor of Maryland created the Subcabinet for Children, Youth, and Families in 1987, which is comprised of the Secretaries of the Departments of Budget and Management, Health and Mental Hygiene, Human Resources, Juvenile Services, the State Superintendent of Schools, the Special Secretary for Children, Youth and Families, the Director of the Office for Individuals with Disabilities, and the Governor's designees from other state agencies. The major function of the Subcabinet is to improve the structure and organization of services to children, youth and families. With regards to serving children with special needs, the Subcabinet focuses on ensuring that children are placed in the least restrictive environment that is appropriate to meet their needs. The Office for Children, Youth and Families (GOCYF) provides staff to the Subcabinet. In order to make certain that adequate community-based resources exist to serve children with special needs, who would otherwise remain in restrictive and distant residential placements, the Subcabinet is interested in preparing a statewide resource development plan to meet the needs of these children. There is a particular interest in determining the needs of children in residential treatment centers (RTC). Thus, in November 2002, REDA International Inc. (REDA) was awarded a contract from GOCYF to evaluate the residential resources for special needs children in the State of Maryland. The purpose of this report is to present the results of the assessment conducted by REDA.

For the purpose of this report, a special needs child is defined as one for whom *out-of-home residential placement* is recommended and for whom a diagnosis has been made from three general areas: developmentally disabled, medically fragile, and/or emotionally disturbed.

The state of Maryland's Developmental Disabilities Administration defines the **developmentally disabled** population as individuals matching the following criteria: persons with a severe chronic disability that is attributable to a physical or mental impairment, other than the sole diagnosis of mental illness, or to a combination of mental and physical impairments; is manifested before the age of 22; is likely to continue indefinitely; results in an inability to live independently without external support or continuing and regular assistance; and reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services that are individually planned and coordinated for the individual.

The **medically fragile** population is defined as individuals who are dependent upon mechanical ventilation for at least part of each day, intravenous administration of nutritional substances or drugs, other device-based respiratory or nutritional support on a daily basis, including tracheotomy tube care, suctioning or oxygen support, other medical devices that compensate for vital body functions, and substantial nursing care in connection with disabilities.

A child with an **emotional disturbance** is defined as one who exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects

their educational performance:

- ◆ Inability to learn that cannot be explained by intellectual, sensory, or health factors;
- ◆ Inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- ◆ Inappropriate types of behavior or feelings under normal circumstances; and
- ◆ General pervasive mood of unhappiness or depression, or a tendency to develop physical symptoms or fears associated with personal or school problems (Maryland Coalition of Families for Children's Mental Health).

While this report addresses the availability and utilization of residential resources other than RTCs, the requirements of the 2001 Joint Chairmen's Report and Health Care Commission dictate that the primary emphasis of this report be on RTC capacity and placement issues. This limitation in scope, however, does not reflect a view by the Subcabinet or by REDA that community-based resources are less important than RTC resources. Furthermore, this report addresses systematically only the needs and services for children already identified as being in need of residential placement. Therefore, this report does not provide an assessment of the needs and services associated with all children who may have special needs, whose needs are less intensive, and who have not yet been considered by a public agency for residential placement. The information contained in this report includes the types of services available, the service delivery system as a whole, and any reported gaps in services and/or resources for the population of children with special needs identified above. Findings from the needs assessment may provide valuable information to the Subcabinet in its function of addressing daily operations, as well as making policy decisions.

## CHAPTER 2

### STUDY METHODOLOGY

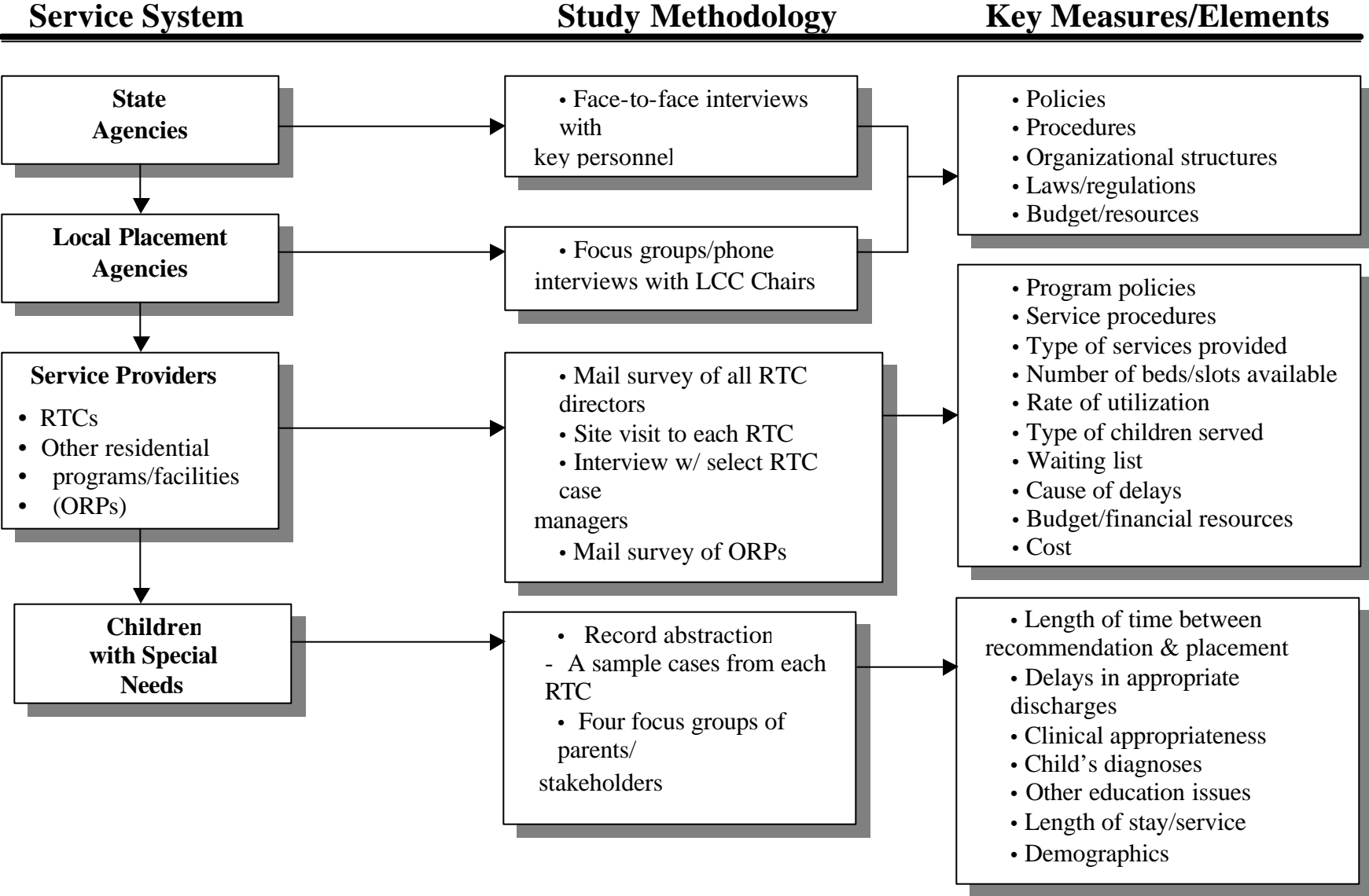
#### 2.1 Study Design

The present needs assessment study was designed to address the following major research questions:

- ◆ With regard to residential resources in the state of Maryland, how does the service delivery system operate for children with special needs?
- ◆ Are there any gaps between service provision and the needs for services? If so, where do the gaps exist?
- ◆ What are the major factors that have created the need for residential resources?
- ◆ What should be done to meet the needs?

An integrated systems approach was employed throughout the study. Data collected from different sources were integrated and analyzed using both qualitative and quantitative techniques to identify and understand the gaps between the needs for services in the target population of children and the availability and accessibility of such services. As illustrated in Figure 2.1-1, the service delivery system for children with special needs for residential services was examined at multiple levels: the state level, the local referral level, the provider level, and the resident level. A variety of methods were used to collect information from different perspectives. The study design was developed in consultation with the GOCYF staff and input from other agencies. The study was approved by the Institutional Review Board of the Department of Health and Mental Hygiene (DHMH). IRB approval ensured that relevant confidentiality and informed consent issues were addressed.

# Figure 2.1-1: Study Design



## **State Agencies**

Guided by the study design, the REDA evaluation team conducted five, semi-structured, in-depth interviews with key state agency representatives. The state entities interviewed included:

- ◆ Department of Health and Mental Hygiene (DHMH)
- ◆ Developmental Disabilities Administration (DDA)
- ◆ Department of Juvenile Services (DJS) - formerly DJJ
- ◆ Department of Human Resources (DHR)
- ◆ Maryland State Department of Education (MSDE)

Please see the Appendix 2.1-A for the interview schedule of personnel from the key state agencies. In general, the representatives were asked to discuss their agency's roles in the service system, the laws and policies affecting children with special needs, their understanding of the gaps in services, and what would be needed in order to better serve children with special needs. Please see Appendix 2.1-B for an interview discussion guide.

In addition to obtaining the perspective of agency personnel, important related documents such as COMAR regulations, the Americans with Disabilities Act, IDEA, the Autism Waiver, the System Reform Initiative, the Medical Necessary Criteria (MHP, 2001), and House Bill 1386 (2002 session) were reviewed to understand the environmental impact of laws, regulations, and policies on the functioning of the service delivery system.

## **Local Placement Agencies**

At the local referral level, REDA conducted interviews with each of the Local Coordinating Council chairs from each county. The interviews were conducted either through a focus group or a one-on-one telephone interview. GOCYF furnished REDA with a list of the current LCC chairs. REDA drafted a letter explaining the purposes of the assessment and the importance of the LCCs input. The focus groups took place on March 13, 2003 at Queen Anne's County Health Department in Centreville, Maryland and March 20, 2003 at the Business Training Center (BTC) in Columbia, Maryland. Since fourteen LCC chairs were not able to attend either focus group, REDA telephoned these individuals to conduct one-on-one telephone interviews. (See Appendix 2.1-C for a detailed list.)

Those individuals interviewed by telephone received the same questions that were presented to the focus group participants. Please refer to Appendix 2.1-D for a review of the discussion guide used in both the telephone interviews and focus group discussions. Many of the Councils share the duty of chair. When necessary, REDA updated the information about the current LCC chair.

## **Service Provider Level**

At the service provider level, data were collected from both RTCs and other residential programs (ORPs). One mail survey was conducted with all of the 14 RTC directors in the state of Maryland. It was intended to collect information on service capacity, rate of utilization, types of children served, average length of stay, waiting list, cause of delay in discharge, types of service provided, types of automated information systems in place, cost of services, staff composition, and coordination with state and local agencies and community organizations.

The original draft version of the questionnaire was developed based on initial information provided by GOCYF, as well as a review of literature. The original draft version was reviewed by GOCYF staff and feedback was incorporated into the questionnaire. The RTC Coalition also provided information that was utilized to revise the questionnaire, particularly regarding waiting list issues. Revisions were continually made based on data obtained through key agency interviews. The final draft version of the questionnaire was reviewed by the Multi-Agency Review Team (MART), a committee made up of child-serving State agencies and charged with monitoring the stays of youth in psychiatric hospitals. During the same time period, the draft was reviewed by the State Coordinating Council Program Review Committee (SCCPRC), a committee which reviews out of state placements for youth. Feedback from both MART and PRC were incorporated, and based on feedback from PRC, each RTC was contacted and the questionnaires ultimately customized for each RTC based on the distinct specialty units operated at each facility (see Chapter 4 for more details). Finally, the questionnaire was pilot-tested with the administrative staff at one of the RTCs in Maryland.

The surveys were mailed to each RTC executive director. A team member attended the RTC Coalition meeting on September 10 to answer any questions about the survey. Follow-up phone calls were made to RTCs who had not returned the survey by the due date. A final step taken was sending via FedEx another copy of the survey with a letter requesting that the survey be completed and returned within a week. In addition to the mail survey, licensed psychologists and social workers were trained in the procedures to be utilized during site visits to each of the 14 RTCs in Maryland. While on site, the study team interviewed the facility's designated case manager(s) and/or other administrative personnel to collect data on the operations of the facilities. Please see Appendix 2.1-E for a review of the Structured Interview Guide.

Another mail survey was conducted with the corporation/organizations licensed to run other residential programs (ORPs) for children/youth under age 22 in the state of Maryland. Since there was not one single complete sampling frame available for the survey, a database was created by augmenting the existing lists of ORP providers licensed by the four licensing bodies in Maryland, namely, the Department of Human Resources (DHR), the Developmental Disabilities Administration (DDA), the Department of Juvenile Services (DJS) and the Department of Health and Mental Hygiene (DHMH). Information for the licensed ORP providers by DHR and DDA was obtained from documents posted on the agencies' respective websites. DJS and DHMH each provided a list of their licensed residential care providers. Some of these providers were licensed to run more than one type of programs or run one type of program at different sites/locations.

After completing the database, phone calls were made to each of the licensed ORP providers to verify information such as its mailing address and the name of its chief administrator. During this process it was discovered that some of the ORP providers were no longer in business or had moved. Information was updated as it was obtained. As a result, the sampling frame was constructed containing a total of 237 licensed ORP providers. The breakdown by licensing body is as follows:

- ◆ 134 licensed by DDA
- ◆ 76 licensed by DHR
- ◆ 18 licensed by DJS
- ◆ 9 licensed by DHMH.

A survey questionnaire was mailed to the chief administrator of each licensed ORP provider and asked him/her to provide information for all the ORPs operating under their licenses. Please see Appendix 2.1-F for a copy of the ORP survey. Three weeks after the mailing, follow-up calls were made to those entities that had not responded to the survey. As part of the follow-up calls, the interviewers inquired whether the corporation/organization ran any residential facilities that served children/youth ages 21 and under. If the licensed entity did not serve the target youth group or served the group in a non-residential capacity, they were recorded as ineligible for the survey. If the ORP provider did serve children in a residential capacity, they were encouraged to respond to the survey. As a result, 57 eligible ORP providers responded to the survey and provided valid data about their programs. However, since very limited information was available about the ORP population in Maryland that could be used for data weighting, the GOCYF recommended that data analyses be conducted using unweighted data.

In addition to data collection with the RTCs and ORPs, the study team also interviewed a representative from the Maryland Association of Resources for Families and Youth (MARFY). MARFY is a non-profit 501(c)3 association of child and family services agencies throughout Maryland. Its membership is made up of 55 private sector agencies providing residential services among other services through nearly two hundred programs across the State.

### **Children with Special Needs**

In order to obtain information about the children for whom the system is designed to serve, the evaluation team employed two strategies; a case record review and parent focus groups. During each site visit, the study team reviewed a designated number of randomly selected individual case records and abstracted information on the child's demographic characteristics, diagnoses, services received, length of stay, discharge plans, educational disability and collaborating agencies. The purpose of the case record reviews was to take a snapshot of the RTC residents in the state of Maryland at an individual level. A consortium of relevant state agencies decided that the target population for the record review should consist of all the Medicaid-funded RTC residents who were admitted during a two-year period since July 1, 2001, including those who have been discharged and those who are still in treatment.

The sampling frame was provided for the 11 privately owned RTCs by Maryland Health Partners (MHP), a private organization that manages the Medicaid payment to RTC residents. This list contained a total of 806 children representing 868 admissions into the 11 privately owned RTCs between July 1, 2001 and August 27, 2003 (the date when the list was compiled). According to this list, 479 of the children were discharged and 327 were still in treatment at the time of the study. Among them, 100 were admitted into these RTCs more than once during the target period, 91 had two admissions and nine had three admissions. Due to the issue of multiple admissions, the sampling unit for the RTC record review was each admission rather than each individual person. A random sample of 20 admissions of current residents and five admissions of discharged residents was drawn from each of the 11 RTCs using the list provided by MHP. If an RTC had fewer than 20 current residents, all of them were taken into the sample. Our site visit staff then took the MHP ID numbers of the sampled admissions to each RTC and asked the RTC staff to provide the actual records accordingly. If a record could not be found for some reason, a random replacement would be made within the same target time frame.

For some reason, the MHP database did not include admissions to the three publicly owned RTCs, namely, the Regional Institutes for Children and Adolescents (RICA) at Baltimore, Rockville, and Southern Maryland. Since no lists of the RICA residents were available to serve as a sampling frame, we had to select a random sample of 5 records of discharged residents and 20 records of current residents in each of the three RTCs during the site visit, following the same selection and replacement rules used for the 11 privately owned RTCs.

As a result, a total of 298 valid records were selected, reviewed, and abstracted using a standardized form. Data abstracted from these records were weighted to represent the total target population, that is, all the Medicaid-funded RTC residents who were admitted between July 1, 2001 and August 27, 2003. Within each of the 14 RTCs, the selected records were stratified into two categories by their discharge status (current vs. discharged) and weighted to their population total. For each private RTC, the total number of records on the MHP list by discharge status was used as a proxy for the target population total. Since such a list was not available for the publicly owned RICAs, their reported enrollment on May 15, 2003 in the survey of RTC directors was used as a proxy for the population total of current residents, whereas the ratio of the records of current residents to those of the discharged residents on the MHP list was used to estimate the target population total of the RICA admissions for which the residents had already been discharged. Data analyses were based on the weighted data and the unit of analysis was in terms of each admission rather than each individual resident.

Parent focus groups were conducted to better understand the issues and service barriers for children with special needs. REDA created a database of parent organizations that contained approximately 90 organizations for parents of children with special needs. These organizations included advocacy groups, educational organizations, and support organizations for parents of children with special needs. The database was divided into 5 groups that contained organizations in each of the 4 geographic regions in which REDA wanted to hold the focus groups. The regions were north, south, Eastern Shore, and west. The southern region was divided into two groups, south 1 and south 2.

REDA sent over 120 information packets to the director/president of each parent organization in each region. The packets contained an introductory letter explaining the project and the reason for conducting the focus groups. The packets also contained 10-20 fliers and fact sheets about the evaluation for distribution to the parents. The one-page focus group solicitation flier for parents listed the date, time, location and purpose of the focus group as well as information about how to respond to REDA if a parent wished to participate. Each region (north, south 1, south 2, Eastern Shore, and west) had a flier with the correct corresponding information. Please see Appendix 2.1-G for a sample of the information packet. The packets were mailed approximately 4 weeks before the focus group was scheduled to take place.

REDA received telephone calls and faxes from parents who wished to participate in the focus groups. For the first focus group, REDA took all parents who responded to the solicitation, thus some parents in the focus group did not have children with special needs that required residential level of care. REDA screened the subsequent potential focus group participants to ensure that they were representative of the special needs population that REDA was evaluating. Please refer to Table 2.1-1 for an overview of the parent focus group composition.

**Table 2.1-1: Parent Focus Group Representation by County, Diagnoses and Services Placement**

Region	Counties by Region	Counties Represented	# of Participants	Diagnoses Represented	Place Services were Received
Central	Anne Arundel, Baltimore County/City, Howard, Harford	Baltimore, Harford, Howard	7	bipolar disorder, ODD, severe emotional problems, visual impairment, autism, developmental delay	In-Home/In-School, ORP
Eastern Shore	Caroline, Cecil, Kent, Dorchester, Queen Anne's, Somerset, Talbot, Wicomico, Worcester	Queen Anne's, Kent	5	ADHD, Asperger's Syndrome, cerebral palsy, developmental delay, arthrogryposis, visual impairment	In-Home/In-School
Southern 1	Calvert, Charles, St. Mary's	Charles, St. Mary's	12	Down syndrome, asthma, memory problems, ADHD, bronchial pulmonary disease, seizures, hearing impaired, autism, spina bifida, Asperger's syndrome,	In-Home/In-School
Southern 2	Montgomery, Prince George's	Montgomery, Prince George's	7	Severe MR, autism, suspected schizophrenia, Asperger's Syndrome, medically fragile, ADHD, anxiety disorder	ORP, RTC, Out-of-State RTC
Western	Allegany, Carroll, Frederick, Garrett, Washington	None	0	Not held due to poor response rate.	n/a

Parent focus group participants were asked to sign a consent form. Please see Appendix 2.1-H for a copy of the consent form. Notes were compiled and analyzed for the focus groups that were held and conducted. REDA held and conducted three of the five scheduled parent focus groups. The parent focus group for the western region was canceled due to a lack of respondents. Though REDA received affirmative responses from parents indicating that they would attend the focus group for Southern region 2, no parents were in attendance. The focus group was not held because the only attendee was a LCC chairperson.

GOCYF asked REDA to convene two additional parent focus groups in the regions where the previous focus groups did not materialize. Emphasis for these two additional parent focus groups was on recruitment of parents whose children were awaiting entry, currently enrolled or recently discharged from an RTC. The two additional parent focus groups were again scheduled in the western region (Allegany, Washington, Garrett, Frederick and Carroll Counties) and southern 2 region (Montgomery and Prince George's Counties).

The recruitment strategy was modified in order to ensure that the population of children in RTCs was tapped. Thus, in addition to the methodology stated above, REDA also distributed information packets to the directors/CEOs of each of the 14 RTCs as well as to the chairs of the Local Management Boards and Local Coordinating Councils for each of the specified counties. The packets were mailed approximately 3 weeks before the focus groups were scheduled to take place. The focus group for the western region received no responses and was again canceled. The focus group for the southern 2 region was held and conducted.

At the request of GOCYF, REDA also attended a PTA meeting held at the RTC located in Rockville. Parents expressed their concerns about not having had an opportunity to voice their opinions in previous focus groups that had been held. REDA re-emphasized the multiple efforts to gain participation in parent focus groups as described above.

The study team interviewed representatives from the State of Maryland's Protection and Advocacy organization, the Maryland Disabilities Law Center (MDLC). The MDLC is a private, non-profit organization staffed by attorneys and paralegals who represent parent concerns.

## **2.2 Needs Assessment Model**

The gap between needs and resources were examined in relation to environmental factors, financial factors, relationships among relevant agencies, program characteristics, and resident characteristics. Figure 2.2-1 is an illustration of the needs assessment model for this study. The gap between needs and services can be measured by:

- ◆ Number of beds/slots available in all the residential treatment programs statewide;
- ◆ Number of beds/slots utilized/occupied currently;
- ◆ Average length of stay in service among children having been served;
- ◆ Availability of services

- ◆ Length of stay on waiting list;
- ◆ Availability of alternative services;
- ◆ Delays in discharge;
- ◆ Children’s educational issues;
- ◆ Type of services delivered/received.

Data systems were designed to establish a common link among all the data files so that relevant data can be merged together to expand the scope of analyses. Quantitative analyses were used in analyzing data collected from surveys of facility directors and individual case record abstractions. Content analysis were performed for all the qualitative data collected from in-depth interviews, document reviews, site visits, and focus groups. These data were used to provide background information and help with the interpretation of findings from the quantitative analyses.

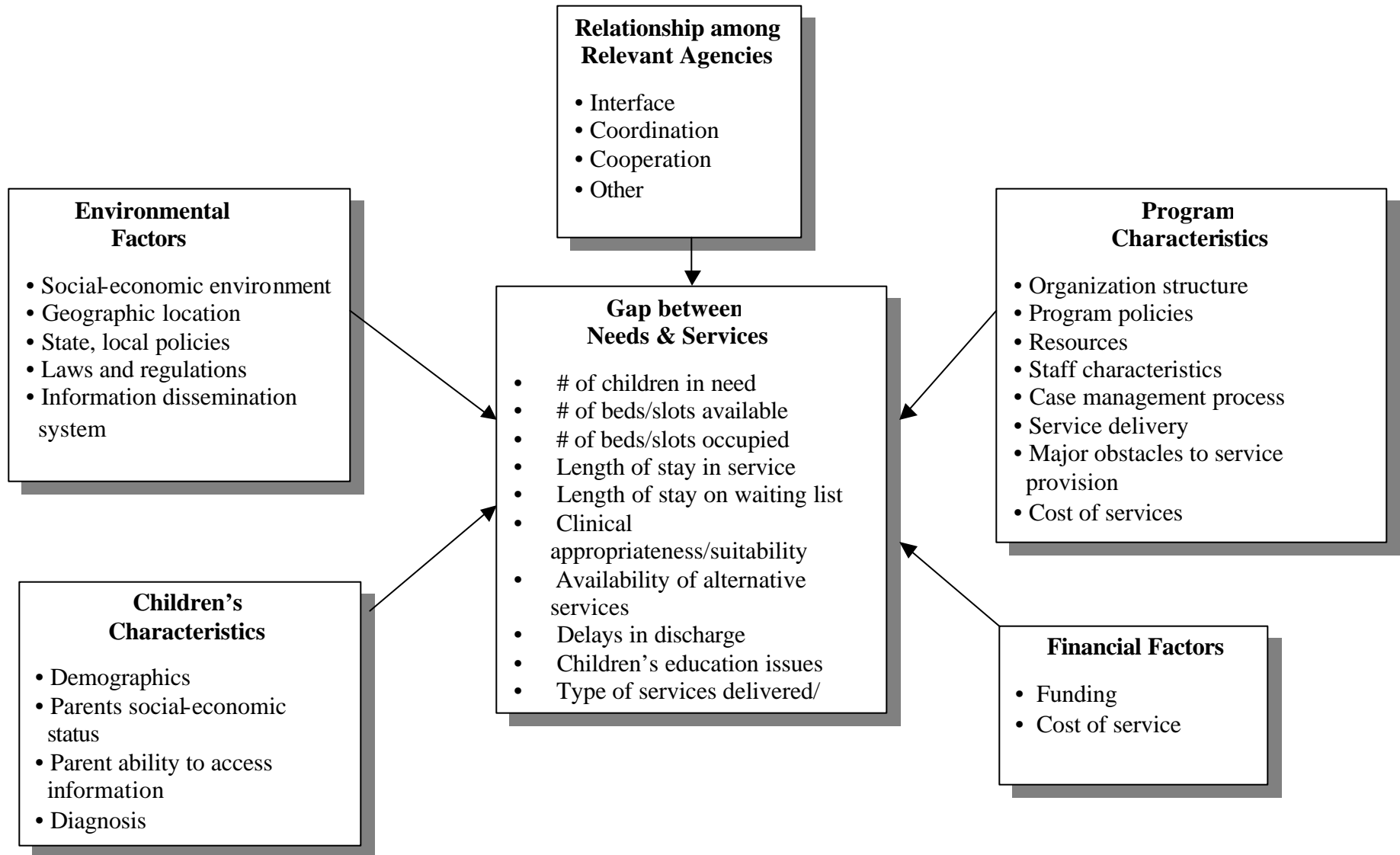
### **2.3 Study Methodology Limitations**

Several limitations to the study present themselves. First, it should be noted that in order to truly measure the gap between needs and services for this special population, a survey of the general population is needed. Only a survey of residential households in the state of Maryland would enable us to estimate the number of children in need of the residential services across the state including both children who are already known to the service system and those unknown. Such a survey was not part of the scope of work for this project, and therefore we utilized data collected from the various sources described above to make a reasonable estimate of the total need for residential services only among children who are known to the system.

Second, the present study focuses on residential treatment capacity and placement issues because of the Joint Chairman’s Report and Health Care Commission requirements. As mentioned earlier, this limitation in scope does not reflect a view by the Subcabinet or by REDA that community-based resources are less important than RTC resources. As a result, this report addresses systematically only the needs and services for children already identified as being in need of residential placement.

Third, as mentioned in the previous sections, there was not one single complete list available of all the individual ORP programs in the state of Maryland that could be used as a sampling frame for the ORP survey. The current ORP survey had to employ a list of licensed “service providers” to draw the sample from. Since one licensed service provider might run more than one ORP program, the aggregate data collected from these service providers limited our ability to make estimates for the individual ORP programs, especially for the different types of ORP programs. Moreover, the lack of information about the target population (e.g., the total number of service providers that provide residential services to children/youth age 21 or younger in Maryland) made it very difficult, if not impossible, to weight the survey data. Following GOCYF’s recommendations, data analyses for the ORP survey was performed using unweighted survey data. Thus, caution should be taken in generalizing the survey results to the total ORP population because unweighted survey data might over represent certain types of respondents who were more likely to respond to the survey, and vice versa.

**Figure 2.2-1 Needs Assessment Model**



Fourth, as stated above, the list of RTC admissions provided by the Maryland Health Partners did not contain admissions to the three publicly owned RTCs and no such lists were available from any other sources including relevant state agencies. As a result, the study team had to randomly select the designated number of records from the pool available at the time of the site visit and had to use some estimates to weight the record abstraction data from the three RICAs. These procedures, to a small extent, may have compromised the accuracy and generalizability of the data.

Finally, data regarding staffing are not reported in this document due to a lack of reliability in the responses to staffing questions. For example, some respondents reported the staff by FTE, whereas others reported by the number of individual employees. Therefore, there it is not possible to aggregate the data for those issues.

## CHAPTER 3

### OVERVIEW OF RESIDENTIAL RESOURCES

#### 3.1 Types of Residential Facilities

In the state of Maryland, there are various types of residential programs for children with special needs. The programs vary on a number of issues, including the level of restrictiveness, average length of stay, types of treatment provided, and cost. The most restrictive and most intensive type of residential programs are RTCs. Under Health-General Article §19-301, an RTC is defined as “a psychiatric institution that provides campus-based intensive and extensive evaluation and treatment of children and adolescents with severe and chronic emotional disturbances who require a self-contained therapeutic, educational, and recreational program in a residential setting whose length of stay averages between 12 and 18 months.” Due to the distinctive nature of RTCs, they are discussed separately from other types of residential programs.

In the state of Maryland, there are 14 RTCs. Eleven of the RTCs are privately owned and three are state-operated facilities. As a whole, the capacity of RTCs in the state is 756 beds, and ranges from 17 beds to 103 beds. On average, the RTCs operate at more than 90% of capacity on an on-going basis, with at least one RTC that is generally at 100% capacity. Further, many of the RTCs have children on the waiting list. It should be noted, however, that according to the RTCs, they do not all serve the same populations. For instance, an RTC may have one unit geared toward a general population of RTC youth and/or a more specialized unit(s) geared towards youth with particular needs, such as more acute behaviors or sexually offending behaviors. This may explain why there are children on a waiting list in spite of the RTCs not operating at 100 percent capacity. Thus, in some instances, it is more telling to examine the 24 specialty units currently operating at the 14 RTCs in Maryland. It should also be noted that there is variety within the specialty units regarding the particular characteristics of the youth being served. Generally speaking, the specialty units currently operated by RTCs in Maryland include:

- ◆ General RTC unit serving males only (n=4);
- ◆ General RTC unit serving females only (n=2);
- ◆ General RTC unit – coed (n=7);
- ◆ Evaluation unit for court-ordered youth (n=2);
- ◆ Intensive treatment unit for youth with more severe/acute behaviors (n=1);
- ◆ Adolescent diagnostic treatment (n=1);
- ◆ Male sex offender unit (n=4);
- ◆ Specialized treatment unit for youth with sexualized behaviors, but not sex offenders per se (n=1);
- ◆ Secured units (n=2).

The vast majority of the 14 RTCs are located in Central Maryland. Six of the nine RTCs in Central Maryland are located in Baltimore City and Baltimore County. The more rural

communities in Maryland have few, if any, RTCs. More specifically, there is only one RTC located in Eastern Maryland and one in Western Maryland (see Table 3.1-1).

**Table 3.1-1: RTC Locations by Region and County**

<i>Location</i>	<i># of RTCs</i>
<b>Southern Maryland</b>	<b>3</b>
Anne Arundel County	1
Prince George’s County	2
<b>Eastern Maryland</b>	<b>1</b>
Dorchester	1
<b>Western Maryland</b>	<b>1</b>
Frederick County	1
<b>Central Maryland</b>	<b>9</b>
Baltimore City	2
Baltimore County	4
Howard County	1
Montgomery County	2

The other types of residential programs, such as group homes, emergency shelter care, psychiatric respite, etc., are discussed as a group and referred to throughout this report as “Other Residential Programs” (ORPs).

Other residential programs range in size, structure, and purpose. What constitutes a particular residential program is defined by the State’s regulations (“COMAR”). The residential programs and their respective definitions are as follows:

◆ **Alternative Living Unit**

- COMAR 10.22.01: An alternative living unit (ALU) provides residential services for children with developmental disabilities in a community-based home-like atmosphere. ALUs may have between 1 and 3 residents.

◆ **Psychiatric Respite Care**

- COMAR 10.21.27 and COMAR 10.22.01: Respite care services are services that are provided for a child with serious emotional disturbance on a short-term basis in either a community setting or a hospital setting. Community-based respite care is designed to support a child to remain in their home by providing an enhanced support or a temporary alternative living arrangement and/or relief for the child and the caregiver.
- There are two hospital-based respite facilities. They are licensed by the Department of Human Resources (DHR) as residential childcare facilities and emerged to provide clinical services for youth transitioning from acute care to an RTC.

- ◆ **Diagnostic Center**
  - As defined by the diagnostic centers: Diagnostic centers are short-term residential programs for youth who are in need of a comprehensive, multidisciplinary assessment to assist with future placement, treatment and education planning. The child can remain in a diagnostic center for 60 to 90 days.
  
- ◆ **Structured Shelter Care**
  - COMAR .01.04.04: Shelter care refers to a temporary placement for children in a non-restrictive environment. Shelter care is typically no longer than 60 days but may be as long as 90 days.
  
- ◆ **Emergency Shelter Group Home**
  - As defined by GOCYF: Emergency shelter group homes are facilities where a child is placed on a very short-term and emergency basis. The length of stay is generally only long enough to find a more suitable placement (24 to 48 hours).
  
- ◆ **Group Homes**

Group homes are the most common "Private Residential Child Care Program" licensed in Maryland and are defined in COMAR 01.04.04.03 as: an entity that provides for children 24-hour-per-day care within a structured set of services and activities that are designed to achieve specific objectives relative to the needs of the children served and that includes the provision of food, clothing, shelter, education, social services, health, mental health, recreation, or any combination of these services and activities. For group homes licensed by DHMH, group homes are further defined as:

  - Per COMAR 10.21.04.02, a group home refers to a community-based residential program that provides services for children who have been under treatment for a mental disorder. When possible the group home should be within the child's community of origin and provide a home-like atmosphere.
  - Per COMAR 10.21.04.02 a small group home should admit between 4 and 8 residents and be deemed a single-family residence permitted to be located in a residential zone. A large group home should admit between 9 and 16 residents and be deemed a multifamily residence.
  - Per GOCYF, for purposes of this assessment, a group home will be considered small if it has less than 15 residents and large if it has 16 residents or more.
  
- ◆ **Therapeutic Group Home**
  - COMAR 10.21.07: A therapeutic group home provides therapeutic living services by providing access to a combination of developmental, diagnostic and therapeutic mental health services in a home-like atmosphere. A therapeutic group home should have between 4 and 8 residents and be located within the child's community of origin.
  
- ◆ **Treatment Foster Care**
  - COMAR 07.02.21: Treatment foster care is 24-hour substitute care with a therapeutic component for children with severe emotional, behavioral, medical or

psychological conditions. A treatment foster care program is operated by a licensed child placement agency or LDSS.

### 3.2 Cost of Residential Facilities

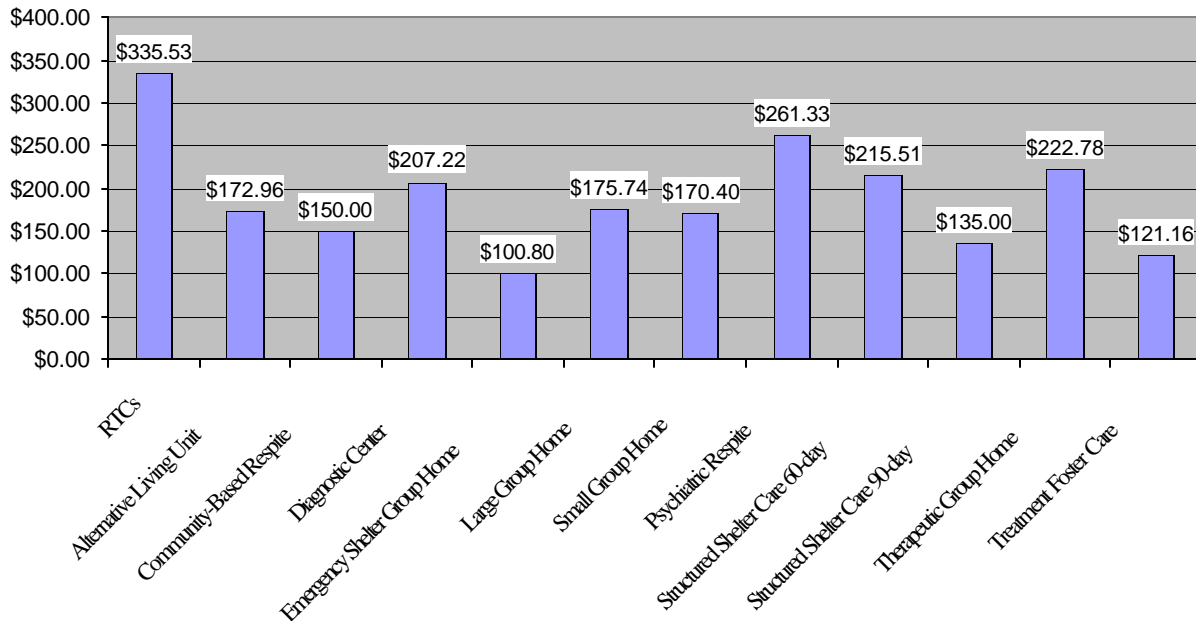
The report *Mental Health: A Report of the Surgeon General* (USDHHS, 1999) summarizes the cost efficiency case against RTCs:

RTCs are the second most restrictive form of care (next to in-patient hospitalization) for children with severe mental disorders. Although used by a relatively small percentage (8 percent) of treated children, nearly one-fourth of the national outlay on child mental health is spent in these settings. However, there is only weak evidence for their effectiveness. (USDHHS, 1999, p. 169-170).

The high cost nationally is reflected in Maryland as well. Analysis of the responses to the survey of RTCs shows that the average cost per day of treatment for each child in a Maryland RTC is \$335.53 (this excludes education costs), and that the average length of treatment for a child is 391 days. This means the typical cost over time for a child in an RTC is over \$130,000.

Figure 3.2-1 offers a comparison between the reported average daily cost of RTCs and those of other residential facilities in Maryland. The costs for the other residential facilities are only estimates based on incomplete data, but the chart shows that RTCs are more expensive.

**Figure 3.2-1: Reported Average Daily Costs of Selected Residential Facility Types**



Direct RTC costs include education costs, security costs, community building costs as well as mental health services costs. Alternatives to RTC placements often externalize these costs, so, compared to alternatives, RTCs have fewer indirect costs. The extent of this cost

shifting should be estimated before any definitive statements about the relative costs of service provision are made. Such an estimate would also require an outcomes measurement system so that the problems faced and the results achieved by the various alternatives could be adequately compared.

## CHAPTER 4

### SERVICE DELIVERY SYSTEM

#### 4.1 Laws and Regulations

There are governing bodies and a number of laws and regulations that have an impact on the population of children with special needs in that they mandate that the interventions are provided to them in the least restrictive setting. The educational aspects of all initiatives are guided by the Individuals with Disabilities Education Act 20 U.S.C. §1400 et seq., (IDEA), a Federal law which states that children with disabilities or special needs should be educated in a “least restrictive environment.” IDEA stipulates that to the extent appropriate, children with disabilities should be educated with children who are not disabled and that special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disabled child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

#### State and Local Coordinating Councils

The Local Coordinating Councils (LCCs) and the State Coordinating Council (SCC) are governing bodies established in the 1980s to bring together resources for children who were placed in residential treatment. In 1990, the SCC moved to the GOCYF and was incorporated in Article 49D, Annotated Code of Maryland. The LCC is a 10-member agency in each county and is comprised of representatives from each of the following entities:

- ◆ Department of Juvenile Services
- ◆ Developmental Disabilities Administration
- ◆ Alcohol and Drug Abuse Administration
- ◆ Local board of education
- ◆ Local health department
- ◆ Local Department of Social Services
- ◆ Local office of the Division of Rehabilitation Services
- ◆ Local Management Board
- ◆ Local core service agency
- ◆ A parent or parent advocate or both as appointed by the chairman of the LCC

Each agency represented at the SCC level is responsible for overseeing the LCC agency representatives. The SCC approves the funding for out-of-state placement. The Community Services Initiative (CSI) is a program, which attempts to divert children from placement when the child can be served appropriately in less restrictive services within the community. The ultimate goal is to keep a child in the least restrictive environment by making an effort to keep the child in the home. If it is found that residential care is necessary, an effort must be made to keep the child in an in-state facility. The Systems Reform Initiative (SRI) legislation (SB 588, 1992 Session), which mandated that children in out-of-state placement be returned to the State, facilitated this effort. Prior to SRI, it was reported that 900 children were sent to out-of-state

placements. Presently there are approximately 100 children in out-of-state facilities, and the Subcabinet is working to build a broader array of community-based services to facilitate placements within Maryland for these children.

On July 1, 2002, House Bill 1386 was enacted. One of the numerous goals of the bill was to support the Federal statute, IDEA. The bill significantly changed the role of the LCC. Implementation of the bill and related regulations are still being established. Among the many provisions of HB 1386, the bill modified the duties of the LCC/SCC and altered the composition of the LCC. The LCC now has a parent, or parent advocate, or both on the LCC.

The duties of the SCC now include the following:

- ◆ Establish and oversee the LCC in each county and Baltimore City
- ◆ Develop procedures for the operation of the LCCs
- ◆ Periodically review placement decision procedures of LCCs
- ◆ Review recommendations for State funding for out-of-state placements
- ◆ Monitor LCCs
- ◆ Plan and coordinate with LCCs
- ◆ Monitor services to children
- ◆ Establish and maintain a multiple agency information system
- ◆ Coordinate evaluations of residential facilities
- ◆ Make regulation recommendations to the appropriate secretary

The duties of the LCC now include the following:

- ◆ Be part of the Local Management Board (LMB) for administrative and budgetary purposes
- ◆ Be independent of LMB in decisions regarding plan of care and policy recommendations
- ◆ Accept placement referrals from agencies represented on the LCC
- ◆ Review recommendation for residential placement of referred children
- ◆ Review residential placement for the purpose of providing technical assistance to the lead agency regarding the availability of community-based alternatives
- ◆ Review and approve other recommended residential placements
- ◆ Review recommended out-of-state placements
- ◆ Refer the out-of-state recommendations to the SCC
- ◆ Provide an inter-agency plan of care for the child's placement
- ◆ Submit recommended plans of care to the SCC
- ◆ Assist the child's lead agency

As evidenced in the newly detailed roles of the LCC, agencies are no longer required to bring referrals to or have approval from the LCC for in-state residential placement when those placements are required under either IDEA or federal Medicaid. Thus, children who qualify for residential placement under IDEA are not required to have LCC approval. Federal law requires the state to provide screening, diagnosis and "all medically necessary" treatment services,

including mental health services, to all Medicaid recipients under 21 years of age. This process known as Early & Periodic Screening, Diagnosis & Treatment (EPSDT) is a way to obtain individualized wrap-around treatment and support services necessary for children to remain at home and in their community, or to return there after a hospitalization or other out-of-home placement.

Out-of-state cases still require LCC/SCC approval, however. HB 1386 codified existing regulations which stipulates that a state or local agency may approve a new out-of-state placement only if:

- ◆ The out-of-state placement is closer in distance to the child's home than an in-state placement
- ◆ The out-of-state placement is less expensive than the in-state placement
- ◆ The child is currently in detention
- ◆ Compliance with IDEA requires an out-of-state placement
- ◆ Child is hospitalized in an acute care psychiatric hospital under the following circumstances:
  - Child has been committed by DJJ (DJS), local DSS or DHMH
  - Child's treatment team determined that child is ready for discharge and must be discharged to a placement within 30 days
  - The only available appropriate placement is out-of-state

### **Maryland Health Partners**

Maryland Health Partners (MHP), the private company authorized by the Mental Hygiene Administration to authorize treatment and payment of mental health claims that are deemed medically necessary, also promotes guidelines to ensure that children and adolescents are treated at the least intensive level appropriate for their condition. In accordance, they developed criteria not only for continued stay in an RTC (the most restrictive level of care), but criteria to determine whether admission to an RTC is necessary. The criteria for admission are based upon the "Severity of Need" and the "Intensity of Service." If the RTC fails to document that a child or adolescent has met the criteria for admission or continued stay in an RTC, MHP reserves the right to decline payment for a resident's stay in an RTC. With regard to the Severity of Need, according to MHP, there must be documentation of the following:

- ◆ Clinical evidence the child or adolescent has a long-term and/or severe mental disorder that has a high degree of potential for leading to or continuing acute psychiatric hospitalization in the absence of residential inpatient services
- ◆ Due to a mental disorder, the child or adolescent exhibits an inability to adequately care for his/her own physical needs, representing potential serious harm to self or others without external support beyond the family or to the non-inpatient community support system
- ◆ The child or adolescent's current living environment does not provide the support and access to therapeutic services necessary for recovery (MHP, 2000)

Intensity of Service requires the following:

- ◆ The child must have a mental disorder amenable to active psychiatric treatment. The evaluation and assignment of a DSM-IV diagnosis must result from a face-to-face psychiatric evaluation
- ◆ The child or adolescent requires assistance in developing the skills necessary for daily living, as well as assistance with planning and arranging access to a range of educational, therapeutic, and aftercare services on a seven day per week 24 hour a day basis
- ◆ The RTC provides 24 hours per day, 7 days per week structure and supportive in-patient living environment. This environment is integral to support the learning experiences necessary for the development of adaptive and functional behavior to allow the child to live outside of an in-patient setting (MHP, 2000).

### **“Lisa L”, and Olmstead vs. L.C.**

As a result of the Lisa L. case (a Federal class action lawsuit brought against the Maryland State DHMH, DJS and DHR in 1987), the Subcabinet has established the Multi-Agency Review Team (MART) to resolve problems regarding discharge of children who were in state custody from state psychiatric hospitals. The suit was brought forth on behalf of all children and adolescents who were in Maryland’s state psychiatric hospitals or in other psychiatric hospitals while in state custody after the time they were ready for discharge, as determined by the hospital treatment team, or who were discharged to placements in which they did not receive the services recommended by the hospital staff. The agreement was designed to ensure those children and adolescents were moved to a less restrictive environment (from the hospital setting) as soon as it was clinically appropriate to do so. Psychiatric respite programs were established to treat the clinical needs of the Lisa L. population while in transition from acute care to either an RTC or less restrictive level of care. MART’s role is to expeditiously facilitate the transition of children in psychiatric hospitals to less restrictive environments.

In July 1999, the Supreme Court issued the Olmstead v. L. C., 527 U.S. 581 decision which stated that States have an obligation under the Americans with Disabilities Act, 42 U.S.C. § 12132 (ADA) to provide community-based services for individuals with disabilities. The Court's decision challenged Federal, state, and local governments to develop more opportunities for individuals with disabilities through more accessible systems of cost-effective community-based services. Failure to do so may be viewed by the courts as a form of discrimination barred by the ADA. The Olmstead principles apply to all qualified individuals with disabilities, including children.

### **Medicaid Autism Waiver and The Medicaid “Inpatient Under 21” Option**

Another bill designed to provide services to children while maintaining them in the least restrictive environment was the Home and Community-Based Services Autism Waiver. The Federal government approved the states’ application for MSDE to administer the waiver under DHMH. The waiver offers services to people whose needs are great enough to be admitted to an institution in order to flexibly allow them to live at home or in home-like settings.

In order to be eligible for the Autism Waiver, the child must be found to be in need of ICF-MR level of care by a licensed psychologist or certified school counselor. This is part of the multi-disciplinary team (MDT) process. The MDT includes:

- ◆ Child's service coordinator
- ◆ Child's parent(s)
- ◆ Licensed psychologist or certified school psychologist
- ◆ A chairman who will represent the local school system or local lead agency
- ◆ Other appropriate professionals who represent the local school system and/or local lead agency
- ◆ Other service providers and individuals, as appropriate

The MDT will determine if the child meets the technical eligibility requirements for the Autism Waiver. In order to meet the technical eligibility requirements, the child must:

- ◆ Be between 1 year old and the end of the school year in which they turn 21 years old
- ◆ Have a developmental disability and be diagnosed with autism spectrum disorder as determined by a diagnostician using an evaluation methodology approved by the MDT
- ◆ Be receiving early intervention services or in a public/non-public or State-operated/supported special education setting
- ◆ Have an individual family service plan (IFSP) or an individualized education plan (IEP)
- ◆ Have received more than 15 hours/week of special education and related services and require a more intensive therapeutic program than other students
- ◆ Be identified through public education or early intervention as being potentially qualified for the Autism Waiver
- ◆ Be safely maintained in the community with assistance from the Autism Waiver services
- ◆ Choose or have their parents choose to enroll them in the Autism Waiver program
- ◆ Not be enrolled in:
  - Home care of disabled children under a model waiver
  - Home and community-based services for developmentally disabled individuals
  - Any other Medicaid waiver program.

The Medicaid "Inpatient Under 21" Option allows for children and youth placed within an RTC to receive funding for treatment. After a period of 30 days, the State can consider the child as a "family of one" for purposes of Medicaid reimbursement because their parents' income is no longer counted towards the income eligibility. Since most children lack sufficient independent income to pay for treatment without their parents, Medicaid pays for treatment as long as the child meets the medical necessity criteria for RTC placement.

These laws and funding regulations create protection as well as dilemmas for policy makers and stakeholders for children with special needs. An analysis of some of the difficulties will be discussed below as administrators, providers, and stakeholders share their concerns.

## 4.2 The Referral and Placement Process

The route to entry to an RTC is multifaceted. Figure 4.2-1 illustrates a broad perspective of the process. Children can enter the system through a number of avenues and usually enter through the lead of one of the following agencies: DHMH (Core Service Agency), DJS, MSDE, Local Education Agency (LEA), DHR, Local Department of Social Services (LDSS) or DDA.

A child may be identified during the first two years of life as being one with special needs as the child attempts to achieve developmental milestones. A child could also display emotional, physical, or behavioral difficulties in one or more of their primary environments (school, daycare, and/or home). A referral is made for an assessment by a trained mental health professional, educational specialist, or medical provider (e.g., developmental pediatrician). This assessment could be completed in the community on an outpatient basis or in a hospital if a crisis situation warranted an emergency hospitalization.

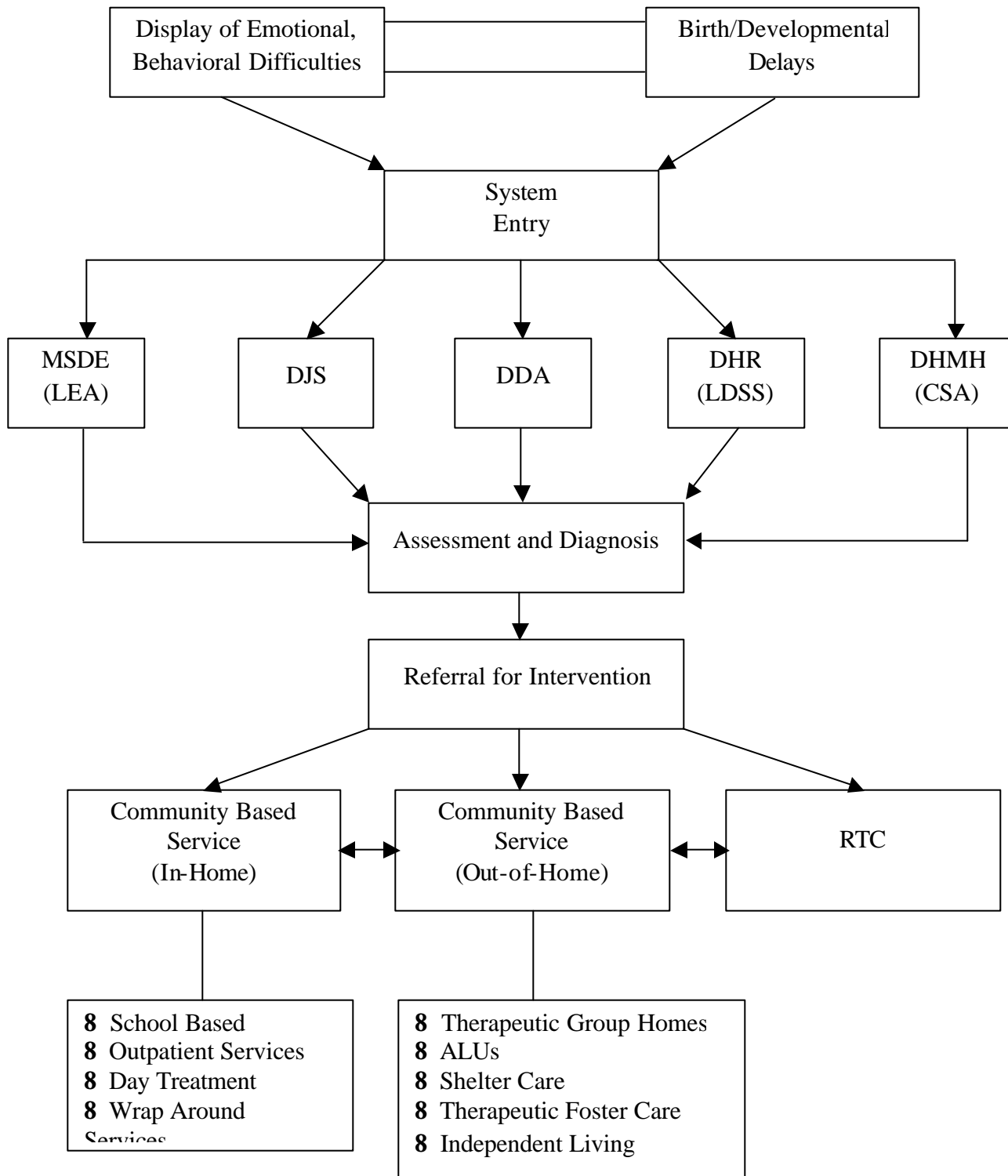
The parents involved in the focus groups had children with a range of physical, psychological, and behavioral difficulties. According to the parents, it was not uncommon for a child to have co-occurring diagnoses that might include both physical and behavioral challenges. Most of the children with medical problems were diagnosed by medical doctors at birth, while autistic and developmentally delayed children were diagnosed between the ages of two and seven, sometimes by psychologists or psychiatrists in treatment centers and at other times by teachers in school or day care.

After an assessment and a diagnosis are made, intervention is first sought in the community through a number of channels: in-home family or wrap-around services, outpatient services, or school intervention. In some cases a combination of all types of interventions are needed to maintain a child in the community.

Referral for out-of-home intervention is made if these services are found to be insufficient and/or the behavioral and emotional condition escalates and the child cannot be maintained in the home. The community-based programs noted by the LCCs that are being utilized are as follows:

- ◆ Shelter care for boys
- ◆ RTCs
- ◆ In-home wrap-around services
- ◆ Psychiatric rehabilitation programs (PRP)
- ◆ Day treatment
- ◆ Mental health for child/adolescents
- ◆ Treatment group homes
- ◆ Inpatient psychosocial rehabilitation
- ◆ Treatment foster care
- ◆ Case management
- ◆ Intervention services

**Figure 4.2-1: Route to Residential Treatment Centers and Other Residential Treatment Programs**



- ◆ Emergency beds
- ◆ Community service initiatives
- ◆ Psychiatric respite beds (note: spaces are available but due to lack of funding, these spaces often remain unoccupied)

### IDEA

If the behaviors or physical condition negatively impact the child's functioning in the educational setting, the LEA becomes involved to make an assessment about the child's eligibility for special educational services and if necessary to develop an IEP or Individual Family Service Plan (IFSP) as per IDEA. The IFSP documents and guides the early intervention process for infants and toddlers who have developmental delays or other special needs and their families. It is the vehicle through which effective early intervention is implemented in accordance with Part C of IDEA. Both the IEP and the IFSP contain information about the services necessary to facilitate a child's development, identify the target problem areas and/or disability, describe the goals and objectives for intervention and prescribe the necessary accommodations to be made in the school to address the child's needs. Through the IEP and IFSP processes, family members and service providers work as a team to plan, implement, and evaluate services tailored to the family's unique concerns, priorities, and resources.

If a child is a student with disabilities under IDEA, the state's public education system can be responsible up until the child is 22 years old. The transition from the educational system to the "real" world begins at age 14 with a discussion about career options. At age 16, a more formal plan is started with specifics as to what will happen with the child after they leave the school (i.e. a job placement, a technical school, etc).

### DDA

If children with disabilities need services after they leave the school system, many will have to get services funded through DDA. The DDA provides a coordinated service delivery system so that individuals with developmental disabilities receive appropriate services oriented toward the goal of integration into the community. These services are provided through a combination of state residential centers (providing services to individuals with mental retardation) and a wide array of community-based services delivered primarily through a network of non-profit providers.

Unfortunately, due to funding constraints, the waiting list for DDA services is very long. The DDA licenses approximately 134 residential service providers such as ALUs and group homes, vocational and support services, as well as individual family care homes. In general, this agency provides behavioral, family and support services, resource coordination, and day and residential services. At times, the agency provides financial assistance to families in need, and in cases where children have dual diagnoses, they work to specialize the child's care. Once a person comes to DDA for residential services they do not age out, but continue to utilize some aspect of service provision from DDA for their entire life.

## DSS

At any point, there exists the possibility for the Local Department of Social Services to become involved. For example, a deterioration of family support/functioning manifested by abuse, neglect, or abandonment may force the courts to place the child in the custody of the LDSS. In other cases, the families may voluntarily relinquish their child to the custody of the LDSS as their child's behavior becomes too difficult to manage or, since the passage of Senate Bill 458 in 2003, they may obtain a "voluntary placement" of their child through the LDSS in order to access needed services and avoid custody relinquishment. If a child with special needs is committed to DSS, the LDSS has a number of options for placement. A child may be placed in therapeutic foster care, an Independent Living Preparation Program (ILPP), a diagnostic center, or a child placement agency, such as a therapeutic group home or ALU. Therapeutic foster care is reserved for children with medically fragile or emotional/behavioral issues and provides more intensive services than regular foster care. A therapeutic group home serves children with mental health needs. An ALU is a residence with no more than three children who have developmental disabilities. The ILPPs provide transitional services such as career counseling, job placement, and life skills to older teens that will soon age out of the child system.

## DJS

A young person is referred to the DJS as a result of complaints from police or citizens after s/he commits a criminal offense before the age of 18. After a review of the youth's history, an assessment is made to determine whether the youth's behavior poses a risk to the community. If officials suspect that the youth may abscond or re-offend while awaiting a court hearing, the minor may be detained in one of several detention centers while pending their adjudication hearing (a process where a determination is made as to whether the youth actually committed a delinquent act). While in detention, children are given assessments in a number of domains: psychosocial, educational, mental health, medical, and substance abuse. These assessments assist the court in determining the best course of action for the youth and contribute to a Pre-Dispositional Investigation prepared by DJS. After a hearing (the child has been adjudicated), the child may be found to be non-delinquent or delinquent. Adjudicated, non-delinquent children are released into the community for resources. If a youth is found to be delinquent, the facts of the complaint are sustained and he/she has been found responsible for the offense with which he/she was charged.

Adjudicated delinquents are committed to the DJS for treatment and rehabilitation. Once the child is in the system, they remain in the jurisdiction of DJS until their 21<sup>st</sup> birthday. They can be referred to an out-of-home placement such as a group home or a residential treatment center for intervention. Children in DJS custody who are identified as needing a highly structured program that provides an intense level of mental health services are referred to RTCs. Once the referral packet is forwarded to the RTC, a case manager may be required to present the case to the LCC for approval of this restrictive level of care. If this level of care is deemed necessary, a tentative admission date is set. A Certificate of Need is ordered to ensure that the youth meets the medical necessity for the placement. Once the placement has been deemed appropriate, the child is placed in an RTC.

## CSA

Another route of entry into the system of care is through the Core Service Agency (CSA) which exists under the authority of the Secretary of DHMH, MHA. The core service agency may become the lead agency for any child who enters an RTC through EPSDT without an LCC

review, who is not an IDEA child through MSDE, and who does not have another state agency already identified as the lead agency. CSAs serve as the local mental health authority responsible for planning, coordinating, and evaluating public mental health services at the local level. Their function is to manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdiction as stipulated by the Health General Article, 10-10-1201 - 10-1203, Annotated Code of Maryland. The CSA must be able to link with other human service agencies to promote comprehensive services for individuals in MHA's priority population who have multiple human needs.

## CHAPTER 5

### RESIDENTIAL TREATMENT CENTERS

Quantitative data about the RTCs were collected from two different sources. One was via a mail survey of RTC directors/administrators (see Appendix 5.0-A). The other was through reviewing individual case records during site visits to each of the 14 RTCs (see Appendix 5.0-B for Record Abstraction Form).

As indicated in Chapter 4: Service Delivery System, there are 14 RTCs operating 24 specialty units in the state of Maryland. Completed mail surveys were received from all 14 RTCs. Where appropriate, findings from the mail survey of RTC directors will be presented by specialty unit.

Regarding the Record Abstraction process, a total of 298 valid records were selected, reviewed, and abstracted using a standardized form. Among the 298 records, 232 were of current residents and 66 were of discharged residents. Data abstracted from these records were weighted to represent the total target population, that is, all the Medicaid-funded RTC residents who were admitted between July 1, 2001 and August 27, 2003. Within each of the 14 RTCs, the selected records were stratified into two categories by their discharge status (current vs. discharged) and weighted to their population total. For each private RTC, the total number of records on the MHP list by discharge status was used as a proxy for the target population total. Since such a list was not available for the publicly owned RICAs, their reported enrollment on May 15, 2003 in the survey of RTC directors was used as a proxy for the population total of current residents, whereas the ratio of the records of current residents to those of the discharged residents on the MHP list was used to estimate the target population total of the RICA admissions for which the residents had already been discharged. The Record Abstraction findings were based on the weighted data and the unit of analysis was in terms of **each admission rather than each individual resident**.

#### 5.1 Capacity and Utilization

As previously mentioned, the total capacity at RTCs in Maryland on May 15, 2003 was 756 beds. Enrollment was 703 residents on that date. Enrollment data by specialty unit is presented in Table 5.1-1. More than three-quarters (76%) of the residents at RTCs were being served in the thirteen general RTC units. The units with the fewest children/youth enrolled were the court evaluation units (1%) and the specialized treatment unit for children with sexualized behaviors (1%).

A more detailed description of capacity and utilization is presented in Table 5.1-2. As indicated, two of the specialty units (specialized treatment and intensive treatment) were operating at 100 percent capacity on May 15, 2003. The adolescent male sex offender units also had a relatively high occupancy rate (97%). As discussed later in the report, LCC representatives noted that children with diagnoses such as sex offending and other more specialized diagnoses represent a harder to place population of children. Thus, it is the

**Table 5.1-1: Enrollment in an RTC by Specialty Unit on May 15, 2003**

<b>Types of Specialty Units</b>	<b># of Specialty Units</b>	<b># of Residents</b>	<b>% of Residents*</b>
General RTC Unit	13	535	76%
Adolescent Male Sex Offender Unit	4	93	13%
Court Evaluation Unit	2	9	1%
Secured Units	2	40	6%
Adolescent Diagnostic Center	1	10	1%
Intensive Treatment Unit	1	6	1%
Specialized Treatment Unit	1	10	1%
<b>Total</b>	<b>24</b>	<b>703</b>	<b>99%</b>

\* Percentages will not total to 100 due to rounding

previously mentioned specialty units with high occupancy rates that are most likely to serve the children with more difficult placements, possibly creating a backlog of children waiting for slots in these units. As well, the need for services for such populations was repeatedly mentioned throughout the course of the study. A more detailed discussion of the most needed services can be found in the Services Provided section of this chapter.

For one specialty unit (adolescent diagnostic treatment), it was reported that the typical occupancy rate (92%) was different than the occupancy rate on May 15, 2003 (83%). Moreover, two specialty units/RTCs indicated that they have plans to increase the capacity of their current programs during the 2004 calendar year, which would increase the capacity of General RTC units by 3 beds and male sex offender units by 3 beds.

**Table 5.1-2: RTC Capacity and Utilization on May 15, 2003**

<b>Types of Specialty Units</b>	<b># of Specialty Units</b>	<b>Capacity</b>	<b>Enrollment</b>	<b>Occupancy Rate</b>	<b>Typical Occupancy Rate</b>
General RTC	13	573	535	93%	n/a
Adolescent Male Sex Offender	4	96	93	97%	n/a
Court Evaluation Unit	2	13	9	69%	n/a
Adolescent Diagnostic Treatment	1	12	10	83%	92%
Secured Unit	2	46	40	87%	n/a
Intensive Treatment Unit	1	6	6	100%	n/a
Specialized Treatment Unit	1	10	10	100%	n/a
<b>Total</b>	<b>24</b>	<b>756</b>	<b>703</b>	<b>93%</b>	<b>n/a</b>

## 5.2 Admission Policies

Concerning admissions policies, a number of criteria may determine whether an applicant will be accepted into an RTC. Some exclusion criteria are presented in Table 5.2-1. Whereas 11 of the 14 RTCs indicated that they would NOT accept an applicant over the age of 18, **none of the RTCs accept children below the age of five.**

Pertaining to developmental delays, all but one (n=13) of the RTCs indicated that they do not accept youth with a diagnosis of profound mental retardation. The results for the number of RTCs who would not admit youth with the remaining levels of developmental delay are: severe mental retardation (n=12), moderate mental retardation (n=12) and mild mental retardation (n=6). Half of the RTCs (n=7) reported that they do not accept children with a major illness or serious medical condition. With regards to legal criteria, half of the RTCs (n=7) do not accept adjudicated or non-adjudicated sex offenders. Moreover, eight of the RTCs reported that they do not accept fire setters.

**Table 5.2-1: Populations NOT Accepted Into RTCs as of May 15, 2003**

<b>Population NOT Accepted</b>	<b>RTCs That Would NOT Accept</b>
Are Older Than 18	11
Are Younger Than 13	3
Are Younger Than 5	14
Are Female	4
Are Male	1
Attend School in Local School System	7
Grade Level Too Low	5
No Insurance or 3rd Party Payer	1
Parents Unable/Unwilling to Participate	0
Substance Abuse/Dependence and Psychiatric Condition	2
Has Developmental Disability	3
Developmental Disability and 1+ Psychiatric Condition	2
Major Illness/Serious Medical Condition	7
Serious Physical Disability	3
Diagnosis of Mild MR	6
Diagnosis of Moderate MR	12
Diagnosis of Severe MR	12
Diagnosis of Profound MR	13
Adjudicated Non-Sex Offenders	2
Adjudicated Sex Offenders	7
Non-Adjudicated Sex Offenders	7
Fire-Setters	8
History of Aggression Towards Staff or Others	0
Considered an AWOL Risk	1
Medication Non-Compliant	1
Other	2

### 5.3 Demographic Characteristics

Demographic information is presented in Table 5.3-1. Slightly more than two thirds (68%) of the youth being served were male. There were no children ages 3 or younger being served in any RTCs on May 15, 2003 because, as previously mentioned, none of the RTCs accept children under the age of 5. It should be noted, however, that, according to a recent article by the American Academy of Pediatrics, 13 percent of all preschoolers in the United States have an emotional and/or behavioral disorder (Jellinek & Murphy, 1999).

More than three-quarters (78%) of the youth being served were between the ages of 13 and 17. Only six percent of those being served were in the 18-21 year old age category. No one over the age of 22 was being served.

Thirteen of the 14 RTCs provided data regarding the racial/ethnic groups represented by the youth being served in RTCs. About half (50.6%) of the residents at the 13 responding RTCs were White, non-Hispanic. More than two-fifths (44%) were African American. Very few residents represented the remaining racial/ethnic groups.

**Table 5.3-1: Demographic Characteristics of Youth in RTCs on May 15, 2003**

Demographic Characteristics	# of Responding RTCs	# of Residents	% of Residents
Male	14	478	68%
Female	14	225	32%
Total		703	100%
Ages 0-3 Years	14	0	0%
Ages 4-12 Years	14	115	16%
Ages 13-17 Years	14	548	78%
Ages 18-21 Years	14	40	6%
Ages 22 and Older	14	0	0%
Total	14	703	100%
White, Non-Hispanic	13	330	51%
African American	13	289	44%
Hispanic	13	15	2%
Asian, Pacific Islander	13	2	0.3%
American Indian/Alaska Native	13	1	0.2%
Other (Bi-racial/Multi-racial)	10	15	2%

### 5.4 Diagnoses of Mental Disorders

In aggregate form, RTC respondents indicated the number of residents on May 15, 2003 whose primary or first-listed diagnosis fell into various diagnostic categories of the DSM-IV (American Psychiatric Association Diagnostic Statistical Manual of Mental Disorders, 4<sup>th</sup> ed.). The DSM-IV employs a classification system to diagnose mental illness. Table 5.4-1 presents the number and percentage of all residents in an RTC whose documented diagnoses fell

into the provided categories. The majority of residents, nearly two thirds (62%), had a primary diagnosis of mood disorders. Slightly less than a tenth (8%) of the residents had a primary diagnosis of behavioral/conduct disorder and another eight percent had impulse control disorders (including fire setting) as a primary diagnosis.

**Table 5.4-1: Primary Diagnoses of RTC Residents on May 15, 2003**

<b>Diagnoses</b>	<b># of Responding RTCs</b>	<b># of Residents</b>	<b>% of Residents</b>
Anxiety, Phobia, Posttraumatic Stress Disorders	14	43	6
Behavior/Conduct Disorders	14	58	8
Impulse Control Disorders (Including Fire Setting)	14	54	8
Mood Disorders	14	439	62
Other Disorders Usually Diagnosed in Early Infancy, Childhood, or Adolescence	14	24	3
Personality Disorders	14	2	0.3
Pervasive Developmental Disorders	14	10	1
Schizophrenia or Other Psychotic Disorders	14	24	3
Severe Developmental Disabilities	14	3	0.4
Sexual and Gender Identity Disorders	14	3	0.4
Substance Abuse/Dependence Disorder	14	2	0.3
Victim of Abuse or Neglect	14	1	0.1
Bipolar	14	15	2
Attention Deficit Hyperactivity Disorder (ADHD)	14	19	3
Other (Includes Oppositional Defiant Disorder, Eating Disorders and Tourette's Syndrome)	14	6	1
Total	--	703	100

RTC respondents also provided the number of residents on May 15, 2003 whose documented *non-primary or non-first-listed* diagnoses fell into various DSM-IV diagnostic categories. Table 5.4-2 presents the number and percentage of all residents in an RTC whose documented non-primary diagnoses fell into the provided categories. It should be noted that some residents had more than one non-primary or non-first-listed diagnosis. Thus, the percentages are based on the total enrollment of 703 residents. More than two-fifths of the residents (42%) had been diagnosed with behavior/conduct disorders. About one quarter (24%) of the residents reportedly had other disorders that are usually diagnosed in early infancy/childhood/adolescence. Nearly one-fifth (17%) of the RTC residents had mood disorders listed as a non-primary diagnosis and nearly one-sixth (16%) had a non-primary diagnosis of anxiety, phobia, post-traumatic stress disorder. Less than one percent were reported to have severe developmental disabilities as a non-primary diagnosis.

Table 5.4-2: Secondary Diagnoses of RTC Residents on May 15, 2003\*

<b>Diagnoses</b>	<b># of Responding RTCs</b>	<b># of Residents</b>	<b>% of Residents</b>
Anxiety, Phobia, Posttraumatic Stress Disorders	14	114	16
Behavior/Conduct Disorders	14	294	42
Impulse Control Disorders (Including Fire Setting)	14	90	13
Mood Disorders	14	122	17
Other Disorders Usually Diagnosed in Early Infancy, Childhood, or Adolescence	14	170	24
Personality Disorders	14	24	3
Pervasive Developmental Disorders	14	21	3
Schizophrenia or Other Psychotic Disorders	14	12	2
Severe Developmental Disabilities	14	3	0.4
Sexual and Gender Identity Disorders	14	13	2
Substance Abuse/Dependence Disorder	14	84	12
Victim of Abuse or Neglect	14	79	11
Other (Includes ADHD, Bipolar, Eating Disorders, and Learning Disorders)	14	62	9

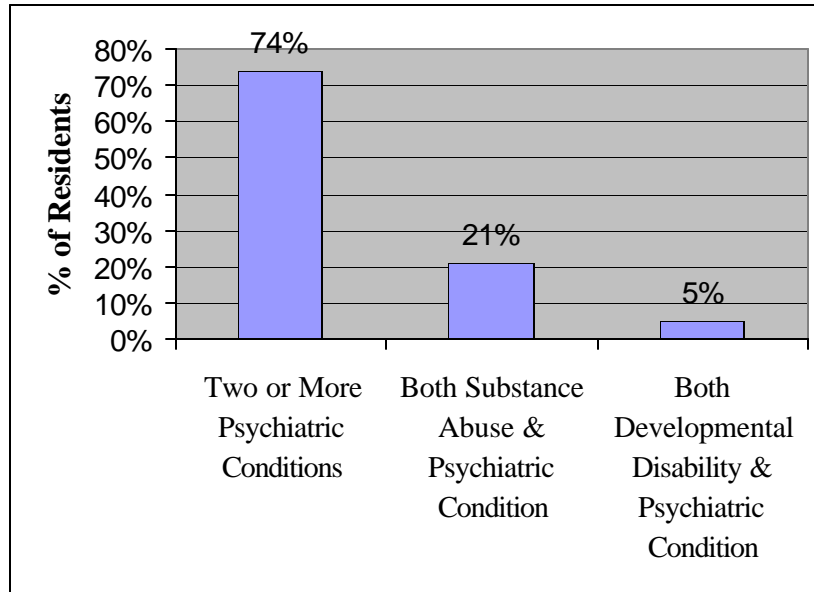
\* Numbers are not totaled because a resident may have more than one secondary diagnosis.

Record reviews also provided information on the DSM-IV diagnoses represented in the group. Axis I of the DSM-IV includes all mental health conditions except personality disorders and mental retardation. Based on record abstractions, the majority of the admissions (63%) during the target time period were to youth with 4 or more Axis I diagnoses (clinical/psychiatric disorders). Only five percent of admissions represented youth with just one Axis I diagnosis.

Thirteen of the 14 RTCs provided responses to questions regarding co-occurring disorders. Figure 5.4-1 indicates that for the 13 RTCs providing responses to this question, nearly three-quarters (74%) of the residents had two or more psychiatric conditions. About one-fifth (21%) of the residents at the 13 responding RTCs had both substance abuse/dependence and a psychiatric condition. Few (5%) reportedly had residents with both a developmental disability and a psychiatric condition.

The incidence of co-occurring psychiatric disorders was further examined in record reviews. Analyses of record abstraction data revealed that nearly two thirds of the admissions (63%) were to youth with co-occurring mood and behavioral/conduct disorders. More than one third of the admissions (35%) were to youth with both a co-occurring mood disorder and substance abuse/dependence disorders. Finally, one third of the admissions involved children with both behavioral/conduct disorders and substance abuse/dependence disorders.

**Figure 5.4-1: Number of Co-occurring Disorders in Residents on May 15, 2003**



Residents of the RTCs presented with a number of issues in addition to their psychiatric condition. Progress notes, treatment summaries, and psycho-social histories were reviewed to obtain a more comprehensive picture of the residents. A large majority of the records (80%) indicated issues related to social support and/or family problems. Nearly two thirds of the records revealed concerns with the resident’s education (63%) and problems within the communities (62%). Community issues included behaviors considered to be a threat to the community, such as sexual predatory behavior or property destruction (e.g. fire setting and vandalism). Drug abuse/dependence and legal problems were indicated in approximately half of the records (51% and 48% respectively). Medical and sexual issues were presented in over one third of the cases (39% and 38% respectively).

Issues regarding substance abuse and sexual abuse survivor issues were also notable. Record abstraction analysis revealed that 51% of the cases reviewed were of youth that had substance abuse as an issue. However, only 35% have substance abuse disorders as part of their diagnostic picture. With regard to sexual abuse, the RTC directors’ survey and the diagnoses listed in the record indicated sexual abuse 11% and 8% of the time respectively. Yet, 38% of the records reviewed at the RTCs revealed that the residents were survivors of sexually abusive experiences.

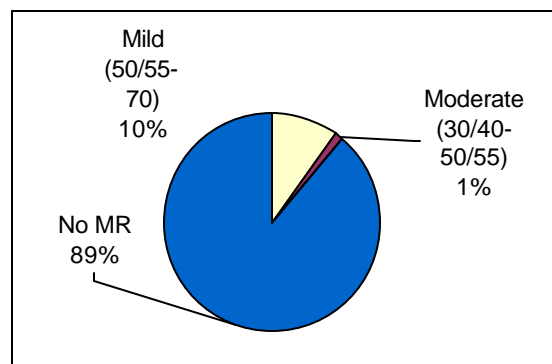
Moreover, research documents the relationship between addiction and sexual abuse survivor issues. One recent study found that children who had been sexually abused displayed higher levels of anxiety, depression and other psychiatric problems than their non-abused counterparts when followed up nine years after the sexual abuse took place (Swanston, Plunkett, O’Toole, Shrimpton, Parkinson & Oates, 2003). Participants were also more likely to use illegal drugs such as cocaine, ecstasy, and amphetamines, as well as legal drugs like nicotine. These research results are consistent with findings by the American Medical Association which state that more than three-quarters of female child sex abuse survivors reported some kind of

psychiatric or drug abuse problem later in life. This number exceeds the incidence rate (approximately 50%) of such problems reported in the general population of all women (AMA, 2003).

## 5.5 Developmental Disabilities

The extent of developmental delay reflected in the residents at the RTCs is presented in Figure 5.5-1. More than one tenth (11%) of the RTC residents have some form of developmental delay. The most frequently reported level of developmental delay was mild (10%). No RTC reported having residents with severe or profound developmental delays.

**Figure 5.5-1: Percentage of RTC Residents with Developmental Disabilities on May 15, 2003**



Research indicates that in the United States over 614,000 children (roughly 11%) ages 6-21 have some level of mental retardation which requires special educational services (U.S. Department of Education, 2001). Moreover, individuals with developmental disabilities are at least four times more likely to also have a psychiatric disorder when compared with the general population. (Bongiorno, 1996; Tonge & Einfeld, 1999). Furthermore, dually-diagnosed individuals with profound mental retardation, acute vision and hearing problems or the inability to articulate present an even more difficult challenge to treat in a facility setting. These individuals may be shuffled around from placement to placement with no real treatment, which serves to exacerbate their emotional, behavioral and mental health needs (Bongiorno, 1996).

In a 2000 study of 582 Australian youth with a dual diagnosis of intellectual disability and psychiatric condition, researchers found that less than 10% of the study's participants received specialized mental health services. The researchers concluded that this was due to the "diagnostic overshadowing" (p. 83) of the child's intellectual disability (Tonge & Einfeld, 2000). In other words, once the child had been diagnosed with an intellectual disability, subsequent behavioral and emotional problems were attributed to their original diagnosis rather than updating the diagnosis to include a psychiatric disorder.

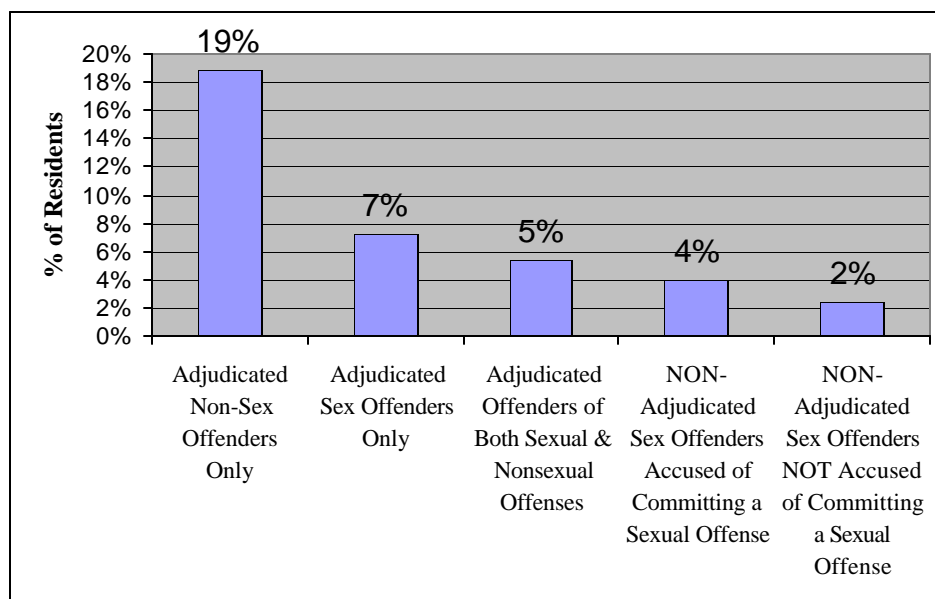
In the state of Maryland, the dually diagnosed population has also been identified as one of the populations most in need of residential services. This finding was reported in the RTC directors survey and key state agency representatives. Moreover, LCC representatives

specifically noted that dually diagnosed children are one of the populations that are hard to place. As noted earlier, 12 RTCs reported that they will not accept youth with moderate or severe developmental delays, and 13 RTCs exclude youth with profound developmental delays from admission.

## 5.6 Legal Status

In addition to examining the diagnostic characteristics, the legal status of the RTC residents was elicited. RTC providers were asked, “How many residents at your facility on May 15, 2003 were court-ordered youth?” In response to this question, the RTC providers reported that slightly more than two-fifths (41%) of the residents were court-ordered youth. About one eighth (12%; n=83) of the residents reportedly had a history of fire setting. Moreover, Figure 5.6-1 displays the distribution of legal status regarding sexual and non-sexual offenses for the 13 responding RTCs. Nearly one-fifth (19%) of the residents were adjudicated non-sex offenders only. A total of twelve percent of the RTC residents were adjudicated sex offenders; five percent of the residents were adjudicated offenders of both sexual and non-sexual offenses and seven percent were adjudicated sex offenders only. It should be noted that, as previously mentioned, only half (n=7) of the RTCs admit adjudicated or non-adjudicated sex offenders. Moreover, eight of the RTCs reported that they do NOT accept fire setters. The need for services for the populations with a history of firesetting and/or sex offenses were echoed throughout the course of the study and are expanded upon in the Services Provided section of this chapter and throughout Chapter 7: Perceived Needs.

**Figure 5.6-1: Distribution of Legal Status of RTC Residents on May 15, 2003**



RTC providers were asked, “How many residents at your facility on May 15, 2003 were court-ordered youth?” Overall, they indicated that they are able to provide appropriate treatment for 97 percent of the court-ordered youth. For the three percent of cases in which the RTCs were unable to provide appropriate treatment, the characteristics of the youth consisted of sex

offending behaviors, severe aggression, lack of parental participation or agreement with placement, and low IQ/mental retardation impeding RTCs' ability to meet educational needs.

## 5.7 Geographic Distribution

Table 5.7-1 displays the number of RTC residents at all 14 RTCs who are from each jurisdiction. The areas with the most youth in RTCs are Baltimore City (17%), Montgomery County (16%), Baltimore County (15%), and Prince George's County (13%). Only one RTC resident was reportedly from another state. The overall distribution of RTC residents was consistent with the population distribution of children under the age of 21 in Maryland. Baltimore City was slightly over-represented in the RTC population.

**Table 5.7-1: Geographic Distribution of RTC Residents On  
May 15, 2003**

Jurisdiction	# of RTC Residents	% of RTC Residents	County Population Under Age 21	% of Total State Population Under Age 21*
Allegany County	2	0.3%	19,374	1.3%
Anne Arundel County	36	5%	140,632	9.1%
Baltimore County	104	15%	207,111	13.3%
Baltimore City	118	17%	193,857	12.5%
Calvert County	11	2%	24,473	1.6%
Caroline County	10	1%	9,013	0.6%
Carroll County	31	4%	47,027	3.0%
Cecil County	23	3%	26,633	1.7%
Charles County	17	2%	38,903	2.5%
Dorchester County	6	1%	8,028	0.5%
Frederick County	33	5%	60,395	3.9%
Garrett County	4	1%	8,686	0.6%
Harford County	15	2%	67,432	4.3%
Howard County	23	3%	75,634	4.9%
Kent County	3	0.4%	5,075	0.3%
Montgomery County	110	16%	244,572	15.7%
Prince George's County	88	13%	251,886	16.2%
Queen Anne's County	10	1%	11,342	0.7%
Somerset County	5	1%	6,502	0.4%
St. Mary's County	12	2%	27,892	1.8%
Talbot County	2	0.3%	8,138	0.5%
Washington County	14	2%	35,313	2.3%
Wicomico County	17	2%	26,018	1.7%
Worcester County	8	1%	10,809	0.7%
Out-of-State	1	0.1%	--	--
Total	703	100.0%	1,554,745	

\* U.S. Census Bureau, 2000

## 5.8 Waiting Lists, Length of Stay, and Delayed Discharges

With respect to waiting lists, six RTCs indicated that they have a formal waiting list for their facility. Only one of the RTCs reported maintaining their waiting list in an electronic format. More specific details about how RTCs manage their waiting lists are presented in section 7.3. For the six RTCs providing data for a waiting list, 1,298 applications were received in a 12-month period of time. Of the applications received, less than one sixth (15%) were deemed eligible and had complete packets. For the eligible and complete applications, almost three-fifths (58%) of the applicants were immediately offered placement, while slightly more than two-fifths (42%) were placed on a waiting list.

It should be noted that the number of applications is not equal to the number of children/youth because an individual may apply to more than one RTC and may be on more than one waiting list. Thus, the number of children on the waiting list is not an unduplicated count and the number of applications may overestimate the actual number of children awaiting placement in an RTC. Regarding the typical length of time a child remains on the waiting list, the range was from 1 month (30 days) to 7 months (210 days). However, only four RTCs provided these data.

Based on record abstraction data, analyses were conducted on the length of time the residents remained in an RTC. For current residents, the length of stay referred to the length of time between the date of their admission and the date of the record abstraction, whereas for discharged cases, it reflected the complete length of time spent in the RTC from the date of admission to the date of discharge. As shown in Table 5.8-1, based on findings from the record abstraction, the median length of stay for all the residents admitted to the RTCs between July 1, 2001 and August 27, 2003 was 306 days, and the average length of stay was 325 days. The median length of stay was 331 for the discharged cases and 230 for those who were admitted during the target time period and were still in treatment at the time of record review. The average length of stay for the two categories of residents was 351 and 280 days, respectively. Table 5.8-1 also shows that approximately two fifths of the residents (41%) admitted to the RTCs between July 1, 2001 and August 27, 2003 stayed or had stayed there for a period of six months to one year. A quarter (26%) had a length of stay between one year and 18 months. Another 13 percent stayed or had stayed for more than 18 months.

These estimates regarding length of stay should be interpreted with caution. Since the sample of residents files reviewed were limited to those admitted to an RTC between July 1, 2001 and August 27, 2003, residents who were admitted to an RTC before July 1, 2001 and who stayed there longer than two years were not represented in these estimates. In other words, the proportion of residents who stayed in an RTC for more than two years should be higher than percentages presented above.

RTC respondents also provided data on the typical length of stay. The typical length of stay, categorized by specialty unit, is presented in Table 5.8-2. The longest length of stay was in the Sex Offender units, which had a median length of stay of 22 months (663 days). The shortest length of stay was in the Court Evaluation Units, with a median length of stay of 67

days. The length-of-stay data for the adolescent diagnostic treatment, intensive treatment, and specialized treatment should be interpreted with caution as well since there was only 1 respondent for each of these units.

**Table 5.8-1: Length of Stay in Treatment**

<b>Length of Stay</b>	<b>Current Residents %</b>	<b>Discharged Cases %</b>	<b>Total* %</b>
Median # of Days	230	331	306
Average # of Days	280	351	325
1. Less Than Three Months	10%	4%	6%
2. Three to Six Months	25%	6%	13%
3. Six Months to One Year	35%	45%	41%
4. One Year to 18 Months	21%	29%	26%
5. 18 Months to Two Years	7%	11%	10%
6. More Than Two Years	2%	5%	3%
	100%	100%	99%

\* Percentage may not total to 100 due to rounding.

**Table 5.8-2: Typical Length of Stay in an RTC on May 15, 2003**

<b>Types of Specialty Units</b>	<b># of Responding Units</b>	<b>Minimum # of Days</b>	<b>Maximum # of Days</b>	<b>Median</b>
General RTC Units	13	158	488	368
Sex Offender Units	4	548	790	663
Court Evaluation Units	2	42	91	67
Adolescent Diagnostic Treatment	1	423	423	423
Secured Unit	2	337	347	342
Intensive Treatment	1	426	426	426
Specialized Treatment	1	228	228	228

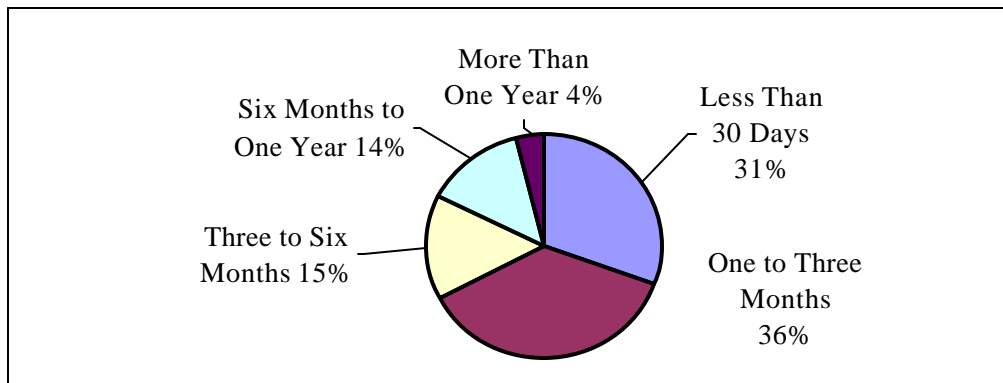
Regarding discharge issues, nine of the RTCs reported having delays in discharge. For the discharges that were delayed, nearly half (46%) were reportedly due to the inability to find a more appropriate, less restrictive placement. Either a less restrictive, more appropriate placement did not exist or there were no slots available. For another nearly one-eighth (12%) of the youth whose discharge was delayed, lack of funding for a more appropriate, less restrictive placement was named as the reason. About another one-eighth of the delays were related to parents' disagreement with the recommended placement. Finally, almost one third (30%) of the discharge delays were due to other reasons, which primarily referred to systems related issues such as case workers neglecting to follow through on necessary paperwork and other agency-

related issues. Inadequate community resources was also one of the most commonly listed “other” reasons for delayed discharges.

Discharge-related issues were further analyzed in the record abstraction data. At the time of the study, 26 percent of the records (both current and discharged resident files) indicated a delay in discharge. Fifteen percent of the **current** residents continued to stay in an RTC though their estimated discharge date had passed. Thirty-two percent of the records of discharged residents indicated that their actual discharge date was after their estimated discharge date. The median number of days discharge was delayed is 51 days and the average length of delay in discharge was 95 days. These estimates represent the lower limit of a possible range because many records indicated more than one estimated discharge date and the latest one was used for the calculation.

Delays in discharge were also analyzed and coded into distinct categories, representing the length of time residents remained at an RTC after his/her estimated discharge date. Findings are illustrated in Figure 5.8-1 below.

Figure 5.8-1: Length of Delays in Discharge



Only one third (34%) of the records with delayed discharges indicated the reasons why a resident could remain in an RTC past his/her estimated discharge date. These records revealed that deterioration or instability in mental state was a major reason for delayed discharges. It was mentioned in nearly three quarters (74%) of the relevant cases. However, in more than one third (36%) of the cases for which reasons for the delay were provided, difficulty in finding a less restrictive place for the resident to transition to was also named as the barrier to discharge. For example, concerns about the resident’s ability to function within the family environment or the family’s willingness to accept them were presented in nearly a quarter of the cases (23%). Waiting for a placement to a less restrictive facility was indicated in 14 percent of the cases<sup>2</sup>.

<sup>2</sup> The two percentages do not add to 36% because one percent of the cases mentioned both reasons.

## 5.9 Services Provided

Based on the responses to the survey, the following units reported providing aftercare or follow-up care after discharge from their program:

- ◆ General RTC units (n=5)
- ◆ Court Evaluation Units (n=1)
- ◆ Adolescent Diagnostic Treatment Unit (n=1)
- ◆ Intensive Treatment Unit (n=1)
- ◆ Specialized Treatment Unit (n=1)

None of the Secured Units or Adolescent Male Sex Offender Units reported providing aftercare or follow-up services to youth after discharge. However, key state representatives, RTC providers, and LCC representatives each reported that after-care and step-down services for children leaving RTCs was of primary importance. RTC providers expressly emphasized the need for aftercare programs and group homes for the adjudicated sex offender population.

For the responding specialty units that reported providing follow-up care, the length of time that it is provided is presented in Table 5.9-1. For those units offering it, the length of time aftercare was provided ranged from 3 months (91 days) to two years (730 days).

**Table 5.9-1: Length of Time Follow-up Care Was Provided by RTCs on May 15, 2003**

Types of Specialty Units	# of Responding Units	Minimum # of Days	Maximum # of Days	Mean	Median
General RTC Units	3	91	730	394	185
Adolescent Male Sex Offender Units*	n/a	n/a	n/a	n/a	n/a
Court Evaluation Unit	1	511	511	511	511
Adolescent Diagnostic Treatment	0	--	--	--	--
Secured Unit Program*	n/a	n/a	n/a	n/a	n/a
Intensive Treatment	1	91	91	91	91
Specialized Treatment	1	91	91	91	91

\*n/a – not applicable, no one provided follow-up care

The percentage of RTC residents using aftercare services is presented in Table 5.9-2. The mean number of youth using follow-up or aftercare services was three-fifths (60%) for General RTC Units, as well as Specialized Treatment. A quarter of the Court Evaluation Unit residents utilized aftercare services. Some of the types of aftercare services reportedly offered were education-related services, transitioning to other programs offered by the organization (e.g., therapeutic group home, day treatment, etc.), and individual and family therapy. For further discussion of the issues see section 7.3 of this report.

**Table 5.9-2: Percentage of Residents Using Follow-up Care on May 15, 2003**

Types of Specialty Units	# of Responding RTCs	Minimum %	Maximum %	Mean %
General RTC Units	4	36%	95%	60%
Adolescent Male Sex Offender Units*	n/a	n/a	n/a	n/a
Court Evaluation Unit	1	25%	25%	25%
Adolescent Diagnostic Treatment Unit	0	--	--	--
Secured Units*	n/a	n/a	n/a	n/a
Intensive Treatment Unit	0	--	--	--
Specialized Treatment Unit	1	60%	60%	60%

n/a -- not applicable, no one provide follow-up care

Four of the RTCs reported that they have a day treatment program. Based on their responses, 254 youth were enrolled in an RTC day treatment program on May 15, 2003. Enrollment for the day treatment programs ranged from 29 youth to 86 youth. Moreover, at each of the four RTCs, a percentage of the residents typically transition from the residential facility to the day treatment program. There was a large range in the responses. At the lowest end, respondents indicated that more than one-eighth (15%) of the RTC residents typically transition to the day treatment program. At the high end, however, respondents reported that nearly all (95%) of the residents typically transition from the residential facility to the day treatment program.

With respect to educational service provision, the majority (97%, n=681) of residents at the 14 RTCs attended school on the grounds of the RTC, whereas only 13 students (2%) attended school off grounds. Six students (1%) received one on one academic tutoring and five students (1%) had other educational arrangements, including special education for residents with developmental delays and residents attending school both on grounds and in the community. It should be noted that some students may receive more than one type of educational service (e.g. may attend school on grounds and receive one-on-one academic tutoring).

The RTCs were also asked to name the top three types of residential programs that are most needed to serve youth with special needs in the state of Maryland. The responses are presented in Table 5.9-3. The top three types of services named are treatment for youth with sexually offending behaviors (n=9), treatment for dually-diagnosed youth (n=6), and more therapeutic group homes (n=4). It should be noted that some of the responses included specifying a particular type of program for youth with certain diagnoses. For instance, according to the RTCs, some of the most needed services for sex offenders are group homes, independent living services, psychiatric respite programs, treatment services for non-adjudicated sex offenders, and programs for sex offenders under the age of 13. The most needed services reported for dually-diagnosed youth were primarily for youth with developmental delays and mental illness.

## 5.10 Intervention

A review of the records indicated that youth residents at RTCs received multiple modes of intervention. The types of interventions provided to each youth in the group were examined. All of the youth represented in the record abstraction process were receiving at least one type of therapy, though the vast majority (94%) were receiving more than one.

The most frequently reported type of intervention was individual therapy. Nearly all of the records (96%) indicated individual therapy as one type of intervention provided to the residents, followed by family therapy (76%), group therapy including milieu therapy (67%), recreational therapy (28%), physical therapy (0.6%), speech/language therapy (0.4%), movement therapy (0.6%), and psychodrama (0.2%).

All of the RTCs offered individual psychotherapy and one utilized sand tray therapy to provide individual intervention. Several provided more focused individual intervention such as one-on-one chemical dependency counseling, counseling for medication management and therapy to address sexually reactive issues. One RTC provided Dialectical Behavior Therapy

**Table 5.9-3: Distribution of Most Needed Residential Services on May 15, 2003**

<b>Services Most Needed</b>	<b># of Responses From RTCs</b>
Sexual Offenders Programs	9
Dual Diagnosis Treatment	6
Therapeutic Group Homes	4
Transitioning Youth Programs	3
Psychiatric Treatment for Special Groups (Regular Education Youth and Youth in Detention Centers)	2
Cognitive, Intellectual & Developmental Disability Treatment – (I.Q. Below 70)	2
Residential Programs for Special Populations (Younger Children & Seriously Emotionally Disturbed Youth)	2
Programs for Pregnant Teens	1
Treatment for Youth with Aggressive Behavior	1
Fire-Setter Treatment	1
Substance Abuse Treatment	1
Psychiatric Rehabilitation Services of Sex Offenders 18 and Older	1
Step-Down Services	1
Foster Care Services	1
Other	1

(DBT) which is the application of a broad array of cognitive and behavior therapy strategies to address the problems of Borderline Personality Disorder (BPD), including suicidal behaviors and other dangerous self-injurious behaviors. Various forms of expressive therapy were offered at about half of the RTCs. They consisted of art and dance/movement therapy and psychodrama.

There were a variety of group modalities offered by the RTCs. One RTC offered pet group therapy and several conducted NA and AA meetings on the grounds. Having NA and AA meetings on the RTC campus was seen as assisting the residents' transition into the community. Two RTCs offered Activity Clubs that allowed residents to hone skills in car detailing and horticulture as well as to participate in arts and crafts, sports, band, drama. Participation in the Activity Clubs was an earned privilege, contingent upon the residents' display of appropriate behaviors on the unit. In addition to milieu group therapy, the traditional process group and recreation group therapy, the RTCs offered specific types of psycho-educational or problem focused groups. The types of groups offered were dependent upon the needs of the current resident population, but in general the following types of groups were represented among all of the RTCs:

- ◆ Chemical dependency
- ◆ Conflict resolution
- ◆ Life skills
- ◆ Social skills
- ◆ Symptom management
- ◆ Anger management
- ◆ Peer mediation
- ◆ Activities of daily living
- ◆ Relaxation
- ◆ Values education
- ◆ Relationship education
- ◆ Specialized group for sex offenders
- ◆ Sexual education
- ◆ Transition
- ◆ Vocational skills
- ◆ Gender-centered therapy

All of the RTCs indicated some attempt to offer family therapy to the residents at least on a biweekly basis. It was noted that in some cases it is counter-therapeutic to involve the families in the treatment due to dysfunctional dynamics within the family system. Three facilities offered family educational or multi-family groups as part of the treatment protocol. Overall, RTCs reported that they get 60% involvement from families. Two RTCs noted that one third to one half of the residents did not have families that were willing or able to participate in family therapy because family members were either incarcerated, in jail or disinterested in their child's treatment. Family involvement not only included participation in family therapy, but included participating in the individual treatment review meetings, providing input into discharge planning, family visitation and facilitating weekend home visits. Six facilities noted that they had special Family Day Activities that involved picnics, recitals, holiday dinners, graduations and other special events.

RTCs have engaged in creative strategies to increase the level of involvement from the families of their residents. In order to keep families informed about activities that take place at the RTCs, three distribute a newsletter periodically. Therapists are available to provide therapy

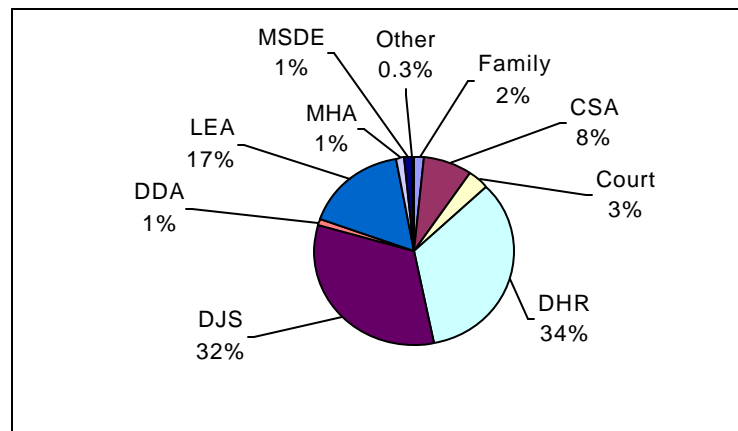
to families in the evenings and on weekends to accommodate parents' work schedules. Therapy is often conducted by teleconference.

Transportation to and from RTCs is an issue so some facilities have paid for the transportation needed by families in order for them to attend therapy sessions. Relatedly, one RTC noted that they had a \$10,000 cab fare bill during the last fiscal year. One facility raises money to pay for lodging and transportation while another will send staff to pick up family members from the train or bus station. The RTCs noted that medical assistance pays for transportation and that DJS or DSS will often provide transportation.

### 5.11 Referral Sources

RTCs reported the original referral sources for their residents. The results are presented in Figure 5.11-1. More than one-third of the residents (34%) were originally referred by DHR/LDSS and about one-third (32%) were referred by DJS. The RTCs reported that, out of the 703 residents, only 3 (all referred by DHR/LDSS) could be better served in a less restrictive environment.

***Figure 5.11-1: Original Referrals for RTC Residents on May 15, 2003***



\* Percentages will not total to 100 due to rounding.

According to the record abstractions, nearly all of admissions (96%) during the period between July 1, 2001 and August 27, 2003 were to youth who had only one lead agency listed in his/her case file. Three percent had two lead agencies listed, and less than one percent had three lead agencies reported in their case files. The most frequently reported lead agency was DJS (42%). As discussed in Chapter 7: Perceived Needs, MARFY and MDLC both opined that the disproportionate number of referrals from DJS reflected a funding advantage on the part of DJS, as Medicaid pays for RTC placements. The remaining lead agencies listed on case files included DHR (24%), MSDE/LEA (18%) and DHMH (14%). Moreover, five percent of admissions represented court-ordered youth.

### 5.12 Management Information Systems (MIS)

Regarding data management systems, some RTCs use an automated system to track or manage admissions. Some of these systems allow for data manipulation or aggregating for

reporting. Results of the survey reveals that the most frequently used data management systems are for admissions and billing. Other uses for data management systems were for human resource related issues, and customer satisfaction. Please see Table 5.12-1.

**Table 5.12-1: Automation of RTC Data Management Systems on May 15, 2003**

<b>Type of System</b>	<b>RTCs That Have Automated Systems</b>	<b>System Allows Manipulation/Aggregation of Data</b>
Admissions	9	9
Discharge	8	8
Diagnosis	7	7
Treatment Plan	3	2
Billing	9	5
Other	2	2

Based on both qualitative and quantitative data, there is currently no statewide centralized system that manages referrals to residential care nor is there a current database of community based service providers and RTCs maintained on a frequent basis. Thus, there is no system documenting the providers' areas of expertise and availability to accept new residents. Moreover, there is no centralized system to manage referrals to RTCs that would allow the State to keep an accurate accounting of children waiting for an RTC placement and no centralized database that allows the progress of children in the system to be tracked. This is a function that is still required of the LCC, however with the new regulations, they may find it challenging to do so when children can bypass them and gain entry to an RTC. It should be noted that, according to one interview, the State is making efforts to develop a Subcabinet Child, Youth and Family Information System (SCYFIS). The SCYFIS would allow the LCC and SCC to input child placement information when they are aware of a referral.

### **5.13 RICAs**

The three state-run Regional Institutes for Children and Adolescents (RICA) are an important component of the RTC community. They serve a total of 147 residents with a total capacity of 157 beds. These make up one fifth (21%) of the total RTC enrollment and RTC capacity respectively. RICAs serve children from across the state (see Table 5.13-1). Montgomery County represents 46% of the RTC population, though the youth population of the county constitutes only 15.7% of the total state youth population. In addition, each of the three RICAs has a day treatment program on site serving as a step-down service. These day treatment programs serve a total of 225 students. Considering the need for RTCs in general, we do not recommend any cut of the RICAs as it would make the need even more prominent, especially when there is a gap between RTCs and community-based services.

**Table 5.13-1: Geographic Distribution of Residents Being Served by RICAs on  
May 15, 2003**

<b>County</b>	<b># of Residents</b>	<b>% of Residents</b>	<b>County Population Under Age 21</b>	<b>% of Total State Population Under Age 21</b>
Allegany County	0	0%	19,374	1.3%
Anne Arundel County	12	8%	140,632	9.1%
Baltimore County	14	10%	207,111	13.3%
Baltimore City	15	10%	193,857	12.5%
Calvert County	2	1%	24,473	1.6%
Caroline County	0	0%	9,013	0.6%
Carroll County	3	2%	47,027	3.0%
Cecil County	3	2%	26,633	1.7%
Charles County	4	3%	38,903	2.5%
Dorchester County	0	0%	8,028	0.5%
Frederick County	2	1%	60,395	3.9%
Garrett County	0	0%	8,686	0.6%
Harford County	3	2%	67,432	4.3%
Howard County	1	0.7%	75,634	4.9%
Kent County	0	0%	5,075	0.3%
Montgomery County	67	46%	244,572	15.7%
Prince George's County	21	14%	251,886	16.2%
Queen Anne's County	0	0%	11,342	0.7%
Somerset County	0	0%	6,502	0.4%
St. Mary's County	0	0%	27,892	1.8%
Talbot County	0	0%	8,138	0.5%
Washington County	0	0%	35,313	2.3%
Wicomico County	0	0%	26,018	1.7%
Worcester County	0	0%	10,809	0.7%
Out-of-State	0	0%	n/a	n/a
<b>Total</b>	<b>147</b>	<b>100%</b>	<b>1,554,745</b>	<b>100%</b>

## CHAPTER 6

### OTHER RESIDENTIAL PROGRAMS (ORPs)

Data about other residential programs were collected from a survey of all the corporations/organizations licensed to provide residential services other than RTCs for children/youth under age 22 in the state of Maryland. The major purpose of the survey was to assess the resources available for children/youth with residential needs in other residential programs (ORPs) in addition to the 14 RTCs. The sampling frame consisted of 237 service providers licensed by DDA, DHR, DJS, and OHCQ/MHA to run residential programs in the state of Maryland. As indicated in Table 6.0-1, of the 237 licensed service providers in the sampling frame, 110 were identified as eligible for the survey because they ran residential programs for children/youth ages 21 or younger. A total of 66 service providers were identified as ineligible for the study either because they did not serve children ages 21 or younger (n=41) or because they were non-residential (e.g., placement agencies, n=25). The remaining 61 were non-respondents whose eligibility status was unknown.

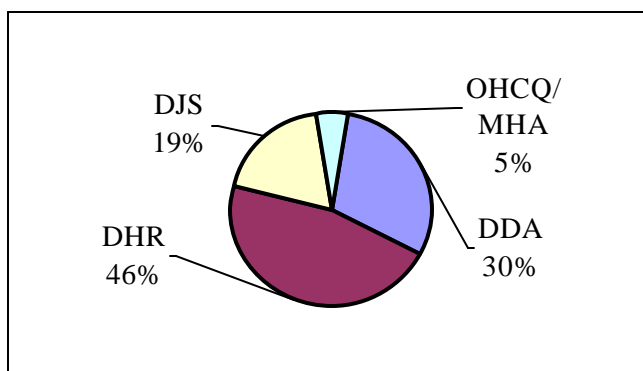
**Table 6.0-1: Eligibility Status by Licensing Body**

<b>Licensing Body</b>	<b>Total # of ORP Providers in the Sampling Frame</b>	<b># of Eligible Providers – Residential and Serving Children/ Youth</b>	<b># of Ineligible Providers - Non-residential</b>	<b># of Ineligible Providers - Adults Only</b>	<b># of Providers - Eligibility Status Unknown</b>	<b>Eligible Respondents</b>
DDA	134	44	22	40	28	17
DHR	76	49	3	1	23	26
DJS	18	13	0	0	5	11
OHCQ/MHA	9	4	0	0	5	3
Total	237	110	25	41	61	57

As of October 22, a total of 57 eligible ORP providers responded to the survey and provided data for the analyses. Thus, a “respondent” in this chapter refers to a responding ORP provider and one ORP provider may operate one or more residential programs (e.g., alternative living units, small or large group homes, psychiatric respites, diagnostic centers, etc.). Since very limited information was available about the ORP population in Maryland that could be used for data weighting, the GOCYF recommended that data analyses be conducted using unweighted data. Thus, caution should be taken in generalizing the survey results to the total ORP population because unweighted survey data might over represent certain types of respondents who were more likely to respond to the survey. (See Chapter 2 for detailed description of the survey methodology.)

As shown in Figure 6.0-1 below, among the 57 eligible ORP providers that responded to the survey, nearly half (46%) were licensed by DHR, 30 percent by DDA, 19 percent by DJS, and 5 percent by OHCQ/MHA.

**Figure 6.0-1: Distribution of Respondents by Licensing Body**



\*Percentages based on a total of 57 responding ORPs.

### 6.1 Types of Programs Run by the ORP Providers

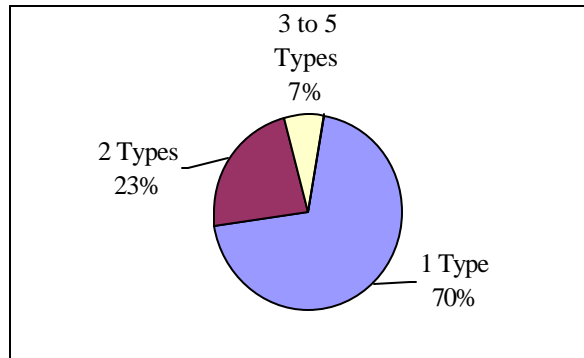
Based on data collected from the survey, the 57 responding ORP providers ran a total of 101 residential programs. Among them, 37 were small group homes with a capacity of 16 or fewer beds (36%), 15 were alternative living units (15%), seven each were 90-day structured shelter care facilities (7%) and therapeutic group homes (7%). The “Other” type of programs included residential schools, medical foster care, and programs for the medically fragile. Please see Table 6.1-1.

**Table 6.1-1: Distribution of Programs Run by the Responding ORP providers**

Type of program	Frequency	Percent
ALU	15	15%
Community-Based Respite	1	1%
Diagnostic Center	1	1%
Emergency Shelter Group Home	1	1%
Large Group Home (cap=>16)	6	6%
Small Group Home (cap<=16)	37	36%
Intermediate Care Facility-MR	1	1%
Hospital-Based/Psychiatric Respite	2	2%
Structured Shelter Care - 60-Day	1	1%
Structured Shelter Care - 90-Day	7	7%
Therapeutic Group Home	7	7%
Treatment Foster Care	11	11%
Other	12	12%
Total	101	100%

As illustrated in Figure 6.1-1, the majority (70%) of the responding ORP providers ran only one type of program. Nearly a quarter (23%) ran two types of programs while the remaining seven percent operated three to five types of programs.

**Figure 6.1-1: Types of Residential Programs Run by the Responding ORP providers**



\* Percentages based on a total of 57 responding ORPs.

## 6.2 Capacity and Utilization

Based on the survey data, the 57 responding ORP providers had a total capacity of approximately 1,792 beds to serve children/youth ages 21 and younger in their residential programs. It is further estimated that on May 15, 2003, around 1,385 children/youth were enrolled in these programs. Table 6.2-1 below presents the distribution of estimated capacity (total number of beds) and enrollment (number of beds filled) across all the different programs. Over one third (37%) of the residential capacity was concentrated in small and large group homes (22% and 15% respectively). Another 15 percent of the beds were available in the treatment foster care programs. Over one quarter (28%) of the residential capacity was provided by “other” types of programs, mostly by residential schools. Consistent with the capacity distribution, 40 percent of the children/youth were being served in small and large group homes, 12 percent in treatment foster care, and another one third (33%) in “other” types of programs. It should be noted that residential programs in which children receive mental health/psychiatric services either on or off-site (e.g., hospital-based respites, diagnostic centers, therapeutic group homes, intermediate care, and treatment foster care) only made up 22 percent of the total ORP capacity and served 21 percent of the children/youth currently enrolled in these ORP programs. Moreover, excluding the treatment foster care programs which provide access to outpatient counseling services to the children in individual foster homes, the conventional ORP programs that serve children/youth with psychiatric conditions (i.e., hospital-based respites, diagnostic centers, and therapeutic group homes) made up only seven percent of the total ORP capacity and served 10 percent of the ORP residents.

**Table 6.2-1: Distribution of Capacity and Enrollment Across Programs**

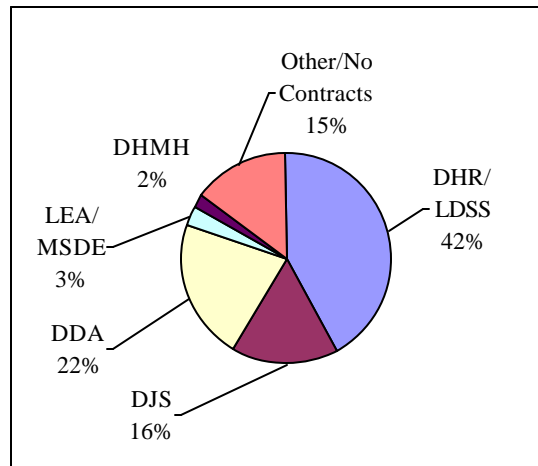
Type of Program	Capacity - # of Beds	Percent	Enrollment - # of Children Being Served on May 15, 2003	Percent	# of Beds Not Filled with Children	Percent
ALU	67	4	29	2	38	9
Community-Based Respite	8	0.4	7	1	1	0.2
Diagnostic Center	42	2	42	3	0	0
Emergency Shelter Group Home	50	3	0	0	50*	12
Large Group Home (cap=>16)	271	15	246	18	25	6
Small Group Home (cap<=16)	392	22	303	22	89	22
Intermediate Care Facility-MR	8	0.4	4	0.3	4	1
Hospital-Based/Psychiatric Respite	42	2	28	2	14	3
Structured Shelter Care - 60-Day	9	1	7	1	2	0.5
Structured Shelter Care - 90-Day	70	4	51	4	19	5
Therapeutic Group Home	54	3	51	4	3	1
Treatment Foster Care	271	15	162	12	109	27
Other	508	28	455	33	53	13
Total	1,792	100	1,385	100	407*	100

\* These might not be true vacancies. It could mean that the beds were not filled with the target children/youth group.

Table 6.2-1 also reveals a difference between the total capacity (n=1,792) and enrollment (n=1,385). A total of 407 beds were either vacant or not filled by the target children/youth group. However, most of these “vacancies” were located in treatment foster care homes (27%), small group homes (22%), emergency shelter group homes (12%), alternative living units (9%), and “other” types of programs (e.g., residential schools). Hardly any vacancies could be found in diagnostic centers (0%), hospital based/psychiatric respites (3%), intermediate care facilities (1%), and therapeutic group homes (1%). This fact further illuminates the need for programs that can serve as a transition between RTCs and other community-based residential programs so that children/youth with psychiatric conditions can be served in an environment that is less restrictive than RTCs.

Most of the beds in these residential programs are contracted by specific state agencies. As illustrated in Figure 6.2-1, nearly half (42%) of the beds are contracted by the Department of Human Resources (DHR) or local Departments of Social Services (DSS), approximately one quarter (22%) by the Developmental Disability Administration (DDA), 16 percent by the Department of Juvenile Services (DJS), three percent by the Local Education Agencies (LEA) or the Maryland State Department of Education (MSDE), and two percent by the Department of Health and Mental Hygiene (DHMH). The remaining 15 percent were either not under any contract or contracted by “other” agencies including out of state public school systems, and an out of state department of health and human services.

**Figure 6.2-1: Distribution of Beds Contracted by State Agencies**



\* Percentages based on a total of 1,792 beds.

In addition to assessing the scope of services currently provided, ORP providers were also asked about any potential plans for 2004. Specifically, over one third (39%) of the ORP providers indicated that they had plans to change the capacity of existing youth-serving residential programs. Nearly two fifths (39%) of the ORP providers had plans to start a new residential program. Based on the survey data, it is estimated that the capacity to serve youth among the responding ORP providers might increase by a total of approximately 410 beds. The capacity of existing programs is slated to increase by 203 beds and new programs are expected to add another 207 beds to the overall OPR capacity. Nearly two thirds (62%) of the planned capacity increase in the existing programs was reported by one residential school. Approximately another quarter (26%) of the planned capacity increase was for some small group homes with 15 or fewer residents. Only less than one tenth (9%) of the planned increase was for programs that provide or provide access to mental health/psychiatric services such as diagnostic centers (6%) and therapeutic group homes (3%). With regard to planned new programs, the new beds would be more evenly distributed across programs with and without a therapeutic component. Specifically, they would be located in small group homes (36%), treatment foster care (23%), 60-day structured shelter care (14%), therapeutic respites (12%), therapeutic group homes (12%), and alternative living units (3%). The populations to be served by the new programs included drug exposed/drug affected infants to two year olds, adolescent females, and transitionally aged youth (ages 18-21). Regarding barriers to starting a new residential program or opening a new site, all except one of the respondents to this question cited lack of funding as a barrier. Gaining community acceptance was another commonly named barrier.

### **6.3 Availability of Beds**

Regarding the availability of beds, the ORP providers were asked how often a bed is immediately available when a child/youth is referred to them. Nearly all (94%) of the ORP providers that responded to the survey reported that beds were not always available at the time of referral. The distribution of survey responses is as follows:

- ◆ Beds immediately available -- all of the time (6%)

- ◆ Beds immediately available -- most of the time (31%)
- ◆ Beds immediately available -- some of the time (59%)
- ◆ Beds immediately available -- none of the time (4%).

Of the 57 responding ORP providers, 17 (30%) reported having a formal waiting list for their programs and only three (5%) had a formal waiting list in an electronic format. According to the 13 ORP providers that provided valid data regarding waitlist, in the 12 months prior to the survey, approximately one third (30%) of the eligible applicants with complete paperwork were placed on a waiting list due to lack of a vacancy. Moreover, based on data provided by 27 ORP providers, the typical length of time a child/adolescent waited for a bed ranged from one day to one year, with a median of 32 days.

#### **6.4 Admissions Policies**

With respect to admissions policies, a number of criteria may determine whether a ORP provider will accept an applicant into an ORP. Some exclusion criteria are presented in Table 6.4-1. A majority of the ORP providers reported that they would not accept an applicant who is an adjudicated sex offender (71%), or younger than age five (67%), or has severe or profound mental retardation (both 65%), or with a history of fire-setting (64%). About half of the ORP providers would not accept an applicant who has a major illness or serious medical condition (52%), or who has a moderate mental retardation (50%).

A further investigation of the admission policy regarding fire setters revealed that whether the fire setting episode was dangerous or not was a key factor in determining whether an applicant with a history of fire setting could be admitted. For example, none of the ORP providers that responded to the survey would consider accepting an applicant with a history of a recent and dangerous fire setting episode (see Table 6.4-2). However, over half (59%) of them would be willing to consider accepting an applicant whose history of fire-setting was not recent or frequent and not dangerous. Nearly two thirds (61%) of them would consider accepting an applicant whose fire setting incident was an isolated episode and not dangerous.

**Table 6.4-1: Populations NOT Accepted By ORP Providers**

<b>Population</b>	<b>ORP Providers That Will <u>NOT</u> Accept*</b>
Are Older Than 18	39%
Are Younger Than 13	31%
Are Younger Than 5	67%
Are Female	29%
Are Male	12%
Attend School in Local School System	6%
Grade Level Too Low	2%
No Insurance or 3rd Party Payer	15%
Parents Unable/Unwilling to Participate	4%
Substance Abuse/Dependence and Psychiatric Condition	27%
Has Developmental Disability	15%
Developmental Disability and 1+ Psychiatric Condition	12%
Major Illness/Serious Medical Condition	52%
Serious Physical Disability	44%
Diagnosis of Mild MR	17%
Diagnosis of Moderate MR	50%
Diagnosis of Severe MR	65%
Diagnosis of Profound MR	65%
Adjudicated Non-Sex Offenders	25%
Adjudicated Sex Offenders	71%
Non-Adjudicated Sex Offenders	42%
Fire-Setters	64%
History of Aggression Towards Staff or Others	23%
Self-Abusive or Injurious	14%
Considered an AWOL Risk	14%
Medication Non-Compliant	25%
Other	4%

\* Percentages were based on 52 responding ORPs and do not total to 100 because categories are not mutually exclusive.

**Table 6.4-2: Admission Policies Regarding Fire-Setting\***

<b>Fire Setting Characterization</b>	<b>% of ORP Providers That Will Accept</b>	<b>% of ORP Providers That Will NOT Accept</b>
Recent and Dangerous	0%	100%
Isolated Episode but Dangerous	20%	80%
Not Recent/Frequent but Dangerous	26%	74%
Recent but Not Dangerous	41%	59%
Not Recent/Frequent and Not Dangerous	59%	41%
Isolated Episode and Not Dangerous	61%	39%

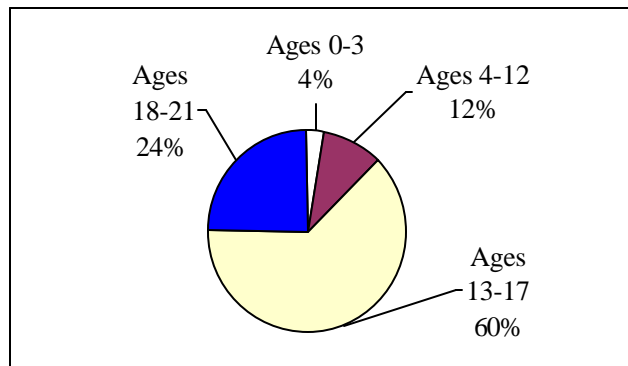
\* Percentages are based on 46 responding ORPs and do not total to 100 because categories are not mutually exclusive.

The ORP providers were also asked if they had ever accepted youth with characteristics outside of their Provider Profile. Approximately two fifths (41%) of the respondents indicated that they had. When asked to describe the characteristics of those youth, the most commonly reported characteristic was low IQ, followed by developmental delays. In addition, over one fifth (22%) of the ORP providers made special provisions for Lisa L. cases (see laws and regulations in Chapter 4 for definition) in that they give priority status to their applications.

### 6.5 Demographic Characteristics of Residents

Based on aggregate data from ORP providers that responded to the survey, nearly two-thirds (67%) of the residents were male while one third (33%) were female. Most (60%) of the children/youth being served in the ORPs are between the ages of 13 and 17, about one-quarter (24%) were 18-21 years old, slightly over one tenth (12%) were 4-12 years old, and only four percent were three years old or younger (see Figure 6.5-1).

**Figure 6.5-1: Age Distribution of Children/Youth Being Served in the ORPs**

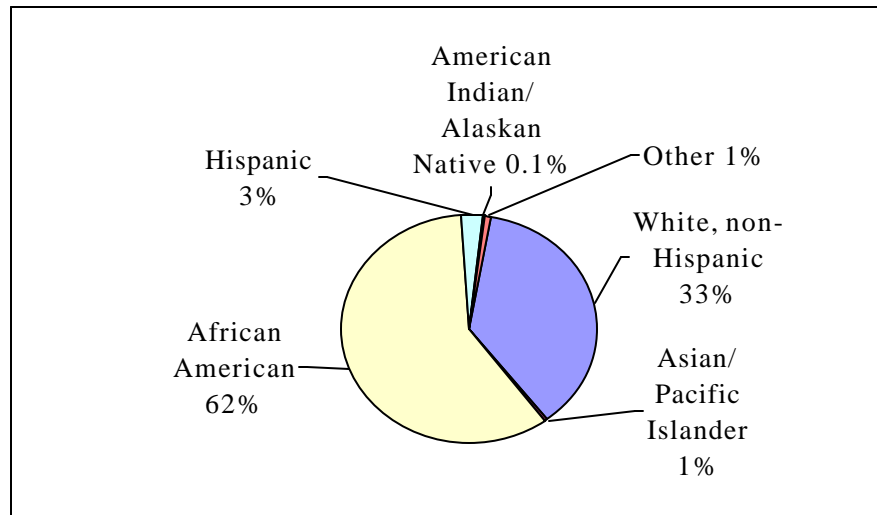


\* Percentages based on a total of 1,273 child/youth residents.

With respect to race/ethnicity, most of the youth being served (62%) were African American (see Figure 6.5-2). Another 33 percent of the youth being served were White, non-

Hispanic. Three percent of the residents were Hispanic. The “other” category included youth identified as bi-racial.

Figure 6-5-2: Racial/Ethnic Distribution of Residents Being Served in ORPs\*



\* Percentages were based on a total of 1,368 residents and do not total to 100 due to rounding.

## 6.6 Diagnoses of Mental Disorders

In aggregate form, respondents indicated the number of youth residents on May 15, 2003 whose diagnoses fell into various DSM-IV diagnostic categories. As presented in Table 6.6-1, the majority of the youth residents in the programs run by the responding ORP providers had been diagnosed with certain mental or psychiatric disorders. Over half of the residents (51%) were diagnosed as having a behavior/conduct disorder. Over one-third (34%) were victims of abuse or neglect. Approximately one-quarter (24%) of the youth residents were diagnosed with anxiety, phobia, or post-traumatic stress disorders; about one fifth (19%) had a mood disorder; and 15 percent had substance abuse/dependence disorders. Other disorders were reported for six percent of the residents and most commonly referred to Attention Deficit Hyperactivity Disorder (ADHD).

The ORP providers were also asked to further identify residents in their programs with issues of being abused or neglected even though these problems might not appear in their most recent DSM-IV diagnoses. Responses to this question revealed that about half (51%) of the children/youth had a history of being abused or neglected. This percentage differs from that noted in the DSM-IV diagnostic categories presented in Table 6.6-1 because not all of the youth with a history of abuse or neglect have a specific diagnosis related to it.

An examination of dual diagnosis or co-morbidity indicated that nearly one-quarter (22%) of the residents reportedly had two or more psychiatric conditions and nearly one fifth (18%) had both a substance abuse/dependence disorder and a psychiatric condition (see Figure

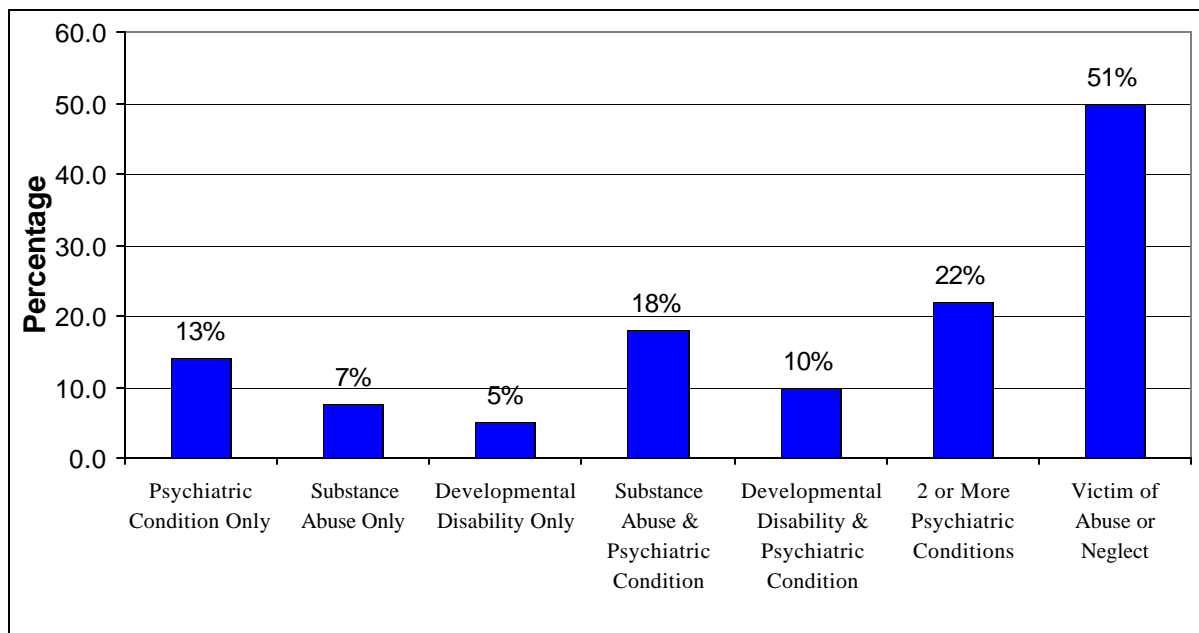
6.6-1). While five percent of residents only had a developmental disability, 10 percent had a co-existing developmental disability and psychiatric condition.

**Table 6.6-1: Distribution of Residents by Diagnostic Category\***

Diagnostic category	Percent of Providers
Anxiety, Phobia, Post-Traumatic Stress Disorders	24
Behavior/Conduct Disorders	51
Impulse Control Disorders (Including Fire-Setting)	9
Mood Disorders	19
Other Disorders Usually Diagnosed in Early Infancy, Childhood, or Adolescence	15
Personality Disorders	3
Pervasive Developmental Disorders	8
Schizophrenia or Other Psychotic Disorders	2
Severe Developmental Disabilities	8
Sexual and Gender Identity Disorders	2
Substance Abuse/Dependence Disorder	15
Victim of Abuse or Neglect	34
Other (Specify)	6

\*Percentages were based on a total of 1,385 residents and do not total to 100 because some residents had more than one of the diagnoses.

**Figure 6.6-1: Distribution of Children/Youth with Singular and Co-occurring Conditions\***



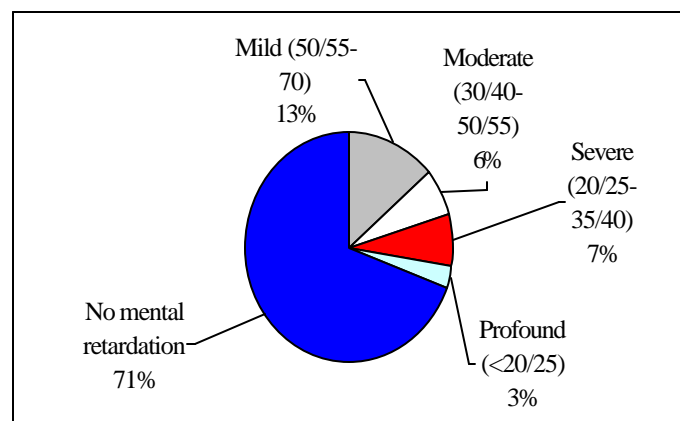
\* Percentages based on a total of 1,385 residents and do not total to 100 because categories are not mutually exclusive.

Again, nearly three quarters (70%) of the youth residents in the ORPs had mental health or psychiatric issues that need intervention. However, as described previously in the section regarding service capacity and utilization, only 21 percent of the youth residents in ORPs were being served in programs that provide mental health or psychiatric services (e.g., hospital-based respites, diagnostic centers, intermediate care facilities, and therapeutic group homes), and these programs only made up 22 percent of the total ORP capacity in the state of Maryland. This points to a lack of community-based residential programs for children/youth with mental health/psychiatric conditions.

## 6.7 Developmental Disabilities

Furthermore, over one quarter (29%) of the youth residents had been diagnosed with mental retardation. These included 13 percent with mild mental retardation, six percent moderate, seven percent severe, and three percent profound (see Figure 6.7-1). As explained in Chapter 5, research literature shows that there is a strong correlation between developmental disabilities and psychiatric disorders (Bongiorno, 1996). However, of these residents with mental retardation, only 13 percent lived in programs that either provided or provided access to mental health or psychiatric services (e.g., hospital-based respites, diagnostic centers, intermediate care, therapeutic group homes, and treatment foster care). The vast majority (83%) lived in small group homes, ALUs, and residential schools, which usually do not provide extensive mental health or psychiatric services. Moreover, the needs for special services to children with developmental disabilities were mentioned repeatedly at our focus group meetings with LCC representatives.

**Figure 6.7-1: Degree of Developmental Delay**

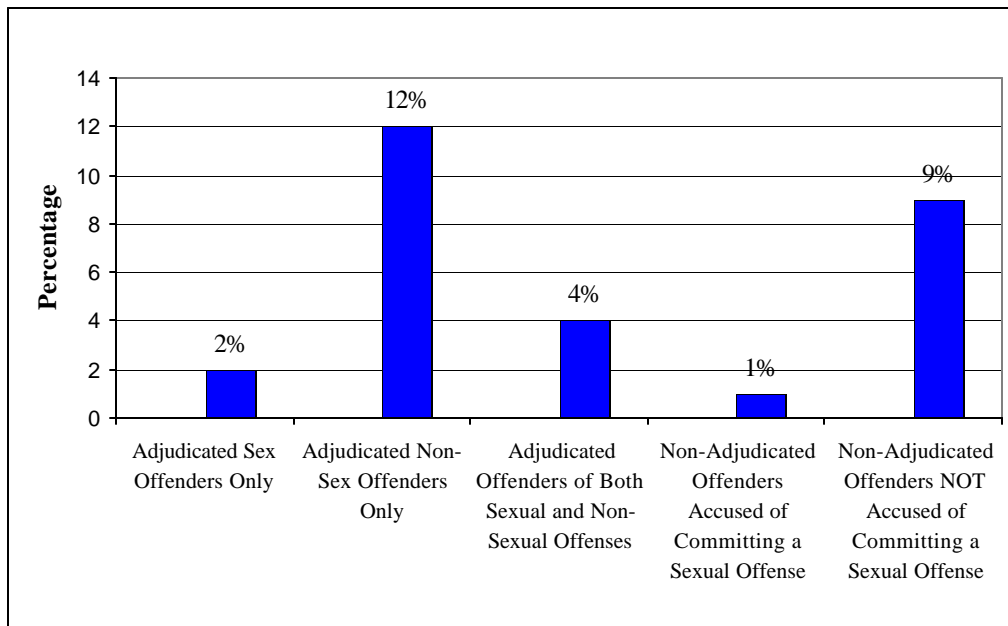


\* Percentages based on a total of 1,385 residents.

## 6.8 Legal Status

In examining the legal history of the youth residents, it was found that nearly one fifth (18%) of the youth residents were adjudicated offenders (see Figure 6.8-1). A total of six percent were adjudicated sex offenders – two percent were adjudicated for sex offense only and four percent were adjudicated offenders of both sexual and non-sexual offenses. Another one tenth (12%) of the youth residents were adjudicated only for non-sexual offenses. Nearly all of the adjudicated offenders (88%) - irrespective of the nature of their offenses - were being served in DJS licensed residential programs. These included 93 percent of the adjudicated sex offenders. In addition, six percent of the youth residents in the ORPs were reported as having a history of fire-setting.

**Figure 6.8-1: Distribution of Legal Status Regarding Sexual Offense\***



\*Percentages based on a total of 1,385 residents and do not total to 100 because categories are not mutually exclusive.

Approximately one third (33%) of the youth residents in the ORPs were court-ordered. Among them, only two percent were reportedly unable to receive appropriate treatment in the ORPs. These were youth with problems such as chronic running away/AWOL risk, refusal to participate in activities, and aggressive, violent behaviors.

## 6.9 Geographic Distribution of Residents

As indicated in Table 6.9-1, the geographical distribution of ORP residents in the survey was not consistent with the state-wide population distribution of youth under age 21 with regard to the most populous jurisdictions in the state of Maryland. Baltimore City was over represented among the ORP residents (34%) as compared to its proportion (13%) in the state population of youth under age 21. On the other hand, however, some major suburban counties were under represented. These included Montgomery County (6% in survey vs.16% in population), Prince George’s County (9% in survey vs. 16% in population), Anne Arundel County (4% in survey vs. 9% population), and Howard County (2% in survey vs. 5% in population). Moreover, of the 101

ORP programs reported in the survey, 36 (36%) were located in either Baltimore City (8%) or Baltimore County (28%). This geographic distribution of ORP programs might, to some extent, explain the distribution of ORP residents in the survey.

**Table 6.9-1: Distribution of Residents by County of Residence\***

<b>County</b>	<b>% of Youth in Residential Programs</b>	<b>% of Total State Population Under Age 21**</b>
Allegany County	0.2%	1%
Anne Arundel County	4%	9%
Baltimore County	14%	13%
Baltimore City	34%	13%
Calvert County	1%	2%
Caroline County	1%	1%
Carroll County	2%	3%
Cecil County	1%	2%
Charles County	1%	3%
Dorchester County	1%	1%
Frederick County	4%	4%
Garrett County	0.1%	1%
Harford County	3%	4%
Howard County	2%	5%
Kent County	0.1%	0.3%
Montgomery County	6%	16%
Prince George's County	9%	16%
Queen Anne's County	0.6%	1%
Somerset County	1%	0.4%
St. Mary's County	1%	2%
Talbot County	1%	1%
Washington County	3%	2%
Wicomico County	3%	2%
Worcester County	1%	1%
Out-of-State	8%	--

\* Percentages were based on a total of 1,385 residents and do not add up to 100 due to rounding.

## **6.10 Length of Stay and Discharge**

Since the length of stay varies greatly across the different types of programs, it is more meaningful to report it by program type. Based on data provided by the responding ORP providers (Table 6.10-1), the median length of stay was 1,140 days (38 months) in an ALU, two days in a community-based respite, 90 days in a diagnostic center, 45 days in an emergency shelter group home, 295 days (10 months) in a large group home (16 or more residents), one year in a small group home (15 or fewer residents), 135 days in a hospital-based/psychiatric respite, 40 days in a 60-day structured shelter care home, 30 days in a 90-day structure shelter care

home, 450 days (15 months) in a therapeutic group home, and 680 days (23 months) in a treatment foster care program. For ALUs and small group homes, some ORP providers reported that residents remain permanently or for the duration of their life.

**Table 6.10-1: Length of Stay by Residential Program**

Type of Program	# of Responding ORP Providers	Minimum Days	Maximum Days	Median Days	Mean Days
Alternative Living Unit	4	730	1825	1140	1209
Community-Based Respite	1	2	2	2	2
Diagnostic Center	1	90	90	90	90
Emergency Shelter Group Home	1	45	45	45	45
Large Group Home (Capacity >= 16 Residents)	6	180	540	295	315
Small Group Home (Capacity <= 15 Residents)	19	180	1642	365	427
Intermediate Care Facility - MR	0	na*	na	na	na
Hospital-Based/Psychiatric Respite	2	90	180	135	135
Structured Shelter Care 60-Day	1	20	60	40	40
Structured Shelter Care 90-Day	2	28	32	30	30
Therapeutic Group Home	2	261	1131	450	580
Treatment Foster Care	7	225	910	680	600

\* Data were not reported.

Pertaining to the issue of delays in discharges, the 57 responding ORP providers reported a total of 148 delayed discharges in the 12 months prior to the survey. As shown in Table 6.10-2<sup>3</sup>, over one third of the delays were in the small group homes (20%) and the diagnostic centers (17%). Another one third were in emergency shelter group homes (10%), large group homes (10%), and 90-day structured shelter care homes (10%). The most commonly reported barriers to discharge included finding a more appropriate place for residents to transition to upon leaving the facility. Primarily, being rejected or waiting for a bed was mentioned, followed closely by the inability to return to their parents. Another, but less frequently reported, barrier to discharge was the resident’s decompensation or lack of progress. It should also be noted that the respondents reported that about four percent of their current residents could be better served by a **more** restrictive level of care and two percent could be better served by a **less** restrictive level of care.

<sup>3</sup> Please note that these estimates should represent the lower limit of a possible range because some respondents did not provide any definitive data regarding this topic by simply leaving the answer blank. In calculating the total number of delayed discharges, these cases were treated automatically as zero even though some of the missing data might mean “don’t know” or “not sure.”

## 6.11 Services Provided

Approximately two fifth (39%) of the respondents reported providing aftercare or follow-up care to their youth residents after discharge from their program. Among the 101 ORP programs run by the responding ORP providers, MSDE certified on-site educational programs were reported for one of the 15 alternative living units, for the one diagnostic center, for five of the six large group homes, for five of the 36 small group homes, for both of the hospital-based/psychiatric respites, for the one 60-day structured shelter care program, for two of the seven 90-day structured shelter care programs, for four of the seven therapeutic group homes, for one of the 11 treatment foster care programs, and for six of the 12 “other” residential programs.

**Table 6.10-2: Discharge Delays by Program Type**

<b>Program Type</b>	<b># of Delayed Discharges</b>	<b>% of Delayed Discharges</b>
ALU	4	3
Community-Based Psychiatric Respite	0	0
Diagnostic Center	25	17
Emergency Shelter Group Home	15	10
Large Group Home	15	10
Small Group Home	30	20
Intermediate Care –MR	na*	na
Psychiatric/Hospital-based Respite	5	3
Structured Shelter Care 60-Day	3	2
Structured Shelter Care 90-Day	15	10
Therapeutic Group Home	6	4
Other	17	11
<b>Total</b>	<b>148</b>	<b>100</b>

\*Data were not reported.

Nearly half (45%) of the youth residents in the ORP programs run by the responding service providers attended school on the grounds whereas slightly over one tenth (13%) received one-on-one academic tutoring. A majority of the youth who attended school on-ground were

residents in “other” programs such as residential schools (50%) and in large group homes (18%). Moreover, Half of the youth who received one-on-one tutoring were residents in large group homes and another 30 percent were in small group homes (16%) and the 60-day structured shelter care programs (14%).

The ORP Providers were also asked what types of residential programs were most needed to serve youth with special needs in the state of Maryland. The top three types of services named are as follows:

- ◆ Group homes/ALUs
- ◆ Services for transitioning youth
- ◆ Emergency/crisis services

With respect to the top three characteristics of populations that need to be served, the results are as follows:

- ◆ Cognitive/intellectual and developmental disabilities
- ◆ Sexual offending behaviors
- ◆ Aggressive/criminal behavioral problems/danger to self/other

## CHAPTER 7

### PERCEIVED NEEDS

Although qualitative information has been presented in prior chapters along with the quantitative data, the following discussion represents more detailed findings from interviews conducted with individuals who represent all levels of the system involved with children who have special needs in the state of Maryland. First, findings are presented from interviews with 10 key state personnel from the following agencies: DJS, DDA, SCC, DHR, DHMH, and MSDE. Then results from interviews and focus groups with persons representing the referral and placement process and provider level are presented. These consisted of two focus groups and 21 phone interviews with LCCs and interviews with all 14 RTC program directors. Lastly, the results from interviews with the stakeholders of the system, the parents of children with special needs, are provided. These data were gathered through four focus group interviews. In addition, information from the interviews held with representatives from MARFY and MDLC are integrated herein.

#### 7.1 Key State Agency Interviews

The key state representatives discussed the major gaps in the service delivery system and shared what they believed would bridge those gaps. Responses generally fell into three main categories relating to workforce development, a lack of community-based programs, and policy and funding issues. There was some discussion about RTCs, but most respondents emphasized the general need for more community-based programs while offering specific suggestions for what types of programs would most benefit the children involved in their respective agency.

#### The Need for Work-Force Development

Every representative explained that there is a need for more mental health training for new and existing direct care staff and professionals in the system. A high turnover rate for these workers was attributed to the “very poor pay and benefits for people who work with special needs children,” as one respondent said. This respondent continued to say that, “with many qualified mental health workers in the metro areas, the need is great in the less centralized counties and rural areas.” Another respondent explained that “there is a lack of properly trained providers [direct care staff], particularly with the population of autistic children, and the workforce development around all special education resources (funds, teachers, aides, etc.) is slow.”

Another respondent explained that with the low pay rate being offered to direct support staff in conjunction with the long, demanding work hours, there is a high turnover rate. Although the staff receives need-specific training at the agency/provider level, the minimum educational requirement for direct care staff is a high school diploma. Specific data required to quantify the actual cost losses for the agency were not provided, however, one can only imagine how this high turnover rate translates into a cycle of losses. With money and time being expended on the continual training of new staff, and missed work days due to “burn out” from

the long hours and challenging work, not only is money being lost, but the quality of the service was reported as being “compromised.”

### **Lack of Community-Based Services**

Every key state agency respondent maintained that a gap exists between the need for community-based services and the availability of those services. What was of most consequence to the key state representatives was that there were not enough community-based programs, particularly specialized programs that would address the needs of more distinct populations. The issue of service location was important for rural populations, however, it was more peripheral in the larger picture.

Children with more complicated diagnoses are harder to place in community programs. These children’s conditions were reported to oftentimes deteriorate due to a lack of community-based services, thus resulting in increased emergency crises that may or may not require more restrictive levels of care. As demonstrated below, many of the suggestions that interviewees offered were preventative measures believed to have the potential of safeguarding children from more restrictive levels of care such as RTC placement. One example of this would be early detection services that would diagnose problems earlier so that the child’s condition would not worsen before securing treatment. Interviewees also believed that more and more appropriate community-based services would shorten the length of stay in an RTC once a child had been placed. Three of the five interviewees explained that one of the main reasons that a child stays in an RTC longer than necessary is because there is such a scarcity of less restrictive, community-based options available to them.

The following list is a compilation of all the community-based services that key state agency representatives indicated would bridge the existing service gap:

- ◆ Programs for sex offenders
- ◆ More programs for children with co-occurring diagnoses
- ◆ More family support services that would intercede before the family reaches the crisis point
- ◆ More services addressing mental health issues
- ◆ More services for medically fragile children
- ◆ Special education services in Baltimore City and Baltimore County
- ◆ Step down services for children leaving RTC placement (respite, one-on-one behavioral aides, one-on-one mentoring, mobile crisis teams and after schools programs) and more providers for these services in rural regions
- ◆ Better crisis response teams
- ◆ More one-on-one aides for families
- ◆ Better trained aides with behavioral specialties
- ◆ Crisis beds within the communities where the families live
- ◆ Comprehensive wraparound services for families
- ◆ Services tailored to the young adults’ (ages 18 to 21) thinking process (i.e. coaching and mentoring, psychiatric rehab and wraparound services)
- ◆ Services for female sex offenders

- ◆ Health services for children in the facilities
- ◆ Special education in the facilities
- ◆ Behavioral management, medical management, psychiatric and psychological treatment, and substance abuse care within facilities
- ◆ More adult services for the transitional youth

### **Issues Relating to Policies and Funding**

Every respondent explained that the issue of parental custody relinquishment in exchange for services represented one of the most sobering dilemmas in the service delivery system. This was perceived to be an issue that arose at the interface of two specific reported policies, one of which has recently been addressed by Governor Ehrlich. One policy relates to income eligibility for services and the other pertained to custody relinquishment. With regard to the former, some parents earn incomes above the eligibility requirements to receive aid, but still need to obtain services that they cannot afford for their child. In these instances, parents resorted to custody relinquishment to get services for their child. When custody was relinquished, parents were put on a registry of people who abandon or neglect children. Because income eligibility criteria were reported as being too stringent, custody relinquishment was used as a desperate attempt on the part of parents to secure treatment for their child. This dilemma, from the key state agency perspectives, originated as a problem at the policy level, which has disastrous results at other levels that directly impact children and parents. It should be noted that Governor Ehrlich has signed an Executive Order to condemn this practice and to study the issue in more depth. SB458 is a new policy that requires local Departments of Social Services to offer voluntary out-of-home placements to children with disabilities without taking custody of the child and eliminates any time limit to the placement.

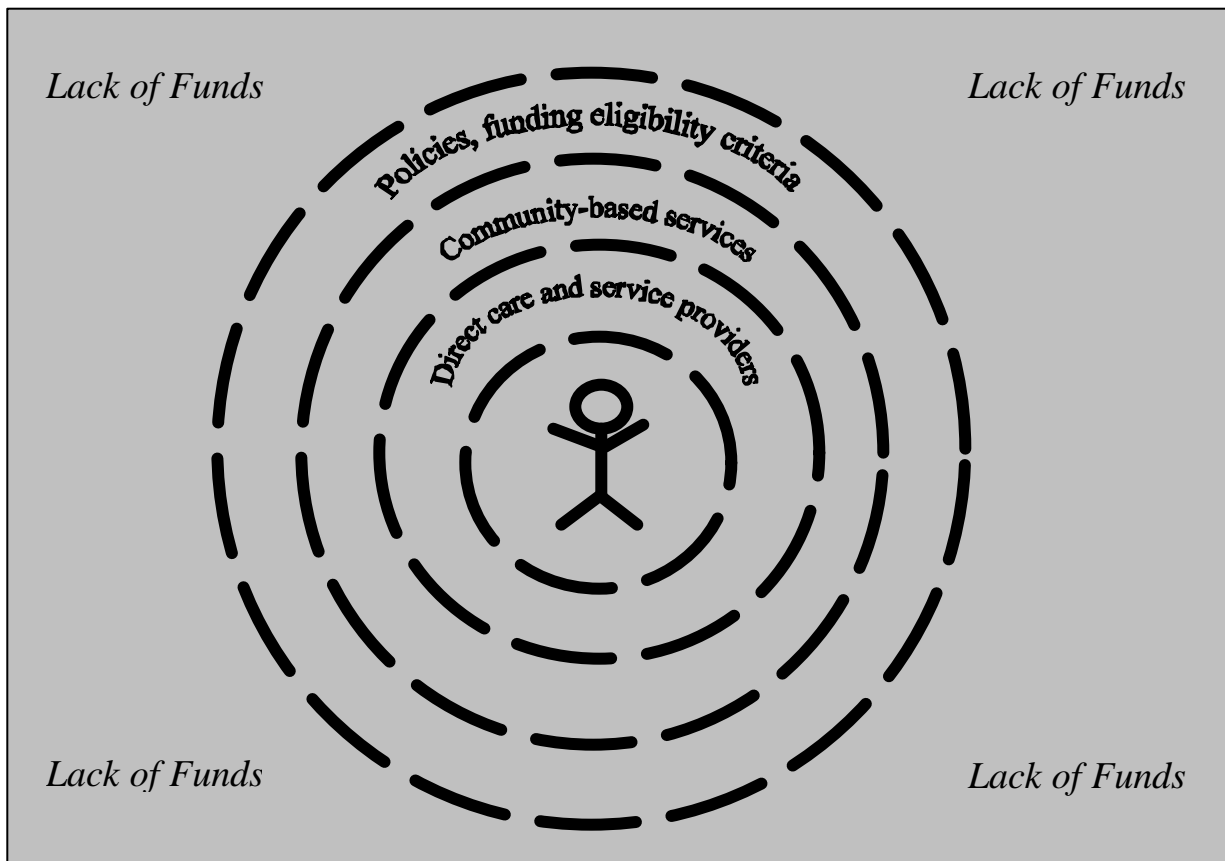
Respondents repeatedly remarked that a lack of funds was at the source of the three aforementioned service gaps and needs. Poor workforce development, a lack of community-based services, and the stringent eligibility criteria for receiving funds/services were all reported to be either direct or indirect outgrowths of scarce funds. For one specific agency representative, a lack of funds required their agency to make tough decisions relating to the approval of services. They had to “choose between crises” under certain conditions when there were only enough funds for one child to be treated. In these circumstances, the agency chooses to fund the child that is experiencing more of a life-threatening crisis. One suggestion that was made that might address this type of problem is, aside from having more funds available, developing a system where the diversion money is made part of the State-matched funds for the Medicaid waiver.

### **Overview of the Gaps at Different Levels of the System**

During the interviews, the representatives explained how problems such as poor workforce development, a lack of community-based programs, problematic policy, and a lack of funds were intertwined with one another. They explained that the interaction between needs at one level and needs at another reinforce the gaps in the overall service delivery system by resulting in the systematic failure to meet the needs of some children. Figure 7.1-1 below illustrates the relationship between needs at different levels of the system and how they are maintained, by depicting the system level boundaries as permeable. Therefore, because the

service needs at one level are contingent upon and are related to the needs at another level, the overall failure to meet the needs of some children continues to perpetuate throughout the system.

**Figure 7.1-1: The Dynamic Relationship Between Reported Gaps at Various Levels of the Service Delivery System**



The child is depicted at the center of the figure. The first concentric circle represents the direct care and service providers who interact with the special needs child on a regular basis. The issues at this level (underpaid, under-educated staff, working long hours with little benefits and a high turnover rate) exert a direct impact upon the child. The issues at this level also impact the next level of the system, represented by the second concentric circle titled “community-based services.” Problems at the community-based level (a lack of services) reinforce the problems at the direct care staff level *and* are impacted by problems at the policy level. The third concentric circle depicts the policy level. Problems at the policy level include issues such as funding allocation and custody relinquishment. Respondents explained that issues at the policy level impact the amount, quality, and type of community-based programs, which impact direct care staff, who in turn compromise the quality of services directly offered to the child.

From this systemic perspective, it becomes clear that gaps and needs at every level of the system, create, perpetuate, or reinforce gaps at other levels. The system in Figure 7.1-1 was depicted within the context of a general lack of funds, which affect the entire system at all levels.

Increasing the funding at all levels of the system while spending those funds wisely seemed to be the most conclusive and widespread assertion that key state agency representatives made with regards to how to improve the system.

## **7.2 LCC Interviews and Focus Group Results**

In general, LCC representatives maintained that RTCs and current community-based services were not meeting children's needs. This gap in services was mainly attributed to a lack of RTC and community-based services, a scope of service treatment that is too narrow to accommodate and treat children with more complicated diagnoses, and funding issues. These three main attributes, according to LCC respondents, were at the source of a number of systemic problems affecting children and were all connected to the referral and placement process. Therefore, the relationship between referrals and placements is considered to be key in uncovering some of the service gaps and in broadly categorizing which children are more or less affected by those gaps.

### **Referrals and Placements**

Based on the combined responses from all the county agency representatives involved in the focus groups and telephone interviews, the LCC receives approximately 159 referrals each month. Referrals come from local bodies of DJS, MSDE, core service agencies and the regional offices of DDA, LDSS. The majority of their referrals reportedly come from DJS and DSS. This perception of the overabundance of referrals coming from DJS was echoed by MARFY and MDLC as well. It was suggested that there is a funding incentive for DJS to refer youth to RTCs (when they may be best served in a less restrictive environment) because payment for their stay does not come from their agency's budget, but would fall under the Medicaid "In patient Under 21" option.

Once a referral reached the LCC, a child's current placement (a less restrictive level of care) had already been deemed unfit by mere virtue of the LCC having received the referral. Limitations to the LCC referral process were noted by MARFY. Namely, that the LCC process is not standardized across the state and "they [LCC] only see children who are on medical assistance and not private pay." There are a number of factors that would determine the rate at which a child moves through the system from referral to RTC placement. Children with simpler diagnoses, proactive case managers, and organized and thorough case files, according to the LCC, tend to move through the system more quickly.

The LCC receives referrals for children with a large range of special needs. Considering that not all children are affected by the service gaps, the majority of the interviews focused on the children with more complicated diagnoses. It was the perception of the LCCs that mental health treatment facilities were reported as being unable to address any issues outside of the realm of anxiety/depression disorders. LCC respondents felt that RICA facilities were unwilling to accept children with more complicated disorders. They also would not accept children with

disabilities, low IQ's, and low cognitive functioning "because RICA facilities maintained that they could not meet the child's Individual Education Plan (IEP) needs." The following list is an overview of LCC responses regarding which children were the most difficult to place:

- ◆ Sex offenders
- ◆ Victims of sexual abuse
- ◆ Pregnant teenagers
- ◆ Girls
- ◆ Mentally ill
- ◆ Younger children
- ◆ Those with low cognitive functioning
- ◆ Those with medical conditions
- ◆ Abusive/aggressive children
- ◆ Autistic children
- ◆ Those with substance abuse problems
- ◆ Self-mutilators
- ◆ Those who have dual diagnoses
- ◆ Children close to the "aging out" cut-off (16 or 17 years old)
- ◆ Children who are involved in more than one agency (for instance, child is at a DJJ facility but also has medical problems)
- ◆ Those with reactive attachment disorder
- ◆ Firestarters
- ◆ Runaways

According to the LCCs, it appears as though children with the above listed characteristics or diagnoses are at higher risk of being placed in an inappropriate setting or of being sent to an out-of-state facility. Two commonly reported outcomes for children who are hard to place are 1) they remain for prolonged periods of time in an inappropriate placement while waiting for another more appropriate facility to accept them, or 2) they are discharged from one placement and put into another that is inappropriate because of a scarcity of programs and services. In cases where a child is sent to an out of state facility, it is usually because there are no available beds in the state or the beds that are available are in inappropriate settings or are inadequate to meet the particular special needs of that child. It was mentioned that an out-of-state placement usually increases the obstacles to family involvement and reunification.

LCC representatives explained that there were a number of drawbacks in the current RTC placement system. A lack of funding was reported as being one of the main reasons why placement is difficult for children who may need RTC services. In order for a child to be considered for placement in an RTC, a lead agency is required to bring the child "to the table." This lead agency is then responsible for funding the child's RTC stay. It was reported that "these lead agencies are suffering from a lack of funding, which results in a widespread hesitation to push children through the system." Children with private insurance were reported as being exceptionally difficult to be brought to the table because private insurers rarely fund RTC placements. According to the LCC representative, in extreme cases DJS has had to resort to arresting children just to get them into the system.

Less restrictive levels of care such as community-based programs and services were also reported to be inadequate options for children. When considering services for a child, LCCs explained that they try to look for the least restrictive environments (in accordance with the law). However, they maintained that because of funding problems and the inability of MSDE and the core service agencies to access group homes for placement, there were barriers to alternative, less restrictive referrals and placements.

Another drawback that LCCs reported was the way that money is categorized for use. It was explained that under the current system of categorization, funds take an unnecessarily long time to make their way through the system and this, in part, is due to the way money is classified. Related to the issue of slow fund disbursements were two other reported drawbacks: restrictions and regulations. Restrictions about the kinds of children that each agency could take on and the many regulations that lead agencies are required to abide by, result in agencies “having to bend the rules in order to make sure a child receives services.” Moreover, the packets that need to be filled out for placement to occur takes too long to complete.

Most of the drawbacks that representatives reported appear to reflect a general consensus that the current RTC placement system is inefficient and overburdened with a large number of children requiring placement. Representatives explained that streamlining the referral and placement system would enhance the quality of services provided to children and could be done through (1) ensuring speedier fund disbursement, (2) pooling funds so that the burden of providing money for a child’s services is shared, and (3) revising policies, procedures, and regulations so that they provide a helpful and guiding framework that does not put lead agencies in a position to have to work around them rather than with them.

## **RTCs**

With waiting lists sometimes six months to a year long, LCC respondents explained that more RTC facilities would help to meet the needs of the population that they are trying to serve. They also explained that it would be necessary for these new facilities and pre-existing facilities to accept children with a broader range of diagnostic categories. By providing broader eligibility criteria and/or more specialized services within RTCs, it was believed that the length of stay in an inappropriate setting would be reduced if not eliminated altogether. More specifically, the need for RTCs that accept non-adjudicated sex offenders, children with dual diagnoses, children with severe mental or psychological problems, and younger children were deemed the most necessary.

LCC respondents explained that they try to exhaust every possible placement option before referring a child to an RTC because that level of care is so restrictive. Once a child is considered in need of RTC placement, respondents believed that there are challenges that the child and family face. These challenges pertain to the location of the facilities and the staff who directly provide services to the children.

Location issues were problematic for children in rural regions. LCC respondents maintained that family involvement and child re-integration were exceptionally difficult when the child is placed in a facility that is far away from their home. Without parent involvement, “the child is set-up for failure” because they oftentimes return to the same environment that they left with “almost no carry-over of any progress made while in the RTC.”

Respondents explained that the quality of services in RTC facilities is seriously compromised due to an underdeveloped workforce. Low wages, demanding work, long hours and insufficient training result in a high turnover rate and poor quality of services for the children. Many LCC representatives believed that more thorough training and higher wages would increase the quality of services for children.

### **Community-Based Services**

When asked about how community-based services could be enhanced, LCC respondents explained that changes and new initiatives pertaining to funding, prevention services, program flexibility, and a continuum of care were needed to adequately treat children with special needs. The issue of workforce development was the same for community-based programs as it was for RTCs. They explained that more and better training should be provided for staff and teachers working with these children for the same reasons mentioned above.

Funding issues were most emphasized during the focus groups and interviews. Currently, the flow of money through the system takes too long. Respondents believed that with easier access to money, LCC could purchase preventative programs that would ultimately cut future costs. Representatives explained that parents should have more services available to them through their private insurance companies. They maintained that oftentimes private insurance companies do not offer coverage for services applicable to their children and that the eligibility criterion for government programs are too stringent for them to receive services because eligibility is based on income and not need. This leaves parents in what is commonly referred to as the “gray zone,” where they do not have access to the services they need. LCC respondents stated that parents’ income levels are usually not accurate reflections of whether or not families could afford services for their children.

A more preventative approach to diagnosis and treatment in community-based services was another suggestion that the LCC respondents offered. “Early identification services,” preventative programs, and long-term case management would not only make services overall more efficient and effective, but also cut the State’s costs. Better screening processes involving the entire family were believed to be linked to prevention, since “family education and early diagnosis could potentially stop the child’s condition from deteriorating.” More integrative family services were stated to be an important measure to take since increased parent involvement in community-based programs was believed to create accountability and smoother transitions for children returning home after treatment in a facility. Family therapy and more

family support were common recommendations. One respondent explained the need for evidence-based intervention strategies. By measuring the outcomes of particular programs, the respondents speculated that inappropriate placements could be prevented and funds would be spent wisely.

It was reported that program flexibility and efforts toward developing a continuum of care would ensure that children in community-based programs would maintain stability or improvement while transitioning between locations. “Day treatment in respite care and group homes are required so that children’s needs are not neglected during these times.” They explained that there should be enough flexibility within programs to be able to develop individualized treatments with input from various sources—a “broker system,” to use one respondent’s phrase.

A list of additional services that the LCC respondents believed were needed to bridge the gaps in the system was compiled. Taken as a whole, the list broadly reflects a desire to integrate reportedly fragmented parts of the service delivery system into more continuous and comprehensive treatment. Key aspects of these suggestions revolve around the notion of strengthening inter-connections between the child, the family, and the school as well as treatment plans across longer periods of time. These were:

- ◆ Family services and treatment
- ◆ In-home behavioral health aides
- ◆ After school programs
- ◆ Longer term residential placements
- ◆ Group homes (specifically for girls)
- ◆ Therapeutic and non-therapeutic foster care
- ◆ Shelter care for DHT and mental health patients
- ◆ Non-traditional therapy
- ◆ Step-down services
- ◆ Respite services for both children and caregivers
- ◆ Mentors in the homes
- ◆ Community-based services for children with IQ’s under 70
- ◆ More funding for classroom services.
- ◆ A “holding-tank” or “emergency respite” with treatment programs

### 7.3 Summary of Interviews with RTC Providers

During each visit to the RTCs in Maryland, representatives from each facility participated in a face to face interview with a member of the evaluation team. Appendix 7.3-A lists the respondents and their respective positions within the RTC.

#### Education

Most of the RTCs accept children who have been classified as needing 100% special education for having a serious emotional disturbance. See Table 7.3-1 below. State financial assistance under Maryland Annotated Code Education Art. § 8-415 is available to cover a child’s RTC educational expenses only if their IEP specifies that they need 100% non-public special education for serious emotional disturbance. If a child is determined to need regular education, but meets the medical criteria for placement in a RTC, the State will not pay for the educational component of their RTC stay. Furthermore, Medicaid does not reimburse RTCs. Unless there is an alternative payment source, the non-public RTCs generally do not accept students whose IEPs fail to designate the need for this restrictive level of educational intervention.

**Table 7.3-1: Education Offered at Residential Treatment Centers**

Name of Facility	Types of Education Offered On Campus	Types of Education Offered Off Campus
Chesapeake Treatment Center	Special Education	NONE
Chesapeake Youth Center	Regular Education, Special Education	NONE
Edgemeade	Special Education	Special Education
Good Shepherd	Special Education	NONE
Jefferson School	Regular Education, Special Education	NONE
Mann RTC	Special Education	Special Education
Potomac Ridge at Anne Arundel	Special Education	NONE
Potomac Ridge	Regular Education, Special Education	NONE
RICA Baltimore	Regular Education, Special Education	NONE
RICA JLG	Special Education	NONE
RICA Southern	Special Education	NONE
Sheppard Pratt at Ellicott City	Special Education	NONE
Villa Maria	Regular Education, Special Education	Regular Education, Special Education
Woodbourne	Special Education	NONE

Five RTCs provide both regular education and special education classes and are thus able to accommodate students who require less than 100% of special education services. These facilities are the Chesapeake Youth Center in Cambridge, the Jefferson School, Potomac Ridge in Rockville, RICA Baltimore, and Villa Maria.

Only two RTCs, Mann and Villa Maria, transport children off grounds to other schools to meet the child’s specific needs as indicated on their IEP (e.g., services for the hearing or visually impaired, less restrictive public educational setting). The fact that so few RTCs provide this

service represents a gap in available treatment for the children who have done well in public school settings, but require RTC level of care.

Another perspective was articulated by two RTC providers who noted that the problem exists in how educators view mental illness; some local educational agencies fail to appreciate that mental illness impacts the ability to learn. For example, in their opinion, schools often fail to acknowledge that truancy, substance abuse and threatening behaviors are indicators of serious mental illness. Thus, a child who has a mental illness after three o'clock (post school hours), should be viewed as having a mental illness that impacts their functioning during school hours. As a result, some children have been categorized as having only behavioral problems and have not been designated as needing the most restrictive level of care in the educational setting (such as a RTC school). Children are consequently either denied the treatment they need or they deteriorate while awaiting admittance to the limited number of RTC placements who offer both regular and special education.

### **Admissions Process and Waiting List**

Waiting lists are handled in various ways by the RTCs. Three facilities indicated that they do not maintain waiting lists. Five of the RTCs remarked that small waiting lists are created when the necessary paperwork required for admission to their facility is outstanding. Three facilities have their admissions managed by an outside entity. The flow of admissions for the Chesapeake Treatment Center is managed by the Department of Juvenile Services. The flow of admissions for Sheppard Pratt at Ellicott City is managed by the MART team. The Montgomery County Public Schools determine the priority for admission for JLG RICA in Rockville after JLG RICA informs them of bed availability.

Several facilities have a priority system that dictates the flow of admissions to their facility. RICA Baltimore gives priority for admission to Lisa L. cases and to children who are hospitalized. Villa Maria gives priority to the children who are already within their continuum of care and to the Lisa L. population. Three RTCs give priority for admission to the children referred for services who come from the counties within the geographical region of the RTC. The Chesapeake Youth Center gives priority to children from the Eastern Shore, The Jefferson School gives priority to kids from Western, Maryland and RICA Southern gives priority to referrals who come from Prince George's, Charles, St. Mary's, and Calvert counties.

The Potomac Ridge system centralizes referrals at the Rockville site for both of their facilities. Thus, Potomac Ridge at Anne Arundel would only review admissions packets after they were screened by the Rockville office.

### **Transitional Services and Discharge**

Most RTCs noted that discharge plans are developed at the point of admission to the facility. It was noted that there are cases where parents remove children against medical advice (AMA), so the discharge plan and transitional services can not be implemented. A number of transitional activities occur to prepare residents for discharge and for the community.

One strategy is to increase the amount of time away from the facility by granting leaves of absences (LOAs) so the resident can have extended visits with their family, foster parents or prospective group home providers. LOAs are initially granted for a few hours, then extended to overnight visits and then to weekend passes if the time away from the facility is successful. If a resident is to return home to their family, the frequency of family therapy sessions is increased.

Transportation to and from RTCs is an issue so some facilities have paid for the transportation needed by families in order for them to attend therapy sessions and to transport residents to community services during the transitional phase. Relatedly, one RTC noted that they had a \$10,000 cab fare bill during the last fiscal year. One facility raises money to pay for lodging and transportation while another will send staff to pick up family members from the train or bus station. The RTCs noted that medical assistance pays for transportation and that DJS or DSS will often provide transportation.

Seven RTCs have Day Schools and Day Treatment Centers that provide a natural transition for residents who are ready to step-down to the community. In some cases, the resident is able to experience continuity with their treatment providers (when clinically appropriate) after being discharged from the RTC, by remaining within the organizational system for day treatment services. Often times residents are interviewed by group home providers either at the site of the group home or at the RTC to determine if the resident is a good fit for a prospective group home.

One facility engages the residents in role playing exercising to prepare for these interviews. Great effort is made to connect residents to the community resources that they will need while in the community. These resources include outpatient therapy, medication monitoring, vocational training, and other community based services such as wrap around and respite care.

Less restrictive settings typically utilized following a stay in an RTC are as follows:

- ◆ Outpatient community mental health centers
- ◆ Group homes
- ◆ Therapeutic group homes
- ◆ Therapeutic foster care
- ◆ Foster care
- ◆ Independent living programs (for residents over 18 years old)

The RTCs identified several agencies, which help to facilitate a resident's transition to the community and assist in maintaining them there. They are as follows:

- ◆ The Institute for Family Centered Services (only available in Frederick, Gaithersburg, Baltimore and Largo, Maryland)
- ◆ Wrap-around services through DHMH
- ◆ Family advocacy

- ◆ Youth ranch in Frederick County
- ◆ The Arrow Project
- ◆ The Children's Home
- ◆ The Children's Guild
- ◆ Fordam Group Home
- ◆ Department of Rehabilitative Services (DORS)
- ◆ National Center on Institutions and Alternatives (NCIA)
- ◆ Edison School of Technology (Montgomery County, MD)
- ◆ St. Luke's Career Transition Project
- ◆ Maryland Family Resources
- ◆ Maryland Alternative Care (Baltimore and PG Counties)
- ◆ Court Appointed Special Advocate (CASA)
- ◆ Big Brother and Big Sister Programs (for younger children)
- ◆ Pride
- ◆ Adolescent Sex Offender Program (ASOP)
- ◆ Finan Center

RTC providers were asked their opinions about what was most needed to reduce the length of stay of residents. One provider expressed the opinion that the law prevented RTC level of care until a child had had a number of placement failures. It was this provider's opinion that if RTC level of intervention was provided earlier (before the children's condition had deteriorated) that the length of stay in RTCs would be reduced. Two providers commented about the need for DSS workers to remain active advocates for their cases, and to be more knowledgeable about RTC regulations and community resources. It was the perception of these providers that DSS workers were less inclined to expeditiously find community placements for their cases when these children were under the auspices of the RTCs. Two other providers noted that more consistent family involvement would reduce the length of stay of residents. Another discussed the staff resources that had been depleted due to budget cuts. For example, the loss of recreation therapists diminished the number of activities provided for the residents, hence making them less available to provide intervention. In addition, it was mentioned that expressive therapies were needed for residents with lower IQs who could not benefit from traditional insight oriented therapy. Specialized programming (such as for children of alcoholics or for low functioning residents) within the RTCs was seen as a needed resource that would reduce the length of stay.

Limited or absence of funding for residents once discharged to the community was reiterated as being a major obstacle to maintaining children in the community, thus resulting in longer RTC stays. A common theme among RTC providers related to the restrictions around the use of Medicaid dollars; Medicaid funding was unavailable for community based settings. These restrictions contributed to discharge delays from RTCs. Also, the Medicaid "family of one" distinction does not follow the child out of their current RTC placement. Thus, some children may be kept in the more restrictive RTC placement because that is where funds are available for them and not because that is where the child can be best served. The fact that Medicaid does not reimburse for one to one interventions for residents of RTCs was seen as a major hindrance to expedited treatment. In addition, it was mentioned that residents could benefit from in-home

services while residents are on weekend home passes. Medicaid does not fund such services unless the parents have Medicaid.

It was reported that the options for acute psychiatric care are diminishing. Relatedly, anxiety was expressed around the closing of Crownsville Hospital, which serviced the more aggressive children. It was reported that hospitalization is often needed to stabilize a resident who is decompensating at an RTC.

Most RTCs indicated that children remained in their RTC when they could be better served by a less restrictive level of care when they were in the transition or discharge process and were awaiting placement in the community. A particularly difficult case is when a child has no agency involvement and the parent is unwilling to reunite with the child post treatment. There were a number of recommendations about needed community based resources that RTC providers believed were needed, but are currently not available for their residents. They were as follows:

- ◆ Aftercare programs and group homes for the adjudicated sex offender population
- ◆ Foster care (particularly for teenage boys)
- ◆ Transitional group homes (supervised independent living) for children 18 years or older and better integration with the adult system
- ◆ Coordination between school placement and group home placement
- ◆ Structured group homes for multiply impaired children and aggressive children
- ◆ Funding for group home level of care
- ◆ Group homes and trauma based community services for adolescent girls
- ◆ Funded wrap around services (mentors, home-based services)
- ◆ Respite care
- ◆ Residential care for the developmentally disabled
- ◆ Vocational programs
- ◆ Partial hospitalization programs
- ◆ After-school programs
- ◆ Group homes for the medically fragile
- ◆ Community psychiatric/mental health clinics
- ◆ Group homes that are interconnected with RTCs
- ◆ More options for hospitalizing youth
- ◆ Emergency therapeutic shelters
- ◆ Substance abuse treatment

The MARFY representative presented a comparable view with regard to the role of RTCs in view of a dearth of community based services. When asked to discuss MARFY's position on RTC capacity, the respondent said that the capacity is too high and that "the agency [MARFY] has actively opposed adding to RTC capacity since 1996." There are three reasons for this. First, "RTCs are not linked up with any other services (community or otherwise) that could help the child." Without step-down services or other appropriate placements after discharge, children stay in RTC facilities longer than necessary. He maintained that "RTC placement is an isolated intervention." Another reason for opposing

increased RTC capacity is because “some children in these facilities do not need that level of care.”

### **Aftercare and Follow Up**

Nine of the RTCs reported that they do not provide any formal aftercare for residents once they are discharged from their RTCs. It was noted by six RTCs that for residents who reside in the catchment area of the RTC and continue in some step down component (usually Day Treatment/School) of the continuum of services, aftercare may be provided. The length of time that aftercare is provided is dependent upon where the resident is in their academic career. One RTC has a yearly reunion with discharged residents. In the case of the Chesapeake Treatment Center, all residents are under the jurisdiction of the Department of Juvenile Services until their 21<sup>st</sup> birthday, so they are monitored by their Probation Officer who coordinates follow up in the community.

Only half of the RTCs formally track the progress of their residents once discharged from their facility. Most of the other facilities who had no formal tracking system indicated an appreciation for the value of having such data and have intentions to institute tracking in the near future. It was reported that follow up is done by all of the RICA programs at one, three, and five years post discharge.

### **Personnel**

RTCs were asked about staff shortages and how such shortages have had an impact on their programs. Common themes related to the expense of needing to hire agency personnel such as nurses and the need to use higher salaried staff to perform functions best managed by staff who were paid lower wages (for example, clinicians needing to do food shopping.) Staff shortages also result in staff needing to work double shifts or overtime. Such work demands lead to burn out, increased stress and eventually, high staff turnover rates. It was noted that under such conditions, overall quality of care is diminished, safety is compromised, and crises among the residents increase. There are clinical manifestations of staff shortages in that high recidivism among staff decreases the continuity of the team and impacts the ability of the residents to form trusting relationships (a key ingredient of the therapeutic process). Positions most needed at RTCs were reported as follows:

- ◆ Bachelor level milieu therapists/residential care counselors/direct care staff
- ◆ Nurses
- ◆ Administrative positions such as a director of development (for fund raising and marketing) and director of nursing
- ◆ Psychiatrists (full time)
- ◆ Specialized group therapists (for eating disorders, sexual abuse)
- ◆ Discharge coordinator
- ◆ Psychologists
- ◆ Pediatricians (full time)
- ◆ Social workers familiar with the DDA system

- ◆ Certified addictions counselors
- ◆ Recreational therapists
- ◆ Occupational therapists
- ◆ Expressive therapists

#### 7.4 Summary of Parent Focus Groups and MDLC Interview

##### Parent Focus Group Results

The purpose of conducting the parent focus groups was to examine their experiences as parents of children with special needs. The interview questions were designed to elicit information about the timeliness of placements and appropriate discharges, clinical appropriateness of placement recommendations and admissions, length of stay/service, types of service received, and obstacles to obtaining services. (See Appendix 7.4-A for a review of the discussion guide.)

The participants were diverse with regards to family constellation and experience. They included single mothers, couples with up to four other children, parents of more than one child with special needs, an adoptive parent, and a parent with a disability. Most had some general, albeit inconsistent, knowledge about the system and services available to them and some have even become advocates as they struggle on behalf of their children with special needs. Three focus groups included parents whose children were using community-based services and the fourth parent focus group included parents whose children were in or had been in RTCs. Some parents expressed their need for RTC services while others worked hard to avoid this level of care for their children. Please see Table 7.4-1 for the counties and diagnostic categories represented in the four parent focus groups.

**Table 7.4-1: Parent Focus Group Representation by Region, County, and Diagnosis**

Region	Counties Represented	Diagnoses Represented
Central	Baltimore, Harford, Howard	bipolar disorder, ODD, severe emotional problems, visual impairment, autism, developmental delay
Eastern Shore	Queen Anne's, Kent	ADHD, Asperger's Syndrome, cerebral palsy, developmental delay, arthrogryposis, visual impairment
Southern 1	Charles, St. Mary's	Down syndrome, asthma, memory problems, ADHD, bronchial pulmonary disease, seizures, hearing impaired, autism, spina bifida, Asperger's syndrome,
Southern 2	Montgomery, Prince George's	severe MR, autism, suspected schizophrenia, Asperger's Syndrome, medically fragile, ADHD, anxiety disorder
Western	None	Not held due to poor response rate.

The parents utilized a broad range of community-based services contingent upon factors such as availability of services, appropriateness of services, geographic distance between home and the facility, their income, and available time. Most were utilizing services in some form from the options available to them either through private companies, state programs, or a

combination of both. Parents reported that their children were having their educational needs met through public schools with special education classes, private schools, the Maryland School for the Blind, Kennedy Krieger School, and a DDA residential group home. The following list reflects an overview of the programs and services utilized by the families represented in the focus groups:

- ◆ Occupational therapy
- ◆ Speech therapy
- ◆ Respite services
- ◆ Summer camps (Easter Seals)
- ◆ School day care
- ◆ Therapeutic group homes
- ◆ Day treatment programs for children with Autism
- ◆ In-home services with an after school care program
- ◆ Home safety upgrades
- ◆ One-on-one aide

As the parents discussed alternative services to residential treatment, they also shared what they believed were the barriers to attaining appropriate services. These were (1) knowledge of services, (2) a service delivery system that lacked standardization, (3) funding issues, and (4) geographic location of available services.

### **Knowledge of Services**

Parents repeatedly asserted that one of their challenges was a lack of awareness of alternative community programs available to them. The respondent from the MDLC interview also highlighted this problem. MDLC explained that families are not aware of the Medicaid services to which they are entitled. Furthermore the Medicaid reimbursement rates are set so low that it is hard to find providers who are willing to offer such services. Most parents who participated in the focus groups made concerted efforts to locate programs and services, however they also did not know with whom they should speak or how to maneuver through the system to get information. In some cases, parents made assumptions about the roles and responsibilities that educators, service deliverers, and case workers performed. If no one mentioned alternative services and parents had already made unsuccessful efforts to locate services, they logically assumed that there were no more options left for them.

Parents explained that one could “self-educate” in order to get information, but that the time required in this process is a luxury that most of the parents could not afford. Other commitments such as work, other children, and their own needs were often immediately pressing and in the forefront of their lives.

Strained communication between facility staff and parents was reported to be another problem for parents who wanted to stay informed about their child's treatment. There were cases when parents became aware that their children were placed in physical restraints, but when parents inquired about these incidents, the staff was not forthright with providing information. One parent whose child had been placed in an RTC in the past reported that the staff at that particular RTC would hang-up the phone if she called "too often."

Another parent, who had worked diligently to strengthen the lines of communication surrounding her child's treatment, described the relationship between pediatricians, specialty doctors, schools, and parents as a circle. "When one person does not communicate with the others, the circle is broken..." and that "it's left up to the parent to make connections and then link up with the school."

### **Lack of Standardization**

The service delivery system was collectively experienced as highly decentralized with programs and services lacking uniformity. Fragmentation was apparent to the respondents in terms of roles (who in the system is responsible for what), service continuity (transitions from one program or service to the next), and discrepancies between formal policy and the implementation of that policy. Parents repeatedly reported that the decentralized nature of the system translated into serious issues of accountability and mainly contributed to their sense of powerlessness. Some specific examples illustrating these issues are stated below.

Parents reported that excellent services may be available in one county but the neighboring county may offer very little or even no services at all. For some parents, important life decisions, such as where to live, were highly contingent upon the services within their vicinities. Some expressed their desire to move to another county in order to take advantage of better services, while others would have preferred to move for personal or employment reasons but felt that they could not. Moving in some cases meant that the parents would have to rescind their child's current services and start over on a waiting-list elsewhere not knowing how long it would be before their child would begin receiving services again.

Other examples of how the system lacked uniformity include parents being approved for in-home aids, but having to find the aids themselves. In other cases, the child's funds had been approved for services and yet the actual services did not exist in the child's region of residence, illustrating a discrepancy between the policy that approved the funds and the actual implementation of the policy. Several parents also explained that their child's transition from one program or service to the next was problematic. For instance, in rural regions like Kent County, parents reported that they had no options for transitional programs because they simply were not available. For this reason, many parents were fearful for when their children became adults or aged out of a service.

## **Funding Issues**

Another barrier to obtaining services was funding. Parents expressed that (1) oftentimes they would be approved for funds but would have to wait for a long period of time to receive those funds, (2) the funding process was not transparent, so parents would simply know that funds were approved, but not know which provider received the money or how much they received, and (3) there were several cases of funds being denied to parents because their income level was “too high.” For the latter case, parents explained that the guidelines were outdated, that they did not take into account inflation and the rise in the cost of living, and that they did not consider a parent’s outstanding debt. As one parent expressed it, “it’s like we have to hit the bottom before we can get help.”

Parents also expressed that they were unable to obtain specific information about funding because access to knowledge in some cases was denied. This was especially a problem with regards to fund allocation. Parents explained that funds had been approved for specific services or programs, but that the process of fund distribution was not transparent. One parent remarked: “There is secrecy surrounding the funds given to children. Parents have no way of knowing if their child is really receiving the amount of funds they are supposed to receive.” Perhaps exclusion from this information has further eroded the trust between service deliverers and parents. Moreover, aside from an erosion of trust, this could be problematic because knowledge of who gets paid and how much reveals who the stakeholders are, who can be held more or less accountable, and what level of quality should be expected and/or demanded. However, if parents had more information about fund allocation, it may better equip them to advocate on behalf of their children.

## **Geographic Location of Available Services**

The final barrier to obtaining appropriate services was the geographical location of service centers or RTCs. Several of the parents who participated in the focus groups explained that the far distance between their homes and service centers was taxing and impeded their ability to be as involved in their child’s life as they would like. One parent explained that she was approved for excellent and appropriate services but that she was not able to spend two hours a day driving to and from the center while working and parenting other children. One-on-one aides also had difficulty with transportation because oftentimes they did not have cars either, so they would not be able to provide the services for which they were hired. This was especially problematic in rural regions that sometimes necessitated extremely long drives to either access services or to have those services come to them.

## **Perceived needs**

An important focus of the parent group interviews was to understand what they believed would bridge the gaps between their needs and the services available. At the end of each interview, they were asked about what services they needed. Overall, the responses that parents made reflect a desire to shift away from a reactive system that is more responsive to parents once

crisis has set in, toward a preventative system that addresses the needs of children before they develop conditions necessitating RTC placement. The following list is a compilation of responses from the first three focus groups and represents what parents believed were needed to appropriately treat their children.

- ◆ Education for parents as well as service providers
- ◆ Increased supply of competent providers
- ◆ Action taken against providers who fail to honor their contracts and/or break the law
- ◆ More funding streams available to children with special needs
- ◆ Families should be informed about where their child's funding is being spent
- ◆ Ongoing evaluations of services to assess quality and appropriateness
- ◆ More family support systems
- ◆ Better transitioning programs from the school setting. Need for job coaches and more businesses willing to take on developmentally delayed children.
- ◆ More programs for the blind and also emergency shelter care in rural regions of Kent County
- ◆ More camps for children with special needs
- ◆ More respite providers
- ◆ More social skills building outside of school
- ◆ More inclusion services
- ◆ Statewide ESY policy
- ◆ Joining the ESY program with the summer camp programs so children benefit from both an educational and social interaction
- ◆ Community awareness and support for families

Parents in the fourth focus group had children who required a more demanding level of care and who were either currently in an RTC placement or had been recently discharged from a placement. Responses from these parents indicated a concern for educators who felt that their job security was threatened if they publicly stated their opinion about what services they believed were really needed for special education students. Instead, parents reported that educators would tell them in confidence how to pursue services for their children, rather than state the opinion in a formal IEP meeting. The parents were able to identify some areas within the service delivery system that, if enhanced, would better meet the needs of children. These were the summer programs, day and after care for their children, and funding for better training of staff. It was interesting to note that all of the suggestions focused on community-based services and not RTCs although they did maintain that RTCs were crucial for some children. This may reflect a more

general desire for keeping their children out of such restrictive levels of care as RTCs and into what they reported to be more effective and nurturing community-based environments.

### **Adequate Age Appropriate Summer Programs**

Parents reported that summers were especially hard for them because their children would not be in school. While there were some summer programs that they liked, they explained that they were not fully adequate. The more diverse and engaging field trips, according to the parents, were usually reserved for older children. Therefore, they would like to see these community-based summer programs expand to be able to provide a better quality for children from a broader age range.

### **Day Care and Aftercare**

The majority of parents shared that they would like to see better day care and aftercare for children with special needs. “Better and more affordable child care for regular children is difficult to find, so you could imagine that the problems for special needs children are much worse.” Finding day or aftercare offered by well-trained staff was especially a problem.

### **Training Funds**

Parents in the focus group explained that there is a need to provide better behavioral training for one-on-one aides and school staff, which includes training for working with older children. They explained that this would require more funding and that teachers in particular should be paid more than what they currently receive.

## CHAPTER 8

### SUMMARY OF FINDINGS

#### 8.1 Highlights of Findings about the RTCs from the Surveys and Record Reviews

The total capacity at RTCs in Maryland on May 15, 2003 was 756 beds whereas enrollment was 703 residents on that date. On average, Maryland's RTCs operate at more than 90 percent of capacity. At least one RTC is generally at 100 percent capacity. Six of the 14 RTCs have children on a formal waitlist. Forty-two percent of eligible applicants with complete paperwork were placed on a waiting list, whereas 58 percent were immediately offered placement. Some RTCs have programs that serve specialized populations including children who have displayed sexually offending behaviors. These programs have high utilization rates. Two of the specialty units (specialized treatment and intensive treatment) were operating at 100 percent capacity on May 15, 2003. The adolescent male sex offender units also had a relatively high occupancy rate (97%). The existence and apparent high demand of these units explains why there may be children on a waiting list in spite of an RTC not operating at 100 percent capacity.

Respondents reported that about one-third (32%) of residents in RTCs were originally referred to the RTC by the Department of Juvenile Services (DJS), as compared to 16 percent in the survey of other residential programs.

Nine of the 14 RTCs reported having delays in discharge. They reported that nearly half (46%) of these delays were due to the inability to find a more appropriate, less restrictive placement. For another 12 percent of the youth whose discharge was delayed, lack of funding for a more appropriate, less restrictive placement was reported by RTCs as the reason. About another one-eighth of the delays were reported to be related to parents' disagreement with the recommended placement. Finally, almost one-third (30%) of the discharge delays were reported to be due to other reasons, including agency-related issues such as case workers neglecting to follow through on necessary paperwork. Inadequate community resources was also one of the most commonly reported "other" reasons for delayed discharges.

A record review of RTC residents indicated that 15 percent of the current residents continued to stay in an RTC though their estimated discharge date had passed. Approximately one-third (32%) of the records of discharged residents indicated that their actual discharge date was after their estimated discharge date. These records revealed that deterioration or instability in mental state was a major reason for delayed discharges. It was mentioned in nearly three-quarters (74%) of the relevant cases. However, in more than one third (36%) of the cases for which reasons for the delay were provided, difficulty in finding a less restrictive place for the resident to transition to was also named as the barrier to discharge. For example, concerns about the resident's ability to function within the family environment or the family's willingness to accept them were presented in nearly a quarter of the cases (23%). Waiting for a placement to a less restrictive facility was indicated in 14 percent of the cases.

None of the RTCs accept children below the age of five. Thirteen of the 14 RTCs indicated that they do not accept youth with a diagnosis of profound mental retardation. Twelve reported that they did not admit youth with severe or moderate mental retardation. Six of the 14 reported that they did not admit youth with mild mental retardation. With regards to legal criteria, half of the RTCs (n=7) do not accept adjudicated or non-adjudicated sex offenders, and eight of the RTCs reported that they do not accept fire setters.

RTCs reported that 12 percent of their residents had a history of fire setting and that 12% of the RTC residents were adjudicated sex offenders. RTC providers were asked, "How many residents at your facility on May 15, 2003 were court-ordered youth?" In response to this question, the RTC providers reported that slightly more than two-fifths (41%) of the residents were court-ordered youth. Overall, the RTCs indicated that they are able to provide appropriate treatment for 97 percent of the court-ordered youth. In the 3 percent of cases in which the RTCs reported being unable to provide appropriate treatment, the youth were characterized by sex offending behaviors, severe aggression, lack of parental participation or parental agreement with placement, or low IQ/mental retardation impeding the RTCs' ability to meet the child's educational needs.

Of the cases reviewed for the RTC record abstraction analysis, 51 percent indicated that the youth had a substance abuse issue, but only 35 percent of the youth had their substance abuse disorders indicated in their DSM-IV diagnostic picture. The RTC directors' reported through their surveys that in 11 percent of the cases sexual abuse was indicated. Yet, 38 percent of the records reviewed at the RTCs revealed that the residents were survivors of sexually abusive experiences. Further investigation of these discrepancies might be warranted.

The percentage of RTC residents using aftercare services was three-fifths (60%) for general RTC units, as well as Specialized Treatment. A quarter of the court evaluation unit residents utilized aftercare services. Some of the types of aftercare services reportedly offered were education-related services, transitioning to other programs offered by the organization (e.g., therapeutic group home, day treatment, etc.), and individual and family therapy.

None of the secured RTC units or Adolescent Male Sex Offender RTC units reported providing aftercare or follow-up services to youth after discharge. Key state representatives, RTC providers, and LCC representatives each reported that after-care and step-down services for children leaving RTCs was of primary importance. RTC providers expressly emphasized the need for aftercare programs and group homes for the adjudicated sex offender population.

## **8.2 Highlights of Findings from the Survey of Other Residential Programs (ORPs)**

Based on unweighted data from a mail survey of ORP providers, ORP programs in which children receive mental health/psychiatric services either on or off-site (e.g., hospital-based respites, diagnostic centers, therapeutic group homes, intermediate care, and treatment foster care) only made up 22 percent of the total ORP capacity and served 21 percent of the children/youth currently enrolled in these ORP programs. Moreover, excluding the treatment foster care programs which provide access to outpatient counseling services to the children in individual foster homes, the conventional ORP programs that serve children/youth with

psychiatric conditions (i.e., hospital-based respites, diagnostic centers, and therapeutic group homes) made up only seven percent of the total ORP capacity and served 10 percent of the ORP residents.

A majority of the ORP providers reported that they would not accept an applicant who is an adjudicated sex offender (71%), or younger than age five (67%), or has severe or profound mental retardation (both 65%, or with a history of fire-setting (64%). About half of the service providers would not accept an applicant who has a major illness or serious medical condition (52%), or who has a moderate mental retardation (50%).

The ORP survey respondents reported that a total of 407 of their slots were either vacant or not filled by the target children/youth group. However, most of these “vacancies” were located in treatment foster care homes (27%), small group homes (22%), emergency shelter group homes (12%), alternative living units (9%), and “other” types of programs (e.g., residential schools). Very few vacancies could be found in community based respites (0.2%), diagnostic centers (0%), hospital based/psychiatric respites (3%), and therapeutic group homes (1%).

Over one third (39%) of the ORP providers indicated that they had plans to change the capacity of existing youth-serving residential programs and nearly two fifths (39%) of the ORP providers had plans to start a new residential program. Based on the survey data, it is estimated that the capacity to serve youth among the responding ORP providers might increase by a total of approximately 410 beds. The capacity of existing programs is slated to increase by 203 beds and new programs are expected to add another 207 beds to the overall OPR capacity. However, nearly two-thirds (62%) of the planned capacity increase in the existing programs was reported by one residential school whereas the beds in the planned new programs would be more evenly distributed across programs with and without a therapeutic component. The populations slated to be served by the new programs included drug exposed/drug affected infants to two year olds, adolescent females, and transitionally aged youth (ages 18-21).

Nearly three-quarters (70%) of the youth residents in the ORPs had mental health or psychiatric issues. Specifically, nearly one-quarter (22%) of the ORP residents had two or more psychiatric conditions; nearly one-fifth (18%) had both a substance abuse/dependence disorder and a psychiatric condition, and 10 percent had a co-existing developmental disability and psychiatric condition.

Over one-quarter (29%) of the youth residents had been diagnosed with mental retardation. However, only 13 percent of them lived in programs that either provided or provided access to mental health or psychiatric services (e.g., hospital-based respites, diagnostic centers, intermediate care, therapeutic group homes, and treatment foster care). The vast majority (83%) lived in small group homes, ALUs, and residential schools, which usually do not provide extensive mental health or psychiatric services.

Based on unweighted data collected from the ORP providers, the geographical distribution of ORP residents in the survey was not consistent with the state-wide population

distribution of youth under age 21 with regard to the most populous jurisdictions in the state of Maryland. Baltimore City was over represented among the ORP residents (34%) as compared to its proportion (13%) in the state population of youth under age 21. On the other hand, however, some major suburban counties were under represented. These included Montgomery County (6% in survey vs. 16% in population), Prince George's County (9% in survey vs. 16% in population), Anne Arundel County (4% in survey vs. 9% population), and Howard County (2% in survey vs. 5% in population).

The 57 responding ORP providers reported a total of 148 delayed discharges in the 12 months prior to the survey. Over one-third of the delays were in the small group homes (20%) and the diagnostic centers (17%). Another one-third were in emergency shelter group homes (10%), large group homes (10%), and 90-day structured shelter care homes (10%). The most commonly reported barriers to discharge included finding a more appropriate place for residents to transition to upon leaving the facility. Primarily, being rejected or waiting for a bed was mentioned, followed closely by the inability to return to their parents.

### **8.3 Highlights of Findings from the Focus Groups and Interviews**

Every key state agency representative explained that there is a need for more mental health training for new and existing direct care staff and professionals in the system. A high turnover rate for these workers was attributed to the "very poor pay and benefits for people who work with special needs children." Every key state agency respondent maintained that there were not enough community-based programs, particularly specialized programs that would address the needs of more distinct populations. Children with more complicated diagnoses represented hard-to-place children in community programs. These children's conditions were reported to oftentimes deteriorate due to a lack of community-based services, thus resulting in increased emergency crises that may or may not require more restrictive levels of care.

Some of the key state agency representatives explained that one of the main reasons that a child stays in an RTC longer than necessary is because there is such a scarcity of less restrictive, community-based options available to them. Every respondent explained that the issue of parental custody relinquishment in exchange for services represented one of the most sobering dilemmas in the service delivery system. They also expressed their belief that because the service needs at one level are contingent upon and are related to the needs at another level, the overall failure to meet the needs of some children can create problems throughout the system.

The dually diagnosed population was also identified as most in need of residential services. This finding was reported both in the RTC directors' survey and by key state agency representatives. LCC representatives specifically noted that dually diagnosed children are one of the populations that are hard to place

LCC respondents' responses appeared to reflect a general consensus that the current RTC placement system is "inefficient" and "overburdened" with a large number of children requiring placement. Representatives explained that streamlining the referral and placement system would enhance the quality of services provided to children and could be done through (1) ensuring

speedier fund disbursement, (2) pooling funds so that the burden of providing money for a child's services is shared, and (3) revising policies, procedures, and regulations so that they provide a helpful and guiding framework that does not put lead agencies in a position to have to work around them rather than with them.

In focus groups, parents articulated some of the barriers to attaining appropriate services. These were (1) knowledge of services, (2) a service delivery system that lacked standardization, (3) funding issues, and (4) geographic location of available services.

In these groups parents explained that one could "self-educate" in order to get information, but that the time required engaging in this process is a luxury that most of the parents could not afford. Strained communication between facility staff and parents was reported to be another problem for parents who wanted to stay informed about their child's treatment. Overall, the responses that parents made seemed to reflect a desire to shift away from a reactive system that is more responsive to parents once crisis has set in, toward a preventative system that addresses the needs of children before they develop conditions necessitating RTC placement.

**APPENDIX 2.1-A**

**INTERVIEW SCHEDULE FOR KEY STATE AGENCY CONTACTS**

**APPENDIX 2.1-A**

**INTERVIEW SCHEDULE FOR KEY STATE AGENCY CONTACTS**

<b>State Agency</b>	<b>State Agency Personnel</b>	<b>Date of Interview</b>
DHR	Carol Chase, Special Assistant Craig Adams, Director Grace Turner, Licensing Manager Catherine M. Shultz, Principal Counsel	April 15, 2003 10:00 AM
DJS	Walter Wirsching, Assistant Secretary of Admissions	April 24, 2003 1:30 PM
DJS	Denise Sulzbach, Deputy Secretary	April 17, 2003 10:00 AM
DDA	Nancy Kirchner, Assistant Director of Program Services	April 14, 2003 1:00 PM
SCC	Ann Marie Lane The State Coordinating Council Governor's Office for Children, Youth and Families	May 6, 2003 2:00 PM
DHMH	Al Zachik, M.D., Director Child & Adolescent Services	August 21, 2003 1:00
MSDE	Rosemary King Johnston	June 24, 2003 1:30PM

**APPENDIX 2.1-B**

**STRUCTURED INTERVIEW GUIDE OF KEY STATE AGENCY PERSONNEL**

## **APPENDIX 2.1-B**

### **STRUCTURED INTERVIEW GUIDE OF KEY STATE AGENCY PERSONNEL**

How many beds does your agency license?

What is your timeline for placing children in a facility once you receive a referral?

What are the goals and objectives from your agency's perspective of House Bill 1386? What is the major impact intended by this new legislation?

What changes has your agency made in response to the Systems Reform Initiative?

What community-based services are needed from your agency's perspective?

Where, if any, do you feel that deficiencies exist regarding human resources to meet the needs of children with disabilities?

Where do you feel that deficiencies exist regarding financial resources to meet the needs of children with disabilities?

How might the financial resources that now exist be better allocated?

Where do you feel gaps exist in available services to meet the needs of children with special needs?

What services are needed for the 18-21 year old age group?

What impact has the Lisa L case had on the children served by your agency?

What percentage of beds licensed by your agency is funded through private insurance?

Are there any regulations or guidelines regarding appropriate space per resident?

#### **Department of Juvenile Justice**

Please discuss these issues regarding adjudicated vs. non-adjudicated sex offenders? What are the issues regarding the need to find appropriate treatment for this population? How do you propose finding treatment slots for non-adjudicated offenders?

#### **Department of Education**

Please describe the level system within the Department of Education.

Please discuss the autism waiver. Are there children on waiting lists?

How does the Maryland State Department of Education handle the educational needs of children placed in RTCs?

Please describe the Extended School Year Program?

Please discuss criteria for placing objectives for critical life skills on IEPs (medical vs. educational model)

Please discuss how special needs children are transitioned from the school system once they graduate.

How is the appropriateness of inclusion decided for a child with special needs? IEP on a case by case basis, based on the IEP, other assessments?

**Department of Health and Mental Hygiene**

What types of step down facilities are funded by your agency? What types of facilities are needed?

**APPENDIX 2.1-C**

**LCC MEMBERS WHO PARTICIPATED IN FOCUS GROUPS OR INTERVIEWED  
OVER THE PHONE**

## Appendix 2.1-C

### LCC MEMBERS WHO PARTICIPATED IN FOCUS GROUPS OR TELEPHONE INTERVIEWS\*

<u>County</u>	Type of discussion
Baltimore City	Focus group
Baltimore County	Focus group
Cecil County	Focus group
Frederick County	Focus group
Kent County	Focus group
Montgomery County	Focus group
P.G. County	Focus group
St. Mary's County	Focus group
Washington County	Focus group
Washington County	Focus group
Wicomico County	Focus group
Allegany County	Phone interview
Anne Arundel	Phone interview
Baltimore City	Phone interview
Baltimore County	Phone interview
Calvert County	Phone interview
Carroll County	Phone interview
Cecil County	Phone interview
Charles County	Phone interview
Dorchester County	Phone interview
Frederick County	Phone interview
Garrett County	Phone interview
Harford County	Phone interview
Howard County	Phone interview
Montgomery County	Phone interview
Prince George's County	Phone interview
Queen Anne's County	Phone interview
Somerset County	Phone interview
St. Mary's County	Phone interview
Talbot County	Phone interview
Washington County	Phone interview
Wicomico County	Phone interview

\* Representatives from Caroline and Worcester Counties did not participate in either the focus groups or the telephone interviews.

**APPENDIX 2.1-D**

**LCC FOCUS GROUP DISCUSSION GUIDE**

## **APPENDIX 2.1-D**

### **LCC FOCUS GROUP DISCUSSION GUIDE**

Please introduce yourself and state the county or agency that you represent.

How many referrals do you receive each month?

From what sources/agencies do you receive referrals? Do you receive more referrals from one source/agency over another?

What types of diagnostic categories represent difficult to place children? Why?

What types of community-based services exist?

For the cases with state/public funding, are the current RTCs meeting the needs of children in your area?

What types of community-based services are MOST needed?

How can community-based services be enhanced?

What are some alternative placement arrangements that you might consider? What barriers might you anticipate in exploring such alternatives?

What are typical reasons why community-based options are deemed inadequate?

What facilitates a smooth referral to an in-state facility?

What are some of the reasons why children are placed on a wait list for in-state facilities?

What are some of the reasons why children are referred for an out-of-state placement?

What are some reasons why parents of children with special needs might prefer more restrictive environments?

What constitutes an emergency case? How differently are emergency cases handled?

How often have deficiencies been found in out-of-state agencies? How does the need to possibly expedite interim placement because of such deficiencies impact the availability of residential resources?

What are the benefits and drawbacks of the current system of placing children with special needs in residential placements?

What would you modify if you had a larger budget and complete discretion?

What type of program would you like to expand first if you had a larger budget?

**APPENDIX 2.1-E**

**STRUCTURED INTERVIEW OF RTC CASE MANAGERS**



Does your program offer families assistance to facilitate/promote higher levels of involvement?

Yes No, If yes, please describe

Are there any publications, such as a newsletter, that are distributed to families?

### **ADMISSIONS**

(Refer to Flow Chart) Does this represent your admissions process? Please elaborate, if necessary.

How do you manage your waiting list?

### **DISCHARGE AND AFTERCARE**

What type of discharge plans is made for residents? Please explain.

What types of transitional services are provided when a resident is ready for discharge?

Do you provide after care services to the residents and their families? If so, what types are most frequently provided?

What is the average length of time that aftercare or follow up is provided?

Do you track the progress of residents who are discharged from your facility? If yes, to what extent do the transitional or aftercare services prevent re-admittance to your program or another residential facility?

Do you have a sense about the number of your residents who have been previously enrolled in either this or some other RTC?

At any given time, what percent of your residents are typically ones who could be better served by a level of care that would enable a less restrictive setting?

What is most needed to reduce the length of stay experienced by your residents?

What are the major causes of delay of discharge from your facility?

To what community programs do you typically discharge residents?

What types of community-based services are most needed (but currently unavailable) to serve the residents you treat here?

### **PERSONNEL**

What is the typical caseload that is carried by case managers/social workers at this facility?

Are direct service (clinical staff) shared between programs?

Do you offer training programs? If so, in what fields or specialty areas?

Where do you experience shortages among your clinical staff (that is, in what positions), if any?

How do staff shortages impact your program?

If you could recruit additional staff, what positions would be most needed in this program?

APPENDIX 2.1-F

QUESTIONNAIRE FOR THE SURVEY OF RESIDENTIAL FACILITY DIRECTORS-  
OTHER RESIDENTIAL PROGRAMS (ORPS)

# GOVERNOR'S OFFICE FOR CHILDREN, YOUTH AND FAMILIES

## Survey of Residential Facility Directors – Residential Programs

This study is being conducted to determine the availability and utilization of the full range of residential resources that would provide a comprehensive continuum of services for special needs children in the state of Maryland. Under Maryland law, the Subcabinet for Children, Youth and Families must provide ongoing examination of the structure and organization of Maryland's system of services to children, youth and families, and facilitate a comprehensive effective, efficient, and integrated service delivery system for such services (*Md. Ann. Code. Art 49D § 4:1(h)*). To monitor and evaluate the range of resources and services to children and their families, the Subcabinet collects and analyzes data regarding individual service recipients and reports, in aggregated form, the results of those analyses to government officials and the public. All of the information you provide will be kept confidential.

Please return the completed survey to REDA in the enclosed business-reply envelope by September 30, 2003. We appreciate your time and effort in completing this questionnaire and ***strongly suggest reading over the entire survey before beginning to answer the questions.*** Should you have any questions, contact Drs. Campbell or Wang at 1-800-646-REDA. Thank you.

1. What is the name of your corporation? \_\_\_\_\_
2. How many sites do you operate in the **state of Maryland**? \_\_\_\_\_
3. How many programs do you operate in the **state of Maryland**? \_\_\_\_\_

***For the remainder of the survey, please respond ONLY for the sites and programs operated in the state of Maryland.***



**If none of those programs in Maryland serve youth (ages 21 and younger), please stop here and return the survey. Thank you.**

**DEMOGRAPHIC CHARACTERISTICS OF RESIDENTS**

*The following questions ask about background characteristics of residents.*

5. Indicate how many of your current residents were in the following age categories?

<b>Age</b>	<b>Do you have the capacity to serve youth in this age category? Indicate Yes or No.</b>	<b>If yes, how many residents, on May 15, 2003, were in this age category?</b>
Under 3 years		
4-12		
13-17		
18-21		
<b><i>Total youth residents in Maryland</i></b>		

**FOR THE REMAINDER OF THE SURVEY, PLEASE ANSWER ONLY FOR THOSE RESIDENTS AGES 21 AND YOUNGER, REFERRED TO AS “YOUTH.”**

6. On May 15, 2003, how many of your youth residents (ages 21 and younger), had the following demographic characteristics?

<b><i>Characteristic</i></b>	<b><i>NUMBER</i></b>
<b><i>Gender</i></b>	
Male	
Female	
<b><i>Total youth residents in Maryland</i></b>	
<b><i>Race/Ethnicity</i></b>	
White, non-Hispanic	
African American	
Hispanic	
Asian or Pacific Islander	
American Indian/Alaskan Native	
Other (specify)	
<b><i>Total youth residents in Maryland</i></b>	

7. How many youth residents (ages 21 and younger) in your programs on May 15, 2003 came from the following jurisdictions?

<b>Jurisdiction</b>	<b>Number</b>
Allegany County	
Anne Arundel County	
Baltimore County	
Baltimore City	
Calvert County	
Caroline County	
Carroll County	
Cecil County	
Charles County	
Dorchester County	
Frederick County	
Garrett County	
Harford County	
Howard County	
Kent County	
Montgomery County	
Prince George's County	
Queen Anne's County	
Somerset County	
St. Mary's County	
Talbot County	
Washington County	
Wicomico County	
Worcester County	
Out-Of-State	
<b><i>Total youth residents in Maryland</i></b>	

## DIAGNOSES AND LEGAL HISTORY OF RESIDENTS

*The following questions ask about the diagnostic characteristics and legal history of residents.*

8. For each of the programs serving youth (ages 21 and younger) in Maryland, please indicate the number whose documented diagnoses fell into each of the following categories on May 15, 2003. Please use the diagnoses from the **most current evaluation**. **\*\*Note: Some residents will have more than one non-primary diagnosis.**

<i>Category</i>	<i>Number</i>
Anxiety, phobia, posttraumatic stress disorders	
Behavior/conduct disorders	
Impulse control disorders (including fire setting)	
Mood disorders	
Other disorders usually diagnosed in early infancy, childhood, or adolescence	
Personality disorders	
Pervasive developmental disorders	
Schizophrenia or other psychotic disorders	
Severe developmental disabilities	
Sexual and gender identity disorders	
Substance abuse/dependence disorder	
Victim of abuse or neglect	
Other (specify)	
Other (specify)	
Other (specify)	

9. For how many current youth residents (ages 21 and younger) are the following statements true?

<i>Issue</i>	<i>Number of youth residents in Maryland</i>
Had a psychiatric condition only	
Had substance abuse/dependence only	
Had a developmental disability only	
Had both substance abuse/dependence and a psychiatric condition	
Had both a developmental disability and a psychiatric condition	
Had two or more psychiatric conditions	
Was a victim of abuse or neglect	



13. Please complete the following grid regarding history of fire setting by youth (ages 21 and younger).

<i>History</i>	Do you consider accepting youth with the following history? <b>Indicate yes or no.</b>	If yes, how many are currently in your programs in Maryland?
Fire setting (not recent or frequent & not dangerous)		
Fire setting (not recent or frequent but dangerous)		
Fire setting (recent but not dangerous)		
Fire setting (recent and dangerous)		
Fire setting (isolated episode, not dangerous)		
Fire setting (isolated episode and dangerous)		

14. How many youth residents (ages 21 and younger) in your programs are court-ordered youth?

\_\_\_\_\_

14a. For how many of those youth are your programs unable to provide appropriate treatment? \_\_\_\_\_

14b. Please describe the characteristics of the youth's needs for whom your programs are **unable** to provide appropriate treatment. (Why were you unable to provide appropriate treatment?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

15. Do you make special provisions for Lisa L cases? (Circle your response.)

Yes                  No

15a. If yes, what are they? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ADMISSIONS PROCEDURES AND CAPACITY

The following questions ask for information regarding procedures in your programs.

---

**16.** According to your admissions policy, what types of youth applicants (ages 21 and younger) would **NOT** be considered by any of your programs for admission? (Check all that apply.)

Applicants who:

- a.  Are older than age 18
- b.  Are younger than age 13
- c.  Are younger than age 5
- d.  Are female
- e.  Are male
- f.  Attend school in a local school system
- g.  Grade level too low
- h.  Do not have insurance or some other third-party payer
- i.  Parents unable/unwilling to participate
- j.  Have both substance abuse/dependence and a psychiatric condition
- k.  Have a developmental disability
- l.  Have a developmental disability and one or more psychiatric conditions
- m.  Have a major illness or serious medical condition
- n.  Have a serious physical disability
- o.  Have a diagnosis of mild (50/55-70) mental retardation
- p.  Have a diagnosis of moderate (30/40-50/55) mental retardation
- q.  Have a diagnosis of severe (20/25-35-40) mental retardation
- r.  Have a diagnosis of profound (<20/25) mental retardation
- s.  Are adjudicated non-sex offenders
- t.  Are adjudicated sex offenders
- u.  Are non-adjudicated sex offenders
- v.  Are fire setters
- w.  Have a history of aggression towards staff or others
- x.  Are self-abusive or injurious
- y.  Is considered an AWOL risk
- z.  Medication non-compliant
- aa.  Other

(Specify.) \_\_\_\_\_

---

17. Have you ever accepted youth with characteristics outside of your Provider Profile? (Circle your response.)

Yes                      No

17a. If yes, please describe the characteristics of those youth. \_\_\_\_\_

18. Do you have plans to change the capacity of existing youth-serving residential programs in Maryland during 2004? (circle your response.)

Yes                      No

18a. If you plan to change capacity, by how many beds? (+/-) \_\_\_\_\_

19. Do you have plans to start a new residential program in Maryland for youth or open a new site to serve youth residents (ages 21 and younger) in 2004? (circle your response)

Yes                      No

19a. If yes, how many beds would this program have? \_\_\_\_\_

19b. What population would this new program serve? \_\_\_\_\_

20. What obstacles are faced when starting a new residential program or opening a new site?

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21. How many beds in programs in Maryland are **contracted** by the following agencies?

<i>Agencies</i>	Number of beds contracted
Dept. of Human Resources/Local Dept. of Social Services	
Dept. of Juvenile Services	
Developmental Disability Administration	
Local Education Agency (LEA)/MSDE	
Dept. of Health and Mental Hygiene	
OCHQ	
Other (Specify)	
Other (Specify)	

22. Currently, how many of your youth residents (ages 21 and younger) are typically ones who could be better served by a level of care that would enable a **more** restrictive setting? \_\_\_\_\_
23. Currently, how many of your youth residents (ages 21 and younger) are typically ones who could be better served by a level of care that would enable a **less** restrictive setting? \_\_\_\_\_
24. Do you have a formal waiting list for your programs? (Circle your response.)

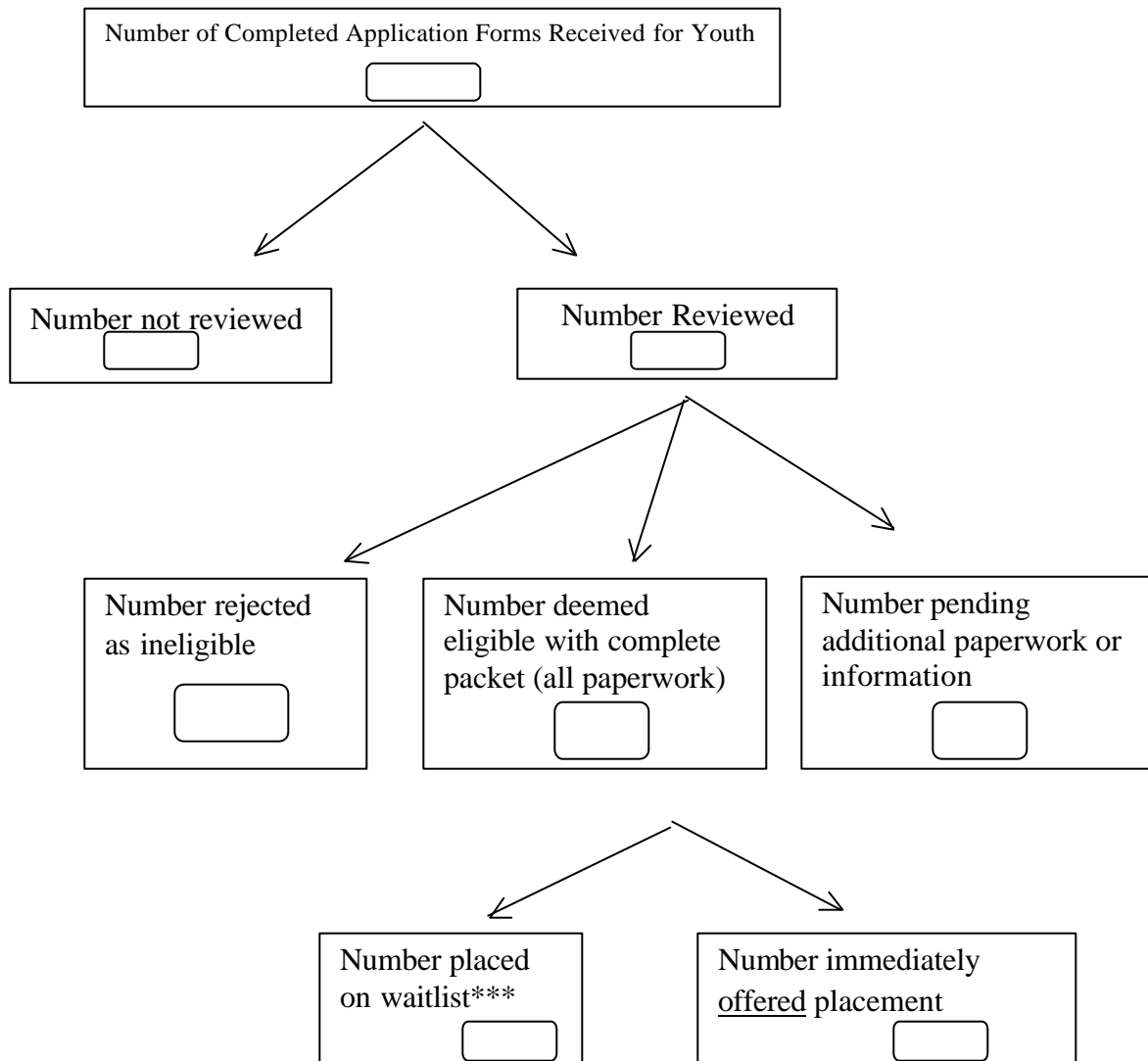
Yes

No

**If no, go to 26.**

**24a.** If yes, what format? (e.g., written; electronic) \_\_\_\_\_

**25. Below is a general description of the admissions process. Please fill in the appropriate numbers for each box based on data from the past 12 months for your programs.**



\*\*\* For all questions regarding waitlist, please refer to this number.

**26.** When a child/adolescent (ages 21 and younger) is referred to your program(s), how often is a bed immediately available? (Circle your response.)

- a. All of the time (go to Q28)
- b. Most of the time
- c. Some of the time
- d. None of the time

**26a.** If not all of the time, is this typically because you do not have any beds available or is it related to the diagnostic characteristics of the youth being referred? (Circle your response.)

- a. No bed available
- b. Diagnostic characteristics

**26b.** If diagnostic characteristics of the youth most often determine whether a bed is available or not, please describe the characteristics of those youth.

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**27.** What is the typical length of time a child/adolescent (ages 21 and younger) waits for a bed?

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**LENGTH OF STAY, CONTINUUM OF CARE, AND PROGRAM COMPONENTS**

*The following questions ask for information related to provision of services.*

**28.** What is the typical length of stay for youth (ages 21 and younger)? (Length of stay is defined as beginning the first day a child is in residence.) \_\_\_\_\_

<b>TYPE OF PROGRAM</b>	<b>TYPICAL LENGTH OF STAY FOR YOUTH</b>
Alternative Living Unit	
Community-Based Respite	
Diagnostic Center	
Emergency Shelter Group Home	
Large Group Home (capacity ≥ 16 residents)	
Small Group Home (capacity ≤ 15 residents)	
Intermediate Care Facility – MR	
Residential Crisis Center	
Hospital-Based Respite	
Psychiatric Respite	
Structured Shelter Care – 60-day	
Structured Shelter Care – 90-day	
Therapeutic Group Home	
Treatment Foster Care	
Other (if applicable)	
Other (if applicable)	



32. For each of the following types of programs serving youth (ages 21 and younger) in Maryland, indicate whether you have an MSDE certified educational program on-site?

<i>Type of program</i>	<b>Indicate yes or no</b>
Alternative Living Unit	
Community-Based Respite	
Diagnostic Center	
Emergency Shelter Group Home	
Large Group Home (capacity $\geq 16$ residents)	
Small Group Home (capacity $\leq 15$ residents)	
Intermediate Care Facility – MR	
Residential Crisis Center	
Hospital-Based Respite	
Psychiatric Respite	
Structured Shelter Care – 60-day	
Structured Shelter Care – 90-day	
Therapeutic Group Home	
Treatment Foster Care	
Other (if applicable)	
Other (if applicable)	

33. Complete the following grid regarding educational service provision.

<i>TYPE OF PROGRAM</i>	Number of youth who attended school off grounds (in the community)	Number of youth who attended school on grounds (in your programs)	Number of youth who received one-on-one academic tutoring	Other (Specify)
Alternative Living Unit				
Community-Based Respite				
Diagnostic Center				
Emergency Shelter Group Home				
Large Group Home (capacity $\geq 16$ residents)				
Small Group Home (capacity $\leq 15$ residents)				
Intermediate Care Facility – MR				
Residential Crisis Center				
Hospital-Based Respite				
Psychiatric Respite				
Structured Shelter Care – 60-day				
Structured Shelter Care – 90-day				
Therapeutic Group Home				
Treatment Foster Care				
Other (if applicable)				
Other (if applicable)				



36. What is the average daily cost per child of providing services for youth (ages 21 and younger) in your residential programs (excluding the educational component)?

<i>Type of program</i>	<b>Average daily cost</b>
Alternative Living Unit	
Community-Based Respite	
Diagnostic Center	
Emergency Shelter Group Home	
Large Group Home (capacity ≥ 16 residents)	
Small Group Home (capacity ≤ 15 residents)	
Intermediate Care Facility – MR	
Residential Crisis Center	
Hospital-Based Respite	
Psychiatric Respite	
Structured Shelter Care – 60-day	
Structured Shelter Care – 90-day	
Therapeutic Group Home	
Treatment Foster Care	
Other (if applicable)	
Other (if applicable)	

37. Complete the following grid for all staff currently working at your facility, including contractual employees. Please add additional major categories as appropriate.

<b>Staff Position</b>	<b>Total FTE**</b>	<b># of Vacancies</b>
Administrator/Director/Medical Director		
Case Manager/Residential Counselors		
Child Care Workers		
Social Worker – Licensed (LCSW-C)		
Social Worker – Licensed (LGSW, LCSW or BSW)		
Psychologist		
Psychiatrist		
Physical Therapist		
Foster Parent Recruiter/Trainer – <i>Treatment Foster Care Programs</i>		
Fiscal Officer		
Nurse		
Secretary		
Behavioral Specialist		
Cook		
Dietician		
Maintenance Staff		
Public Relations		
Administrative Assistant		
Parent Liaison		
Recreational Director		
Education Director		
Special Education Teacher		
Qualified Developmental Disabilities Professional		
Speech Pathology and Audiology		
Occupational Therapists		
Other (Specify)		
Other (Specify)		
Other (Specify)		

\*\* Full-time equivalent is based on the number of hours performed in each activity. For example, an employee working 40 hrs/week is counted as 1 FTE, whereas an employee working 20 hours/week is counted as .5 FTE



**APPENDIX 2.1-G**

**PARENT FOCUS GROUP SOLICITATION MATERIALS**

Date

Name  
Parent Organization Name  
Street Address  
City, State, Zip

Dear M/M :

REDA International, a social science research firm, has been engaged by the Governor's Office for Children, Youth and Families to evaluate the residential resources for children with special needs in the state of Maryland. As part of our evaluation, REDA would like to hear from the parents of children with special needs. You and the parents in your organization are invited to participate in a focus group meeting to discuss your experiences regarding the availability of resources to meet the needs of your children. The location and time of the focus group is as follows:

**Monday, June 2, 2003**

7pm until 8:30pm

Charles County Government Building  
200 Baltimore Street  
LaPlata, MD 20695

Your members' participation is extremely important to our evaluation. Dinner will be provided at the meeting and a \$25.00 honorarium will be distributed immediately following the focus group. Enclosed please find solicitation forms and fact sheets about the project for distribution to the members of your organization. REDA will randomly select no more than ten respondents who represent the categories of special needs children served by the state.

If you have any questions, please call Dr. Kimberly Campbell at 1-800-646-REDA (7332). Thank you, in advance, for your response and interest. I look forward to hearing from you soon.

Sincerely,

Kimberly Campbell, Ph.D.  
Project Manager

# FACT SHEET

## EVALUATION OF RESIDENTIAL RESOURCES FOR CHILDREN IN MARYLAND

### *Why is the evaluation being conducted?*

The Governor's Office for Children, Youth and Families (OCYF) is a coordinating office developed as an effort to promote statewide interagency collaboration regarding issues pertaining to children and their families. OCYF has insufficient data at its disposal to adequately assess the availability and utilization of the full range of residential resources for special needs children in the State. The major goal of the study is to assess the needs for residential services among children with special needs and to assess the gap between the needs for services and the services that are available. This information is needed in order to inform policy decisions and planning activities.

### *Who is conducting the evaluation?*

OCYF has engaged REDA International, Inc. (REDA), a 100% woman owned professional services firm, to conduct this evaluation. REDA provides social science applied research, program evaluation, and statistical analysis and development services. Such services have been provided for Federal, state, and local governments, international development agencies, and a variety of commercial businesses. REDA staff has conducted similar evaluations for other clients such as the Maryland Child Support Enforcement Administration, the United States Agency for International Development (AID), Maryland State Department of Human Resources and the Department of Health and Human Services (DHHS) Administration for Children and Families.

### *What will the evaluation involve?*

REDA's approach to conducting this evaluation is to obtain information from four sources that have a direct relationship to serving children with special needs: State agencies, local placement agencies, service providers, and children with special needs. Several strategies will be employed to collect data. REDA will review pertinent laws, regulations, and policies, and conduct individual and focus group meetings with key personnel and representatives from the Local Coordinating Councils. Mail surveys of program/facility directors will be conducted. No children will be interviewed; rather information about their needs will be abstracted from records. The study methodology also employs focus groups of stakeholders and parents of children with special needs.

### *How will the evaluation impact staff?*

REDA will make every effort to be sensitive to and respectful of staff's time and work obligations. Site visits, personal interviews, and telephone interviews will be arranged with consideration made to the demands on staff time.

### *How long will the evaluation last?*

OCYF would like to present a report to the Subcabinet in December of 2003. REDA is planning to complete all data collection in the early summer months.

### *Who should I contact if I have any questions or concerns about this evaluation?*

Dr. Kimberly Campbell or Dr. Joan Wang, REDA International, Inc. 11141 Georgia Avenue, Suite 517, Wheaton, MD 20902, 1-800-646-7332.

THE GOVERNOR'S OFFICE FOR CHILDREN, YOUTH, AND FAMILIES  
(OCYF)

EVALUATION OF RESIDENTIAL RESOURCES FOR CHILDREN IN  
MARYLAND  
PARENT FOCUS GROUP

**WHO CAN ATTEND:** ADULTS 21 YEARS OLD OR OLDER WHO HAVE CHILDREN WITH SPECIAL NEEDS

**WHERE:** Charles County Government Building  
200 Baltimore Street  
LaPlata, MD 20695

**WHEN:** Monday, June 2, 2003

**TIME:** 7:00 PM UNTIL 8:30 PM

**SALARY:** EACH PARTICIPANT WILL BE PAID \$25.00 FOR THEIR PARTICIPATION AT THE END OF THE MEETING. EXPENSES WILL BE REIMBURSED WITHIN SEVEN (7) BUSINESS DAYS.

**\*\*DINNER WILL BE PROVIDED\*\***

BILINGUAL INDIVIDUALS ARE ENCOURAGED TO ATTEND, HOWEVER THE GROUP DISCUSSION WILL BE FACILITATED IN ENGLISH.

IF YOU ARE INTERESTED IN PARTICIPATING IN THIS FOCUS GROUP, PLEASE COMPLETE THE FORM BELOW AND FAX TO THE ATTENTION OF AMY STERNER AT REDA: 301-946-1911 OR CALL MS. STERNER AT 1-800-646-7332. **WE MUST HEAR FROM YOU BY MAY 20, 2003.**

---

**PLEASE PRINT CLEARLY**

**NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_  
Street City Zip Code County

**PHONE NUMBER** ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(DAY) (EVENING)

**CHILD'S AGE** \_\_\_\_\_ **CHILD'S GENDER:** ( ) Male ( ) Female

**PLEASE DESCRIBE YOUR CHILD'S DISABILITY** \_\_\_\_\_

THE GOVERNOR'S OFFICE FOR CHILDREN, YOUTH, AND FAMILIES  
(OCYF)

EVALUATION OF RESIDENTIAL RESOURCES FOR CHILDREN WITH  
SPECIAL NEEDS IN MARYLAND  
PARENT FOCUS GROUP

**WHO CAN ATTEND:** ADULTS 21 YEARS OLD OR OLDER WHO HAVE CHILDREN  
AWAITING ENTRY, CURRENTLY IN, OR RECENTLY DISCHARGED FROM A RESIDENTIAL  
TREATMENT CENTER (RTC) IN THE FOLLOWING COUNTIES:

*Allegany, Garrett, Frederick  
Carroll, Washington*

Western MD Focus Group

**WHERE:** George's Creek Regional Library  
Meeting Room  
76 Main Street  
Lonaconing, MD 21539

**WHEN:** Saturday, December 6, 2003

**TIME:** 12:00 PM UNTIL 2:00 PM

*Prince George's & Montgomery*

Southern MD Focus Group

**WHERE:** New Carrollton Public Library  
Large Meeting Room  
7414 Riverdale Road  
New Carrollton, MD 20784  
(Bus Route: F4)

**WHEN:** Monday, December 8, 2003

**TIME:** 7:00 PM UNTIL 8:30PM

**SALARY:** EACH FAMILY WILL BE PAID \$25.00 FOR THEIR PARTICIPATION AT THE END  
OF THE MEETING.

**\*\*A MEAL WILL BE PROVIDED\*\***

BILINGUAL INDIVIDUALS ARE ENCOURAGED TO ATTEND, HOWEVER THE GROUP  
DISCUSSION WILL BE FACILITATED IN ENGLISH.

IF YOU ARE INTERESTED IN PARTICIPATING IN THIS FOCUS GROUP, PLEASE COMPLETE THE  
FORM BELOW AND FAX TO THE ATTENTION OF AMY DJANGALI AT REDA: 301-946-1911 OR  
CALL MS. DJANGALI AT 1-800-646-7332. WE MUST HEAR FROM YOU BY December 1, 2003

PLEASE PRINT CLEARLY

**FOCUS GROUP OF INTEREST:** WESTERN SOUTHERN

NAME \_\_\_\_\_ COUNTY \_\_\_\_\_

PHONE NUMBER ( ) \_\_\_\_\_ (DAY) ( ) \_\_\_\_\_ (EVENING)

CHILD'S AGE \_\_\_\_\_ CHILD'S GENDER: ( ) Male ( ) Female

PLEASE CHOOSE ONE:

\_\_\_\_\_RTC RESIDENT \_\_\_\_\_ RECENTLY DISCHARGED FROM A RTC \_\_\_\_\_ AWAITING ENTRY INTO A  
RTC

**APPENDIX 2.1-H**

**PARENT FOCUS GROUP CONSENT FORM**

# REDA International, Inc.

11141 Georgia Ave ♦ Suite 517 ♦ Wheaton, MD 20902-4680 ♦ (301) 946-9790 ♦ (800) 646-REDA ♦ Fax (301) 946-1911

## EVALUATION OF RESIDENTIAL RESOURCES FOR CHILDREN WITH SPECIAL NEEDS

### PARENT FOCUS GROUP CONSENT FORM

You have been invited to participate in a focus group meeting to discuss your experience as the parent of a child with special needs. The information collected during the focus group will be used in the evaluation of residential resources for children with special needs in the state of Maryland. The focus group is being conducted by researchers from REDA International, Inc. a research company. REDA is under contract with the Governor's Office for Children, Youth, and Families (OCYF) in Maryland.

The focus group will last no more than two hours. Handwritten notes will be taken during the focus groups. The session will also be taped to ensure accuracy. You will be identified in the written report by your county of residence and by the nature of your child's disability. No information that identifies you (such as your name, address, or social security number) will appear in the transcript or any published reports. The notes from the focus groups will remain at REDA International, Inc. until they are destroyed 12 months after the completion of the evaluation report.

Topics to be discussed will include, but will not be limited to, experiences with timeliness of placements and appropriate discharges, clinical appropriateness of placement recommendations and admissions, length of stay/service, types of service received, and obstacles to obtaining service.

**Your participation is completely VOLUNTARY.** If you do not want to give your consent, we will not include you in the meeting. You may leave any time either before the group starts or while it is in session. Each family will receive \$25 for their participation at the end of the meeting.

***If you have other questions about the research project, notify or call:*** Dr. Kimberly Y. Campbell or Dr. Joan Wang, REDA International, Inc., 11141 Georgia Avenue, Suite 517, Wheaton, MD 20902-4680, 1-800-646-7332. ***If you have other questions regarding your rights as a group participant notify or call:*** Gay Hutchen, IRB Administrator, DHMH Institutional Review Board, 201 W. Preston Street, Baltimore MD 21201 (410) 767-8448

I consent to participate in the Evaluation of Residential Resources for Children with Special Needs Focus Group conducted by REDA International, Inc. I also agree to keep the confidences of my fellow focus group members and not discuss comments made outside of the group. I have received a copy of this consent form.

SIGNED (participant)

DATE

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APPENDIX 5.0-A

QUESTIONNAIRE FOR THE SURVEY OF RTC DIRECTORS

# GOVERNOR’S OFFICE FOR CHILDREN, YOUTH AND FAMILIES

## Survey of Residential Facility Directors –RICA - Southern

This study is being conducted to determine the availability and utilization of the full range of residential resources that would provide a comprehensive continuum of services for special needs children in the state of Maryland. Under Maryland law, the Subcabinet for Children, Youth and Families must provide ongoing examination of the structure and organization of Maryland’s system of services to children, youth and families, and facilitate a comprehensive effective, efficient, and integrated service delivery system for such services (*Md. Ann. Code. Art 49D § 4:1(h)*). To monitor and evaluate the range of resources and services to children and their families, the Subcabinet collects and analyzes data regarding individual service recipients and reports, in aggregated form, the results of those analyses to government officials and the public. All of the information you provide will be kept confidential.

Please return the completed survey to REDA in the enclosed business-reply envelope by September 2, 2003. We appreciate your time and effort in completing this questionnaire and ***strongly suggest reading over the entire survey before beginning to answer the questions.*** Should you have any questions, contact Drs. Campbell or Wang at 1-800-646-REDA. Thank you.

2. Complete the following grid regarding data management systems.

	<b>1a.</b> Do you use an automated system to track and/or manage data? <b>Indicate Yes or No</b>	<b>1b.</b> Does the system allow you to manipulate or aggregate data for reporting? <b>Indicate Yes or No</b>
Admissions		
Discharge		
Diagnosis		
Treatment plan		
Billing		
Other (specify)		
Other (specify)		

3. We are interested in the types of **residential** programs at your facility. Which of the following are in place at RICA- Southern? (Check all that apply.) Please add any other programs to the list **if applicable**. Other programs refer to separate programs or units at your RTC, such as a court evaluation unit, secured units, programs for very young children, sex offender program, etc, that are NOT included in any of the programs listed below. ***\*\*Note: a resident should not be enrolled in more than one of the programs listed below.***

- a.  General RTC program
- b.  Court Evaluation Unit
- c.  Other (Name of *residential* program) \_\_\_\_\_

4. For each individual residential program that RICA - Southern operates, as indicated in question 2, how many residents were enrolled on May 15, 2003?

<b>Program</b>	<b>Number of Residents</b>
General RTC program	
Court Evaluation Unit	
Other program as indicated in question 2 (if applicable)	
<i><b>Total residents at RICA - Southern</b></i>	

**DEMOGRAPHIC CHARACTERISTICS OF RESIDENTS**

*The following questions ask about background characteristics of residents.*

5. For each individual program that RICA - Southern operates, as indicated in question 2, indicate how many of your residents, on May 15, 2003, were in the following age categories?

<i>Age</i>	<i>Number of residents</i>			
	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other Program (if applicable)</b>	<i>Total by age</i>
Under 3 years				
4-12				
13-17				
18-21				
22 and older				
<i><b>Total by program</b></i>				

6. On May 15, 2003, how many of your residents, had the following demographic characteristics?

<i>Characteristic</i>	<b>NUMBER OF RESIDENTS</b>			
	<b>General RTC program</b>	<b>Court Evaluation Unit</b>	<b>Other program (if applicable)</b>	<i>Total</i>
<i>Gender</i>				
Male				
Female				
<i><b>Total</b></i>				
<i>Race/Ethnicity</i>				
White, non-Hispanic				
African American				
Hispanic				
Asian or Pacific Islander				
American Indian/Alaskan Native				
Other (specify)				
<i><b>Total</b></i>				

7. How many residents at your facility on May 15, 2003 came from the following jurisdictions?

<b>Jurisdiction</b>	<b>Number</b>
Allegany County	
Anne Arundel County	
Baltimore County	
Baltimore City	
Calvert County	
Caroline County	
Carroll County	
Cecil County	
Charles County	
Dorchester County	
Frederick County	
Garrett County	
Harford County	
<b>Howard County</b>	
Kent County	
Montgomery County	
Prince George's County	
Queen Anne's County	
Somerset County	
St. Mary's County	
Talbot County	
Washington County	
Wicomico County	
Worcester County	
<b>Out-Of-State</b>	
<b><i>Total residents at RICA - Southern</i></b>	

## DIAGNOSES AND LEGAL HISTORY OF RESIDENTS

*The following questions ask about the diagnostic characteristics and legal history of residents.*

8. For each of the residents at your facility on May 15, 2003, please indicate the number of your residents whose documented **primary, or first-listed**, diagnosis falls into each of the following categories. Please use the diagnosis determined from the **most current evaluation**. *\*\*Note: each resident should have only one primary diagnosis.*

<i>Category</i>	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other Program</b>
Anxiety, phobia, posttraumatic stress disorders			
Behavior/conduct disorders			
Impulse control disorders (including fire setting)			
Mood disorders			
Other disorders usually diagnosed in early infancy, childhood, or adolescence			
Personality disorders			
Pervasive developmental disorders			
Schizophrenia or other psychotic disorders			
Severe developmental disabilities			
Sexual and gender identity disorders			
Substance abuse/dependence disorder			
Victim of abuse or neglect			
Other (Specify)			
Other (Specify)			
Other (Specify)			
<b>Total Residents</b>			

9. For each of the residents at your facility on May 15, 2003, indicate the number of residents whose documented **non-primary, or non-first-listed** diagnoses fall into each of the following categories. Please use the diagnoses from the **most current evaluation**. *\*\*Note: Some residents will have more than one non-primary diagnosis.*

<i>Category</i>	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other program</b>
Anxiety, phobia, posttraumatic stress disorders			
Behavior/conduct disorders			
Impulse control disorders (including fire setting)			
Mood disorders			
Other disorders usually diagnosed in early infancy, childhood, or adolescence			
Personality disorders			
Pervasive developmental disorders			
Schizophrenia or other psychotic disorders			
Severe developmental disabilities			
Sexual and gender identity disorders			
Substance abuse/dependence disorder			
Victim of abuse or neglect			
Other (specify)			
Other (specify)			
Other (specify)			

10. On May 15, 2003, how many residents had the following co-occurring disorders?

	<i>Number of residents</i>			
	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other Program (if applicable)</b>	<b>Total</b>
Both substance abuse/dependence and a psychiatric condition				
Both a developmental disability and a psychiatric condition				
Two or more psychiatric conditions				

11. On May 15, 2003, how many of your residents had a major medical illness or serious physical disability?

<i>Type of Illness or Disability (Describe.)</i>	<i>Number of residents</i>			
	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other Program (if applicable)</b>	<b>Total</b>

12. On May 15, 2003, how many residents had a diagnosis of mental retardation?

<i>Degree of Developmental Delay</i>	<i>Number of residents</i>			
	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other Program (if applicable)</b>	<b>Total by degree</b>
<i>Mild (50/55-70)</i>				
<i>Moderate (30/40-50/55)</i>				
<i>Severe (20/25-35-40)</i>				
<i>Profound (&lt;20/25)</i>				
<b><i>Total by program</i></b>				

13. On May 15, 2003, for how many residents were the following statements true?

<i>Statement</i>	<i>Number of residents</i>			
	<b>General RTC Program</b>	<b>Court Evaluation Unit</b>	<b>Other Program (if applicable)</b>	<b>Total</b>
They were adjudicated sex offenders only				
They were adjudicated non-sex offenders only				
They were adjudicated offenders of both sexual and non-sexual offenses				
They were <b>non-adjudicated</b> offenders who <b>have</b> been accused of committing a sexual offense				
They were <b>non-adjudicated</b> offenders who have <b>NOT</b> been accused of a sexual offense				

14. On May 15, 2003, how many residents had a history of fire setting?

<b>Program</b>	<b>Number of Fire Setters</b>
General RTC program	
Court Evaluation Unit	
Other program as indicated in question 2 (if applicable)	
<b>Total # of residents with fire setting history</b>	

15. How many residents at your facility on May 15, 2003 were court-ordered youth?

<b>Program</b>	<b>Number Court-Ordered</b>
General RTC program	
Court Evaluation Unit	
Other program as indicated in question 2 (if applicable)	
<b>Total # of court-ordered residents</b>	

14a. For how many of those children was your facility unable to provide appropriate treatment? \_\_\_\_\_

14b. Please describe the characteristics of the children's needs for whom your facility was **unable** to provide appropriate treatment. (Why were you unable to provide appropriate treatment?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **ADMISSIONS PROCEDURES AND CAPACITY**

The following questions ask for information regarding procedures at your facility.

---

**16.** According to your admissions policy on May 15, 2003, what types of child applicants would **NOT** be admitted to your RTC? (Check all that apply.)

Applicants who:

- a.  Are older than age 18
  - b.  Are younger than age 13
  - c.  Are younger than age 5
  - d.  Are female
  - e.  Are male
  - f.  Attend school in a local school system
  - g.  Grade level too low
  - h.  Do not have insurance or some other third-party payer
  - i.  Parents unable/unwilling to participate
  - j.  Have both substance abuse/dependence and a psychiatric condition
  - k.  Have a developmental disability
  - l.  Have a developmental disability and one or more psychiatric conditions
  - m.  Have a major illness or serious medical condition
  - n.  Have a serious physical disability
  - o.  Have a diagnosis of mild (50/55-70) mental retardation
  - p.  Have a diagnosis of moderate (30/40-50/55) mental retardation
  - q.  Have a diagnosis of severe (20/25-35-40) mental retardation
  - r.  Have a diagnosis of profound (<20/25) mental retardation
  - s.  Are adjudicated non-sex offenders
  - t.  Are adjudicated sex offenders
  - u.  Are non-adjudicated sex offenders
  - v.  Are fire setters
  - w.  Have a history of aggression towards staff or others
  - x.  Is considered an AWOL risk
  - y.  Medication non-compliant
  - z.  Other (Specify.) \_\_\_\_\_
-

16. Please complete the following grid regarding capacity and enrollment issues as of May 15, 2003.

<i>Program</i>	<b>16a.</b> Total capacity (total number of beds), whether or not they were filled on 5/15/03?	<b>16b.</b> On 5/15/03, what was your actual enrollment in each program?	<b>16c.</b> Does enrollment on 5/15/03 represent a fairly typical day? (yes or no)	<b>16d.</b> If enrollment on 5/15/03 is <b>not</b> typical, what is the typical occupancy rate?	<b>16e.</b> Do you have plans to change the capacity of existing programs during 2004? (yes or no)	<b>16f.</b> If you plan to change capacity, by how many beds? (+/-)	<b>16g.</b> Ideally, what would you like your capacity to be?
General RTC program							
Court Evaluation Unit							
Other program (if applicable)							

17. Do you have plans to start a new program in 2004? (circle your response)

**Yes**                      **No**

**17a.** If yes, how many beds would this program have? \_\_\_\_\_

**17b.** What population would this new program serve? \_\_\_\_\_

18. How many residents at your facility on May 15, 2003 were **originally** referred by the following sources?

<i>Sources</i>	Number of residents	Number who could be better served in a <b>less</b> restrictive environment.
Family of the resident		
Core Service Agency		
Court		
Dept. of Human Resources/Local Dept. of Social Services		
Dept. of Juvenile Services		
Developmental Disability Administration		
Local Education Agency (LEA)		
<u>Mental Hygiene Administration</u>		
<u>Other (Specify)</u>		
Other (Specify)		

19. Do you have a formal waiting list for your facility? (Circle your response.)

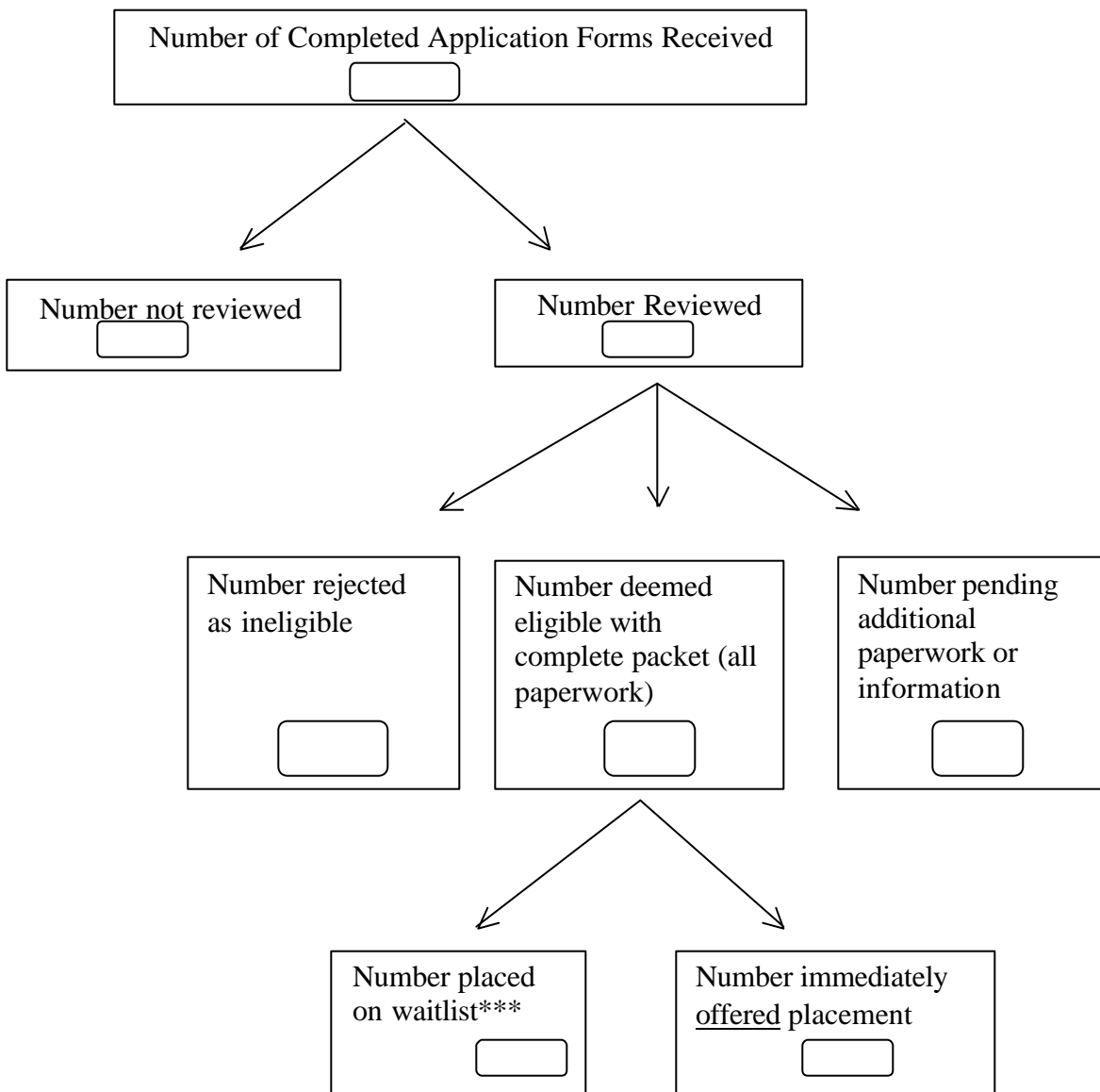
Yes

No

If no, go to 23.

19a. If yes, what format? (e.g., written; electronic) \_\_\_\_\_

20. Below is a general description of the admissions process. Please fill in the appropriate numbers for **each box** based on data from the **past 12 months** for your facility.



\*\*\* For all questions regarding waitlist, please refer to this number.

**21. Complete the following grid regarding children on the waitlist, based on the number indicated in the flowchart above.**

<b>Program</b>	<b>21a. Number placed on waitlist</b>	<b>21b. Typically length of time a child waits for a bed</b>
General RTC program		
Court Evaluation Unit		
Other program (if applicable)		

**22. In the past 12 months, what percentage of the children on your waiting list rejected placement when a slot became available? \_\_\_\_\_%**

**22a. What do you believe was the **most common** reason for rejecting an offered placement? Select only one. (Circle your response.)**

1. On the waiting list too long
2. Found an alternative placement due to long waiting period
3. Found an alternative placement that is more appropriate for the child
4. No funding/Lack of funding for the placement
5. Your program found to be an inappropriate match
6. Found an earlier placement in another RTC.
7. Other(Specify.) \_\_\_\_\_

### **LENGTH OF STAY, CONTINUUM OF CARE, AND PROGRAM COMPONENTS**

*The following questions ask for information related to provision of services.*

**23. Complete the following grid regarding length of stay issues. (Length of stay is defined as beginning the first day a child is in residence.)**

<b>Program</b>	<b>What is the typical length of stay for children?</b>
General RTC program	
Court Evaluation Unit	
Other program (if applicable)	

**24. We understand that there are times when a resident may stay in an RTC longer than anticipated. In the past 12 months, how many residents in your facility were expected to be discharged, but the discharge was delayed?**

**If none, go to 26.**

<b>Program</b>	<b>Number of expected discharges</b>
General RTC program	
Court Evaluation Unit	
Other program (if applicable)	

25. Of the cases that experienced a delay in discharge, how many can be attributed to the following reasons?

Reason	Number
No funding for a more appropriate (less restrictive) placement	
A more appropriate (less restrictive) placement did not exist	
A more appropriate (less restrictive) placement existed, but no slots were available	
Parents in disagreement with recommended placement	
Other (Specify.)	
Other (Specify.)	
Other (Specify.)	
Other (Specify.)	

26. Complete the following grid regarding continuum of care (e.g., day treatment).

Question			
Program	26a. Do you provide aftercare or follow-up care after discharge from your RTC? (if no, go to Q28)	26b. What is the average length of time aftercare or follow up care is provided?	26c. What percent of residents typically use those services after discharge?
General RTC program			
Court Evaluation Unit			
Other program (if applicable)			

27. List the types of aftercare or follow-up services most frequently offered by your program (see example).

Services	<i>Indicate with an X which programs offer the service.</i>		
	General RTC Program	Court Evaluation Unit	Other Program (if applicable)
(for example, community-based family therapy)	X		X

28. Describe the community programs with which you have collaborative relationships and for what purpose (e.g. referral services or aftercare treatment).

Program Name	Nature of Collaboration

29. Do you have a day treatment program?

Yes                      No

29a. If yes, how many students were enrolled in the day treatment program on May 15, 2003? \_\_\_\_\_

29b. What percentage of residents typically transition to day treatment?

Program	Percent who transition
General RTC program	%
Court Evaluation Unit	%
Other program (if applicable)	%

30. Regarding educational services, how many residents at your facility on May 15, 2003:

- a. \_\_\_\_\_ Attended school off grounds (in the community)
- b. \_\_\_\_\_ Attended school on grounds (on your campus)
- c. \_\_\_\_\_ Received one-on-one academic tutoring on site
- d. \_\_\_\_\_ Other (Specify.) \_\_\_\_\_

31. In your opinion, what types of residential programs are most needed in serving children with special needs in the State of Maryland? (List the **top three** and describe what populations they would serve.)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**ADMINISTRATIVE OPERATIONS – FINANCIAL AND PERSONNEL ISSUES**

*The following questions ask for financial and staffing information.*

32. On May 15, 2003, how many residents were NOT funded by medical assistance? \_\_\_\_\_

33. For the residents at your facility on May 15, 2003, how many were funded by the following sources for residential services? (Some children may have more than one source of funding.)

Source of funding	Number
Medicaid	
MSDE	
DDA	
Other Public Funding (Specify.)	
Private Insurance	
Self-Pay	
Other (Specify.)	

34. What is the average daily cost per child of providing services for children in your residential facility (excluding the educational component)?

Program	Daily cost per child
General RTC program	
Court Evaluation Unit	
Other program (if applicable)	

35. How many staff, in total, does your RTC employ, including both clinical and non-clinical staff, such as janitors and kitchen staff? \_\_\_\_\_

36. Complete the following grid for all staff currently working at your facility, including contractual employees. Please add additional major categories as appropriate.

<b>Staff Position</b>	<b>Full-Time Equivalent (FTE)** for Residential Programs</b>	<b>FTE for Day Treatment (if applicable)</b>	<b>TOTAL FTE (Residential + Day Treatment)</b>	<b># of Vacancies</b>
<b>ADMINISTRATIVE AND SUPPORT STAFF</b>				
Administrator/Director				
Deputy Director				
Building manager/engineer				
Security				
Office Manager				
Secretary/Administrative Assistant				
Receptionist				
Custodial Aide				
Kitchen Staff				
Resident Care				
Other (Specify)				
Other (Specify)				
Other (Specify)				
Other (Specify)				
Other (Specify)				
Other (Specify)				
<b>DIRECT CARE STAFF</b>				
Psychiatrists				
Psychologists				
Social Workers				
Nurses				
Rehabilitation Therapists				
Physical Therapists				
Recreation Therapists				
Occupational Therapists				
Speech-language Therapists				
Movement/psychodrama Therapist				
Art Therapists				
Music Therapists				
Other (Specify)				
Other (Specify)				
Other (Specify)				
Other (Specify)				

\*\* Full-time equivalent is based on the number of hours performed in each activity. For example, an employee working 40 hrs/week is counted as 1 FTE, whereas an employee working 20 hours/week is counted as .5 FTE

37. Complete the following grid for all staff who are currently in training (e.g., interns, externs, etc.).

Discipline	Paid? (Yes/No)	# of hours/week

38. For your direct care staff only, please complete the following grid regarding their **highest degree completed**.

Highest Degree Earned	# FTE
Less than high school degree	
High school diploma or GED	
Some college	
Associate's degree	
Bachelor's degree	
Some graduate work	
Master's degree	
Doctoral degree (e.g., M.D., Ph.D., Ed.D., etc.)	
Other (specify.)	

39. For which types of direct care positions do you experience the most critical staff shortages?

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---

40. How do these staff shortages affect quality of services?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

I do **hereby certify** that, to the best of my knowledge and belief, the information that I have provided in this survey is true and accurate.

\_\_\_\_\_  
**Name of CEO** Full Title

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Name of person completing survey (if different from above) Full Title

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Name of person completing survey (if different from above) Full Title

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Name of person completing survey (if different from above) Full Title

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Name of person completing survey (if different from above) Full Title

\_\_\_\_\_  
Phone Email

\_\_\_\_\_  
Signature Date

Should you have any questions, contact Drs. Campbell or Wang at 1-800-646-REDA.  
***Thank you for your time and effort in completing this survey.***

**APPENDIX 5.0-B**

**RECORD ABSTRACTION FORM**

**REDA International, Inc.**  
**OCYF Evaluation**  
**RECORD ABSTRACTION FORM**

Program (facility name): \_\_\_\_\_

Resident (unique identifier): \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ SEX: M F RACE: \_\_\_\_\_

Lead Agency:

DJS     DHMH     MSDE/LEA     DDA     DHR/LDSS     Court Ordered

Other (specify) \_\_\_\_\_

Date of Admittance: \_\_\_/\_\_\_/\_\_\_ Current Resident?  NO  YES

Previous RTC admissions?  NO  YES How many? \_\_\_\_\_

I.E.P.?  NO  YES Last Update? \_\_\_/\_\_\_/\_\_\_

Disability Classifications:

Impairments:  Motor  Visual  Hearing  Physical  Speech/Language

Mental Retardation  Autism  Emotional Disorder  Other (specify) \_\_\_\_\_

Name of school \_\_\_\_\_

Off grounds  On grounds  N/A

Home school district \_\_\_\_\_ Not Indicated: \_\_\_\_\_

Most Recent DSM-IV Diagnosis

Axis I: 1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Axis IV: 1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

**Review the last three months of progress notes for major issues addressed during stay.**

Y= YES    N= NO    NI= Not Indicated

Issue	<u>N</u> <u>I</u>	N	Y	Specify
Drug abuse				
Social support/family				
Education concerns				
Legal problems				
Medical issues				
Sexual issues				
Community issues				

**Problems addressed on treatment plan:**

- 1. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 6. \_\_\_\_\_
- 3. \_\_\_\_\_ 7. \_\_\_\_\_
- 4. \_\_\_\_\_ 8. \_\_\_\_\_

**Types of Intervention (select all that apply):**

- Psychiatric medication
- Therapy (what type?)
  - Individual  Family  Group  Physical  Recreational  Speech/Language
  - Occupational  Movement  Psychodrama
  - Other therapy (specify) \_\_\_\_\_ Other therapy (specify) \_\_\_\_\_
  - Other therapy (specify) \_\_\_\_\_ Other therapy (specify) \_\_\_\_\_
  - Other therapy (specify) \_\_\_\_\_ Other therapy (specify) \_\_\_\_\_
- Other medical services (specify) \_\_\_\_\_

**Collaborating agencies:**

**Purpose of collaboration:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**Estimated discharge date:** \_\_\_/\_\_\_/\_\_\_

**Actual discharge date:** \_\_\_/\_\_\_/\_\_\_

**Discharge plan:**

- 1. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 6. \_\_\_\_\_
- 3. \_\_\_\_\_ 7. \_\_\_\_\_
- 4. \_\_\_\_\_ 8. \_\_\_\_\_

**Barriers to discharge:** \_\_\_N/A (Discharge occurred as scheduled.)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**INTERNAL USE ONLY**

Discharge date (year/mm/dd) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Admission date (year/mm/dd) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Length of stay:

**DJS** = Department of Juvenile Services

**DHMH** = Department of Health & Mental Hygiene

**MSDE** = Maryland Department of Education

**LEA** = Local Education Agency

**DHR** = Department of Human Resources

**LDSS** = Local Department of Social Services

**APPENDIX 7.3-A**

**RTC CASE MANAGER RESPONDENTS**

**APPENDIX 7.3-A**

**RTC CASE MANAGER RESPONDENTS**

<b>Name of Facility</b>	<b>Location of Facility</b>	<b>Titles of Respondents</b>
Chesapeake Treatment Center	Parkville, MD	Executive Director
Chesapeake Youth Center	Cambridge, MD	Administration
Edgemeade	Upper Marlboro, MD	Director of Admissions, CEO
Good Shepherd	Baltimore, MD	Assistant Director or Social Services, Social Worker
Jefferson School	Jefferson, MD	Social Worker
Mann RTC	Towson, MD	Quality Evaluation, Senior Social Services, Admissions and IEP Coordinator
Potomac Ridge at Anne Arundel	Crownsville, MD	Clinical Care Manager
Potomac Ridge	Rockville, MD	Chief Clinical Officer
RICA Baltimore	Baltimore, MD	Admissions Director, CEO, Clinical Coordinator Chief Psychologist, Assistant Superintendent
RICA JLG	Rockville, MD	Medical Director, Director of Nursing and Residence, Principal, Director of Clinical Services, Clinical Team Leader, Medical Records, CDO, Director of Community Resources and Development, Director of Perform and Improvement
RICA Southern	Cheltenham, MD	Chief Social Worker
Sheppard Pratt at Ellicott City	Ellicott City, MD	Secretary, Clinical Director
Villa Maria	Timonium, MD	Associate Administrator
Woodbourne	Baltimore, MD	Program Director, Clinical Care Manager

**APPENDIX 7.4-A**

**PARENT FOCUS GROUP DISCUSSION GUIDE**

## **APPENDIX 7.4-A**

### **PARENT FOCUS GROUP DISCUSSION GUIDE**

Please introduce yourself by stating the county of residence and a little about the son or daughter of interest to our group tonight. (Prompt with questions about their child's age, nature of disability, where their child receives services).

Please describe the process by which your son or daughter was diagnosed as being a child with special needs.

Have any of your children been considered for placement in an RTC? Please describe your experience with the RTC placement process.

Have other community-based/alternative services to residential treatment been explored for your children? Why or why not?

What alternative arrangements to provide care for your children have you considered? What barriers might you anticipate in exploring such alternatives?

What has facilitated the process in getting the necessary services for your child?

Please describe your participation with your child's treatment plan.

In your opinion, what types of community-based services are most needed? How can community-based services be enhanced?

In your opinion, do the available residential treatment services in Maryland adequately meet the needs of the children who require such care? Why or why not?

How is treatment funded for your children?

Have any of your children been placed on a waiting list for a facility within the state? Why? How long was the wait/has the wait been?

Have any of your children been referred for an out-of-state placement?

What are the benefits and drawbacks of the current system of placing children with special needs in residential placements?

What would you like to see changed about the system that serves children with special needs?