Report to the Governor

Interagency Out-of-State Residential Placement Work Group

June 1, 2005

Submitted by:

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COUNCIL ON CHILDREN AND FAMILIES

State of New York
Council on Children and Families

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June 1, 2005

Honorable George E. Pataki
Governor
State Capitol
Albany, New York 12224-0341

Dear Governor Pataki:

I am pleased to submit, for your consideration, the final report of the Interagency Workgroup on Out–of-State Residential Placements. This workgroup was convened in response to the concerns of the Council on Children and Families' Commissioners who had been monitoring data that indicated that the number of placements of children out of state was increasing through both the education and social services systems. The workgroup was asked to conduct an in-depth study of this issue.

Subsequent to the beginning of work on out-of-state residential placements, in your veto message of *Billy's Law*, you expanded the workgroup's charge to explore "changes to the mechanisms by which the state oversees such placements," and further charged the workgroup to determine whether out-of-state placements serve the best interest of the child and if policies and procedures need to be developed to minimize the need for such placements. This report fulfills that charge.

As you stated in your veto message, "The best way to address these problems [in the current system] is to ensure that disabled students receive the services they need, in facilities located in New York State." To that end, the workgroup conducted visits to both in and out-of-state providers, to counties with high placement rates and to New York State facilities that are successfully treating children with similar needs to those currently placed out-of-state. The result is a comprehensive report with a series of recommendations that serve to strengthen our in-state system of care by identifying specific actions to monitor and ensure quality of care both in and out-of-state, create placement processes that are cognizant of all in-state options and develop an in-state capacity to treat these children.

We look forward to your review of this report and welcome the opportunity to implement its recommendations to better serve this vulnerable population of children.

Sincerely,

Alana M Sweeny

Alana Sweeny, CEO

cc: Mark Kissinger, Chairman of the Council

Interagency Work Group on Out-of-State Residential Placements
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Executive Summary

I. STATEMENT OF PROBLEM

In October 2003, the Governor's Office, through the Council on Children and Families, established an Interagency Work Group on Out-of-State Residential Placements (hereinafter, the Work Group) to determine the causes at the state and community levels for the number of out-of-state residential placements in both the education and social services systems. Although Committee on Special Education (CSE) placements through local education agencies (LEA) continue to increase, placements through local departments of social services (LDSS) have declined significantly, as reflected in both 2004 annual data and April 2005 data. Concerns about out-of-state residential placements include:

- the quality of care a NYS child receives when he or she is in an out-of-state residential facility. Currently, New York State agencies have limited control and only limited oversight or resource capacity to monitor an out-of-state residential institution;
- the economic impact and job losses that result from exporting dollars and jobs to other states The combined tuition and maintenance costs for some children are greater than $200,000 per year, and some out-of-state institutions receive payments in excess of $7 million annually;
- The cost: it is estimated that NYS pays $200 million annually to out-of-state residential facilities where NYS youth are placed;
- the aggressive marketing efforts of certain out-of-state providers to local departments of social services (LDSS), Local Educational Agencies (LEAs)[1], parents and parent organizations, and if this may be inappropriately influencing the local decision-making processes; and
- the geographic and regional disparities in service delivery and placement patterns.

Subsequent to the beginning of work on out-of-state residential placements, the State Legislature passed "Billy's Law" (S5681-B/A9112-B), which was a response to the case of a child who was alleged to have been abused in an out-of-state facility. Among its many provisions, the bill established out-of-state monitoring responsibility for children placed in out-of-state residential facilities through the education system, required multi-agency oversight in the approval of out-of-state residential facilities and programs, and tasked a group of state agencies to study the feasibility of repatriating children to New York State from out-of-state residential placements. This bill was vetoed by the Governor, due to issues related to its implementation. However, in response to some of the issues the bill, the Governor informed the Legislature of this Work Group, expanded the Work Group's charge to explore "changes to the mechanisms by which the State oversees such placements,"[2] and further charged the Work Group to determine whether out-of-state placements serve the best interest of the child and if policies and procedures

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need to be developed to minimize the need for such placements. The Governor stated that, "The best way to address these problems [in the current system] is to ensure that disabled students can receive the services they need in facilities located within New York State."

Further, the Governor asked the Work Group to recommend whether or not out-of-state residential placements should continue. The Work Group acknowledges that, in some cases, out-of-state residential placements for New York children may sometimes be the best available alternative, or in some cases, the only known option to meet the needs of individual disabled children. However, the Work Group's philosophy is that each New York State child should receive the most appropriate community based services that will support a child's ability to remain in his or her own home, or be placed in the least restrictive setting that will address his or her individual needs. The Work Group believes that consistent expectations and standards for the quality of education and residential services provided to NYS children should be applied equally to children placed in either NYS congregate care settings or out-of-state institutions. In response to the Governor's charge, the Work Group has produced a set of findings with recommendations which are stated below[3].

II. OVERVIEW

There are approximately 1,400 children being served in residential facilities outside of New York State[4]. These children have been placed out-of-state through Committees on Special Education (CSEs) in their Local Educational Agencies (LEA) and through their Local Departments of Social Services (LDSS). Placements through these agencies receive financial reimbursement and technical support from the State Education Department (SED) and the Office of Children and Family Services (OCFS), respectively, as well as federal funds and county tax dollars. In the five-and-a-half-year period, 1998 to 2004[5], the number of out-of-state placements:

- increased from 490 to 1,007 for the educational system; and
- increased from 222 to 355 from the social services system (this number speaks only to children in congregate residential programs and does not include children placed in foster or pre-adoptive homes out-of-state).

Since 2003, the number of children placed out of state by the New York City Administration for Children Services (ACS) has decreased from 92 to 38, due to various factors, including the concerted effort by ACS to provide placements in the child's community.

The concern over placing children in out-of-state residential facilities is not new. Over the past 25 years, efforts have been made to identify the scope of this issue and address trends of increasing out-of-state placements, as well as the larger issue of out-of-home placements in New York State. Some of these initiatives, such as the Coordinated Children's Services Initiative (CCSI) and Integrated County Planning are part of the ongoing efforts that are integral to the recommendations presented herein.

[3] Recommendations are integrated into the body of this report, with their original numbers in parentheses; a full set of recommendations is available within this summary.
[4] OCFS Data Warehouse, Snapshot Data, 6/30/04.
[5] Point in Time Data: 12/31/98, 6/30/2003 and 6/30/2004.

III. WHY NYS CHILDREN ARE GOING OUT-OF-STATE

The Work Group has identified a set of reasons why children are referred to out-of-state residential facilities. These reasons will be explored in more detail in the findings of the report.

A. Quality of Care – Reflected by Issues with In-State Capacity

The issue of in-state capacity can be stated in two ways: 1) the level of care necessary to serve children with specific needs and 2) the capacity to serve children in New York State schools and residential facilities. Other additional factors affect capacity as well, such as the timing of the request for placement and geographic distribution of referrals in relation to available resources.

1) **Level of Care:** Based on the expertise and observations of informed staff making site visits to four out-of-state institutions, there appear to be no substantial differences in program models and service quality between in- and out-of state residential facilities. In-state capacity to serve children with complex and/or multi-system needs is impeded by the following:
   - rate structure to support higher levels of supervision;
   - resources to provide necessary technical assistance to voluntary agencies seeking rate adjustments due to high turnover rates, difficulty in hiring and retaining qualified childcare workers, social workers and educators; and
   - the lack of career development incentives for childcare staff and educators.

2) **Capacity to Serve Children:**

Bed Space: Combined bed space for OCFS, OMH, and OMRDD is 14,140.

	OCFS	OMH	OMRDD	SED
Beds	9,587 beds[6]	2,553 beds[7]	2,000 beds[8]	N/A[9]

Geographic Proximity: New York City, Suffolk County, Westchester County and Nassau County have the largest number of children being served in out-of-state residential facilities.

An overwhelming number of out-of-state residential placements come from these counties and are concentrated in the neighboring states of

[6] OCFS numbers include all congregate care which are more than 6 bed capacity, but not Therapeutic or regular Foster Boarding Homes.

[7] Includes Intensive Psychiatric Services (Residential Treatment Facilities (RTFs), Child Psychiatric Hospitals, Articles 31 & 28, beds in crisis residences, community residences, family based treatment and teaching family homes). Complete breakdown including slots in section on OMH placement process and service provisions.

[8] Current number of children being served in OMRDD residential settings.

[9] With the exception of state-supported schools (4201s) and the two State Operated Schools, NYS School for the Blind (Batavia) and NYS School for the Deaf (Rome), State Education does not identify itself as having residential beds and relies on the accommodations of other systems where schools are co-located to provide their students with residential services.

Massachusetts (JRC) and Pennsylvania (Kids Peace, Devereux and Woods Services).

Timing of Placement – Some out-of-state residential placements occur because at the time a school district or a social services district makes an inquiry to an in-state school, that facility may be at capacity or assess that the agency does not have adequate resources to assume care for another child with these specific clinical needs at that time. However, if contacted two or three days later, there may be, in fact, a vacancy. The statutory timelines require that school districts place a student after that student is identified as having a disability and after the CSE meeting, within 30 days. Thus, follow-up with the in-state providers is not usually conducted, and referrals are made to other schools until a child is accepted. These timelines are identified in Federal law for the placement process for Local Educational Agencies.

B. Local Level Coordination and State Level Oversight

Despite national trends toward provision of a coordinated system of care for each child and family, many localities and regions continue to be fragmented with various systems providing services solely within the boundaries of their own system, rather than creating a comprehensive plan of care that is coordinated across systems. This fragmentation and lack of coordination impedes the ability of the local entity that is developing a plan for the child from accessing the specific services from the various systems necessary to serve the child in the least restrictive setting as appropriate. It is critical to point out, however, that State education, mental hygiene and social services laws provide strict standards related to how services are delivered. Local systems at county and school district levels may be impeded by these federal or state statutory or regulatory requirements regarding eligibility that may indirectly create exclusionary criteria.

This fragmentation is further compounded by the barriers created by varying philosophies, regulations, and funding streams within each child serving system. These factors also affect monitoring and accountability functions within and across various state-level agencies.

Another critical factor regarding coordination issues across systems is that information and data systems that track the clinical needs and demographic/diagnostic issues of these children are not comprehensive or standardized within or across each system.

C. Marketing

There is a difference between the levels and intensity of marketing by out-of-state residential facilities that serve New York State children and the in-state residential facilities in New York. Out-of-state residential facilities often have proactive business administration and marketing staff and are able to market themselves aggressively to Local Educational Agency Committees on Special Education, parents, family advocates and the community. In contrast, in-state facilities have not developed the same level of intensity in marketing.

D. Impact of Family Members in Placement Process

Another critical factor in determining placement for children in out-of-state residential facilities, primarily within the educational system, is the role of family members and their advocates. The Work Group is sensitive to the needs of family members and conducted two family focus groups to receive feedback from parents whose children were placed in out-of-state residential facilities. In most cases, families would prefer to have their child served in the least restrictive setting and as close to home as possible. If an appropriate placement to address the needs of a child could not be located within NYS, parents felt duty bound to search for the most appropriate placement for their child. Depending on a child's needs, that residential placement could be located in any of the 18 different states with residential programs that serve NYS children, and it could be with a program whose practices are not recognized or approved in New York State.

IV. CONCLUSION

By addressing the specific topic of out-of-state residential placements, the Work Group has identified many issues and concerns regarding the delivery of services to children with complex and/or multiply diagnosed needs, including those who are currently served in their communities and in residential facilities in and outside of New York State.

The recommendations are offered with the intent that they be evaluated on their ability to be implemented interdependent of each other. The Work Group believes that approving these recommendations and taking the critical next steps could address the immediate concern of out-of-state residential placements and also promote a comprehensive and coordinated system of care throughout New York State that would provide services to all children in the least restrictive settings.

The agencies of this Work Group, along with its partners in the State Legislature and family representatives, are committed to finding practical and sustainable solutions to this issue and look forward to fulfilling the recommendations through individual initiatives and through various coordinated and collaborative forums.

V. RECOMMENDATIONS

Caveat: The enclosed set of goals and the recommendations and objectives enumerated herein are agreed to in principle by representatives of the Interagency Work Group on Out of State Residential Placements and have been reviewed by the respective agency Commissioners. To effectively address the concerns expressed by the Council on Children and Families Commissioners around out-of-state residential placements, it is advised that these recommendations be examined and considered interdependent of each other.

GOAL #1: TO ENHANCE OR IMPROVE ACCESS TO THE STATEWIDE SYSTEMS OF CARE TO PROVIDE FOR CHILDREN WITH COMPLEX OR MULTIPLY-DIAGNOSED NEEDS; INCREASE AND STRENGTHEN PREVENTION AND RESIDENTIAL SERVICES; AND PREVENT, WHERE POSSIBLE, THE PLACEMENT OF CHILDREN OUT-OF STATE.

Recommendation 1.1: *Integrate NYS children in in-state and out-of-state residential care into a comprehensive statewide System of Care, which collaborates to meet all of the child's complex and/or multi-systems needs in the least restrictive settings, as appropriate, within New York State.*

Objective 1.1A: *Strengthen local and regional service coordination and streamline placement processes and access to community-based services, which include or complement existing infrastructures (e.g., Single Points of Access, Hard to Place/Serve Committees and Coordinated Children's Services Initiative counties).*

Objective 1.1B: *Develop a multi-level interagency process, coordinated by an existing single state agency, to guide placements of children with specialized, complex and/or multi-systems needs who may require consideration for residential services outside of NYS. This process should be engaged at the point when a social services district or school district identifies a child who has the potential to be placed outside of NYS. Such process will identify the necessary activities a social services district or school district must engage in prior to a request for an out of state placement for an individual child and must be in compliance with existing federal and state mandates. Key activities are as follows:*

1) *Reinforce and strengthen the use of an interagency three-tiered process on the local, regional and state levels to facilitate treatment and service planning for children at risk of placement as defined in various child-serving systems. Such processes should complement existing initiatives at the local, regional and state levels. Examples of such processes include SPOA, CCSI and Hard to Place committees on the local level, Region II on the regional level and the Hard to Place Committee at the State level.*
2) *Monitor of data on children across service systems who might be referred out of state;*
3) *Create a review process for out-of-state placements referred by either CSEs or LDSS that would explore all available and least restrictive options before a CSE or LDSS out-of-state recommendation is made to SED and/or the Family Court judge and identify alternatives to out-of-state residential placements.*

Objective 1.1C: *Strengthen SED's (VESID) oversight and coordination of students with disabilities placed or potentially placed out-of-state with technical support from OMRDD, OMH, DOH, and OCFS, including CCF. Also, require consultation between CSE and LDSS by strengthening current law to review all CSE placements to out-of-state facilities, including Emergency Interim Placements (EIPs), and verify that all appropriate in-state options are exhausted.*

Objective 1.1D: *Strengthen the approval process for new and existing schools/residential facilities for children placed through Local Educational Agencies/Committees on Special Education, including Emergency Interim Placement schools. Key concepts for this objective include:*

1) *evaluating and determining NYS oversight licensing/certification criteria with licensing/certification criteria from host states;*
2) *verifying that programs where children are placed out of state meet all licensing and inspection requirements of the home at the time of and duration of the placement of the child;*
3) *exploring the feasibility of requiring all out-of-state facilities providing residential educational services to children or youth who are New York State residents, or interested in providing such services to apply for registration with the State Education Department. Such registration would require the payment of a fee by the facility into a dedicated "Special Revenue – Other" account in an amount intended to cover the costs of review and oversight of such facilities and the placements of New York students in such facilities; this initiative will need to account for the issues related to the Interstate Commerce Clause of the U.S. Constitution;*
4) *confirming consistency of Local Educational Agency and local departments of social service contracts in developing standard language to reflect criteria and require relevant information and reporting obligations (e.g., abuse cases) from approved agencies, , reporting of incidents, appropriate arrangements with receiving state, and notification of relevant program issues, among other information issues.*

Objective 1.1E*: Where appropriate, develop consistent eligibility criteria, discharge planning and service coordination guidelines across systems for children going in and out of residential placements.*

Objective 1.1F*: Include wraparound funding to serve children with complex and/or multiply diagnosed needs and expand upon the success of local initiatives to integrate funds and services to provide for children with these needs. Funding would follow the child and be flexible to serve the child in the least restrictive setting, as appropriate.*

Objective 1.1G: *Reinvest any resources from returning/diverting children, if any, from out of state placements for community-based programs, and residential pilot programs, among other initiatives.*

Objective 1.1H: *Explore funding and program expansion to support least restrictive settings to treat children with multiply diagnosed needs, including children in foster care.*

Objective 1.1I: *Revise local planning procedures to include participation by the local DSS and other service systems representatives in the local CSE placement process[10], where relevant. Through this improved and enforced participation, incorporate permanency-planning concepts in the Individual Education Program for all New York State children, including children with complex and or multiply diagnosed needs who might be at risk of out-of- home or out-of-state residential placements.*

Recommendation 1.2: *Develop and continuously update a set of statewide child and family technical assistance resources such as service directories, assessment tools, referral guides, funding maps, and consulting services.*

Objective 1.2A: *Develop a centralized clearinghouse of research and evidence based practices, and a list of children residential services providers.*

Recommendation 1.3: *Develop recommendations regarding a comprehensive assessment process to address the needs of children placed out of state including children with complex and/or multiply-diagnosed needs.*

GOAL #2: TO COORDINATE A CENTRALIZED/SHARED DATA COLLECTION SYSTEM ACROSS SYSTEMS AND LEVELS OF GOVERNMENT.

Recommendation 2.1: *Improve methods of data collection to provide consistent feedback to systems' stakeholders on the number and needs of children who are hard to-serve and are at risk of future out-of-state placement*[11]*.*

Objective 2.1A: *Identify and define a consistent set of data elements for each student placed out of state by each state agency: name, DOB, disabling condition, prior placements and educational profile (academic, behavioral, physical, social and medical), and anecdotal information on previous interventions, and the reason for a referral for out-of-state placement. Development and sharing of data must comply with OCFS and SED confidentiality provisions.*

Objective 2.1B: *Identify current availability and capacity of in-state residential and nonresidential services varying service needs of each child.*

Recommendation 2.2: *Conduct a statewide cross-systems needs assessment to identify low-incidence/high-need children, identify obstacles to the provision of in-state residential services to meet the specific needs of these children, and design an appropriate response.*

Recommendation 2.3: *Develop and implement a comprehensive review of individual cases of children placed out-of-state.*

[10] Must be in compliance with IDEA.

[11] Consistent with FERPA, provisions of IDEA, and provisions of federal Part 300 regulations that relate to confidentiality of information concerning students with disabilities.

GOAL #3: TO STRENGTHEN THE STATE'S CAPACITY AND RESOURCES IN ORDER TO PROVIDE OPPORTUNITIES TO MAINTAIN CHILDREN IN NEW YORK STATE IN THE LEAST RESTRICTIVE SETTING AVAILABLE THAT CAN ADDRESS THEIR COMPLEX NEEDS.

Recommendation 3.1: *Establish a coordinated development process to determine in-state capacity to address the needs of children placed out of state; define and promote flexibility in rate-setting mechanisms; and streamline licensing procedures so that eligible in-state institutions can apply for and receive multiple licenses in a timely, "fast track" manner.*

Recommendation 3.2: *Strengthen resources to serve children, including but not limited to supervision, classroom staffing, clinical services, security and safety, and physical plant reconfigurations.*

> ***Objective 3.2A:*** *Re-assess all applicable funding mechanisms and rate setting methodologies to determine the need for program intensification or modification to existing funding mechanisms that are responsive to unanticipated cost increases, to the need for enhanced services for the current or anticipated populations, or to the need for structural reconfigurations to meet the specialized needs of the population. This re-assessment would focus on rate setting methodologies to encourage development of programs for children at risk of out-of-state residential placement.*
>
> ***Objective 3.2B:*** *Create flexibility for reimbursing capital costs for building new structures and renovating/adding to existing structures within existing rate methodologies. This includes exploring new bonding/securitizing options beyond the Dormitory Authority of the State of New York (DASNY).*

Interagency Work Group on Out-of-State Residential Placements
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I. STATEMENT OF PROBLEM

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II. OVERVIEW

There are approximately 1,400 children and youth being served in residential facilities outside of New York State[4]. These children and youth have been placed out-of-state through Committees on Special Education (CSEs) in their Local Educational Agencies (LEA) and through their Local Departments of Social Services (LDSS). Placements through these agencies receive financial reimbursement and technical support from the State Education Department (SED) and the Office of Children and Family Services (OCFS), respectively, as well as federal funds and county tax dollars. In the five-and-a-half-year period, 1998 to 2004[5], the number of out-of-state placements.

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The concern over placing children and youth in out-of-state residential facilities is not new. Over the past 25 years, efforts have been made to identify the scope of this issue and address trends of increasing out-of-state placements, as well as the larger issue of out-of-home placements in New York State. Some of these initiatives, such as the Coordinated Children's Services Initiative (CCSI) and Integrated County Planning are part of the ongoing efforts that are integral to the recommendations presented herein.

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A. Children and Youth Being Served Out-of-state

Listed below is an overview of systems referrals, geographic origins, and sample diagnoses of some of the youth receiving residential services.

1.) Where Children and Youth Originate[6]

Breakdown by Local Educational Agency (LEA) and Local Departments of Social Services (LDSS)

- LEA/CSE: On June 30, 2004, there were 1,007 children and youth placed in out-of-state residential facilities and 1,114 children and youth in NYS residential facilities.
- LDSS: On June 30, 2004, there were 355 children and youth receiving residential services in congregate care placements out-of-state; and 6,866 children placed in congregate care in state.

Breakdown by County for Local Educational Agency and Local Departments of Social Services

Analysis of the out-of-state residential placement data shows that specific counties and New York City yield a higher number of out-of-state placements.

The 5 counties (including all of NYC) with the highest residential placements through the Local Educational Agency Committees on Special Education (CSEs) as of 6/30/04 are:

1. New York City, with 537 children and youth
2. Nassau, with 82 children and youth
3. Westchester, with 76 children and youth
4. Suffolk, with 68 children and youth
5. Dutchess, with 35 children and youth

The 5 counties (including all of NYC) with the highest residential placements through the local social services system[7] as of 6/30/04 are:

1. Suffolk, with 82 children and youth
2. Westchester, with 67 children and youth
3. New York City, with 38 children and youth
4. Nassau, with 29 children and youth
5. Ulster, with 21 children and youth

Most utilized out-of-state residential facilities for NYS children and youth[8] are:

1. Kids Peace (PA), with 196 children and youth
2. Judge Rotenberg Center (MA), with 157 children and youth
3. Woods Services (PA), with 137 children and youth
4. Devereux (PA) with 72 children and youth

[6] Point in Time: 6/30/2004.
[7] As of April 2005, overall out-of-state residential placement numbers for social services have decreased to 275
[8] CSE Only, 2003-04 Data, 4/21/05.

2.) Sample Children and Youth Profiles:

The summary of youth profiles for out-of-state residential facilities serving New York State children was culled from information collected from 3 of 4 residential facilities visited by the Work Group: Easter Seals New Hampshire, Woods Services, and Devereux Foundation – Beneto Center, in Pennsylvania. These facilities serve approximately 245 NYS children and youth, or 17.5 percent of the 1,400 NYS children and youth served out-of-state. These include children from both LEA/CSE and LDSS placements, the larger majority of which are LEA/CSE placements.

An examination of demographic information regarding these children indicates that while there is a broad age range of children, an overwhelming proportion are adolescent males.

The youth served in out-of-home and out-of-state residential placements tend to have multiple diagnoses, typically found in children placed in unique services or levels of service by various New York State agencies and services systems. NYS currently serves children with these diagnoses in-state as well. The diagnoses provided were as follows:

- disruptive behavior and attention deficit disorders (e.g., conduct, oppositional defiant, disruptive behavior and attention deficit/hyperactivity disorders);
- mental retardation and/or developmental disabilities;
- pervasive developmental disorders (e.g., Autism, Rhett's and Asperger's; and
- Other diagnoses were related to mood disorders, impulse control, anxiety, schizophrenia and psychotic disorders, and learning disabilities.

Note: The Work Group does not know the specific service needs of each child and would not be able to obtain such knowledge without a comprehensive review of each New York State child's case history.

3.) Recent Related Surveys:

In 1999, the New York Public Welfare Association conducted a statewide survey of all children deemed as hard to place. The most significant cause for out of state placements was identified as children with multiple needs related to mental health, mental retardation/developmental disabilities, substance abuse, history of sexual abuse or sexually aggressive behaviors, and fire-setting. The most significant individual issue was fire-setting.

In 2003, NYS OCFS conducted a survey of the four counties (NYC, Suffolk, Westchester, and Nassau) with the highest rates of out of state placements. Only 4% (15/415) of the children out of state were identified with only one clinical issue, which included sex offender behaviors or extremely violent behaviors. All other children were identified with multiple complex diagnoses including, in descending order of needs, a high level of mental health, MR/DD, violent or criminal behavior, sex offender behaviors, learning disabilities, and physical health.

III. WHY NYS CHILDREN AND YOUTH ARE GOING OUT-OF-STATE

The Work Group has identified a set of reasons why children and youth are referred to out-of-state residential facilities. These reasons will be explored in more detail in the findings of the report.

A. Quality of Care – Reflected by Issues with In-State Capacity

The issue of in-state capacity can be stated in two ways: 1) the level of care necessary to serve children with specific needs and 2) the capacity to serve children and youth in New York State schools and residential facilities. Other additional factors effect capacity as well, such as the timing of the request for placement and geographic distribution of referrals in relation to available resources.

1) **Level of Care:** Based on the expertise and observations of informed staff making site visits to four out-of-state institutions, there appear to be no substantial differences in program models and service quality between in- and out-of state residential facilities. In-state capacity to serve children and youth with complex and/or multi-system needs is impeded by the following:
   - rate structure to support higher levels of supervision;
   - resources to provide necessary technical assistance to voluntary agencies seeking rate adjustments due to high turnover rates, difficulty in hiring and retaining qualified childcare workers, social workers and educators; and
   - the lack of career development incentives for childcare staff and educators.

2) **Capacity to Serve Children and Youth:**

Bed Space: Combined bed space for OCFS, OMH, and OMRDD is 14,140.

	OCFS	OMH	OMRDD	SED
Beds	9,587 beds[9]	2,553 beds[10]	2,000 beds[11]	N/A[12]

Geographic Proximity: New York City, Suffolk County, Westchester County and Nassau County have the largest number of children and youth being served in out-of-state residential facilities.

An overwhelming number of out-of-state residential placements come from these counties and are concentrated in the neighboring states of

[9] OCFS numbers include all congregate care which are more than 6 bed capacity, but not Therapeutic or regular Foster Boarding Homes

[10] Includes Intensive Psychiatric Services (Residential Treatment Facilities (RTFs), Child Psychiatric Hospitals, Articles 31 & 28, beds in crisis residences, community residences, family based treatment and teaching family homes). Complete breakdown including slots in section on OMH placement process and service provisions.

[11] Current number of children and youth being served in OMRDD residential settings.

[12] With the exception of state-supported schools (4201s) and the two State Operated Schools, NYS School for the Blind (Batavia) and NYS School for the Deaf (Rome), State Education does not identify itself as having residential beds and relies on the accommodations of other systems where schools are co-located to provide their students with residential services.

Massachusetts (JRC) and Pennsylvania (Kids Peace, Devereux and Woods Services).

Timing of Placement – Some out-of-state residential placements occur because at the time a school district or a social services district makes an inquiry to an in-state school, that facility may be at capacity or assess that the agency does not have adequate resources to assume care for another child with these specific clinical needs at that time. However, if contacted two or three days later, there may be, in fact, a vacancy. The statutory timelines require that school districts place a student after that student is identified as having a disability and after the CSE meeting, within 30 days. Thus, follow-up with the in-state providers is not usually conducted, and referrals are made to other schools until a child is accepted. These timelines are identified in Federal law for the placement process for Local Educational Agencies.

B. Local Level Coordination and State Level Oversight

Despite national trends toward provision of a coordinated system of care for each child and family, many localities and regions continue to be fragmented with various systems providing services solely within the boundaries of their own system, rather than creating a comprehensive plan of care that is coordinated across systems. This fragmentation and lack of coordination impedes the ability of the local entity that is developing a plan for the child from accessing the specific services from the various systems necessary to serve the child in the least restrictive setting as appropriate. It is critical to point out, however, that State education, mental hygiene and social services laws provide strict standards related to how services are delivered. Local systems at county and school district levels may be impeded by these federal or state statutory or regulatory requirements regarding eligibility that may indirectly create exclusionary criteria.

This fragmentation is further compounded by the barriers created by varying philosophies, regulations, and funding streams within each child serving system. These factors also effect monitoring and accountability functions within and across various state-level agencies.

Another critical factor regarding coordination issues across systems is that information and data systems that track the clinical needs and demographic/diagnostic issues of these children are not comprehensive or standardized within or across each system.

C. Marketing

There is a difference between the levels and intensity of marketing by out-of-state residential facilities that serve New York State children and youth and the in-state residential facilities in New York. Out-of-state residential facilities often have proactive business administration and marketing staff and are able to market themselves aggressively to Local Educational Agency Committees on Special Education, parents, family advocates and the community. In contrast, in-state facilities have not developed the same level of intensity in marketing.

D. Impact of Family Members in Placement Process

Another critical factor in determining placement for children in out-of-state residential facilities, primarily within the educational system, is the role of family members and their advocates. The Work Group is sensitive to the needs of family members and conducted two family focus groups to receive feedback from parents whose children were placed in out-of-state residential facilities. In most cases, families would prefer to have their child served in the least restrictive setting and as close to home as possible. If an appropriate placement to address the needs of a child could not be located within NYS, parents felt duty bound to search for the most appropriate placement for their child. Depending on a child's needs, that residential placement could be located in any of the 18 different states with residential programs that serve NYS children, and it could be with a program whose practices are not recognized or approved in New York State.

In light of these findings, the relevant Goals that the Work Group seeks to address are:

Goal #1: To enhance or improve access to the statewide systems of care to provide for children with complex or multiply-diagnosed needs; increase and strengthen prevention and residential services; and prevent, where possible, the placement of children out-of state,

Goal #2: To coordinate a centralized/shared data collection system across systems and levels of government, and

Goal #3: To strengthen the state's capacity and resources in order to provide opportunities to maintain children in New York State in the least restrictive setting available that can address their complex needs.

IV. FINDINGS AND RECOMMENDATIONS

A. Quality of Care – In State Capacity

1.) Devereux Foundation at Red Hook, NY

In addition to the four out-of-state residential facilities visited by the Work Group, an in-state site visit was made to Devereux Foundation in Red Hook, NY. This facility models best practices that could be replicated to serve children similar to those now being sent out of state. Devereux Red Hook is an OMRDD-licensed facility that provides residential and educational services for 104 campus residents and day educational services for 26 students. There were 20 students who were served through their Intermediate Care Facility (ICF) and 84 students treated through their 853 programs. The breakdown for CSE/LDSS referred students is 70 percent CSE and 30 percent LDSS.

Geographically, 65 percent of the students come from 10 counties in the Hudson Valley; 18 percent from upstate New York; and 17 percent from 3 boroughs in New York City.

Devereux Red Hook serves a group of children (28 females and 102 males) whose IQ's range from 30 to 81, with most falling between 40 and 70. Of this group, 23 have unique Axis I diagnoses, and most are clustered around attention deficit disorder and pervasive developmental disorders. More than half of the children have had prior psychiatric hospitalizations.

The academic program at Devereux Red Hook focuses on functional academics, community awareness and Activities of Daily Living (ADL) skills. The student-teacher-aide ratio for 4 classrooms was 6:1:2, and in 17 classrooms it was 6:1:1. Devereux Red Hook also implements a character education program to instill core values (respect, fairness, honesty, caring and responsibility) and qualities in students, reflect the values of parents, staff, and community members, and improve the ability of students to make moral and ethical decisions in their lives.

The residential program at Devereux provided a structured environment with strategic supervision based on risk assessment and risk management. This supervision may, in limited instances, include 1:1 staffing, which is supported through a special request/add-on for children for a specific duration. Residential settings were similar to what the Work Group saw at Woods Services: home-like environments, personalized bedrooms, age appropriate settings, and personalized common spaces. Efforts are also made at community integration.

The clinical services treatment orientation is behavior modification; emphasis is on skill acquisition and termination of challenging behaviors. Students and residents receive at least 2 group-training sessions per week, which address issues of social skill training, conflict resolution and anger management. All students receive at least one individual session a month. Coordinated with the school program, behavior modification is tied to the five core values identified above.

Red Hook has also been working on providing staff incentives to increase quality and reduce turnover, including reducing administrative costs to provide base salaries of $10/hour; offer Associate and Bachelor degree incentives and on-site college classes; and provide financial incentives (out of pocket school costs reimbursed, flat amount – based on longevity; and performance incentives).

Most of the funding for Devereux Red Hook comes from tuition and maintenance.

2.) Descriptions of the Types of Services Provided at the Out-of-state Sites:

The Work Group conducted site visits to three out of the four out-of-state residential institutions that serve the largest number of children and youth (the Devereux Foundation and Woods Services in Pennsylvania, and Judge Rotenberg Center in Massachusetts) and one with an increasing population of New York State children and youth (Easter Seals in New Hampshire). The purpose of these site visits was to get a first-hand understanding of how New York State children and youth are served and what factors make these institutions preferable to comparable facilities in New York State. Some observations from these visits are as follows:

- While there appear to be no substantial differences in program models and service quality between in-state and out-of-state residential facilities, the Work Group is

concerned that some children may be placed in facilities that employ behavior modification techniques not approved for use in New York State.

- Each of the out-of-state residential facilities visited had higher starting salaries for their childcare workers, provided intensive training and offered career opportunities, such as college tuition benefits and had established career ladders.

- Each facility is diversified in their treatment programs and does not focus on a specific target population, but may have specialized programs within their agencies (i.e., treatment for serious psychiatric or emotional disturbance).

- Education: Each of the sites visited had on-site schools with curricula designed to address the Individualized Education Program (IEP) of each student. The classes were broken down by age, functioning level and by diagnoses (e.g., classes that served children and youth with behavior disorders or with autism and then by chronological age, are matched with level of functioning). There often appears to be a higher student-teacher ratio in schools serving low-functioning and behaviorally-challenged youth than is available in NYS institutions.

- Each out of state facility typically provides basic medical/nursing servings and dispensing of prescribed pharmaceuticals as well as psychiatric, psychological, and social worker services separate and apart from the educational program. The LEA-placed children rely upon their parents' health insurance, and/or if enrolled, New York State Medicaid to purchase pharmaceuticals, dental care, and those medical services which are beyond that available through the facility's in-house nursing staff. LDSS-placed foster care children who are eligible for Title IV-E are enrolled in the Medicaid program of the state in which the facility is located and therefore access those medical services not provided directly by the facility through the use of that state's enrolled Medicaid providers. LDSS-placed foster care children who are not Title IV-E eligible are enrolled in New York State Medicaid. New York State Medicaid pays only those practitioners and medical institutions whose services are covered by New York State Medicaid, but many pharmacies and practitioners choose not to enroll. Therefore, the out-of-state residential facilities often obtain the New York State children's prescriptions by mail from pharmacies located in New York State and arrange for the children to receive medical and dental care in New York State. One residential facility, which served children with various mental health conditions, provides access to an on-site hospital for acute care services, allowing for flexibility for short stays in acute care when needed and return to program.

- Each of the campuses was relatively large in area with safe walking and driving infrastructures between schools and residences. There were varying degrees of quality in the residences across the out-of-state institutions.

3.) Length of Stay, Discharge and Communication Issues

At almost all of the visited out-of-state residential facilities, children and youth from New York State often <u>stay twice as long as children and youth from the host state</u>.

For example, children from the host state might stay for 6 to 9 months at one out-of-state facility, where New York State children could stay 15 to 24 months. At another out-

of-state residential facility, children from the host state might stay 24 to 48 months, while New York State children might stay 48 to 72 months.

In the more extreme cases, some NYS youth may age into the adult programs, if no appropriate aftercare option was located within NYS. Because of their severe conditions, some youth will never leave the facility before they age out at 21 years.

The Work Group is concerned about the contrast in lengths of stay between in-state/other-state children and youth and New York State children and youth being served at the visited institutions. The out-of-state residential placement facilities stated that the lack of sufficient transitioning and after care services was a key reason why New York State children and youth stayed longer than other states or their own state's children and youth.

A common theme among the four site visits is that NYS referral agencies (LEAs or LDSS) are not proactive in communicating with the facilities. Management staff at the visited sites stated that they reached out to the referring school districts, local departments of social service, including the NYC Administration for Children Services. When quarterly or annual reports on individual cases were sent, the institutions rarely heard back from the local referring entities with questions, comments or concerns.

Also, each of the institutions stated that they would provide comprehensive assessments on the admitted child, which they would share and consult with the parents and the referral agencies as they then developed a treatment plan, with limited feedback from the CSEs or LDSS.

4.) Family Involvement Through Out-of-State Residential Facilities

The four visited out-of-state residential facilities stated that they took pride in their family involvement activities and parent relations. Examples of opportunities for family involvement supported by these facilities include:

- Initial outreach and marketing through visits to NYS schools and communities;
- Online account access through their websites (with user IDs);
- Continuous e-mail correspondence;
- Frequently Asked Questions (FAQs) posted online;
- Monthly consultation by phone or e-mail on their child's progress;
- Coordinated and paid for transportation and lodging arrangements for parents visiting the facilities; and
- Parental involvement in the assessment, diagnosis and treatment planning for the child.

Recommendations:

- ✓ *Establish a coordinated development process to determine in-state capacity to address the needs of children placed out of state; define and promote flexibility in rate-setting mechanisms; and streamline licensing procedures so that eligible in-state institutions can apply for and receive multiple licenses in a timely, "fast track" manner. (3.1).*

- ✓ *Strengthen resources to serve children and youth, including but not limited to supervision, classroom staffing, clinical services, security and safety, and physical plant reconfigurations. (3.2).*

For example, children from the host state might stay for 6 to 9 months at one out-of-state facility, where New York State children might stay 15 to 24 months. At another out-of-state residential facility, children from the host state might stay 24 to 48 months, while New York State children might stay 48 to 72 months.

5.) Licensing of Residential Facilities

Each voluntary agency or school that provides specific services to children and youth must obtain a license from each service system, based on the type of services provided. If a facility wants to deliver services to children who have multiple service needs or needs beyond the scope of its license, it would have to apply through more than one system's licensing process and be responsible to each of those systems oversight procedures. Through its discussions, the Work Group considered the idea of developing a streamlined, fast-track process to enable facilities to quickly obtain multiple licenses to adapt to an emerging need for placement options.

6.) Preliminary Needs Assessment of In-State Residential Facilities

In addition to site visits to residential facilities in New York State, the Work Group has developed and distributed a preliminary needs assessment to 20 voluntary and New York State operated residential facilities. The purpose of this Needs Assessment is to gain information and insight on current assets and needs in providing services for New York State children; enhancing in-state residential and community services for children and families; decreasing the utilization of out-of-state residential placements; and shortening lengths of stay for New York's children and youth.

B. Lack of Service Coordination

New York State's system of care[13] for children and youth must be enhanced to provide a more coordinated and comprehensive system that facilitates access and eligibility for services for children and youth with complex or multiply diagnosed needs. Despite numerous initiatives and efforts by a number of localities, provision of services for children and youth with these needs can be fragmented, difficult for families to navigate, and uncoordinated.

1.) CCSI Tier I and Tier II Activities

The Coordinated Children's Services Initiative (CCSI) is a cross-systems process for serving children and youth with special emotional and behavioral service needs that builds upon legislation enacted in 2002. The process utilizes strength-based approaches, consistent and meaningful family involvement, individualized planning, and encourages creative, flexible decision-making and funding strategies. CCSI is designed to infuse local decision making processes with a set of core principles for helping

[13] Stroul and Friedman (1994) define system of care as "a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families."

children and youth and their families who have needs that cross administrative and service delivery lines. By working within a collaborative framework, agencies, organizations, and families can combine their respective skills and services to produce far greater benefits than when acting individually. CCSI has grown to include over 50 counties and boroughs across the state, and will expand by four additional counties in 2005.

The CCSI mission supports the development of coordinated *systems of care* that:

- *Develop and plan for one child and family at a time:* Service plans are developed around individual needs, not program categories;
- *Provide supports and services in family and community settings***:** Reduce over-reliance on restrictive and expensive out-of-home placements;
- *Develop parent/professional partnerships***:** Parents are involved at all levels of service planning and delivery
- *Use strength-based approaches:* Focus on child and family strengths as opposed to problems or pathology;
- *Deliver services that are culturally competent:* Recognize that a family's cultural background might affect the determination of appropriate services and incorporate dialogues, materials, and processes that respect the family's culture; and
- *Provide care that is unconditional:* Embrace the idea that services are provided to all in need regardless of how, when, or where they enter the child and family serving system.

CCSI works across and within a broad range of child and family service systems. There is no prescribed programmatic component to the Initiative beyond the formation of local teams that develop individualized service plans and collaborate on system-wide coordination and improvement.

Localities are encouraged to develop approaches that will best serve their target populations and that complement existing or anticipated efforts to improve services to children and youth and their families.

The activities of CCSI in 2005 will continue to focus on its core mission of keeping children and youth in their homes and with their families; monitoring the need for out-of-home placements, and, as they are determined to be necessary, assessing the placements are appropriate, serve the best interest of the child and that the child is placed in the least restrictive setting that will meet the child's needs. It also supports efforts to reintegrate the children and youth into their homes, schools, and communities as soon as possible. As in the past, these efforts will include family members and representatives across all child and family service systems at the state, regional and local levels.

Tier III, state agency representation of CCSI, identified priority areas which include continuing support for the implementation of the cross-systems recommendations, increasing county participation through the Phase VII CCSI expansion, and supporting localities and family members through increased technical assistance and training opportunities through the following activities:

- *Conducting regional training sessions*;

- *Developing best practices resources for counties;*
- *Expanding outreach efforts;* and
- *Providing Family Advocacy Training*.

2.) County Engagement

The Work Group has visited three counties and met with representatives of two others to assess how the service delivery system affects out-of-state residential placements by their county. Two of the three counties visited have recently received System of Care grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). Westchester, in spite of its many collaborative efforts, has a large number of out-of-state residential placements. Erie County has very low numbers of out-of-home and out-of-state residential placements. Columbia County does not have high placement numbers, but its rate of placement is relatively high.

Findings:

- School engagement – Among counties and at times among service systems in specific counties, there is a wide range of perception, relative to the role of schools in affecting out-of-state residential placements. These perceptions mostly focus on the extent to which schools and other systems communicate with each other. In Columbia County, the representatives that the Work Group met identified two school districts as having strong communication with the county systems, while others were not equally as involved. In Erie County, there was agreement that the relationship between the various systems and the Buffalo public schools was strong, and they were looking forward to reaching out to other school districts across the county. Westchester's systems representatives had varying experiences and relationships with the individual school districts.
- Reinvestment strategies – All three counties are focusing on some level of reinvestment/prevention strategy. The underlying concept is to reinvest any resources that would have been used to support out-of-home/out-of-state residential placements to prevention, wraparound or flexible funding options;
- Wraparound Funding – Erie and Westchester, as System of Care counties, promoted wraparound programs;
- Role of Family Members: All of the counties demonstrated varied levels of family involvement in their placement and decision-making processes; and
- Family Court judges play significant roles in the collaborative processes in Columbia and Erie Counties.

Recommendations:

- ✓ *Integrate NYS children and youth in in-state and out-of-state residential care into a comprehensive statewide System of Care, which collaborates to meet all of the child's complex and/or multi-systems needs in the least restrictive settings, as appropriate, within New York State. (1.1).*

- ✓ *Strengthen local and regional service coordination and streamline placement processes and access to community-based services, which include or complement*

existing infrastructures (e.g., Single Points of Access, Hard to Place/Serve Committees, and Coordinated Children's Services Initiative counties). (1.1-A).

- ✓ *Include wraparound funding to serve children with complex and/or multiply diagnosed needs and expand upon the success of local initiatives to integrate funds and services to provide for children with these needs. Funding would follow the child and be flexible to serve the child in the least restrictive setting, as appropriate. (1.1F).*

- ✓ *Reinvest any resources from returning/diverting children, if any, from out-of-state placements for community-based programs, and residential pilot programs, among other initiatives. (1.1G).*

- ✓ *Explore funding and program expansion to support least restrictive settings to treat children with multiply diagnosed needs, including children in foster care. (1.1H).*

3.) Comprehensive Assessment

Children and youth with intense, complex and/or cross-systems needs must receive services in the least restrictive setting appropriate to serve the needs of the child, (note that the most common populations for whom out-of-state placement occurs includes those children and youth who are multiply diagnosed). In order to determine the plan of care, children and youth must have comprehensive screening and assessment that address domains including: Health, Mental Health, Substance Abuse, Education, Developmental, and Social/Adaptive.

Proper assessment must also occur within the context of system of care practice and principles. Regardless of where a child enters the system of care, a full assessment of strengths and needs must be addressed according to these principles, which also parallel the Child and Adolescent Services System Principles (CASSP). These principles support that treatment is: individualized and child-centered, family focused, community based, culturally competent, collaborative, and in the least restrictive setting appropriate to serve the needs of the child. Several models exist at the local levels that are often used to monitor and support the implementation of these practices. They include local or regional Hard to Place committees, Integrated County Planning, Single Point of Access, and the Coordinated Children's' Services Initiative, among others.

The Work Group was charged with developing a report that addressed existing assessment initiatives and offered recommendations for comprehensive assessments. Attached to the Appendix is a copy of the report, *"Assessing the Needs of Multi-Systems Children: Recommendations and Guidelines*."

Recommendation:

- ✓ *Develop recommendations regarding a comprehensive assessment process to address the needs of children placed out of their homes, including children with complex and/or multiply diagnosed needs. (1.3).*

4. Data Collection Issues

Information and data systems that track the clinical needs and demographic/diagnostic issues of children and youth placed in out-of-state residential facilities are not comprehensive or standardized within or across each system. This conclusion was reached after efforts to collect data by the Council's Hard-to-Serve/Hard-to-Place staff yielded data that, in 2003, contained undifferentiated counts of children in residential placements and day services programs who were receiving daily educational services in close proximity to their community, but over the New York State border. Also, to identify the number and types of children and youth in out-of-state residential placements, the Work Group requested NYS youth profiles from three of the four out-of-state residential facilities visited, instead of having data on hand from its participating agencies.

Lastly, while individual agencies may collect specific youth information, this information was not generally shared with other systems. Statistical data might be available, but needs assessments, comprehensive youth profiles and other relevant information could not be accessed.

Recommendations:

- ✓ *Improve methods of data collection to provide consistent feedback to systems' stakeholders on the number and needs of children and youth who are hard-to-serve and are at risk of future out-of-state placement.*[14] *(2.1).*

- ✓ *Identify and define a consistent set of data elements for each student placed out-of-state by each state agency: name, DOB, disabling condition, prior placements and educational profile (academic, behavioral, physical, social and medical), and anecdotal information on previous interventions, and the reason for a referral for out of state placement. Development and sharing of data must comply with OCFS and SED confidentiality provisions. (2.1A).*

- ✓ *Identify current availability and capacity of in-state residential and nonresidential services varying service needs of each child. (2.1B).*

- ✓ *Conduct a statewide cross-systems needs assessment to identify low-incidence/high-need children, identify obstacles to the provision of in-state residential services to meet the specific needs of these children, and design an appropriate response. (2.2).*

- ✓ *Develop and implement a comprehensive review of individual cases of children and youth placed out-of-state. (2.3).*

5.) Placement Processes and Service Provision

Each of the child serving systems represented on the Work Group has a specific and identified constituency for which it is required by state and federal law to provide services. A majority of the specific constituencies can be served within the parameters

[14] Consistent with FERPA, provisions of IDEA, and provisions of federal Part 300 regulations that relate to confidentiality of information concerning students with disabilities.

of each respective services system. Below are descriptions of the systems capacity and processes for the provision of children and youth services.

- **Office of Children and Family Services:** The delivery of child welfare services including foster care services for children in the custody of local social services commissioners in New York is a State supervised, locally administered system. Foster care is provided either directly by the social services district through the placement of a child in a certified foster home or through a contract with a licensed voluntary foster care agency, which may operate a continuum of residential services from certified foster homes to institutional level of care. Children enter the foster care system through various paths. Most placements are a result of child abuse or maltreatment, but some are a result of a voluntary placement, Person in Need of Supervision or Juvenile Delinquency petition. Family Court reviews all placements on a periodic basis as required by state and federal statute. OCFS is responsible for the oversight, supervision, and regulation of child welfare services in New York and the licensing of voluntary authorized foster care agencies.

- Federal and state standards require that children and youth in foster care be placed in the least restrictive, most home-like setting, appropriate to meet the needs of the child. Where possible, a child in foster care must be placed in a setting that supports the child's ability to maintain contact with parent, caretakers, siblings and other persons, groups, or institutions with which the child had contact prior to placement.

- For all children and youth in foster care, including children and youth placed out of state, there are federal and State statutory requirements for periodic review of all placements every 6 months through a service plan review. The parent and the child, if age appropriate, are encouraged to participate in the development of the service plan and to attend the service plan review. This is in addition to the periodic permanency hearing and court review required for every child in foster care at least once every 12 months, at which time the family court must review and approve the child's permanency plan. The court has the option to modify the child's plan if it is not satisfied with the proposed plan of services and placement.

- There are 123 OCFS-approved voluntary authorized foster are agencies with certified congregate care programs in NY, 623 individual facilities, and 9,587 beds. Voluntary authorized foster care agencies are required to have a viable plan to educate children and youth in care and provide medical services. Local Departments of Social Services (LDSS) must send letters of support on behalf of a voluntary authorized agency before OCFS will approve the voluntary authorized agency. Congregate care residential services for children include agency operated boarding homes (capacity 1-6), group homes (capacity 7-12), group residences (capacity 13-25) and institutions (25 or more). These numbers change periodically throughout the year due to expansions or closed programs.

  Local Departments of Social Services implement a rigorous process in trying to keep children and youth in state, as opposed to going out-of-state. It is rare that children and youth are placed out-of-state without multiple diagnoses. The children may need more intensive services than are available in state/community at the time of the need for placement. Further, foster care funding is block

granted and capped. As most out of state placements are more costly than in-state services, the counties incur a higher expense for most out of state placements and make all efforts to seek in-state resources first.

OCFS Oversight: While an LDSS may place children and youth out-of-state, the rules for licensing, regulation and monitoring of residential programs are state specific.

When a child is placed in foster care, including out-of-state placements, the court is mandated to make a determination whether continued placement remains in the best interests of the child. When a child is to be placed in a foster care setting in another state, the placement must first be approved by the Interstate Compact on the Placement of Children (ICPC) Office of the receiving state. The standard used by that Office is that the placement does not appear to be contrary to the best interests of the child in foster care. It is expected that the receiving state's ICPC Office will verify the licensure status of the residential program in which the child will be placed. Children and youth in foster care who are adjudicated as juvenile delinquents may only be placed out-of-state following a court order authorizing such a placement.

The legal authority for the Interstate Compact on the Placement of Children and youth is Section 374-a of the Social Services Law, which was enacted in New York in 1960. Along with New York State, all 50 states and the District of Columbia are members. The purpose of the Interstate Compact is to provide an orderly mechanism with uniform rules and procedures to govern the placement of children and youth from one state to another.

ICPC is applicable in adoption, where the child is placed from one state to another and for foster care placements into congregate care facilities and foster homes from one state to another. This would include all categories of foster care: abused, neglected, Persons in Need of Supervision (PINS), juvenile delinquents and voluntary placements. In some states, the scope of ICPC has been interpreted to apply when a child is placed with a parent or relative in another state where the court retains jurisdiction or that there is a child protective services concern, even if the child is not in foster care. This interpretation is not applied in New York State.

ICPC is not applicable regarding the placement of a child – even if the child is in foster care – in a congregate setting caring for the mentally ill, mentally defective or epileptic primarily educational in character or a hospital or other medical facility. For example, New York does not require ICPC approval for CSE placements into New York, while some states such as Pennsylvania, Massachusetts, Connecticut and Virginia do require processing of CSE placements as ICPC cases to ensure commitment of payment. The relationship between the ICPC and New York State CSE placement processes is an area that will require further study by the Work Group.

State Education Department (SED): Public school districts are required under the Federal Individuals with Disabilities Education Act (IDEA) to operate Multi-disciplinary Teams. Committees on Special Education (CSE) are the Multi-disciplinary Teams mandated in Part 200 of the Commissioner's Regulations.

The CSEs have the regulatory responsibility to identify students needing special education, develop or locate an appropriate placement and oversee the student's Individualized Education Program (IEP). Currently, there are 1,034 students that receive special education services outside of the state. The CSEs that represent these students have demonstrated through evaluations that a more specialized or intensive special education program is required and is not currently available to the student within New York State. CSEs must document that five in-state residential schools have declined to accept the student being placed out-of-state.

When a School District's Committee on Special Education (CSE) determines that a student with a disability needs to be placed outside the school district in order to fulfill the provisions of the student's individualized education program (IEP), the LEA must apply to NYSED VESID for funding approval for the residential placement. The first step in the placement process is for the LEA to seek pre-approval for reimbursement by submitting an **Application for Approved Private School Reimbursement.** This application is submitted electronically through the STAC system.

If the placement funding has been pre-approved, the LEA may use information available through www.vesid.nysed.gov/specialed/privateschools to search all appropriate approved private schools with disabilities where the student can be placed. Program information including age range, gender, and disability classification is available. The LEA will apply for placement to appropriate schools.

If the LEA applies to all appropriate in-state schools that match the student's requirements and cannot find a placement, it may pursue out-of-state placement. The LEA provides documentation to VESID that placement of the student outside of the school district has received funding approval; documentation about the in-state schools that rejected the student and a recommended out-of-state school for placement. The LEA then proceeds with the out-of-state placement. It must be noted, however, that the LEA would be required to proceed with the placement, in accordance with the IEP, even if funding was denied.

If the LEA is unable to find an approved in-state school or approved out-of-state school it may pursue an Emergency Interim Placement (EIP). The LEA completes an EIP application (which includes documentation of in state and out of state schools rejecting the student and background information on the students needs) and submits it to VESID. The request is reviewed and if appropriate the approval for EIP placement is granted. The school district is provided with some suggestions of out-of-state schools that have been approved for individual student placements that may meet the needs of the student. The school district contacts the schools, determines the appropriate school that meets the needs of the student. Once a school is identified, the LEA applies to the school and when accepted, submits confirmation of acceptance and a STAC form to VESID for placement approval. Each EIP placement is only granted for one school year, although these approvals are often extended.

SED Activities Regarding Out-of-State Placements: The New York State Education Department (SED) recognizes that all students should have the opportunity to receive an education within their home school districts or counties.

In order to reduce the need for CSEs to seek placements out-of-state, a number of initiatives have been identified and are being implemented. SED is

- attempting to identify gaps in special education services on a county, regional and at a statewide level through BOCES and in-state private schools.
- beginning to analyze the types of students being placed in out-of-state residential facilities by disability, gender, and age to establish appropriate special education program initiatives and priorities.
- exploring the expansion of special education and residential services currently being offered in State Supported and State Operated schools for the deaf, blind and physically disabled to include students with more severe disabilities.
- continuing to provide technical assistance to CSEs and require they utilize the Coordinated Children's Services Initiative (CCSI) as a local resource before recommending a residential placement.
- requiring documentations that there are no in-state residential programs and that five in-state schools have declined to serve the child, prior to approving funding for an out-of-state residential placement;
- improving management and oversight of out-of-state residential placement requests by CSEs, and
- continuing to require the completion of a Statement of Assurance, signed by the chairperson of the local CSE.

Additionally, the following information is provided to update the Work Group on specific SED-led efforts to divert out-of-state residential placements and to lay the groundwork for children and youth currently receiving services in out-of-state residential facilities to receive them in-state.

- St. Christopher Ottile, located in Glen Cove, Long Island: VESID staff met with their administration staff regarding increasing capacity across New York City and Long Island to address students placed out of state. A second meeting, which will include OMRDD and OCFS, will be scheduled to discuss their proposal, which includes school expansion and residential opportunities. They will consider educating both students who meet OMRDD eligibility and those who are Emotionally Disturbed.

- VESID staff met with the Inter-Agency Council (IAC) which represents a group of private schools in NYC and Long Island and indicated that several of its schools are interested in expanding their capacity to address the service needs of students referred out of state. Continued discussion will address individual schools and specific populations.

- Meetings with the Council of Family and Child Caring Agencies (COFCCA) will be convened to further explore several private schools and their ability to address this issue.

- All students who are deaf and considered for out of state placement are being evaluated for placement at the Rome School for the Deaf's 5-day program.

- Up State United Cerebral Palsy is opening a 24 bed ICF, and 5 beds are reserved for NYS students currently place out-of-state.

- VESID is engaged with United Cerebral Palsy of New York and several of its affiliates to explore their capacity to address the issue of building capacity in state.

Recommendations:

- ✓ *Strengthen SED's (VESID) oversight and coordination of students with disabilities placed or potentially placed out-of-state with technical support from OMRDD, OMH, DOH, and OCFS, including CCF. Also, require consultation between CSE and LDSS by strengthening current law to review all CSE placements to out-of-state facilities, including Emergency Interim Placements (EIPs), and verify that all appropriate in-state options are exhausted (1.1C)*

- ✓ *Strengthen the approval process for new and existing schools/residential facilities for children placed through Local Educational Agencies/Committees on Special Education, including Emergency Interim Placement schools. Key concepts for this objective include:*
  1) *evaluating and determining NYS oversight licensing/certification criteria with licensing/certification criteria from host states;*
  2) *verifying that programs where children are placed out of state meet all licensing and inspection requirements of the home at the time of and duration of the placement of the child;*
  3) *exploring the feasibility of requiring all out-of-state facilities providing residential educational services to children or youth who are New York State residents, or interested in providing such services to apply for registration with the State Education Department. Such registration would require the payment of a fee by the facility into a dedicated "Special Revenue – Other" account in an amount intended to cover the costs of review and oversight of such facilities and the placements of New York students in such facilities; this initiative will need to account for the issues related to the Interstate Commerce Clause of the U.S. Constitution;*
  4) *confirming consistency of Local Educational Agency and local departments of social service contracts in developing standard language to reflect criteria and require relevant information and reporting obligations (e.g., abuse cases) from approved agencies, , reporting of incidents, appropriate arrangements with receiving state, and notification of relevant program issues, among other information issues (1.1D); and*

- ✓ *Revise local planning procedures to include participation by the local DSS and other service systems representatives in the local CSE placement process[15], where relevant. Through this improved and enforced participation, incorporate permanency-planning concepts in the Individual Education Program for all New York State children, including children with complex and or multiply diagnosed needs who might be at risk of out-of- home or out-of-state residential placements. (1.1I)*

[15] Must be in compliance with IDEA.

Office of Mental Health

The Office of Mental Health has a strong commitment to meeting the mental health needs of children and adolescents with serious emotional disturbance (SED). In New York State over the past 20 years, the system of care for children and adolescents with SED has evolved gradually from a system based primarily on inpatient treatment to a system that provides treatment primarily in the community. The shift to a community-based system of care has been made possible by advances in psychotropic medications, emerging scientific evidence about the effectiveness of home based clinical intervention, and the infusion of new resources into community-based mental health programs. It embodies the philosophy that the family, defined in its broadest sense, is the best place to raise children with SED so that they can stay at home and in school (Statewide Comprehensive Plan for Children's Mental Health). Approximately 140,000 children and adolescents are served in the public mental health system each year.

OMH provides children and adolescents with SED access to a comprehensive array of services including Emergency and Crisis Services, Intensive Psychiatric Services Family Support, Outpatient Services, Community Residential Services and Inpatient Services.

Additional, services include: School Based Mental Health Services, Functional Family Therapy, Family Support Services, day treatment, and clinic treatment.

In FY 2000-01 under the OMH Governor's New Initiatives, significant new funding was made available to local governments to both improve upon and expand the capacity of the mental health system. As part of this initiative, each local government was asked to establish/designate a Single Point of Access for children and youth and families.

The purpose of the SPOA for children and youth and families is to identify those children and youth at the highest risk of placement in out of home settings, and to develop appropriate strategies to manage them in their home communities

SPOA also identifies and plans for services for children who are at risk of residential treatment. By identifying and planning for children and families who are at risk earlier in the treatment process, it is anticipated that the need for inpatient hospitalization is reduced. SPOAs have reported that when identified children are evaluated and planned for early, they are less likely to need residential treatment services. They have also reported that less intensive, in-home supportive services provided to families are working to help children and youth in least restrictive settings (OMH Statewide Comprehensive Plan for Mental Health Services, 2004-2008).

Office of Mental Retardation and Developmental Disabilities (OMRDD):

The Office of Mental Retardation and Developmental Disabilities provides supports and services to a significant number of school-aged children and youth and their families. Most of these children and youth are served in their own homes and most OMRDD services are ancillary to services provided by their

families and local educational and social services agencies. OMRDD provides such services directly or can help families find the services they need through nearly 700 voluntary, not-for-profit agencies.

Recognizing that most families wish to raise their child with a disability at home, OMRDD has developed an individualized service system that enables them to do so. Most school-aged individuals served by OMRDD receive assistance through the family support program, which provides, among other things, respite care, counseling, transportation, parenting skills training, social work and advocacy services, and recreational and nutritional services.

Many families care for their child at home with support provided through the OMRDD Home and Community-Based Services (HCBS) Medicaid Waiver. The OMRDD HCBS Waiver program provides residential habilitation, day habilitation, family education and training, adaptive devices, environmental modifications as well as Medicaid state plan services. Children in foster care are not eligible to receive HCBS through the OMRDD waiver.

OMRDD also manages three specialized Medicaid Care-at-Home waivers for children and youth under the age of 18 who have a developmental disability and a pervasive medical condition. These waivers allow nearly 500 families to keep their child at home rather than resorting to institutional placement.

For families who are unable to care for their child at home, OMRDD offers a number of residential options. Nearly 2,000 school-aged children and youth currently reside in settings licensed or operated by OMRDD, the vast majority of whom live in family care homes, community intermediate care facilities for the developmentally disabled (ICF/DDs) and individualized residential alternatives (IRAs).

Since 1987, the State Education Department, the Office of Children and Family Services and OMRDD have jointly administered the Children's Residential Project (CRP), originally developed to provide both educational and residential programs for up to 300 students with severe developmental disabilities. CRP programs consist of a SED-approved private school, also known as an 853 School, and an OMRDD-certified ICF/DD. Admission to CRP programs is limited to those students identified through the education system as needing educational and residential services who also meet the residential eligibility criteria for the ICFDD established by OMRDD.

OMRDD also licenses several private residential schools in New York State, overseeing the quality of care provided by such programs. OMRDD does not have authority to place students with disabilities into these schools and does not have any fiscal responsibility for these programs.

Generally, residential or non-residential services are obtained through the Developmental Disabilities Services Office (DDSO), which alone determines eligibility for services, or through voluntary agencies.

Office of Alcoholism and Substance Abuse Services (OASAS)

OASAS outpatient and residential programs provide services to youth ages of 12 through 18, and family members of youths suffering from chemical dependency. While other programs may also offer appropriate services to youths and their families, Chemical Dependency for Youth programs have been certified as meeting New York State regulatory standards for outpatient or residential youth services.

OASAS also provides other services to substance-dependent children and youth, including crisis, inpatient, and outpatient services.

The Division of Probation and Correctional Alternatives (DPCA) is the state regulatory agency with responsibility to exercise general supervision over the administration of probation and correctional alternative services throughout New York State through funding and oversight. DPCA's mission is to be a leader in innovative community corrections and juvenile justice programming that provides for community safety, accountability and competency development through training and education, technology and financial assistance in partnership with public and private organizations.

DPCA adopts and promulgates rules and regulations concerning methods and procedure used in the administration of local probation services, and develops standards and contracts for the operation of alternative to incarceration programs. The State Director serves as the Chair of the New York State Probation Commission.

The Division coordinates program development and offers technical assistance for criminal and juvenile justice services provided by local probation departments and alternatives to incarceration agencies, and oversees interstate compact probation services.

The Division actively partners with other youth serving state agencies on interagency teams to improve early identification of youth at-risk and/or in need of specialized services. For the past 20 years DPCA has overseen the review and approval of Person in Need of Supervision (PINS). PINS Planning under Article 735 of the Family Court Act, and coordinated the PINS State Interagency Workgroup in these efforts; effective April 1, 2005, DPCA and OCFS will jointly review and approve the PINS diversion services portion of the county multi-year services plan.

DPCA meets regularly with DCJS, OCFS, OASAS, OMH, SED, and DOH staff around cross-systems issues for youth and families, with specific emphasis on collaboration and partnership. This occurs regularly through a number of meetings and forums, including Adolescent Partners for Children, Community Justice Forum, Coordinated Children's Services Initiative, and the Mental Health/Juvenile Justice Initiative.

The Division is committed to developing the tools and technology for effective screening and assessment, case management that targets criminogenic needs, is

anchored in strengths and accountability and connects youth and families to evidence-based interventions to build competencies.

Among DPCA's top priorities are articulating clear outcome measures for juvenile intake and supervision cases and developing specialized curriculum and training opportunities for juvenile probation officers. DPCA actively seeks new partnerships both with sister agencies at the state level, and promotes meaningful collaboration improvements on the local level.

6.). Training/TA and Education

While the Work Group and the CCSI Tier III Committee have recently initiated local training on out-of-state residential placements, historically such cross-systems training and coordination has been limited.

Recommendation:

- ✓ *Develop and continuously update a set of statewide child and family technical assistance resources such as service directories, assessment tools, referral guides, funding maps, and consulting services (1.2)*

7.) State Level Coordination of Monitoring and Accountability

Notwithstanding the substantial services provided by the various New York State agencies, the Work Group's investigation and discussions have demonstrated that there are obstacles to oversight and coordination across service systems regarding out-of-state residential placements, including:

- Lack of collaboration and dialogue at the community level between CSEs and other stakeholders (LDSS, DDSOs, SPOAs, CCSI) in placement decisions;
- Limited oversight of placement decisions and contracts at the State level for CSE recommended placements.
- Limited scrutiny and ongoing monitoring of out of state schools where CSE youth are placed by SED, along with a lack of information sharing with relevant state agencies;
- No requirement for reporting of abuse or neglect of CSE-referred youth to the referring agencies in New York State;
- Limited oversight by the State Education Department for Local Educational Agencies that utilize out of state Emergency Interim Placements (EIPs);
- Lack of coordinated sharing of data on NYS youth residing in out-of-state residential facilities;
- No prohibition to sending a child to an out-of-state residential facility with treatment services that would not be approved within New York State;
- No requirement for NYS review and verification of appropriate licensing and inspections of an out of state facility before the facility is approved by NYS for placements. SED is required to verify that school programs are approved by the host state, however, SED is not notified by the host state when an approval lapses;
- Tuition and maintenance rates are set by the host state and are established as mandated rates in most jurisdictions in New York State;

- Alternatives to out-of-state placements may not be well known.

Recommendation:

- ✓ *Develop a multi-level interagency process, coordinated by an existing single state agency, to guide placements of children with specialized, complex and/or multi-systems needs who may require consideration for residential services outside of NYS. This process should be engaged at the point when a social services district or school district identifies a child who has the potential to be placed outside of NYS. Such process will identify the necessary activities a social services district or school district must engage in prior to a request for an out of state placement for an individual child and must be in compliance with existing federal and state mandates. Key activities are as follows:*

  1) *Reinforce and strengthen the use of an interagency three tiered process on the local, regional and state levels to facilitate treatment and service planning for children at risk of placement as defined in various child-serving systems. Such processes should complement existing initiatives at the local, regional and state levels. Examples of such processes include SPOA, CCSI and Hard to Place committees on the local level, Region II on the regional level and the Hard to Place Committee at the State level.*
  2) *Monitor of data on children across service systems who might be referred out of state;*
  3) *Create a review process for out-of-state placements referred by either CSEs or LDSS that would explore all available and least restrictive options before a CSE or LDSS out-of-state recommendation is made to SED and/or the Family Court judge and identify alternatives to out-of-state residential placements. (1.1B)*

- ✓ *Where appropriate, develop consistent eligibility criteria, discharge planning and service coordination guidelines across systems for children going in and out of residential placements. (1.1E)*

8.) Fiscal Costs

The Work Group was charged with assembling a comparison of costs between out-of-state schools versus in-state schools serving students with similar disabilities. It cannot be assumed that the characteristics of the out-of-state schools are equal to those of the in-state schools in areas including, but not limited to, programming, staff intensity, and physical plant. One of the perceptions of out-of-state placements is that the out-of-state schools provide some greater intensity of programming than do in-state schools. This has yet to be proven accurate.

The Work Group was also directed to determine the economic impact of the flow of State and local dollars out-of-state. This analysis was prepared on a very general, but useful level.

A complete draft of this report will be included in the Appendix.

Summary of Funding Sources for Out-of-State Tuition and Residential Costs:

Children and youth placed out-of-state in residential schools or other institutional settings may be placed by Local Educational Agency Committees on Special Education (CSE) or by social services districts. The first group may be referred to as residential CSE placements and the second group as residential foster care placements.

The State's framework for financing a residential CSE placement involves two funding components: the funding of the child's special education program (tuition) and the funding of the care and maintenance and medical services associated with the child's daily care and supervision (maintenance).

The State's framework for financing a residential foster care placement involves three funding components: the funding of care and maintenance and case management costs associated with the child's daily care and supervision (maintenance); the funding of the child's educational program (tuition); and the funding of medical services (medical).

For foster children and youth placed in residential facilities, the challenge of maximizing Federal Title IV-E or Federal Medicaid reimbursement may be much greater than for in-state settings. This is because New York State does not establish a foster care reimbursement rate for such placements in other states. Whereas the foster care rate setting methodologies within New York State are specifically designed to maximize reimbursement from the available federal programs, the payment rates used by programs in other states may not be similarly structured. Thus, social services districts would typically receive a lower percentage of federal reimbursement for foster care placements in other states.

In-State Capital Costs

The rate setting methodologies that reimburse the costs of residential foster care or CSE placements have a property component in the rate that supports ongoing operational costs associated with the residential facility's physical plant. Those property components also have some capacity to support the costs of smaller capital projects. Capital projects of significance need an alternate source of funding.

The residential facilities, in terms of capital for the education component, have financing options that include a waiver of the property screens in the regular tuition rate, as well as a process for add-on rate financing by the Dormitory Authority of the State of New York (DASNY).

In terms of capital for the maintenance component, a new law effective April 1, 2005, will allow the Office of Children and Family Services (OCFS) to receive and approve applications for capital improvement projects for up to $30 million using the DASNY financing mechanism, and that mechanism would include a capital add-on rate. Apart from that, it is the property component of either the maintenance or medical rate that defines the maximum level of support for capital related costs for reimbursement of existing facilities. For new development, the rate setting structure permits more, but not adequate allocation of funds.

In addition to the current DASNY funding for voluntary authorized agencies, additional funding opportunities were presented and include use of additional sources for capital funding, such as ways to bond and securitize capital funding, and exploring such avenues as use of requests for qualifications (RFQs), which are used in other states to identify contractors for future capital construction and facility expansion activities.

Recommendation:

- ✓ *Create flexibility for reimbursing capital costs for building new structures and renovating/adding to existing structures within existing rate methodologies. This includes exploring new bonding/securitizing options beyond the Dormitory Authority of the State of New York (DASNY). (3.2B).*

Economic Impact

The Work Group developed an analysis of the economic impact of serving children in-state rather than out-of-state. Since it is unlikely that a proposal could be implemented to serve all 1,400 students currently placed out-of-state, the Work Group considered the impact of serving an additional 100 students in-state and averting the future out-of-state placement. In order to determine the economic impact of serving an additional 100 children and youth in-state, the Work Group compared the cost of serving these children and youth in-state with the cost of serving the children and youth out-of-state. Additionally, the cost of serving the children and youth in-state was then offset by the economic benefits New York State would receive in terms of job creation and additional dollars flowing through the community. These figures assume current salary rates, staff to youth ratios and fringe benefits and do not account for the potential need for more intense levels of service for children and youth with complex and/or multiply-diagnosed needs.

Hypothetical 100 Children and Youth Served In-State

The Work Group's analysis focused on the fiscal impact to NYS of serving 100 out-of-state residential placements in existing in-state residential programs. The Work Group selected the five (5) out-of-state providers with the greatest number of CSE placements, representing 75% of all out-of-state CSE placements in approved programs, to extract the 100-student sample. The Work Group consulted with SED program staff, who reviewed the characteristics of the program models of the 5 out-of-state schools selected and recommended for each out-of-state school one or more in-state programs that they determined are the most comparable model(s). The Work Group gathered the most recent per student tuition, maintenance, and medical costs for NYS students at the 5 selected out-of-state schools, as well as for students at the comparable in-state schools. The Work Group computed the cost of serving twenty (20) students at each of the five out-of-state schools (100 students in total), and computed the cost of serving twenty students at each of the 5 out-of-state schools' comparable in-state matches. When computing the cost of serving students in state, additional costs were factored in for capital construction to accommodate the potential need for additional facility space. The Work Group then calculated the cost differential of serving the 100-residential students sample in-state versus out-of-state. Finally, the Work Group determined the economic benefit to NYS of serving 100 additional residential students in-state.

Several assumptions were made by the Work Group in its approach to calculate the fiscal impact of serving 100 students in state versus out-of-state. One primary assumption is that the characteristics and needs of many NYS students currently being served out-of-state could be met with a similar level of service as currently being offered at the in-state program. (However, in some cases an increase in the intensity of services is needed.) Another assumption made is that each in-state provider is almost at full capacity; thus capital construction costs would have to be incurred at each of the in-state matches in order to accommodate the 100 students. Working under these assumptions, the Work Group determined that the cost of serving the 100-student sample in-state ($17,396,846) was slightly less than the cost of serving this group out-of-state ($17,516,477).

Economic Benefit of Serving 100 Additional Students In-State

Using a model developed by the Empire State Development Corporation (ESDC), the Work Group gathered information on staffing ratios and salaries, construction and rehabilitation costs and the region with the highest number of out-of-state placements. The total staffing ratio was 1.48 direct care workers per child with an average salary of $38,456. The number of new direct care jobs created as a result of serving an additional 100 students in-state is 148. Additionally, it is estimated that 45 new ancillary jobs would be created as a result of this proposal for a total of 193 jobs.

The construction parameters were developed using OCFS, OMRDD and SED data. The analysis included half of the youth being placed in new facilities, which would require new construction and half entering facilities that need some level of rehabilitation. The total construction cost is estimated at about $1.5 million.

The majority of children and youth placed out-of-state originated from the Long Island or the Mid-Hudson region. The economic model included this regional information to provide a geographically sensitive economic benefit model. The table below shows the economic impact related to serving 100 youth in-state compared to the cost of serving them out-of-state.

Economic Impact to Serve 100 Youth In-State as Opposed to Out-of-State

	Cost Benefit Analysis	In-State Cost	Out-of-State Cost	Savings for Serving Youth In-State
1	Annual cost of placing 100 students	$17,396,846	$17,516,477	$119,631
2	Total Economic Benefit	$7,762,151	$0	$7,762,151
3	**Net Economic Impact**	**$9,634,695**	**$17,516,477**	**$7,881,782**

The total cost to serve the 100 out-of-state student sample in-state versus out-of-state is nearly identical, whereas the economic benefit to NYS in terms of an additional 193 jobs created and an infusion of $7.8 million into the local economies makes this proposal fiscally beneficial to NYS.

Previously identified was the issue of the longer lengths of stay for NYS children in out of state placements. What has not been prospectively evaluated is the anticipated savings to local social services districts and school districts, if there are shorter lengths of stay at the more expensive residential settings.

Recommendation:

- ✓ *Re-assess all applicable funding mechanisms and rate setting methodologies to determine the need for program intensification or modification to existing funding mechanisms that are responsive to unanticipated cost increases, to the need for enhanced services for the current or anticipated populations, or to the need for structural reconfigurations to meet the specialized needs of the population. This re-assessment would focus on rate setting methodologies to encourage development of programs for children and youth at risk of out-of-state residential placements. (3.2A).*

C. Marketing and Public Awareness Issues

There is a difference between the levels and intensity of marketing by out-of-state residential facilities that serve New York State children and youth and the in-state residential facilities in New York State. Some out-of-state residential facilities have proactive business administration and marketing staff and are able to market themselves aggressively to Local Educational Agency CSEs, parents, family advocates and the community. In contrast, in-state facilities have not developed the same level of intensity in marketing.

Recommendation:

- ✓ *Develop a centralized clearinghouse of research and evidence based practices, and a list of children and youth residential services providers. (1.2A).*

D. Family Involvement/Family Issues

Another critical factor in determining placement for children and youth in out-of-state residential facilities is the role of family members and their advocates. The Work Group is sensitive to the needs of family members and conducted two family focus groups in April to receive feedback from parents whose children and youth were placed in out-of-state residential facilities. In most cases, families would prefer to have their child served in the least restrictive setting and as close to home as possible. If an appropriate placement to address the needs of a child could not be located within NYS, parents felt duty bound to search for the most appropriate placement for their child, likely out of state. Depending on a child's needs, that residential placement could be located in any of the 18 different states with residential programs that serve NYS children, and it could be with a program whose practices are not recognized or approved in New York State.

During April 2005, two parent focus groups were held and were attended by parents of children and youth who have received services in out-of-state residential facilities. It is critical to note that the feedback provided below is from a limited number of parents/caregivers in a focus group setting and does not represent the experiences of all family members and caregivers with children who are being served in out-of-state residential facilities. In order to obtain a broader range of opinions from a larger sample of families, a more comprehensive process would be necessary.

Parent feedback on improving the current residential services system is provided below:

Service, Capacity and Staffing Issues

1. Offer additional early intervention services for families;
2. Provide additional vocational rehabilitation opportunities for children and youth who reside in residential facilities;
3. Expand availability of New York State programs for sexually offending youth, and expand programs for children and youth with mental health and mental retardation/developmental disabilities needs.
4. Define eligibility criteria for Office of Mental Health Residential Treatment Facilities (RTF) hospitalizations;
5. Provide additional training for service providers in residential facilities on cultural competency; and
6. Reduce high staff turnover in order to prevent the interruption of a streamlined service delivery process for children and youth in residential settings.

Family Support Issues

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1. Provide training and technical assistance to families on navigating the child welfare system;
2. Develop additional respite services for families;
3. Offer additional mentoring opportunities; and
4. Search for and identify appropriate residential settings for children and youth that are closer to home.

Systemic Issues

1. Streamline and specialize assessment process;
2. Increase training and resources for family advocates;
3. Initiate earlier development of after care services for children and youth in residential facilities; and
4. Make Committee on Preschool Special Education/Committee on Special Education less intimidating for families.

Recommendations[16]:

- ✓ *Develop and continuously update a set of statewide child and family technical assistance resources such as service directories, assessment tools, referral guides, funding maps, and consulting services. (1.2).*

- ✓ *Develop a centralized clearinghouse of research and evidence-based practices, and a list of children and youth residential services providers that includes a web-based platform. (1.2A).*

[16] These recommendations are repeated from above to reinforce their specific value to the family engagement and decision-making role in the residential placement process.

- ✓ *Develop and implement a comprehensive review of individual cases of children and youth placed out-of-state. (2.3).*

V. CONCLUSION

By addressing the specific topic of out-of-state residential placements, the Work Group has identified many issues and concerns regarding the delivery of services to children with complex and/or multiply diagnosed needs, including those who are currently served in their communities and in residential facilities in and outside of New York State.

The recommendations are offered with the intent that they be evaluated on their ability to be implemented interdependent of each other. The Work Group believes that approving these recommendations and taking the critical next steps could address the immediate concern of out-of-state residential placements and also promote a comprehensive and coordinated system of care throughout New York State that would provide services to all children in the least restrictive settings.

The agencies of this Work Group, along with its partners in the State Legislature and family representatives, are committed to finding practical and sustainable solutions to this issue and look forward to fulfilling the recommendations through individual initiatives and through various coordinated and collaborative forums.

ASSESSING THE NEEDS OF MULTI-SYSTEMS CHILDREN:
RECOMMENDATIONS AND GUIDELINES

INTRODUCTION AND BACKGROUND:

In New York State, there is an ever-increasing reliance and utilization of out-of-state residential facilities. Such placements cost the state over $200 million per year, and result in loss of jobs in the state health and human services industry. Such placements result in removal of children from their home and community and disrupt efforts to maintain them with family.

The general target population for whom out-of-state placement occurs includes those children who are multiply diagnosed. These youth are not easily or efficiently served by any one child serving system. Recent documentation has shown that there are emerging and existing trends among hard-to-serve, cross-systems children in New York State. These trends include:

- Children requiring sex offender treatment services;
- Children who are dually diagnosed with developmental disabilities and severe mental illness;
- Children who require residential placement settings but do not function well in group settings;
- Children with very aggressive behaviors; and
- Children with combinations of various high-risk behaviors, such as aggressive and assaultive behaviors, alcohol and/or substance abuse, sexual offending and/or victimization, fire setting, suicidal ideation, and mood disorders, among others.

CALL TO ACTION:

Children with cross-systems needs must receive services in the least restrictive, yet integrated setting in order to ensure the most comprehensive and appropriate services possible. In order to determine the plan of care for such services, children with cross-systems needs must have comprehensive screening and assessment that addresses the following domains:

- Health
- Mental Health
- Substance Abuse
- Educational
- Developmental
- Social/Adaptive

Proper assessment must also occur within the context of system of care practice and principles. Regardless of where a child enters the system of care, a full assessment of strengths and needs must be addressed according to these principles and guidelines. To

ensure proper assessment this must occur consistently across all systems and levels of care.

The concept of the System of Care was developed in the 1980s to ensure that appropriate services and supports for children with Serious Emotional Disturbance were provided. These principles were developed after a national study in 1982 found that 2/3 of all children with severe emotional disturbances were not receiving appropriate services (J. Knitzer, Unclaimed Children, 1982). These children were unclaimed by the public agencies responsible to serve them, and there was little coordination among the various child-serving systems. Many of these children received services from multiple agencies, and thus could meet the definition of cross-systems children, similar to those children currently being placed out of state. In response to this study, the system of care principles (also summarized in the Child and Adolescent Service System Program) were developed.

The Child and Adolescent Service System Principles (CASSP) are as follows:

- Individualized and Child Centered: The system of care should be child-centered, unconditional, and individualized to meet the unique needs of each child.
- Family Focused: Services should be family focused, with the view that the family is the best place in which to raise children and that families should be involved in all levels of service planning and decision making.
- Community Based: The system of care should be community-based, with the locus of services as well as the management and decision-making responsibility resting at the community level.
- Culturally Competent: The system of care should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial and ethnic differences of the populations they serve.
- Collaborative: Services should be planned in a collaborative manner, with all child-serving agencies and systems who are involved in the child's situation, in order to serve the multi-system needs of the child.
- Least Restrictive Setting: Services should occur in settings that are the least restrictive, natural and community based whenever possible.

TWO EXAMPLES OF MODELS TO MAINTAIN CHILDREN AT HOME, IN COMMUNITY AND IN STATE:

Coordinated Children's Services Initiative (CCSI):

In New York State several forums exist which were created to implement these systems of care principles and practices. In the early 1990s, the Coordinated Children's Services Initiative was developed in New York State. The program was developed in response to the fragmented system of care for children and families which existed CCSI's original charge was to maintain children at risk of placement, in their home and community whenever possible. The CCSI process promotes a set of core principles at all levels of government, across a broad range of service agencies, and throughout the service planning and delivery process. These principles guide a process of cooperative interagency planning that develops and delivers individualized services to children and

their families. The CCSI process relies on those principles set forth in the CASSP system of care as delineated above.

Currently the CCSI process exists in over 50 counties and all five boroughs of New York State. In 2003, those counties submitting semi-annual reports to CCSI Tier III indicated that 1,491 children were referred to CCSI and of those 1,319 were accepted into the process. Of the cases reviewed through the CCSI process, only 77 or 5.8 % resulted in an out-of-home placement and 42% of semi-annual reports showed no out of home placements for that six month period.

Single Point of Access for Children and Families (SPOA):

In 2000-01, the state Governor's New Initiatives increased spending for children's mental health services by $42 million. The funding focused on expansion of children's mental health services and asked for each county and borough in New York State to designate and establish a Single Point of Access for Children and Families (SPOA). The SPOA serves to identify those children at highest risk of placement in out of home settings and develop appropriate strategies to manage those children in their home communities. Although the SPOA was intended to focus on children with serious emotional disturbance, it has also served as a forum to address the needs of children who cross multiple systems. The SPOA process achieves this goal through: 1.) Use of a screening instrument to identify the high risk/high need target population; 2.) Use of a Universal Referral Form to facilitate coordinated, efficient entry into high end services; 3.) Use of a process to manage slot vacancies; and 4) Assurance that families receive family support when needed.

In 2002, over 6000 children statewide were referred through the SPOA process. Outcomes from the SPOA have included: 1.) Reduction in time and more streamlined referral to receipt of services; 2.) Increase in community tenure and community integration for high needs children; 3.) Earlier identification and prevention of more high risk behaviors; 4.) More integration and collaboration with other child-serving agencies who are stakeholders at the SPOA table, including local social services in over 95% of counties, probation, local and state inpatient psychiatric hospitals, family court, law enforcement, schools, and others; 5.) Development of a utilization plan for services and implementation of satisfaction surveys using evidence-based or best practice assessment instruments; and 6.) Ever increasing involvement of families and children at the SPOA table and at all levels of decision making.

RECOMMENDATIONS FOR ASSESSMENT:

Using and building upon existing processes in New York State such as CCSI and SPOA, standards for assessment and screening for children with multi-systems needs must be incorporated. These standards must: 1.) Identify the considerations, dimensions and domains that each child-serving system should meet to support the identification of strengths, needs, risk factors and treatment issues; 2.) Promote the development of case plans that target the highest risk areas for intervention and which maintain the child at home and in the community or in the least restrictive setting; 3.) Provide a mechanism to measure progress over time; 4.) Be applied on a consistent basis at all levels of decision

making from the local to the regional to the state level; and 5.) Assessments must be done by qualified personnel trained or qualified to administer the instrument.

It is also important to recognize that children with cross-systems needs have strengths and often multiple needs. This "special needs" population requires access to high quality services, across multiple disciplines that are well coordinated, comprehensive, community-based, family friendly, culturally competent, individualized and strength-based. To assess for multiple needs, assessment should occur as a collaborative assessment that encompasses all assessments deemed necessary to formulate a plan of care and discharge. Whenever possible, a multi-system assessment should be done at one point in time, and as early as possible, in order to assure consistency in the child's presentation of strengths and needs. Such assessment should include a multi-disciplinary team trained in cross-systems issues including a psychiatric or mental health professionals, psychologist, education specialist, health care professional, family advocate and other specialists as needed (e.g., substance abuse, sexual offender treatment, etc.).

A Description of Cross-systems Planning and Assessment:

Following section describes the process of quality assessment and treatment plan development. It also delineates options at local, county/regional and state levels when barriers arise preventing the child from remaining at home, in community and/or in state.

I. Individualized/ Local Level of Planning and Assessment/Level I:

The child enters the system in one agency. That agency completes an assessment and service plan according to that system's standards, but also incorporating the system of care or CASSP principles and involves the child and family. Such assessment must incorporate consideration of all domains of treatment and must incorporate evidence based or best practice instruments available. Each plan of care is individualized, utilizing the strengths of each child and family. Using existing interagency processes which may include but are not limited to SPOA, Hard to Place Committees, or CCSI, a comprehensive, efficient, and strength-based, individualized plan of care is developed in order to maintain the child in home and community whenever and wherever possible.

In those instances where out of home and community placement is required (after all avenues for maintaining the child at home and community are exhausted) the SPOA and/or CCSI or other interagency forum should work with the placement agency to return the child to the community and coordinate with the placement agency to develop a comprehensive plan of care and treatment and to expedite the child's return to the community as soon as possible.

II. County/Regional Level II:

There are some situations where the local system of care and interagency efforts have not resulted in an effective plan of care for the cross-systems child, or have not been able to maintain the child at home and in their community. In these cases, a county wide or regional forum, composed of county and regional agency stakeholders, families and youth should convene, to attempt to address the barriers that prevented implementation of an individualized plan of care for children and families in their county. This group may take the

place of a county wide or regional forum. Examples of such forums include Tier II of CCSI, or regional forums such as Region II.

III. State Level III:

When the county or regional forum finds that more substantial changes are required, (e.g. regulation or policy issues) then the issues and barriers are referred on to a state level forum of stakeholders for resolution. This interagency forum must include child-serving agencies, families and youth. Such forums currently exist at the state level through CCSI Tier III. In addition there exists through the Council on Children and Families a Hard to Place Committee for children whose multi-system needs have not been met at the local level.

Research Next Steps:

- ✓ Research demonstrates that early assessment of children and families is beneficial to avert the need for more serious intervention in the future. There is a critical need to do research to provide information about the feasibility of various assessment instruments across different service settings, with different child-serving systems, and across various diagnostic groups. In addition the applicability of use of various assessment use with demographic groups including age, gender and ethnic groups is needed to provide assessment and provision of services that comprehensively and effectively meet the needs of the cross-systems child and his family, (Emotional and Behavioral Disorders in Youth, Spring 2003, p.p. 31-50).

- ✓ In addition education should be done on multiple levels. Public awareness regarding the need to consider cross-systems issues should be done for parents, providers, pediatricians, educators, care providers and the public at large. Training for professionals in cross-systems issues and the system of care should also be done on a statewide basis.

RESOURCES:

Appendix A incorporates assessment and evaluation requirements including mandated assessments, qualified personnel and timeframes for each child serving system in New York State (includes Summary of OMRDD Guidelines, Health Services for Children in Foster Care Timeframes, OMH assessment timeframes – draft).

Appendix B references some best practice or evidence based instruments for assessment as recommended by child serving agencies in New York State (includes CeASAR CRAFFT Instrument for Adolescent Substance Abuse, Service Needs Assessment Profile/SNAP, Youth Assessment and Screening Instrument Project/YASI, Child and Adolescent Functional Assessment Scale/CAFAS, and Child and Adolescent Needs and Strengths Survey/CANS, Article on Evidence-Based Assessment of Children with Behavioral and Emotional Disorders from the Spring 2003 issue of Emotional and Behavioral Disorders in Youth).

Appendix A:

Assessment Guidelines

Summary of OMRDD Eligibility Guidelines

- Our system uses broad OMRDD services eligibility criteria and related ICF/DD or HCBS eligibility criteria

- OMRDD Eligibility = Criteria permitting enrollment into various services

OMRDD Eligibility and the Mental Hygiene Law (14 NYCRR 1.03):

(21) "Mental retardation" means sub-average intellectual functioning which originates during the developmental period and is associated with impairment in adaptive behavior.

(22) "Developmental disability" means a disability of a person which:

(a) (1) Is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, or autism;

(2) Is attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such person; or

(3) Is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;

(b) Originates before such person attains age twenty-two;

(c) Has continued or can be expected to continue indefinitely; and

(d) Constitutes a substantial handicap to such person's ability to function normally in society.

The information contained in this summary document was taken in part from the OMRDD Eligibility Guidelines Policy Advisory issued on August 10, 2001. Please refer to the actual 2001 OMRDD Eligibility Advisory for complete information about eligibility requirements.

For ICF/MR Level of Care

- Must have a formal diagnosis of mental retardation or other developmental disability which includes: autism, cerebral palsy, epilepsy, mental retardation, and/or other neurological impairments; the onset of this disability must have been manifested prior to age twenty-two; must receive New York Medicaid; and must demonstrate a need for a continuous active treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services, in some or all of the following areas:

    - Adaptive behaviors or independent living skills
    - Affective development
    - Auditory functioning
    - Cognitive development
    - Nutritional status
    - Physical development and health
    - Sensorimotor development
    - Social development
    - Speech/language development
    - Vocational/prevocational development

- The person must also demonstrate one or more of the following criteria for admission to an ICF/MR:

    - A need for acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible, OR,
    - Require continuous supervision and the structure, support, and resources of a comprehensive service program on an ongoing basis, OR,
    - Require assistance to continue to function independently because he/she has learned to depend upon the provided programmatic structure.

The information contained in this summary document was taken in part from the OMRDD Eligibility Guidelines Policy Advisory issued on August 10, 2001. Please refer to the actual 2001 OMRDD Eligibility Advisory for complete information about eligibility requirements.

OMRDD Eligibility Determination Policy Advisory

Issued August 10, 2001

- This advisory defines terms and processes for eligibility determination

Applicability of the Advisory

- The advisory applies to eligibility regardless of whether services are provided by OMRDD or by not-for-profit organizations licensed or certified by OMRDD

- Only authorized DDSO staff may determine eligibility for OMRDD services, regardless of what agency, provider, or practitioner will render the services.

- Other providers of professional services can conduct assessments on which eligibility determinations are based.

Eligibility due to Mental Retardation

- Must meet professional diagnostic standards for sub-average intellectual performance (@-2 SD IQ), demonstrate substantial limitations in adaptive functioning (see later), and demonstrate onset before age 22 years

Eligibility due to conditions other than Mental Retardation

- For conditions such as autism, cerebral palsy, epilepsy, familial dysautonomia, and neurological impairment:
  - The diagnosis of the named condition, or a related condition is required.
  - Also required are:
    - (1) Onset prior to age 22,
    - (2) Likelihood of indefinite continuation, and
    - (3) Presence of substantial handicap and functional limitations.

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Need for Complete Clinical Information

- History and presence of developmental disability must be evident prior to the age of 22.
- Standardized intelligence testing is required as a component of comprehensive assessment of the clinical condition.
- Standardized measures of adaptive functioning that can detect substantial handicaps or functional limitations must be used.

Evidence of Developmental Onset of a Condition

When no information is available about age of onset of disability during the developmental period (e.g., for someone now in her 50s):

- Practitioners are advised to make efforts to acquire school records and should not assume that these do not exist.
- DDSOs are advised to rely on the clinical judgment of appropriately licensed or certified professionals.
- These judgments should be based on the best available and obtainable information.

Functional Limitations and Substantial Handicap

Functional Limitations

- Are generally considered to constitute a substantial handicap when they prohibit a person from: engaging in self-care or exercising self-direction independently, or when development of self-care and self-direction skills are significantly below age level

Functional Limitations that Constitute Substantial Handicap

- Are significant limitations in adaptive functioning that are determined from the findings of assessment by using a nationally normed and validated, comprehensive, individual measure of adaptive behavior, administered by a qualified practitioner.

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Onset of Functional Limitations

- Must be before the person attains age 22 in order to satisfy the requirements of MHL 1.03(22)(b).

- Onset must be verified as appearance of significant limitations in adaptive behavior prior to age 22

Defining Functional Limitations

For adaptive behavior measures that provide an overall composite or summary index score:

- Substantial Handicap is an overall composite or summary index score that is 2.0 or more SDs below the mean for the appropriate norming sample, or within the range of adaptive behavior consistent with mild to profound MR in the norms.

Alternate Criterion I

- **An alternate criterion is that the majority of these factor or multiple scale summary scores lie 2.0 or more standard deviations below the mean for the appropriate norming sample, or lie within the range of adaptive behavior associated with mild to profound MR in the norms.**

Alternate Criterion II

- **Substantial handicap may also be demonstrated if the majority of factor or multiple scale summary scores from an adaptive behavior measure lie at 2.0 or more standard deviations below the mean, and the composite score is less than 2.0 standard deviations below the mean**

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Key Distinctions

Adaptive behavior measures that:

- Do not provide either overall summary index scores or factor or scale scores, or
- Are not normed on general population samples,
- Are unacceptable as means for determining presence of substantial handicap.

Key Distinctions

- Substantial handicap = limitations in adaptive functioning

- Presence of clinically significant maladaptive behavior without significant limitations in adaptive behavior, does not satisfy the requirements for substantial handicap, although it is often measured by adaptive behavior scales

Assessing Intellectual Skills

- Requires a nationally normed, validated, and comprehensive, individual measure of intelligence;
- Administered in a standardized format, in its entirety in the standardized way; and
- Is interpreted by a qualified practitioner.
- When a qualified practitioner finds standardized formats inappropriate, other formats can be used, but the format and rationale must be thoroughly documented.

Assessing Adaptive Behavior

- Requires a nationally normed, validated, comprehensive, individual measure of adaptive behavior
- A low IQ does not automatically validate substantial handicap
- With a formal assessment finding of IQ < 60, DDSOs may permit clinical assessment of adaptive behavior instead

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Differential Diagnosis

- Determination should be made, based on available evidence and clinical judgment, that significant functional limitations:
  - Are not due to a current acute or severe phase of a psychiatric disorder
  - Are not a consequence of psychiatric disorder, alcoholism, or alcohol or substance abuse disorders
- Determination should be made that functional limitations are associated with, attendant to, or result from, a particular developmental disorder or combination of such disorders.
- Developmental disorders are conditions that involve injury, dysfunction, disorder, or impairment of the central nervous system, i.e., brain or spinal cord

Criteria for Standardized Measures (I.Q. and A.B.)

- Reliability and Validity are suitably verified
- Reliability, Validity, Indicated Uses, and Performance Parameters are stated in test manuals
- Normed or Criterion Referenced on a suitable population and the Norms or Criterion Referencing are not outdated
- Standardized in their administration, and so used
- Suitably Structured and Comprehensive or Targeted for their specific purpose

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American Academy of Pediatrics
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Policy Statement

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Indications for Management and Referral of Patients Involved in Substance Abuse (RE9947)

AMERICAN ACADEMY OF PEDIATRICS

Committee on Substance Abuse

ABSTRACT. This statement addresses the challenge of evaluating and managing the various stages of substance use by children and adolescents in the context of pediatric practice. Approaches are suggested that would assist the pediatrician in differentiating highly prevalent experimental and occasional use from more severe use with adverse consequences that affect emotional, behavioral, educational, or physical health. Comorbid psychiatric conditions are common and should be evaluated and treated simultaneously by child and adolescent mental health specialists. Guidelines for referral based on severity of involvement using established patient treatment-matching criteria are outlined. Pediatricians need to become familiar with treatment professionals and facilities in their communities and to ensure that treatment for adolescent patients is appropriate based on their developmental, psychosocial, medical, and mental health needs. The family should be encouraged to participate actively in the treatment process.

ABBREVIATIONS. *DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; DSM-PC, Diagnostic and Statistical Manual for Primary Care Child and Adolescent Version.*

The stages of substance use leading to abuse and dependency were defined more than a decade ago (Table 1).[1] Since then, the American Academy of Pediatrics has published a number of related policy statements and has defined the role of the pediatrician in the management of substance abuse by children and adolescents.[2] One challenge that remains for the practitioner, however, is to determine the severity of the young person's drug involvement and then make a decision about continued office follow-up or referral for evaluation and possible treatment. If specialized treatment is needed, the practitioner should determine the most appropriate referral for that patient.

The early stages of substance abuse are often the most difficult to evaluate. Although experimentation with mood-altering chemicals, including nicotine, is common, it is important that the experimentation not be condoned or trivialized by adults. The first and only use of even the so-called gateway drugs (alcohol, marijuana, and inhalants) may result in tragic consequences as a result of unintentional injuries or even death. Often the early user is naive about the effects of a substance, is uninitiated in its use, and has no tolerance for the effects of the drug.

For the young person who is experimenting with drugs (stage 2), the pediatrician can have an important role in the educational process for the patient and the family. If there have been no adverse

consequences, brief counseling and in-office follow-up may be all that are needed. For the young person who has begun to experience adverse consequences of substance abuse, such as injuries associated with acute intoxication, trouble with the law, truancy, decline in school performance, or deterioration in physical or mental health, intervention is indicated.

Although confidentiality is the cornerstone of establishing a relationship with older children and adolescents, sometimes the behaviors of a young person are dangerous enough to justify and require a discussion with the parents. Depending on the circumstances, maintenance of confidentiality with the adolescent and the family may not be possible. A level of substance abuse associated with injuries, legal entanglements, failure in school, or deterioration of physical or mental health requires that family members be made aware of the dangers so that they can become involved in the therapeutic process.

At follow-up office visits, the pediatrician has the opportunity to assess continued use or abuse. Families should be advised to set firm rules about their children's involvement with tobacco, alcohol, and other drugs, and the consequences for use should be defined so that all persons understand the expectations. Behavior by parents, teachers, other adults, and health care professionals that enables tobacco, alcohol, and other drug use (such as tolerating an adolescent's erratic behavior, decline in school performance, or association with known substance users) must be recognized and avoided. The pediatrician can become part of the chain of adults emphasizing the non-use message by providing clear and consistent information to parents and their children while maintaining a trusting and caring relationship. A nonjudgmental approach that emphasizes health risk is paramount.

Some adolescents are able to discontinue the use of alcohol and other drugs by making a personal commitment with little formal treatment and with the aid of self-help groups or family support only. Developmentally, most teenagers will stop abusing alcohol or other drugs by early adulthood. The goal should be not only to recommend treatment, but also to identify the consequences of a lifestyle of alcohol and other drug abuse and motivate the patient to seek the help needed to initiate and maintain recovery. This can be most difficult with the adolescent patient, and literature is emerging on the role of motivational interviewing to encourage change in the patient who is dependent on nicotine or other psychoactive drugs.[3,4] Physicians can enhance the motivational process in their patients by expressing their concerns and encouraging an evaluation or formal assessment. Successful recovery usually begins when the patient stops denying that substance abuse is the cause of the life consequences experienced. Active participation by the pediatrician can assist in breaking down the denial and facilitate entry into the recovery process.

The decision to refer more heavily involved children and adolescents (stages 3-5) is straightforward if their symptoms and signs are recognized as being caused by substance abuse or dependence. Deciding where to refer the identified adolescent in need of treatment often is more complicated. For admission, most treatment programs require a diagnosis of abuse or dependence based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*[5] (*DSM-IV*), (Tables 2 and 3). Some treatment programs or communities have education and prevention services available for those identified early. Although most primary care practitioners do not have a working knowledge of *DSM-IV* diagnoses, an understanding of "substance abuse" and "substance dependence" criteria can help decide who needs referral and where the person should be referred.[5] The *Diagnostic and Statistical Manual for Primary Care* (*DSM-PC*) *Child and Adolescent Version,* published by the American Academy of Pediatrics in 1996, also classifies substance use/abuse by adolescents.[6] Any adolescent meeting the *DSM-IV* criteria for abuse or dependence should be assessed by a professional experienced in adolescent chemical dependency. If the patient or family is unwilling to pursue evaluation in this phase of the drug use continuum, it may be a challenge to avoid an adversarial relationship as the pediatrician makes referral recommendations that clearly are indicated but not accepted by the patient or family. Although

resistance and denial are intrinsic to the disease and are expected at this stage, it is important to make the best recommendation for the teenager and family while remaining available and supportive.

DUAL DIAGNOSIS

Adolescents who manifest psychiatric diagnoses in addition to substance abuse raise additional diagnostic concerns. [7-10] Other psychiatric disorders, especially major depressive disorders and conduct disorder, have been demonstrated in adolescents who use tobacco, alcohol, and other drugs.[11] Although a high prevalence of comorbidity has been reported in adolescent substance abusers receiving inpatient treatment,[12-16] the number of adolescents who exhibit psychiatric symptoms because of the substance abuse disorder and the number who have a primary or coexisting psychiatric diagnosis is unclear. Miller and Fine[17] believe that methodological considerations, including the length of abstinence required before the diagnosis is made, the population sampled, and the perspective of the examiner, affect prevalence rates for psychiatric disorders in substance abusers and account for the variability. They see the prevalence rates for psychiatric disorders as being artificially elevated by the tendency to establish a diagnosis before some of the psychiatric symptomatology secondary to the substance use abates. Ideally, the patient in a stable condition should be observed for a minimum of 1 month after discontinuing drug use and before diagnosing a comorbid disorder or initiating treatment with a psychopharmacologic agent. In this era of very brief (or no) hospitalization, it may make sense to diagnose and prescribe medication sooner, especially if the disorder predates the substance use or if there is a family history of psychiatric disorder.

Awareness of the prevalence and manifestations of psychiatric diagnoses is essential for the quality treatment of adolescent substance abusers, and the clinician needs to know what kind of comorbid conditions are commonly seen. Large-scale population studies have not been conducted on children and adolescents, but the National Institute of Mental Health's Epidemiologic Catchment Area Study[18] attempted to estimate the true prevalence rates of alcohol abuse, other drug abuse disorders, and mental disorders in a community and institutional sample of more than 20 000 adults standardized to the US census. Of persons with alcohol disorders, 37% had another mental disorder, with the highest prevalence for affective, anxiety, and antisocial personality disorders. More than 50% of those with drug disorders other than alcohol use disorders had a comorbid mental disorder: 28% had anxiety disorders, 26% had affective disorders, 18% had antisocial personality disorder, and 7% had schizophrenia. The study[18] verified the widely held impression that comorbidity rates are much higher for patients in treatment and institutional settings than in the general population.

The diagnostic categories most likely to be encountered in the pediatrician's office are affective, anxiety, and disruptive behavior disorders. Pediatricians will best serve these patients if they:

1. Conduct a complete evaluation of each patient that includes a comprehensive psychosocial history and physical examination, as well as a mental status examination and an inquiry into other psychiatric symptomatology by using information obtained from collateral sources, such as parents or teachers;
2. Have a high index of suspicion for psychiatric comorbidity in adolescents whose conditions do not respond to treatment or who are presenting problems in treatment;
3. Individualize treatment to accommodate other psychiatric diagnoses; and
4. Have a working relationship with and know when to consult a mental health specialist. The close integration of mental health care and primary care are important; managed care arrangements that separate mental health and addiction services from primary care make this coordination more difficult.

WHERE TO REFER PATIENTS

In addiction medicine, the concept of "patient-treatment matching" has become increasingly important in determining the appropriate level of care for the patient with a diagnosis of substance abuse or dependence.[19] Matching is based on a comprehensive biopsychosocial assessment of the patient and considers the history of current and past drug use, previous treatment, health consequences, comorbid psychiatric conditions, family and social issues, vocational-educational effects, experience with the justice system, motivation for treatment, and support systems available.

Managed care dictates treatment options in chemical dependency and mental health as rigorously as for medical and surgical treatments, and the primary care physician is routinely required to approve referrals for substance abuse and mental health treatment. Firm guidelines are being established that determine the level of care and length of treatment, and inpatient treatment is no longer the norm for the initial referral. More commonly, the patient must be unsuccessful at outpatient treatment before being recommended for inpatient treatment. The presence of a comorbid psychiatric condition may necessitate an earlier inpatient admission.

The American Society of Addiction Medicine has published *Patient Placement Criteria* that define levels of adult and adolescent treatment.[20] Adolescent levels include early intervention, outpatient treatment, and medically monitored or managed inpatient care. Placement is based on 6 dimensions that include acute intoxication/withdrawal potential, previous medical conditions and complications, emotional/behavioral conditions and complications, treatment acceptance/resistance, relapse/continued use potential, and recovery environment (Table 4). The publication also includes parameters for continued stay and discharge from the various levels of treatment.

A more comprehensive and detailed description of the continuum of adolescent treatment options based on multiple client assessment criteria has been published by the Center for Substance Abuse Treatment.[21] The treatment levels include more intensive outpatient options, as well as long-term residential psychosocial care (therapeutic communities), half-way houses, and group home living arrangements for seriously involved adolescents.

Successful addiction treatment usually involves more than one level of care during a long recovery process. The treatment may involve outpatient or inpatient care in the beginning with continued care at a level appropriate for the patient's recovery process. Most chemically dependent patients in treatment consider themselves "recovering" rather than "recovered" and are involved in sequential treatment levels that usually include a formal structured program, attendance at 12-step self-help groups (eg, Alcoholics Anonymous, Narcotics Anonymous), and continued self-recovery work. Relapse is an expected part of recovery and can be viewed as a learning opportunity that is important to the process rather than a failure. If relapse occurs, pediatricians once again can have an important supportive role or initiate further referral if additional formal treatment is required. By collaborating with a counselor or addiction specialist, as well as the insurance company, the school, and the family, the pediatrician can make a meaningful contribution to the recovery process.

CRITERIA FOR THE SELECTION OF A SUBSTANCE ABUSE TREATMENT PROGRAM

Appropriate substance abuse treatment facilities for children and adolescents must have staff with adequate experience in dealing with these age groups. The following criteria may be useful in evaluating an inpatient or outpatient adolescent substance abuse treatment program.

1. The program views drug and alcohol abuse as a primary disease rather than a symptom.

2. The program includes a comprehensive evaluation of the patient and appropriately manages or refers for treatment any associated medical, emotional, or behavioral problems identified in the initial assessment.
3. The program adheres to an abstinence philosophy. Any use is abuse. Drug use is a chronic disease, and a drug-free environment is essential. Tobacco use ideally should be prohibited, or nicotine cessation treatment should at least be part of the overall treatment plan.
4. There is a low ratio of patients to staff. Treatment professionals should be knowledgeable in the treatment of chemical dependency and adolescent behavior and development.
5. Professionally led support groups and self-help groups are integral parts of the program.
6. Adolescent groups are separate from the adult groups if both are treated at the same facility.
7. The entire family is involved in treatment. The program relates to parents and patients with compassion and concern with the goal of reunification of the family whenever possible.
8. Follow-up and continuing care are integral parts of the program.
9. As progress is made in the program, patients have an opportunity to continue academic and vocational education and are assisted in restructuring family, school, and social life.
10. The program administration discusses costs and financial arrangements for inpatient and outpatient care and facilitates communication with managed care organizations.
11. The program is as close to home as possible to facilitate family involvement, even though separation of the adolescent from the family may be indicated initially.

RECOMMENDATIONS FOR PEDIATRICIANS

1. Pediatricians need to become familiar with the patterns of adolescent nicotine, alcohol, and drug use and the stages of substance abuse. Knowledge of the *DSM-IV* and *DSM-PC* criteria for diagnosis is useful for differentiating experimental use from problem use.
2. A thorough psychosocial and medical assessment of the patient is essential before making a referral for evaluation or treatment. Familiarity with the levels of treatment available and the multidimensional assessment criteria used to determine the intensity of services required can assist the pediatrician to make an appropriate referral.
3. Substance abuse is a potentially fatal disease. Use to the point at which school, activities, home, or work is affected represents symptomatic substance abuse and usually warrants parental involvement and a comprehensive interview and assessment.
4. Awareness of the high prevalence of psychiatric disorders among adolescents who abuse or are dependent on psychoactive substances will affect the decision as to where to refer the adolescent. If the pediatrician suspects a comorbid psychiatric diagnosis and needs assistance in determining appropriate treatment, psychiatric consultation should be obtained.
5. As advocates for adolescents and families requiring substance abuse treatment, pediatricians have the opportunity and obligation to become familiar with professionals and programs in their communities that provide education, prevention, and treatment services, including smoking cessation. A close working relationship facilitates referrals and communication.
6. Pediatricians also can advocate with local managed care organizations to provide quality mental health and substance abuse services that are appropriate for specific ages and developmental stages and that are integrated with primary care. Knowledge of the criteria for selecting an adolescent treatment program and the American Society of Addiction Medicine *Patient Placement Criteria* form the basis for these advocacy efforts.
7. Pediatricians must be familiar with state and federal regulations governing confidential exchange of information about substance abuse treatment. These are available from the state alcohol and substance abuse treatment regulatory agencies.

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REFERENCES

1. Comerci GD. Recognizing the 5 stages of substance abuse. *Contemp Pediatr.* 1985;2:57-68
2. American Academy of Pediatrics, Committee on Substance Abuse. The role of the pediatrician in the prevention and management of substance abuse. *Pediatrics.* 1997;91:1010-1013
3. Miller WR, Rollnick S. *Motivational Intervening: Preparing People to Change Addictive Behavior.* New York, NY: Guilford Press; 1991
4. Werner MJ, Adger H. Early identification, screening, and brief intervention for adolescent alcohol use. *Arch Pediatr Adolesc Med.* 1995;149:1241-1248
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed. Washington, DC: American Psychiatric Association; 1994
6. American Academy of Pediatrics. Wolraich ML, Felice ME, Drotar D, eds. *The Classification of Child and Adolescent Mental Diagnosis in Primary Care. Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version.* Elk Grove Village, IL: American Academy of Pediatrics; 1996
7. Bukstein O, Kaminer Y. The nosology of adolescent substance abuse. *Am J Addict.* 1994;3:1-13
8. DeMilio L. Psychiatric syndromes in adolescent substance abusers. *Am J Psychiatry.* 1989;146:1212-1214
9. Shuckit MA. Genetic and clinical implications of alcoholism and affective disorder. *Am J Psychiatry.* 1986;143:140-147
10. Stowell RJ, Estroff TW. Psychiatric disorders in substance abusing adolescent inpatients: a pilot study. *J Am Acad Child Adolesc Psychiatry.* 1992;31:1036-1040
11. Brown RA, Lewinsohn PM, Seeley JR, Wagner EF. Cigarette smoking, major depression, and other psychiatric disorders among adolescents. *J Am Acad Child Adolesc Psychiatry.* 1996;35:1602-1610
12. Grilo CM, Becker DF, Walker ML, Levy KN, Edell WS, McGlashan TH. Psychiatric comorbidity in adolescent inpatients with substance use disorders. *J Am Acad Child Adolesc Psychiatry.* 1995;34:1085-1091
13. Hovens JG, Cantwell DP, Kiriakos R. Psychiatric comorbidity in hospitalized adolescent

substance abusers. *J Am Acad Child Adolesc Psychiatry.* 1994;33:476-483
14. Clark DB, Pollock N, Bukstein OG, Mezzich AC, Bromberger JT, Donovan JE. Gender and comorbid psychopathology in adolescents with alcohol dependence. *J Am Acad Child Adolesc Psychiatry.* 1997;36:1195-1203
15. Clark DB, Neighbors B. Adolescent substance abuse and internalizing disorders. *Child Adolesc Psychiatr Clin North Am.* 1996;5:45-57
16. Brown PJ, Recupero PR, Stout R. PTSD substance abuse comorbidity and treatment utilization. *Addict Behav.* 1995;20:251-254
17. Miller NS, Fine J. Current epidemiology of comorbidity of psychiatric and addictive disorders. *Psychiatr Clin North Am.* 1993;16:1-10
18. Rieger DA, Farmer ME, Rae DS, et al. Comorbidity of mental disorders with alcohol and other drug abuse: results from the Epidemiologic Catchment Area (ECA) Study. *JAMA.* 1990;264:2511-2518
19. Mee-Lee D. Matching in addictions treatment: how do we get there from here? In: Miller NS, ed. *Treatment of the Addictions: Applications of Outcome Research for Clinical Management.* Binghamton, NY: Haworth Press, Inc; 1995:113-127
20. Mee-Lee D. *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders.* 2nd ed. Chevy Chase, MD: The American Society of Addiction Medicine, Inc; 1996
21. McLellan T, Dembo R. *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents.* Rockville, MD: US Dept of Health and Human Services; 1993. Treatment improvement protocol (TIP) series. Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. DHHS Publication No. (SMA) 93-2009

TABLE 1
Stages of Adolescent Substance Abuse*

Stage	Description
1	Potential for abuse
	Decreased impulse control
	Need for immediate gratification
	Availability of tobacco, drugs, alcohol, inhalants
	Need for peer acceptance
2	Experimentation: learning the euphoria
	Use of inhalants, tobacco, marijuana, and alcohol with friends
	Few, if any, consequences
	May increase to regular weekend use
	Little change in behavior
3	Regular use: seeking the euphoria
	Use of other drugs, eg, stimulants, lysergic acid diethylamide (LSD), sedatives
	Behavioral changes and some consequences
	Increased frequency of use; use alone
	Buying or stealing drugs
4	Regular use: preoccupation with the "high"
	Daily use of drugs

	Loss of control
	Multiple consequences and risk-taking
	Estrangement from family and "straight" friends
5	Burnout: use of drugs to feel normal
	Use of multiple substances; cross-addiction
	Guilt, withdrawal, shame, remorse, depression
	Physical and mental deterioration
	Increased risk-taking, self-destructive behavior, or suicidal behavior

* Adapted from Comerci.[1(pp58-59)]

TABLE 2

*DSM-IV** Criteria for Substance Abuse[5]

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by 1 (or more) of the following, occurring within a 12-month period:
a. recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (eg, repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
b. recurrent substance use in situations in which it is physically hazardous (eg, driving an automobile or operating a machine when impaired by substance use)
c. recurrent substance-related legal problems (eg, arrests for substance-related disorderly conduct)
d. continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (eg, arguments with spouse about consequences of intoxication, physical fights)
2. The symptoms have never met the criteria for substance dependence for this class of substance.

* *DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.*[5(pp182-183)]

TABLE 3

*DSM-IV** Criteria for Substance Dependence[5(p181)]

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by 3 (or more) of the following, occurring at any time in the same 12-month period:
1. tolerance, as defined by either of the following:
a. a need for markedly increased amounts of the substance to achieve intoxication or desired effect
b. markedly diminished effect with continued use of the same amount of the substance
2. withdrawal, as manifested by either of the following:
a. the characteristic withdrawal syndrome for the substance
b. the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. the substance is often taken in larger amounts or over a longer period than was intended

4. there is a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance (eg, visiting multiple doctors or driving long distances), use the substance (eg, chain-smoking), or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (eg, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

* *DSM-IV* indicates *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.*[5(p181)]

TABLE 4
Adolescent Criteria: Crosswalk of Levels 0.5 Through IV*

Criteria Dimensions	Levels of Service				
	Level 0.5 Early Intervention	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment	Level IV Medically Managed Intensive Inpatient Treatment
Dimension I: acute intoxication and/or withdrawal potential	No withdrawal risk	No withdrawal risk	Manifests no overt symptoms of withdrawal risk	Risk of withdrawal syndrome is present but manageable in Level III	Severe withdrawal risk
Dimension 2: biomedical conditions and complications	None or very stable	None or very stable	None or, if present, does not distract from addiction treatment; manageable at Level II	Require Medical monitoring but not intensive treatment	Requires 24-hour medical and nursing care
Dimension 3: emotional/behavioral	None or very stable	None or manageable in an outpatient structured environment	Mild severity, with the potential to distract from recovery efforts	Moderate severity; requires a 24-hour structured setting	Severe problems require 24-hour psychiatric care, with concomitant addiction treatment
Dimension 4: treatment acceptance/resistance	Willing to understand how current use	Willing to cooperate but needs	Resistance high enough to require	Resistance high despite negative consequences;	Problems in this dimension do

OMH INPATIENT/OUTPATIENT ASSESSMENT TIME FRAMES- EXAMPLE

Time Frame	Activity	Mandated	Who Performs	Inpatient/ Outpatient
On admission Within 60 hrs. of admission..	Adm./ Screening Psychiatric Evaluation	X	Psychiatrist	Inpatient. admission note done on admission. Psychiatric evaluation done within 60 hrs of admission Outpatient allows three visits prior to admission and then admission note on admission
Begun in first 24hrs and completed on first treatment plan	Physical Exam and Assessment/Pediatric Health Screening	X	MD	Inpatient.- Physical exam is done in first 24 hrs. with assessment completed prior to initial treatment plan formulation. Outpatient- Pediatric Health Screening is done prior to initial treatment plan formulation.
Initial Pt. I	Nursing	X		

completed in first 24 hrs and update Pt. II completed prior to initial treatment plan.	Assessment Pt. I and Pt. II		RN	Inpatient
Begun on admission and completed within 5 days of admission.	Core History	X	Social Worker	Inpatient. and outpatient. (for outpatient. Needs to be completed prior to core evaluation and is begun at initial contact).

Done prior to completion of treatment plan.	Core Evaluation which on inpatient includes risk factors, problems, strengths, family functioning, and treatment needs and reccommenda-tions. On outpatient Includes mental health, physical, educational, family, psychological, vocational, mental status	X	Clinician	Outpatient includes psychiatric evaluation. and mental status exam.

Health Services Time Frames

The chart below outlines the time frames for initial health activities, to be completed within 60 days of placement. The column labeled Mandated indicates whether an activity is required. The **"M"** in the time frame column indicates that the activity is required within a mandated time frame. Initial health activities include:

- Immediate screening of the child's medical condition, including assessment for child abuse/neglect.
- Immediate efforts to obtain medical consent.
- Immediate attention to HIV risk assessment.
- Comprehensive health evaluation: A series of five assessments provides a complete picture of the child's health needs and is the basis for developing a comprehensive problem list and plan of care.
- Follow-up health evaluation that incorporates information from the five initial assessments.
- Ongoing efforts to obtain child's medical records and document medical activities.

INITIAL HEALTH SERVICES TIME FRAMES

Time Frame	Activity	Mandated	Who Performs
24 Hours	Initial screening/screening for abuse/neglect		Health practitioner (preferred) or caseworker/health staff
5 Days **M**	Initial determination of capacity to consent for HIV risk assessment & testing	X	Caseworker or designated staff
5 Days **M**	Initial HIV risk assessment for child without capacity to consent	X	Caseworker or designated staff
10 Days **M**	Request consent for release of medical records & treatment	X	Caseworker or health staff
30 Days **M**	Initial medical assessment	X	Health practitioner
30 Days **M**	Initial dental assessment	X	Health practitioner
30 Days	Initial mental health assessment	X	Mental health practitioner
30 Days **M**	HIV risk assessment for child with possible capacity to consent	X	Caseworker or designated staff
30 Days **M**	Arrange HIV testing for child with no possibility of capacity to consent & assessed to be at risk of HIV infection	X	Caseworker or health staff
45 Days	Initial developmental assessment	X	Health practitioner
45 Days	Initial substance abuse assessment		Health practitioner
60 Days	Follow-up health evaluation		Health practitioner
60 Days **M**	Arrange HIV testing for child determined in follow-up assessment to be without capacity to consent & assessed to be at risk of HIV infection	X	Caseworker or health staff
60 Days **M**	Arrange HIV testing for child with capacity to consent who has agreed in writing to consent to testing	X	Caseworker or health staff

	may affect personal goals	motivating and monitoring strategies	structured program but not so high as to render outpatient treatment ineffective	needs intensive motivating strategies in a 24-hour structured setting	not qualify patient for level IV treatment
Dimension 5: relapse/continued use potential	Needs understanding of, or skills to change, current use patterns	Able to maintain abstinence and recovery goals with minimal support	Intensification of addiction symptoms; high likelihood of relapse without close monitoring and support	Unable to control use despite active participation in less intensive care; needs 24-hour structure	Problems in this dimension do not qualify patient for level IV treatment
Dimension 6: recovery environment	Social support system or significant others increase risk of personal conflict about alcohol/other drug use	Supportive recovery environment and/or patient has skills to cope	Environment unsupportive but, with structure or support, patient can cope	Environment dangerous for recovery, necessitating removal from the environment; logistical impediments to outpatient treatment	Problems in this dimension do not qualify patient for level IV treatment

* This overview of the adolescent admission criteria is an approximate summary to illustrate the principal concepts and structure of the criteria.
From the American Society of Addiction Medicine.[20(p131)]

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	and needs, strengths and recommendations.			
Done no later than treatment plan and is done earlier for clients with specified health triggers.	Nutrition Evaluation	X	Dietician	Inpatient
Done within 5-7 days of admission. unless triggered by risk factors	Treatment Plan ** note that treatment plan reviews are done every 30 days.	X	Primary Therapist/Clinician	Inpatient. Outpatient. (for outpatient due date varies with program type.
Part I is done prior to arrival of client or no later than 15 days after date discharge. Part. II completed by time of discharge	Discharge Summary/ Service Plan	X		Inpatient. Outpatient: (for clinic is done prior to arrival of client or within two weeks and for day treatment. is completed within 15 days of discharge).
Done at any time as indicated during course of treatment Identified triggers may indicate need for assessment in each area.	Psychiatric Rehab Evaluation. Drug/Alcohol Evaluation. Cultural Evaluation. Psychological		Done by qualified clinician	Inpatient Outpatient.

Appendix B:

Some recommended system assessment instruments

200.4 Procedures for referral, evaluation, individualized education program (IEP) development, placement and review.

(a) *Referral.* A student suspected of having a disability shall be referred in writing to the chairperson of the district's committee on special education or to the building administrator of the school which the student attends or is eligible to attend for an individual evaluation and determination of eligibility for special education programs and services.

(1) A referral may be made by:

(i) a student's parent or person in parental relationship;

(ii) a professional staff member of the school district in which the student resides, or the public or private school the student legally attends;

(iii) a licensed physician;

(iv) a judicial officer;

(v) the commissioner or designee of a public agency with responsibility for welfare, health or education of children; or

(vi) for purposes of referring one's self, a student who is over 18 years of age or older, or an emancipated minor, who is eligible to attend the public schools of the district.

(2) A referral submitted by persons other than the parent, student or a judicial officer shall:

(i) state the reasons for the referral and include any test results, records or reports upon which the referral is based that may be in the possession of the person submitting the referral;

(ii) describe in writing, intervention services, programs or instructional methodologies used to remediate the student's performance prior to referral, including any supplementary aids or support services provided for this purpose, or state the reasons why no such attempts were made; and

(iii) describe the extent of parental contact or involvement prior to the referral.

(3) The *date of receipt of a referral* means the date on which either the committee chairperson or the building administrator receives the referral, whichever is earlier.

(4) If a referral is received by the building administrator, it shall be forwarded to the committee chairperson immediately upon its receipt by the administrator.

(5) If a referral is received by the committee chairperson, a copy shall be forwarded to the building administrator within five school days of its receipt by the committee chairperson.

(6) A committee chairperson who receives a referral shall immediately notify the parent pursuant to section 200.5(a) of this Part.

(7) In the event that the parent and the person submitting the referral agree in writing pursuant to section 200.5(b) of this Part that the referral shall be withdrawn, the chairperson of the committee on special education shall provide the parent and the referring person a copy of the agreement. Each such agreement shall specify any alternative methods suggested to resolve the identified learning difficulty of the student and shall provide the opportunity for a follow-up conference within an agreed period of time to review the student's progress. A copy of the agreement shall also be placed in the student's cumulative educational record file.

(8) In the absence of a written agreement to withdraw a referral, as described in paragraph (7) of this subdivision, and in the event that parental consent is not obtained within 30 days of the date of receipt of referral, the chairperson shall document attempts made by the chairperson or other representatives of the committee to obtain parental consent, and shall request that the board of education initiate an impartial hearing in accordance with section 200.5(b)(1)(i)(c) of this Part.

(9) The building administrator, upon receipt of a referral or copy of a referral, may request a meeting with the parent or person in parental relationship to the student, and the student, if appropriate, to determine whether the student would benefit from additional general education support services as an alternative to special education, including the provision of educationally related support services, speech and language improvement services, academic intervention services, and any other services designed to address the learning needs of the student and maintain a student's placement in general education with the provision of appropriate educational and support services. If the person making the referral is a professional staff member of the school district in which the student resides, that person shall attend such meeting. The building administrator shall ensure that the parent understands the proceedings of the meeting and shall arrange for the presence of an interpreter, if necessary. Any other person making a referral shall have the opportunity to attend such meeting. If at such meeting the parent or person in parental relationship and the building administrator agree in writing that, with the provision of additional general education support services, the referral is unwarranted, the referral shall be deemed withdrawn, and the building administrator shall provide the chairperson of the committee on special education, the person who made the referral if a professional staff member of the school district, the parent or person in parental relationship to the student, and the student, if appropriate, with copies of the agreement. The copy of the agreement provided to the parent or person in parental relationship shall be in the native language of such person. Such agreement shall contain a description of the

additional general education support services to be provided and the proposed duration of such program. A copy of the agreement shall also be placed in the student's cumulative education record file. The meeting:

(i) shall be conducted within 10 school days of the building administrator's receipt of the referral; and

(ii) shall not impede a committee on special education from continuing its duties and functions under this Part.

(b) *Individual evaluation.* (1) Unless a referral is withdrawn pursuant to paragraph (a) (7) or (9) of this section, an individual evaluation of the referred student shall be initiated by a committee on special education and shall include a variety of assessment tools and strategies, including information provided by the parent, to gather relevant functional and developmental information about the student and information related to enabling the student to participate and progress in the general education curriculum (or for a preschool child, to participate in appropriate activities). The individual evaluation must be at no cost to the parent, and the initial evaluation must include at least:

(i) a physical examination in accordance with the provisions of sections 903, 904 and 905 of the Education Law;

(ii) an individual psychological evaluation, except when a school psychologist determines after an assessment of a school-age student, pursuant to paragraph (2) of this subdivision, that further evaluation is unnecessary;

(iii) a social history;

(iv) an observation of the student in the current educational placement; and

(v) other appropriate assessments or evaluations, including a functional behavioral assessment for a student whose behavior impedes his or her learning or that of others, as necessary to ascertain the physical, mental, behavioral and emotional factors which contribute to the suspected disabilities.

(2) A determination by a school psychologist of the need to administer an individual psychological evaluation to a student of school-age pursuant to Education Law, section 4402(1)(b)(3)(a) and section 200.1 (aa) and (bb) of this Part, shall be based upon an assessment conducted by the school psychologist to substantiate his or her determination. Whenever a school psychologist determines that a psychological evaluation is unnecessary, the psychologist shall prepare a written report of such assessment, including a statement of the reasons such evaluation is unnecessary, which shall be reviewed by the committee.

(3) Notwithstanding any provisions of this subdivision or section 200.1 (aa) of this Part to the contrary, the committee on special education may direct that

additional evaluations or assessments be conducted in order to appropriately assess the student in all areas related to the suspected disabilities.

(4) A committee on special education shall arrange for an appropriate reevaluation of each student with a disability if conditions warrant a reevaluation, or if the student's parent or teacher requests a reevaluation, but at least once every three years by a multidisciplinary team or group of persons, including at least one teacher or other specialist with knowledge in the area of the student's disability. In accordance with paragraph (5) of this subdivision, the reevaluation shall be sufficient to determine the student's individual needs, educational progress and achievement, the student's ability to participate in instructional programs in regular education and the student's continuing eligibility for special education. The results of any reevaluations must be addressed by the committee on special education in reviewing and, as appropriate, revising the student's IEP.

(5) Determination of needed evaluation data.

(i) As a part of an initial evaluation, if appropriate, and as part of any reevaluation in accordance with section 200.4(b)(4) of this Part, a group that includes the committee on special education, and other qualified professionals, as appropriate, shall review existing evaluation data on the student including evaluations and information provided by the parents of the student, current classroom-based assessments and observations, and observations by teachers and related services providers. The group may conduct its review without a meeting.

(ii) On the basis of that review, and input from the student's parents, the committee on special education and other qualified professionals, as appropriate, shall identify what additional data, if any, are needed to determine

(*a*) whether the student has a particular category of disability, or, in the case of a reevaluation of a student, whether the student continues to have such a disability;

(*b*) the present levels of performance and educational needs of the student;

(*c*) whether the student needs special education, or, in the case of a reevaluation of a student, whether the student continues to need special education; and

(*d*) whether any additions or modifications to the special education services are needed to enable the student to meet the measurable annual goals set out in the IEP of the student and to participate, as appropriate, in the general curriculum.

(iii) The school district shall administer tests and other evaluation materials as may be needed to produce the data identified under subparagraph (ii) of the section.

(iv) If additional data are not needed, the school district must notify the parents of that determination and the reasons for it and of the right of the parents to request an assessment to determine whether, for purposes of services under this Part, the student continues to be a student with a disability. The school district is not required to conduct the assessment unless requested to do so by the student's parents.

(6) School districts shall ensure that:

(i) tests and other assessment procedures:

(a) are provided and administered in the student's native language or other mode of communication, unless it is clearly not feasible to do so;

(b) have been validated for the specific purpose for which they are used;

(c) are administered by trained and knowledgeable personnel in accordance with the instruction provided by those who developed such tests or procedures; and

(d) are administered so as not to be racially or culturally discriminatory;

(ii) if an assessment is not conducted under standard conditions, a description of the extent to which it varied from standard conditions (e.g., the qualifications of the person administering the test, or the method of test administration) must be included in the evaluation report;

(iii) tests and other assessment procedures include those tailored to assess specific areas of educational need and not merely those which are designed to provide a general intelligence quotient;

(iv) tests are selected and administered to ensure that, when a test is administered to a student with impaired sensory, manual or speaking skills, the test results accurately reflect the student's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the student's impaired sensory, manual or speaking skills, except where those skills are factors which the test purports to measure;

(v) no single procedure is used as the sole criterion for determining whether a student is a student with a disability and for determining an appropriate educational program for a student;

(vi) the evaluation is made by a multidisciplinary team or group of persons, including at least one teacher or other specialist with certification or knowledge in the area of the suspected disability;

(vii) the student is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, vocational skills, communicative status and motor abilities;

(viii) students age 12 and those referred to special education for the first time who are age 12 and over, shall receive an assessment that includes a review of school records and teacher assessments, and parent and student interviews to determine vocational skills, aptitudes and interests;

(ix) the evaluation is sufficiently comprehensive to identify all of the student's special education needs, whether or not commonly linked to the disability category in which the student has been identified;

(x) technically sound instruments are used that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors;

(xi) assessment tools and strategies are used that provide relevant information that directly assists persons in determining the educational needs of the student;

(xii) the results of the evaluation are provided to the parents or persons in parental relationship in their native language or mode of communication;

(xiii) for purposes of eligibility and continuing eligibility determinations, a copy of the evaluation report and the documentation of determination of eligibility are provided to the parent;

(xiv) the procedures for evaluating students suspected of having a learning disability are in accordance with sections 300.540 through 300.543 of title 34 of the Code of Federal Regulations (Code of Federal Regulations, 1999 edition, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402: 1999 - available at the Office of Vocational and Educational Services for

Individuals with Disabilities, Room 1624, One Commerce Plaza, Albany, NY 12234);

(xv) the procedures for conducting expedited evaluations are conducted pursuant to Part 201 of this Title; and

(xvi) materials and procedures used to assess a student with limited English proficiency are selected and administered to ensure that they measure the extent to which the student has a disability and needs special education, rather than measure the student's English language skills.

(c) Eligibility Determinations

(1) Upon completing the administration of tests and other evaluation materials, the committee on special education and other qualified individuals must determine whether the student is a student with a disability, as defined in sections 200.1(mm) or 200.1(zz) of this Part and the school district must provide a copy of the evaluation report and the documentation of eligibility to the student's parent.

(2) A student may not be determined to be eligible for special education if the determinant factor for that eligibility determination is lack of instruction in reading or math or limited English proficiency.

(3) A school district must evaluate a student with a disability prior to determining that the student is no longer a student with a disability, in accordance with section 200.4(b)(4) of the Part, and the school district must provide a copy of the evaluation report and the documentation of eligibility to the student's parent. A school district is not required to conduct a reevaluation of a student before the termination of a student's eligibility due to graduation with a local high school or Regents diploma or exceeding the age eligibility for a free appropriate public education.

(4) A free appropriate public education must be available to any student with a disability who needs special education and related services, even though the student is advancing from grade to grade.

(f) *Annual review and reevaluation.* The individualized education program (IEP) of each student with a disability shall be reviewed and, if appropriate, revised, periodically but not less than annually.

(1) Any meeting to develop, review or revise the IEP of each student with a disability to be conducted by the committee on special education or subcommittee thereof, pursuant to section 4402(1)(b)(2) of the Education Law, shall be based upon review of a student's IEP and other current information pertaining to the student's performance. Such review shall:

(i) consider the strengths of the student, the concerns of the parents for enhancing the education of their child, the results of the initial or most recent evaluation of the student, the results of the student's performance on any general State or district-wide assessment programs, the special factors described in paragraph (3) of subdivision (d) of this section, the educational progress and achievement of the student with a disability and the student's ability to participate in instructional programs in regular education and in the least restrictive environment; and

(ii) upon consideration of the factors in subparagraph (a) of this paragraph, revise the IEP as appropriate to address

(a) any lack of expected progress toward the annual goals and in the general curriculum, if appropriate;

(b) the results of any reevaluation and any information about the student provided to, or by, the parents;

(c) the student's anticipated needs;

(d) or other matters, including a student's need for test accommodations and/or modifications.

(2) Prior to the annual review, the committee on special education shall notify the parent of its intent to review the student's program and placement in accordance with section 200.5(a) of this Part.

(3) Upon completion of the annual review, the committee on special education shall notify the parents of the committee's recommendation in accordance with section 200.5(a) of this Part.

(4) In accordance with section 200.4(b)(4) of this Part, the results of any reevaluations must be addressed by the committee on special education in a meeting to review, and, as appropriate, revise the student's IEP.

Instruments Utilized to Assess Children and Adolescents in NYS-OMH Children's Programs

June 2003

Assessment Instrument (alphabetical)	Children's Programs
ASI (Adolescent Symptom Inventory - Stonybrook)	* Inpatient (Sagamore CPC)
CAFAS (Child & Adolescent Functional Assessment Scale)	* Kids Oneida (Oneida county) * SPOA (1 county)
CANS-MH (Child and Adolescent Needs and Strengths - Mental Health)	* NYS-OMH study (statewide) * Kids Oneida * SPOAs (most counties)
C-DISC (Computer voice - Diagnostic Interview Schedule for Children)	* Inpatient (Sagamore CPC) * School Support III (NYC) (6 sites)
CSI (Child Symptom Inventory - Stonybrook)	* Inpatient (Sagamore CPC)
SACA (Service Assessments for Children and Adolescents)	* FFT (Functional Family Therapy) (11 teams/5 locations)
SDQ (Strengths and Difficulties Questionnaire)	* FFT (Functional Family Therapy) (11 teams/5 locations) * School Support III (NYC) (6 sites)
YI (Youth Inventory - Stonybrook)	* Inpatient (Sagamore CPC)
YOQ (Youth Outcome Questionnaire)	* FFT (Functional Family Therapy) (11 teams/5 locations)
YSBI (Youth Symptom Behavior Inventory) (Child/Adolescent Measurement System)	* FFT (Functional Family Therapy) (11 teams/5 locations)

Child and Adolescent Functional Assessment Scale (CAFAS)

Reliability and Validity

The Child and Adolescent Functional Assessment Scale (CAFAS: Hodges, 1990, 1994) measures degree of impairment in youth with emotional, behavioral, psychiatric, psychological, or substance use problems. The psychometric properties of the CAFAS have been investigated extensively, using large data sets generated by two evaluation studies: the Fort Bragg Evaluation Project (FBEP: Breda, 1996) and the national evaluation of the demonstration service grants funded by the Center for Mental health Services (CMHS) branch of the Substance Abuse and Mental Health Services Administration (SAMHSA). These demonstrations are funded to help communities develop systems of care for providing services to youth with serious emotional disturbance (SED: Federal Register, 1993).

The two samples were quite different, permitting an opportunity to examine the CAFAS in varying contexts. In the FBEP, the youth were dependents of Army personnel, lived mostly in middle income family settings, had generous mental health benefits, and were referred for mental health problems, with no requirement that they be impaired or SED (Hodges, Wong, & Latessa, 1998). In the CMHS-funded evaluation, the youth had been diagnosed as having a SED, were for the most part from impoverished families, were a diverse group in terms of socio-demographic characteristics and involvement with multiple agencies serving children and families, and received mental health services within developing systems of care which were sponsored with the grant awards (Hodges, Doucette-Gates, & Liao, in press; Hodges, Kim, & Doucette-Gates, 1998). Each grantee is required to contribute data to a national sample, which is managed by Macro International Inc., in collaboration with partners at the University of South Florida and staff assistance from the Federation of Families for Children's Mental Health.

Reliability

Internal Consistency: Internal consistency has been demonstrated in both evaluations.

Interrater Reliability: High interrater reliability has been reported for the CAFAS across different sites and with both lay and clinician raters (Hodges & Wong, 1996). These studies have used the *CAFAS Self-Training Manual* (Hodges, 1994) to train raters and demonstrate reliability.

Test-Retest Reliability: Good test-retest reliability was demonstrated in a study in which lay interviewers rated the CAFAS after administering the CAFAS interview via the telephone (Hodges, 1995).

Validity

Content Validity: The items on the CAFAS have high content validity. Items refer to specific behaviors in specified domains of functioning.

Concurrent Validity: Concurrent criterion-related validity has been demonstrated in the FBEP and the CMHS study. Studies have been conducted to determine whether CAFAS scores differed for youth: (a) being served at different levels of intensity of care, (b) living in settings which differ in restrictiveness and in use of staff with specialized skills at handling problem behaviors, (c)severity of psychiatric diagnosis, and (d) specific problematic behaviors and risk factors. It was shown that inpatients scored significantly higher on the CAFAS, indicating greater impairment, than youths receiving home-based services, day treatment, etc., who in term scored significantly higher than youths in outpatient care (Hodges & Wong, 1996). Children living with their parents or in regular foster care were significantly less impaired than youths in various residential placements, with youths in therapeutic foster care scoring

Hodges, K. (In press). Child and Adolescent Functional Assessment Scale (CAFAS). In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcome assessment*. 2nd ed.

Hodges, K., Doucette-Gates, A., & Liao, Q. (In press). The relationship between the Child and Adolescent Functional Assessment Scale (CAFAS) and indicators of functioning. *Journal of Child and Family Studies*.

Hodges, K., & Gust, J. (1995). Measures of impairment for children and adolescents. *Journal of Mental Health Administration, 22*, 403-413.

Hodges, K., & Kim, C. S. (1998). *Psychometric study of the CAFAS: Prediction of contact with the law and school nonattendance*. Unpublished manuscript.

Hodges, K., Kim, C. S., & Doucette-Gates, A. (1998). *Predicting service utilization with the CAFAS in a sample of SED youths served by CMHS-funded demonstrations*. Manuscript submitted for publication.

Hodges, K., & Wong, M. M. (1996). Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale. *Journal of Child and Family Studies, 5(4)*, 445-467.

Hodges, K., & Wong, M. M. (1997). Use of the Child and Adolescent Functional Assessment Scale to predict service utilization and cost. *Journal of Mental Health Administration, 24(3)*, 278-290.

Hodges, K., Wong, M., & Latessa, M. (1998). Use of the Child and Adolescent Functional Assessment Scale (CAFAS) as an outcome measure in clinical settings. *Journal of Behavioral Health Services & Research, 25(3)*, 326-337.

Hodges, K., Wotring, J., Warren, B., Pernice, F., & Wale, H. (1998). *Michigan: Using a state database to help providers assess outcome and resource management*. Submitted for Presentation at the 12th Annual Research Conference on a System of Care for Children's Mental Health: Expanding the Research Base, Tampa, FL, February, 1999.

Rosenblatt, J. A. & Furlong, M. J. (1998). Outcomes in a system of care for youths with emotional and behavioral disorders: An examination of differential change across clinical profiles. *Journal of Child and Family Studies, 7(2)*, 217-232.

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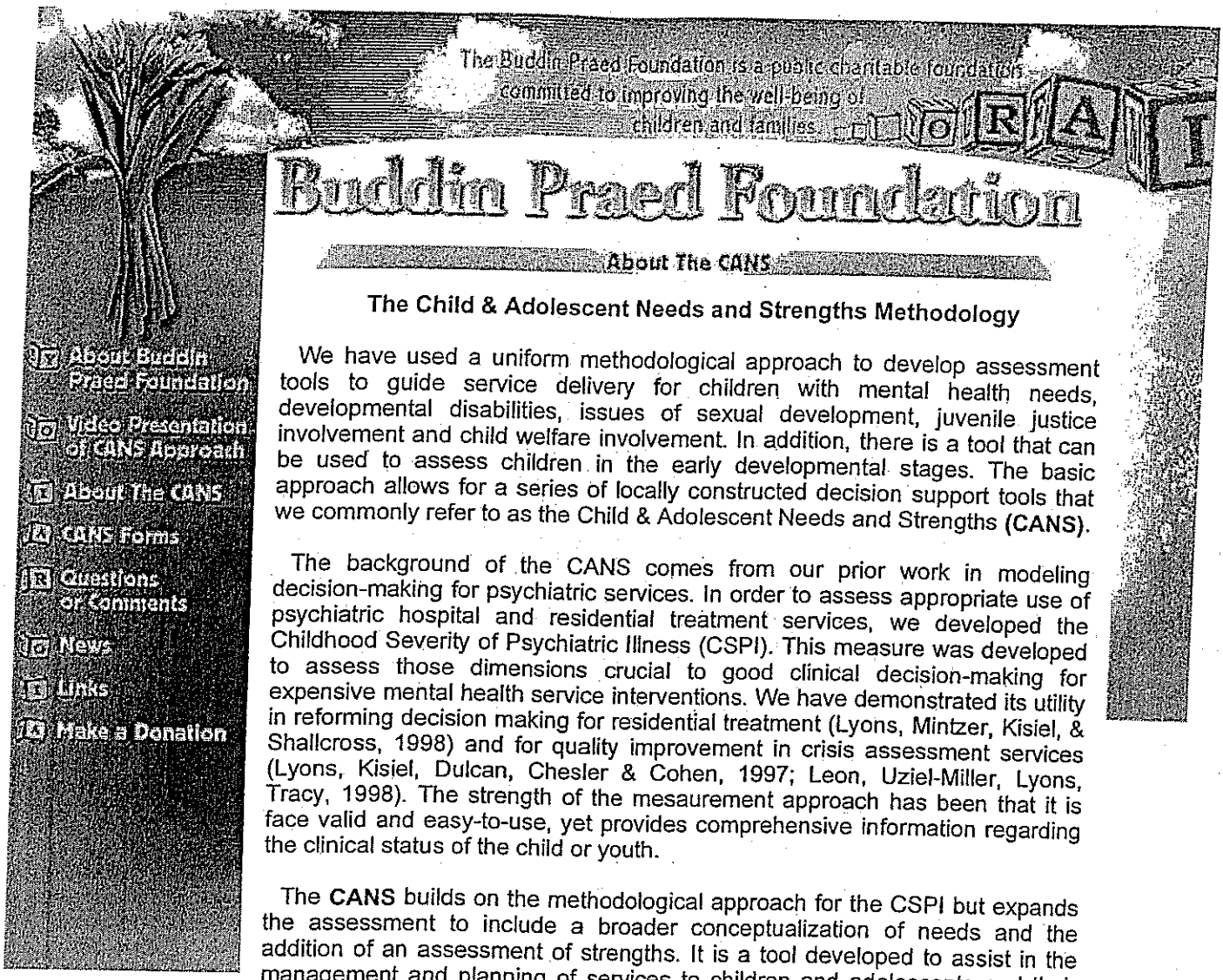

The Child & Adolescent Needs and Strengths Methodology

We have used a uniform methodological approach to develop assessment tools to guide service delivery for children with mental health needs, developmental disabilities, issues of sexual development, juvenile justice involvement and child welfare involvement. In addition, there is a tool that can be used to assess children in the early developmental stages. The basic approach allows for a series of locally constructed decision support tools that we commonly refer to as the Child & Adolescent Needs and Strengths **(CANS)**.

The background of the CANS comes from our prior work in modeling decision-making for psychiatric services. In order to assess appropriate use of psychiatric hospital and residential treatment services, we developed the Childhood Severity of Psychiatric Illness (CSPI). This measure was developed to assess those dimensions crucial to good clinical decision-making for expensive mental health service interventions. We have demonstrated its utility in reforming decision making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1998). The strength of the mesaurement approach has been that it is face valid and easy-to-use, yet provides comprehensive information regarding the clinical status of the child or youth.

The **CANS** builds on the methodological approach for the CSPI but expands the assessment to include a broader conceptualization of needs and the addition of an assessment of strengths. It is a tool developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality in of life. The **CANS** is designed to be used either as a prospective assessment tool for decision support during the process of planning services or as a retrospective assessment tool based on the review of existing information for use in the design of high quality systems of services. This flexibility allows for a variety of innovative applications. The **CANS** can be used for retrospective file reviews for planning purposes. Retrospective review of prospectively completed **CANS** allows for a form of measurement audit to facilitate the reliability and accuracy of information (Lyons, Yeh, Leon, Uziel-Miller & Tracy, 1999).

The **CANS** is designed for use at two levels-for the individual child and family and for the system of care. The **CANS** provides a structured assessment of children along a set of dimensions relevant to service planning and decision making. Also, the **CANS** provides information regarding the child and family's service needs for use during system planning and/or quality assurance monitoring. Due to its modular design the tool can be adapted for local applications without jeopardizing its psychometric properties

The dimensions and objective anchors used in the **CANS** are developed by focus groups with a variety of participants including families, representatives of the provider community, case managers, and staff. The goal of the

measurement design is to ensure participation of representatives of all partners to begin building a common assessment language. The **CANS** measure is then seen predominantly as a communication strategy. Testing of the reliability of the **CANS** in its applications for developmental disabilities and mental health indicate that this measurement approach can be used reliably by trained professionals and family advocates.

As an example, the following are a summary of the dimensions of the **CANS-MH**. Unless otherwise specified, each rating is based on the last 30 days. Each of the dimensions is rated on a 4-point scale after routine service contact or following review of case files. The basic design is that '0' reflects no evidence, a rating of '1' reflects a mild degree of the dimension, a rating of '2' reflects a moderate degree and a rating of '3' reflects a severe or profound degree of the dimension. Another way to conceptualize these ratings is that a '0' indicates no need for action, a '1' indicates a need for preventive services or watchful waiting to see whether action is warranted in the future, a '2' indicates a need for action, and a '3' indicates the need for either immediate or intensive action. In order to maximize the ease of use and interpretation, please note that the last two clusters of dimensions, Caregiver Capacity and Strengths, are rated in the **opposite manner** to maintain consistency across the measure.

The item structure of the **CANS-MH** is:

A. Problem Presentation
- Psychosis
- Attention Deficit/Impulse Control
- Depression/Anxiety
- Oppositional Behavior
- Antisocial Behavior
- Substance Abuse
- Adjustment to Trauma
- Situational Consistency of Problems
- Temporal Consistency of Problems

B. Risk Behaviors
- Danger to Self
- Danger to Others
- Elopement
- Sexually Abusive Behavior
- Social Behavior
- Crime/Delinquency

C. Functioning
- Intellectual/Developmental
- Physical/Medical
- Family
- School/Day Care

D. Care Intensity & Organization
- Monitoring
- Treatment
- Transportation
- Service Permanence

E. Caregiver Capacity
- Physical
- Supervision
- Involvement with Care
- Knowledge

Organization
Residential Stability
Resources
Safety

F. **Strengths**

Family
Interpersonal
Relationship Permanence
Education
Vocational
Well-being
Spiritual/Religious
Creative/Artistic
Inclusion

REFERENCES

Leon, SC, Lyons, JS, Uziel-Miller, ND, Tracy, P. (1999). Psychiatric hospital utilization of children and adolescents in state custody. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 305-310.

Lyons, JS, Kisiel, CL, Dulcan, M, Cohen, R, Chesler, P. (1997). Crisis assessment and psychiatric hospitalization of children and adolescents in state custody. *Journal of Child and Family Studies*, 6, 311-320.

Lyons, JS, Mintzer, LL, Kisiel, CL, Shallcross, H. (1998). Understanding the mental health needs of children and adolescents in residential treatment. *Professional Psychology: Research and Practice*, 29. 582-587.

Lyons, JS, Yeh, I, Leon, SC, Uziel-Miller, ND, Tracy, P. (1999). Use of measurement audit in outcomes management. manuscript under review.

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Tools for Assessing Children in Foster Care

- Fostering Health – Health Care for Children in Foster Care – AAP, District II, NYS (2001) re: Developmental/educational assessment – "Measurement tools are not specified here because they will vary depending upon the child's age, developmental stage and previous history. Well-standardized measures should be used."

- Overview of Developmental Screening Tools – National Academy for State Health Policy – October 2002

- Bright Futures – Second Edition, Revised – 2002

- Bright Futures in Practice – Mental Health Volume 1 – Practice Guide – 2002

- Bright Futures in Practice – Mental Health Volume 2 – Tool Kit – 2002 Includes the Pediatric Symptom Checklist, Center for Epidemiological Studies Depression Scale for Children (CES-DC), and tools for dealing with Attention Deficit Hyperactivity Disorder, Substance use problems and disorders, mood disorders, eating disorders, and others.

- Bright Futures in Practice Oral Health – 1996

CAK/6/3/2003

Overview of Developmental Screening Tools

	ASQ[1]	BINS[2]	DDST[3]	PEDS[4]	CDI[5]	BRIGANCE[6]	PSC[7]	GAPS[8]
Type/Ages	Parent questionnaire (2 mos-5 yrs)	Direct elicitation (3-24 mos)	Direct elicitation	Parent questionnaire (0-8 yrs)	Parent questionnaire (3 mos-6 yrs)	Direct elicitation (21 mos-7.5 yrs)	Parent questionnaire	Child & parent questionnaires (11-21 yrs)
Staff required	Para-professional	MA or equivalent	3.5 hours of training	Para-professional	Para-professional	Professional	Para-professional	No Scoring
Time to score	5 minutes	10-15 minutes	20-30 minutes	5 minutes	10 minutes	10-15 minutes	7 minutes	20 minutes
Cost (per kit)	$190	$195	$91 kit $185 training materials	$39	$41	$249	Free down-load	Free download from AMA
Refills	OK to copy	Needed	$26-$100	$30-$50			OK to copy	OK to copy
Languages	English Spanish	English	English	English Spanish	English Spanish	English Spanish	English	English Spanish
Reading Level	4th - 6th Grade	NA	NA	5th Grade	NA	NA	NA	NA

[1] Ages and Stages Questionnaire. Paul Brooks Publishing Co., PO Box 10624, Baltimore, MD 21285-0624. 1-800-638-3775. www.pbrookes.com.

[2] Bayley Infant Neurodevelopmental Screen. The Psychological Corp., 555 Academic Court, San Antonio, TX 78204. 1-800-228-0752. www.psychcorp.com

[3] Denver Developmental Screening Test. Denver Developmental Materials, Inc., PO Box 371075, Denver, CO 80206-0919. 1-800-419-4729

[4] Parents Evaluation Developmental Status. Ellsworth & Vandermeer Press, PO Box 68164, Nashville, TN 37206. 1-888-729-1697. www.pedstest.com

[5] Child Development Inventory. Behavior Science Systems, Inc., PO Box 580274, Minneapolis, MN 55458.

[6] Brigance Diagnostic Inventory of Early Development. Curriculum Associates, Inc., 153 Rangeway Road, North Billerica, MA 01862. 1-800-225-0248. www.curricassoc.com

[7] Pediatric Symptom Checklist. Child Psychiatry, Bulfinch 351, Massachusetts General Hospital, Boston, MA 02114. 617-724-3163.

[8] Guidelines for Adolescent Preventive Services. American Medical Association. www.ama-assn.org/

Guideline on periodicity of examination, preventive dental services, anticipatory guidance and oral treatment for children

Originating Committee
Clinical Affairs Committee

Review Council
Council on Clinical Affairs

Adopted
1991

Revised
1992, 1996, 2000

Procedures

Birth - 12 months

1. Complete the clinical oral assessment and appropriate diagnostic tests to assess oral growth and development and/or pathology.
2. Provide oral hygiene counseling for parents, guardians and caregivers, including the implications of the oral health of the caregiver.
3. Remove supragingival and subgingival stains or deposits as indicated.
4. Assess the child's systemic and topical fluoride status (including type of infant formula used, if any, and exposure to fluoridated toothpaste) and provide counseling regarding fluoride. Prescribe systemic fluoride supplements, if indicated, following assessment of total fluoride intake from drinking water, diet and oral hygiene products.
5. Assess appropriateness of feeding practices, including bottle and breast-feeding and provide counseling as indicated.
6. Provide dietary counseling related to oral health.
7. Provide age-appropriate injury prevention counseling for orofacial trauma.
8. Provide counseling for non-nutritive oral habits (digit, pacifiers, etc).
9. Provide diagnosis and required treatment and/or appropriate referral for any oral diseases or injuries.
10. Provide anticipatory guidance for parent/guardian.
11. Consult with the child's physician as needed.
12. Based on evaluation and history, assess the patient's risk for oral disease.
13. Determine the interval for periodic re-evaluation.

12 - 24 months

1. Repeat birth to 12-month procedures every 6 months or as indicated by individual patient's needs/susceptibility to disease.
2. Review patient's fluoride status–including any childcare arrangements, which may impact on systemic fluoride intake–and provide parental counseling.
3. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.

2 - 6 years

1. Repeat 12- to 24- month procedures every 6 months or as indicated by individual patient's needs/susceptibility to disease. Provide age-appropriate oral hygiene instructions.
2. Complete a radiographic assessment of pathology and/or abnormal growth and development, as indicated by individual patient's needs.
3. Scale and clean the teeth every 6 months or as indicated by the individual patient's needs.
4. Provide topical fluoride treatments every 6 months or as indicated by the individual patient's needs.
5. Provide pit and fissure sealants for primary and permanent teeth as indicated by individual patient's needs.
6. Provide counseling and services (athletic mouthguards) as needed for orofacial trauma prevention.
7. Provide assessment/treatment or referral of developing malocclusion as indicated by individual patient's needs.
8. Provide diagnosis and required treatment and/or appropriate referral for any oral diseases, habits or injuries as indicated.
9. Assess speech and language development and provide appropriate referral as indicated.

6 - 12 years

1. Repeat 2- to 6-year procedures every 6 months or as indicated by individual patient's needs/susceptibility to disease.
2. Provide substance abuse counseling (smoking, smokeless tobacco, etc).

12 - 18 years

1. Repeat 6- to 12-year procedures every 6 months or as indicated by individual patient's needs/susceptibility to disease.
2. At an age determined by patient, parent and dentist, refer the patient to a general dentist for continuing oral care.

Recommendations for Preventive Pediatric Dental Care*

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal.

The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of *very* early professional intervention and the continuity of care based on the individualized needs of the child.

Age[1]	Infancy 6–12 months	Late infancy 12–24 months	Preschool 2–6 years	School-aged 6–12 years	Adolescence 12–18 years
Oral hygiene[2] counseling	Parents/guardians/ caregivers	Parents/guardians/ caregivers	Patient/parents/ guardians/caregivers	Patient/parents/ guardians/caregivers	Patient
Injury prevention counseling[3]	•	•	•	•	•
Dietary counseling[4]	•	•	•	•	•
Counseling for non-nutritive habits[5]	•	•	•	•	•
Fluoride supplementation[6,7]	•	•	•	•	•
Assess oral growth and development[8]	•	•	•	•	•
Clinical oral examination	•	•	•	•	•
Prophylaxis and topical fluoride treatment[9]		•	•	•	•
Radiographic assessment[10]			•	•	•
Pit and fissure sealants			If indicated on primary molars	First permanent molars as soon as possible after eruption	Second permanent molars and appropriate premolars as soon as possible after eruption
Treatment of dental disease/injury	•	•	•	•	•
Assessment and treatment of developing malocclusion			•	•	•
Substance abuse counseling				•	•
Assessment and/or removal of third molars					•
Referral for regular and periodic dental care					•
Anticipatory guidance[11]	•	•	•	•	•

*American Academy of Pediatric Dentistry, May, 1992

1. First examination at the eruption of the first tooth and no later than 12 months
2. Initially, responsibility of parent; as child develops, jointly with parents; then, when indicated, only child
3. Initially play objects, pacifiers, car seats; then when learning to walk; sports, routine playing and intraoral/perioral piercing
4. At every appointment discuss the role of refined carbohydrates; frequency of snacking
5. At first discuss the need for additional sucking; digits vs pacifiers; then the need to wean from the habit before the eruption of a permanent incisor. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching or bruxism.
6. As per American Academy of Pediatrics/American Dental Association guidelines and the water source
7. Up to at least 16 years
8. By clinical examination
9. Especially for children at high risk for caries and periodontal disease
10. As per AAPD Guideline on Prescribing Dental Radiographs
11. Appropriate discussion and counseling should be an integral part of each visit for care

SERVICE NEEDS ASSESSMENT PROFILE

The purpose of the *Service Needs Assessment Profile (SNAP)* is to prescriptively identify appropriate levels of clinical services, across three clinical program areas, for newly admitted OCFS youth. These areas are identified and described as follows:

- ✓ **Mental Health SNAP (MH SNAP):** To identify the level of mental health treatment services a youth will require during her/his stay in OCFS. Five levels of mental health care are available for newly admitted youth, including procedures for accessing psychiatric inpatient care outside of OCFS.
- ✓ **Alcohol and Other Drugs SNAP (AOD SNAP):** To identify the level of substance abuse treatment a youth will require during her/his stay in OCFS. Four levels of treatment are available for newly admitted youth.
- ✓ **Sex Offense Treatment SNAP (SO SNAP):** To identify the level of sex offense treatment an adjudicated or non-adjudicated sex offender will require during her/his stay in OCFS. Four levels of treatment are available for newly admitted youth.

SNAP scores are determined at the OCFS Reception Center for Non-Secure and Limited Secure boys. For youth not processed through a Reception Center, first placement facilities will be determined by Assessment Codes derived by Intake Workers, based on historical information and interviews of both the youth and family member(s). At the facility of first placement, a mental health clinician will follow the same assessment protocol as Reception Center clinicians to establish SNAP scores.

The SNAP scores (1.0 to 5.0) correspond to facility *Tier Designations* (I to V) indicating an appropriate level of clinical resources to prescriptively provide varying levels of clinical services. Any facility within a designated Tier can provide the SNAP-identified level of clinical services.

The Central Office Coordinators for Mental Health, Substance Abuse and Sex Offense Treatment are available to assist in determining the appropriate Tier when the clinical SNAP scores indicate multiple or conflicting priorities for clinical services within the three program areas.

Assessment Codes Derived by Intake Staff:

Intake personnel select ALL applicable codes within the highest facility Tier Designation from the Assessment Codes Checklist. The designated code descriptor corresponds to the resident's status and history. When a youth presents with suicidality or other signs of mental illness at the Intake level, a mental health clinician should be contacted immediately to evaluate the youth.

THE OFFICE OF CHILDREN & FAMILY SERVICES
MENTAL HEALTH SERVICE NEEDS ASSESSMENT PROFILE (MH SNAP)

INTRODUCTION

Every youth assessed at an OCFS Reception Center is assigned a **Mental Health Service Needs Assessment Profile (MH SNAP)** score designating the mental health level of care projected to meet the youth's needs during her/his stay in care and custody. Mental Health Tiers I through V provide incremental levels of service, and represent a continuum of care for mental health treatment.

For all youth placed or sentenced into the care and custody of OCFS, MH SNAP scores are derived from the results of assessments conducted either at a Reception Center or at the first placement facility ***by mental health clinicians***. MH SNAP scores designate the projected level of mental health service a youth will require during placement in OCFS. The MH SNAP score also designates facilities within a Tier Designation with the clinical resources to provide services to meet the youths' needs, or procedures for accessing psychiatric inpatient care outside of OCFS.

Mental Health SNAP scores may be modified during the youth's stay in OCFS, allowing for step-downs to lower levels of care and upgrades to higher levels of care, as the youth's needs change. MH SNAP score changes must result from an assessment by a mental health clinician.

TIER I

At Tier I facilities mental health clinicians may be available (on-site or in the community). Staffing does not allow for the administration of psychiatric medications.

Youth Profile:

The youth's mental health service needs are best met through standard program interventions such as structured group living and cognitive behavioral interventions provided by OCFS childcare and counseling staff.

Youth's mental health needs may be situational, and may require time-limited mental health intervention other than psychiatric medication.

NOTE for TIER II through TIER V: **Resident has significant needs for mental health services, and requires clinical monitoring and support.**

TIER II

At Tier II facilities mental health clinicians are available on-site. Staffing does not allow for the administration of psychiatric medications. Mental health assessment, treatment, and crisis intervention services are available.

Youth Profile:

Youth have significant needs for mental health services. Youth exhibit current signs or symptoms of emotional disturbance requiring *non-psychiatric* mental health services, and have no histories, *within the six (6) months prior to placement with OCFS,* of any of the following: (1) outpatient mental health treatment, (2) inpatient psychiatric care, (3) residential treatment for emotional disturbance, (4) treatment with psychiatric medications.

TIER III

At Tier III facilities mental health clinicians are available on-site. On-site psychiatrist and sufficient nursing coverage are available for the administration of psychiatric medications, as prescribed by the psychiatrist.

Youth Profile:

Youth have significant needs for mental health services. Youth exhibit current signs or symptoms of emotional disturbance requiring services of a *psychiatrist* (may be in current treatment with psychiatric medication(s)); and/or have, *within the six (6) months prior to placement with OCFS,* histories of any of the following: (1) outpatient mental health treatment, (2) inpatient psychiatric care, (3) prior residential treatment for emotional disturbance, (4) treatment with psychiatric medications.

TIER IV

Tier IV consists of discrete Mental Health Units (MHUs), which have been developed within OCFS residential facilities. All childcare staff working on the units have received training in areas of mental health. Several mental health clinicians are affiliated with the units, including nurses, social workers, psychologists, and a psychiatrist. The MHUs are a structured therapeutic environment designed to stabilize psychiatric symptoms and promote emotional and social skills development.

Due to limited Mental Health Unit bed space, youth assessed for Tier IV level of care may enter the Tier III, or Tier V level of care (referral for psychiatric hospital admission), depending on the youth's needs.

Youth Profile:

Residents are eligible for Mental Health Unit services when they present with a major mental illness, have received a DSM-IV, Axis I diagnostic impression, other than or in addition to Conduct Disorders, Disruptive Disorders NOS, Oppositional-Defiant Disorder, Intermittent-Explosive Disorder, Attention-Deficit Hyperactivity Disorder, Adolescent Anti-Social Behavior, Substance Abuse, or Substance Dependence; AND exhibit serious and persistent psychopathology, with significant functional limitations in the areas of self-care, social relationships, and/or self-direction/self-control.

DSM-IV diagnostic categories of inclusion are Depressive, Bipolar, Anxiety or Psychotic Disorders.

Note: Youth who present behavior/management problems not attributable to a major mental illness are not appropriate for admission to a mental health unit.

ARTICLE

Validity of the CRAFFT Substance Abuse Screening Test Among Adolescent Clinic Patients

John R. Knight, MD; Lon Sherritt, MPH; Lydia A. Shrier, MD, MPH; Sion Kim Harris, PhD; Grace Chang, MD, MPH

Objective: To determine the accuracy of the CRAFFT substance abuse screening test.

Design: Criterion standard validation study comparing the score on the 6-item CRAFFT test with screening categories determined by a concurrently administered substance-use problem scale and a structured psychiatric diagnostic interview. Screening categories were "any problem" (ie, problem use, abuse, or dependence), "any disorder" (ie, abuse or dependence), and "dependence."

Setting: A large, hospital-based adolescent clinic.

Participants: Patients aged 14 to 18 years arriving for routine health care.

Main Outcome Measures: The CRAFFT receiver operating characteristic curve, sensitivity, specificity, positive predictive value, and negative predictive value.

Results: Of the 538 participants, 68.4% were female, and 75.8% were from racial and ethnic minority groups. Diagnostic classifications for substance use during the past 12 months were no use (49.6%), occasional use (23.6%), problem use (10.6%), abuse (9.5%), and dependence (6.7%). Classifications were strongly correlated with the CRAFFT score (Spearman ρ, 0.72; $P<.001$). A CRAFFT score of 2 or higher was optimal for identifying any problem (sensitivity, 0.76; specificity, 0.94; positive predictive value, 0.83; and negative predictive value, 0.91), any disorder (sensitivity, 0.80; specificity, 0.86; positive predictive value, 0.53; and negative predictive value, 0.96) and dependence (sensitivity, 0.92; specificity, 0.80; positive predictive value, 0.25; and negative predictive value 0.99). Approximately one fourth of participants had a CRAFFT score of 2 or higher. Validity was not significantly affected by age, sex, or race.

Conclusion: The CRAFFT test is a valid means of screening adolescents for substance-related problems and disorders, which may be common in some general clinic populations.

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SUBSTANCE ABUSE is the number-one health problem in the United States, with an estimated annual cost of over $414 billion.[1] It is linked to more than 400 000 preventable deaths each year, and the treatment of associated medical problems places a huge burden on the US health care system. Substance abuse affects men and women of all races, ethnic groups, and ages—including adolescents. Recent studies show that half of high school students are current drinkers, one third binge drink, and one fourth smoke marijuana.[2] By their senior year in high school, more than one half of students have used an illicit drug at least once, and more than one fourth have used an illicit drug other than marijuana.[3]

Substance abuse has been linked to both mental and physical health problems, making settings where adolescents receive medical care ideal places for screening and early intervention.[4-6] In recognition of this opportunity, the American Medical Association's Guidelines for Adolescent Preventive Services recommend that health care providers ask all adolescent patients annually about their use of alcohol and other drugs as part of routine care and further assess those who report any use.[7] However, adherence to this recommendation is low; less than one half of physicians report screening all adolescent patients for substance use, and less than one fourth report screening for drinking and driving.[8,9]

The precise reasons that so many physicians fail to screen are unknown. However, barriers to screening for other preventable health risks include a belief that the prevalence of the problem is low in the physician's own patient population, inadequate training, lack of time or personnel

PARTICIPANTS AND METHODS

DESIGN

This criterion standard study compared the CRAFFT score with diagnostic classifications and screening categories determined by a concurrently administered substance use/abuse problem scale and a structured psychiatric diagnostic interview.

PARTICIPANTS AND SETTING

The 538 study participants were 14- to 18-year-old patients coming for routine medical care to the Adolescent/Young Adult Medical Practice at Children's Hospital Boston, Boston, Mass, between March 15, 1999, and September 14, 2000. This practice serves both inner-city and suburban youth from a wide range of social strata, racial groups, and ethnic backgrounds. During the study recruitment period, the practice provided care to 4995 patients aged 10 to 24 years through both routine well-care and urgent-care visits; 2986 (60%) of these patients were aged 14 to 18 years.

RECRUITMENT PROCEDURES

A research assistant reviewed the birth dates of all scheduled patients before a clinic session and placed a recruitment reminder form on the cover of the chart of each age-eligible patient. At the conclusion of the medical visit, the primary care provider (ie, physician or nurse practitioner) invited eligible patients to participate in the study. The provider completed the recruitment form, which included demographic information, the provider's impression of the patient's level of alcohol and other drug use, and the patient's response to the invitation to participate. We informed providers at the beginning of the study and periodically reminded them that their patient need not ever have used alcohol or other drugs to participate.

We excluded patients who were unable to read and understand English and those who were deemed by the provider to have acute medical or psychiatric problems that precluded participation in research. A research assistant explained the study procedures to interested patients and obtained signed assent. The Children's Hospital Boston Committee on Clinical Investigation (institutional review board) waived the requirement for parental consent in accordance with current guidelines for adolescent health research.[21,22]

The research assistant told participants that the purpose of the study was to assess the value of screening questions on use of alcohol and other drugs and that we would keep their answers confidential. However, if we identified a serious problem, we would notify their primary care provider so that he or she could arrange appropriate care, which could include involving their parents. After completing the assessment battery, each participant received a $25 merchandise certificate as compensation for his or her time.

MEASUREMENTS

The assessment battery included the 6-item CRAFFT test and 2 criterion standards. The first criterion standard was the 17-item Substance Use/Abuse Scale from the Problem Oriented Screening Instrument for Teenagers (POSIT),[23] which assesses substance-related problems and risks. Developed by the National Institute on Drug Abuse (Bethesda, Md), the POSIT was previously shown to be reliable among adolescent medical patients and a Substance Use/Abuse Scale score of 2 or higher indicates increased risk.[24,25] The second criterion standard was the Adolescent Diagnostic Interview (ADI),[26] a 30- to 90-minute structured diagnostic interview, which yields alcohol- and drug-related diagnoses (ie, abuse and dependence), according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*.[27] The ADI has been well validated among adolescents, and it can be administered by an appropriately trained research assistant.[28,29] We used a structured ADI training protocol for this study. All research assistants read the ADI manual, watched model interviews, prac-

to perform the screening, and perceived lack of effective treatments.[10-13] Physicians may also lack familiarity with simple screening methods that can be easily incorporated into their office routines.

The ideal instrument for screening adolescents must be developmentally appropriate, valid and reliable, and practical for use in busy medical offices. A number of screening devices are available for this purpose, including brief questionnaires and orally administered tests.[14,15] Questionnaires are usually administered to patients in the waiting room. To be practical, they must be designed to be completed by patients within the usual waiting time, and scoring procedures must be sufficiently streamlined so that results can be given to the physician before the medical visit begins. Questionnaires may be targeted at substance use alone or include this as just one part of a more comprehensive adolescent screening. Questionnaires have certain limitations. They may require staff time for administration or scoring. They may also pose a risk to adolescents' confidentiality, especially when parents are present in the waiting area.

Orally administered brief screens are usually targeted at substance abuse alone and can be administered by the physician as part of the general health interview or while performing the physical examination. To be practical, they must be easy to administer, score, and remember. Simple yes or no questions that lend themselves to mnemonic acronyms are ideal. The CAGE questions, which are widely used in medical settings, are a good example of this type of brief screen.[16] The CAGE test has been shown to have good validity among adult medical patients.[17] However, studies among adolescents have not provided adequate evidence of the CAGE test's sensitivity or reliability.[18,19] In addition, some of its items (eg, "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover [eye-opener]?") are not developmentally appropriate for adolescents.

One brief screening device, the CRAFFT test, was developed specifically for use among adolescent medical patients.[20] Like CAGE,[16] CRAFFT is verbally administered, simple to score (each yes answer = 1 point), and

ticed on volunteers, and were videotaped conducting practice interviews. Study investigators and the ADI's author reviewed all videotapes to ensure initial competence, and the trained research assistants periodically observed and rated each other to ensure adherence.

A research assistant verbally administered the CRAFFT questions and recorded participants' responses, conducted the ADI interview, and monitored participants' completion of the paper/pencil version of the POSIT scale. All data were entered twice into a specially designed data management program based on Access 97 software (Microsoft, Redmond, Wash), which included automatic range and logic checks and an entry-tracking log. We compared the dual-entry files to identify discrepancies and reconciled them by checking the original data source. The study data manager then imported the cleaned dataset into Statistical Product and Service Solutions (SPSS) software (SPSS Inc, Chicago, Ill) for analysis.

DATA ANALYSIS

Participants were divided into 5 mutually exclusive diagnostic groups based on their pattern of alcohol and other drug use within the previous 12 months: (1) "no use" included participants who reported no use of alcohol or other drugs; (2) "occasional use" included those who reported any use but had a POSIT score less than 2 and did not have an ADI diagnosis; (3) "problem use" included those with a POSIT score of 2 or higher but no ADI diagnosis; and (4) "abuse" and (5) "dependence" included those who met corresponding diagnostic criteria on the ADI interview for either an alcohol- or drug-related disorder. Each ADI was scored twice, first by a research assistant using the standard written instructions and then by computer using an SPSS syntax algorithm developed by the instrument's author.[26] In cases where the diagnoses were unclear, the principal investigator (J.R.K.) and the study addiction psychiatrist (G.C.) separately reviewed the entire ADI, discussed any differences, and recorded the agreed-upon final diagnoses. They were blinded to participants' CRAFFT scores while conducting these reviews.

The frequencies of demographic variables and participants' diagnostic classifications were computed, and χ^2 tests were performed to determine whether proportions of demographic characteristics (ie, sex, age, and race/ethnicity) or provider impressions of alcohol or drug involvement differed between the study sample and the group of refusers. We transformed participant age into a dichotomous variable (ie, younger youth and older youth) based on the sample median to preserve adequate cell size for analyses. We also transformed the provider impression variables (ie, no use, occasional use, problem use, abuse, dependence, and no impression) into trichotomous variables (ie, no use/occasional use, problem use/abuse/dependence, and no impression) because abuse and dependence impressions were uncommon and cell sizes were not adequate for analysis.

We assessed the internal consistency of the CRAFFT test using the standardized α coefficient. We computed the frequencies and distributions of the CRAFFT score and the diagnostic classifications and measured their associations using the nonparametric Spearman ρ coefficient. To assess the ability of the CRAFFT test to discriminate among diagnostic classification groups, we first converted CRAFFT scores to ranks, then used 1-way analysis of variance and a post-hoc comparison test to compare mean ranks between pairs of groups. Due to heteroscedasticity, we used the Tamhane T2 post hoc comparison test (based on a t test) that did not assume equal variance.

We plotted receiver operating characteristic curves to determine the optimal cut point for the CRAFFT test (ie, total score with the highest product of sensitivity and specificity) for identifying 3 screening categories: any problem (ie, problem use, abuse, or dependence), any diagnosis (ie, abuse or dependence), or dependence. We calculated sensitivity (ie, probability that a true positive would be identified correctly by CRAFFT), specificity (ie, probability that a true negative would be identified correctly by CRAFFT), positive predictive value (ie, probability that a CRAFFT-positive participant was identified correctly), and negative predictive value (ie, probability that a CRAFFT-negative participant was identified correctly) and used the bootstrap technique to estimate 95% confidence intervals.[30-32]

easy to remember. Its name is a mnemonic of the first letters of key words in the test's 6 questions. (**Figure 1**)

In contrast to the CAGE test, however, the CRAFFT test screens for other drugs as well as for alcohol, and its questions were designed to be developmentally appropriate for teenagers. A pilot study among adolescent patients who had used alcohol and other drugs found that CRAFFT had promising concurrent validity compared with a more lengthy scale.[20] The purpose of the current study was to determine the criterion validity of the CRAFFT test among a larger, more general population of adolescent medical patients, including those who had used alcohol and other drugs and those who had not.

C	Have you ever ridden in a *car* driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to *relax*, feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, *alone*?
F	Do you ever *forget* things you did while using alcohol or drugs?
F	Do your family or *friends* ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into *trouble* while you were using alcohol or drugs?

Figure 1. The CRAFFT questions.

RESULTS

STUDY SAMPLE

During the 18-month recruitment period, providers invited 711 adolescent patients to participate in the study. We excluded a total of 41 patients (5.8%) because of cognitive impairment (n=27), insufficient fluency in English (n=9), severe hearing impairment (n=2), anorexia nervosa (n=2), and psychosis (n=1). Of the 670

Table 1. Frequencies of Alcohol and Other Drug Diagnostic Classifications by Sex and Age in 538 Adolescent Patients*

Patient Characteristic	No. of Patients	Diagnosis				
		No Use	Occasional Use	Problem Use	Abuse	Dependence
Total	538	267 (49.6)	127 (23.6)	57 (10.6)	51 (9.5)	36 (6.7)
Sex						
Male	170	102 (60.0)	28 (16.5)	15 (8.8)	13 (7.6)	12 (7.1)
Female	368	165 (44.8)	99 (26.9)	42 (11.4)	38 (10.3)	24 (6.5)
Age, y						
14	103	75 (72.8)	19 (18.4)	3 (2.9)	5 (4.9)	1 (1.0)
15	85	46 (54.1)	21 (24.7)	8 (9.4)	4 (4.7)	6 (7.1)
16	121	60 (49.6)	23 (19.0)	19 (15.7)	13 (10.7)	6 (5.0)
17	127	51 (40.2)	41 (32.3)	12 (9.4)	14 (11.0)	9 (7.1)
18	102	35 (34.3)	23 (22.5)	15 (14.7)	15 (14.7)	14 (13.7)

*Data given as number (percentage) of subjects unless otherwise indicated.

eligible patients, 538 (80.3%) agreed to participate. Reasons most commonly cited for refusing included not enough time (n=74), not interested (n=44), or came with a parent (n=8). The group of refusers did not differ significantly from the study sample in age, sex, race/ethnicity, or provider impressions of alcohol use, other drug use, or any substance use. The study sample was also similar to the entire group of 14- to 18-year-old clinic patients in distribution by age and race/ethnicity but included a significantly greater proportion of females (68.4% vs 59.4%; $P<.001$).

DIAGNOSTIC CLASSIFICATIONS

Frequencies of participants' demographic characteristics and substance-related diagnostic classifications during the previous 12 months are presented in **Table 1**. Participants were almost equally distributed across years of age; 68.4% were female, 50.6% were black non-Hispanic, 24.2% were white non-Hispanic, 18.8% were Hispanic, and 6.5% were Asian/other. Approximately one half of participants had used alcohol or other drugs during the past year, and more than one fourth had experienced alcohol- or drug-related problems. There were a total of 59 abuse diagnoses; 16 were for alcohol alone, 30 for other drugs alone, and 13 for both alcohol and other drugs. Of the 43 drug abuse diagnoses, 36 were related to cannabis, 5 to stimulants (including caffeine pills, methylphenidate hydrochloride, and amphetamines), and 2 to both cannabis and stimulants. There were a total of 36 dependence diagnoses; 7 were for alcohol alone, 24 for other drugs alone, and 5 for both alcohol and other drugs. Of the 29 drug dependence diagnoses, 27 were related to cannabis use, and 2 were related to use of 3,4-methylenedioxymethamphetamine (MDMA or "ecstasy"). Participants with both abuse and dependence diagnoses (eg, cannabis abuse and alcohol dependence) were classified as having dependence. Almost 10% of participants were classified with abuse and almost 7% with dependence.

CRAFFT CHARACTERISTICS

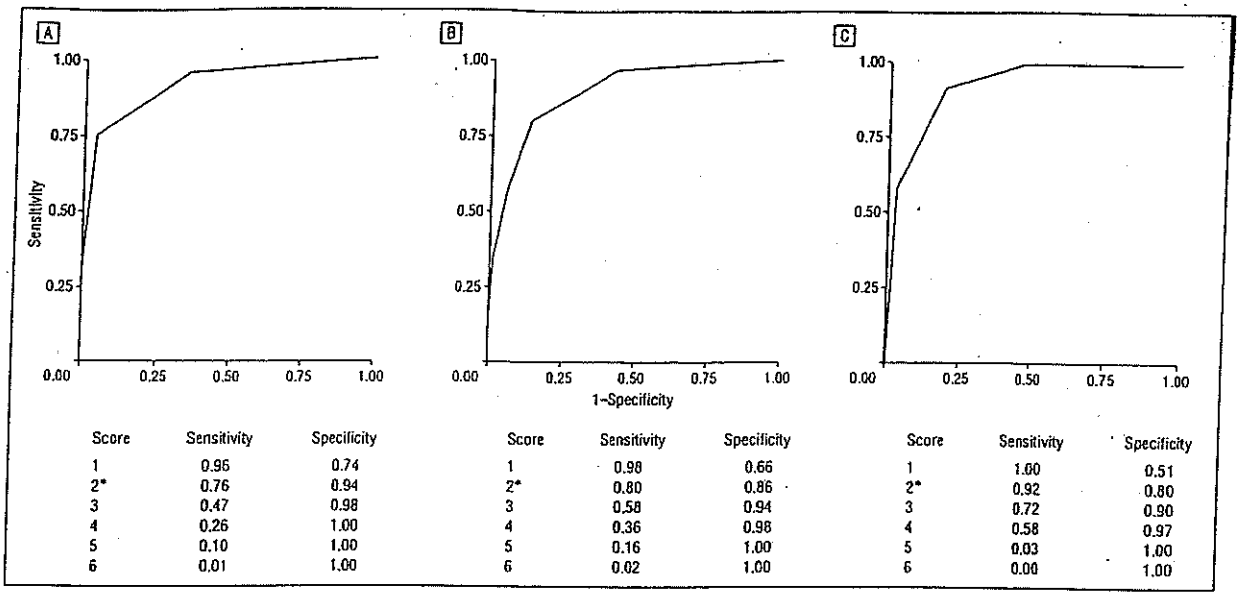
The CRAFFT standardized item α was .68 and did not increase with deletion of any item (range, .61-.65). Frequencies of positive responses to individual CRAFFT items (Figure 1) were "ridden in a car," 42.6%; "use to relax," 15.6%; "use alone," 10.8%; "forget things you did," 12.3%; "friends tell you to cut down," 8.4%; and "gotten into trouble," 10.6%. The CRAFFT score median was 1 (range, 0-6), and its distribution was highly skewed.

The CRAFFT score was strongly correlated with diagnostic classification (Spearman $\rho=0.72$; $P<.001$). For diagnostic groups, the CRAFFT median scores (with interquartile ranges) were no use, 0 (0-0); occasional use, 1 (0-1); problem use, 2 (1-3); abuse, 2 (1-3); and dependence, 4 (2-5). The CRAFFT score discriminated adequately among all groups (ie, mean ranks differed significantly from each other and from all other groups) except for problem use and abuse (Tamhane T2; $P=.95$).

Receiver operating characteristic curves are presented in **Figure 2**. These curves plot sensitivity against 1−specificity so that the curve area is an overall measure of a test's accuracy. A receiver operating characteristic area of 1 (upper-left corner of the graph) theoretically indicates that the test is always correct, and an area of 0.5 (a diagonal line bisecting the plot area) indicates that the accuracy is no better than chance alone. The receiver operating characteristic areas for CRAFFT were high for all screening categories (any problem=0.92; any diagnosis=0.90; and dependence=0.93). A CRAFFT score of 2 or higher was associated with the maximal product of sensitivity and specificity, which is also the cut point closest to the upper-left corner of the graph. This is one way of identifying a screening test's optimal cut point, although it does not take into account the test's cost/benefit ratio.[33] The CRAFFT optimal cut point was 2 for all 3 screening categories. One hundred thirty-two (25%) of 538 participants had a CRAFFT score of 2 or higher. Sensitivity, specificity, and positive and negative predictive values of a CRAFFT score of 2 or higher for identifying each of the 3 screening categories are presented in **Table 2**. Criterion validity did not differ significantly by sex, age, or race/ethnicity.

COMMENT

This study provides good supportive evidence for the validity of the CRAFFT test as a substance abuse screening device for use among a general population of ado-



Score	Sensitivity	Specificity
1	0.96	0.74
2*	0.76	0.94
3	0.47	0.98
4	0.26	1.00
5	0.10	1.00
6	0.01	1.00

Score	Sensitivity	Specificity
1	0.98	0.66
2*	0.80	0.86
3	0.58	0.94
4	0.36	0.98
5	0.16	1.00
6	0.02	1.00

Score	Sensitivity	Specificity
1	1.00	0.51
2*	0.92	0.80
3	0.72	0.90
4	0.58	0.97
5	0.03	1.00
6	0.00	1.00

Figure 2. The CRAFFT test receiver operating characteristic curves for any problem (ie, alcohol or other drug problem use, abuse, or dependence) (A), any diagnosis (ie, abuse or dependence) (B), and a dependence diagnosis (C). Asterisk indicates the optimal cut point (ie, the maximum product of sensitivity and specificity).

Table 2. Sensitivity, Specificity, Positive Predictive Value (PPV), and Negative Predictive Value (NPV) for Patients With CRAFFT Scores of 2 or Higher*

Patient Characteristic	Sensitivity (95% CI)	Specificity (95% CI)	PPV (95% CI)	NPV (95% CI)
Any Problem (Problem Use, Abuse, or Dependence)				
Overall	0.76 (0.68-0.83)	0.94 (0.92-0.96)	0.83 (0.76-0.89)	0.91 (0.88-0.94)
Male	0.78 (0.64-0.91)	0.94 (0.89-0.98)	0.79 (0.66-0.92)	0.93 (0.88-0.98)
Female	0.75 (0.66-0.83)	0.94 (0.91-0.97)	0.84 (0.76-0.91)	0.91 (0.87-0.94)
Younger†	0.68 (0.54-0.81)	0.96 (0.93-0.98)	0.79 (0.66-0.91)	0.93 (0.89-0.96)
Older‡	0.80 (0.71-0.88)	0.92 (0.88-0.96)	0.84 (0.76-0.92)	0.89 (0.85-0.94)
Any Diagnosis (Abuse or Dependence)				
Overall	0.80 (0.72-0.89)	0.86 (0.83-0.89)	0.53 (0.44-0.61)	0.96 (0.94-0.98)
Male	0.92 (0.80-1.00)	0.89 (0.83-0.94)	0.59 (0.41-0.74)	0.98 (0.96-1.00)
Female	0.76 (0.66-0.86)	0.85 (0.81-0.89)	0.51 (0.40-0.60)	0.95 (0.92-0.97)
Younger†	0.70 (0.53-0.87)	0.90 (0.86-0.94)	0.44 (0.28-0.59)	0.96 (0.94-0.99)
Older‡	0.85 (0.75-0.94)	0.82 (0.76-0.87)	0.57 (0.47-0.67)	0.95 (0.91-0.98)
Dependence				
Overall	0.92 (0.82-1.00)	0.80 (0.77-0.83)	0.25 (0.18-0.33)	0.99 (0.98-1.00)
Male	0.92 (0.73-1.00)	0.82 (0.76-0.88)	0.28 (0.14-0.43)	0.99 (0.98-1.00)
Female	0.92 (0.78-1.00)	0.79 (0.75-0.83)	0.24 (0.15-0.32)	0.99 (0.98-1.00)
Younger†	0.92 (0.75-1.00)	0.88 (0.84-0.91)	0.28 (0.15-0.41)	1.00 (0.99-1.00)
Older‡	0.91 (0.77-1.00)	0.72 (0.67-0.78)	0.24 (0.15-0.33)	0.99 (0.97-1.00)

*CI indicates confidence interval.
†Younger patients were aged 14 years or older but younger than 16.7 years.
‡Older patients were aged 16.7 years or older but younger than 19 years.

lescent clinic patients. The CRAFFT test has acceptable sensitivity and specificity for identifying all screening categories and among all demographic subgroups. The sensitivity and specificity found in this study for the dependence category were close to those reported in the previous pilot study (0.92 and 0.82, respectively) for identifying the need for inpatient treatment, a similar condition, even though the pilot study was conducted in a much-higher-risk sample.[20] The CRAFFT test is designed to be a screening tool, so its result is either positive or negative, and a positive result indicates a need for further assessment. However, the CRAFFT score is correlated with increasing severity of diagnostic classification. Therefore, its discriminant properties can help clinicians estimate not only the presence but also the magnitude of risk of substance-related problems. For example, a score of 4 or higher should raise suspicion of substance dependence.

The standardized α of .68 indicates that CRAFFT has an acceptable degree of internal consistency. Although an α of .70 or higher is generally considered de-

sirable, α is partly a function of scale length, and the CRAFFT test has only 6 items.[34] It is interesting that the α did not increase with the deletion of any item, despite the fact that the car question differs from all other items in the scale. This question is designed to screen for risk of alcohol-related car crashes. Although important, this risk is not necessarily related to having an alcohol- or drug-related disorder. Some adolescents may answer this question affirmatively based on having ridden in a car with an intoxicated family member, rather than driving after drinking or riding with an intoxicated peer. Nonetheless, almost 43% of the study participants answered "yes" to this question, and providers need effective strategies to deal with this risk.

We have provided detailed information on the characteristics of CRAFFT in Figure 2 and Table 2. Providers can therefore determine the optimal score cut point for the screening category they most wish to target and how best to interpret a positive screen in their own patient populations. Overall, we recommend using a score of 2 or higher as indicating a need for further assessment. A clinic provider can be reasonably reassured when CRAFFT is negative but should assess his or her patient further when the test is positive. However, the relative risk of a false-positive test (eg, additional interview) is low compared with that of a false-negative (ie, missed diagnosis and opportunity for early intervention). Some providers may therefore choose to further assess those adolescents whose score is only 1.

The sensitivity and specificity (0.80 and 0.86, respectively) found in this study for CRAFFT in identifying any disorder compare quite favorably with those found by Bastiaens et al[35] for the substantively different RAFFT test (0.89 and 0.69, respectively) and by Chung et al[18] for modified versions of the CAGE[16] (0.67 and 0.82, respectively), TWEAK[36] (0.84 and 0.80, respectively), and AUDIT[37] (0.97 and 0.75, respectively). The CRAFFT test presents some clear advantages over these other brief screening tests. First, the CRAFFT is the only screening test that includes an item on drinking and driving (or riding with an intoxicated driver). Alcohol-associated motor vehicle accidents are a leading cause of death among adolescents,[38] and a question regarding this risk should be a part of routine screening.

Second, the CRAFFT test screens for both alcohol and other drug problems, whereas the CAGE, TWEAK, and AUDIT tests screen for alcohol problems alone. Drug use is highly prevalent among adolescents,[2] and most providers would likely prefer a single test that can screen for all psychoactive substances simultaneously. Third, the CRAFFT test is simpler to administer and score than either the TWEAK or AUDIT tests. The TWEAK items are weighted, and AUDIT was not designed for oral administration. Although written questionnaires may present an advantage in efficiency when patients complete them in the waiting area, they are limited by risks to confidentiality. One study reported that adolescent medical patients were frequently dishonest when answering providers' questions about substance use because parents were present.[39] Providers can ask the CRAFFT questions during the course of the adolescent's physical examination, after parents have left the room. However, some adolescents may be reluctant to discuss their alcohol and other drug use with the pediatrician, even when parents are not present.

Few comparable validation studies have been conducted in general adolescent clinic settings, and none of these included both a risk assessment (ie, the POSIT scale) and a psychiatric diagnostic interview (ie, the ADI).[18-20,24,35] Our unique approach to validation of the CRAFFT test allows us to report on the estimated prevalence and range of substance-related disorders among patients in a general adolescent clinic. More than one half of patients in our clinic had used alcohol or other drugs during the past year, and more than one fourth had experienced serious substance-related problems. Almost 1 in 6 (16.3%) had a substance-related diagnosis of abuse or dependence as defined by the *DSM-IV*.

These findings have serious implications for adolescent health care. They unquestionably reinforce the importance of the existing Guidelines for Adolescent Preventive Services recommendations for universal substance abuse screening. These findings also suggest a need for additional time and personnel to further assess the substantial numbers of adolescents who will screen positive when universal screening is implemented. Positive screens should be followed by a more complete substance use history, taken by either a physician or some other trained health care professional. Unfortunately, recent changes in the health care system have already placed pressure on providers to see more patients quickly. If universal screening is to improve, health care systems must find ways to provide the additional resources needed for assessment of substance-using adolescents.

These findings also suggest a need to increase the capacity of systems and communities to provide substance abuse treatment for adolescents. In clinic settings such as ours, one fourth of patients need at least a brief intervention, and one sixth likely need referral to a treatment specialist. Current resources are not adequate to meet this need. In our own metropolitan area, adolescents needing substance abuse treatment are most often referred to adult programs because so few adolescent-only programs exist. Adult programs rarely accept younger adolescents, and they are not designed to respond to the unique developmental needs of younger or older adolescents. New approaches, such as office-based interventions, must be developed to adequately meet the need for treatment.

There are limitations to the generalizability of our findings regarding diagnostic classifications. This study was conducted in a single urban hospital-based adolescent clinic. Prevalence rates among adolescent patients seen in other clinics, family practices, or general pediatric practices may be different. However, Chung et al[18] found a similar rate (18%) of alcohol disorders in an adolescent emergency department sample, and one large study estimated the rate of current alcohol dependence for the 18 years and older US population at large to be 4.4%, with higher rates among the young.[40]

This study relied on adolescents' self-report. The extent to which some participants may have underreported and others overreported their use of substances is unknown. However, self-report of alcohol and other drug use has been shown to be generally reliable and com-

What This Study Adds

Guidelines for universal screening of adolescent patients for substance use have been available for some time. However, little attention has been given to the specifics of how this screening should be conducted. Many widely used screening devices are either impractical for busy medical offices or developmentally inappropriate for adolescents. Also unknown is the likely outcome of universal screening, ie, what proportion of adolescent patients have alcohol- and drug-related disorders.

This study demonstrates that the brief CRAFFT test has good validity for identifying substance-related problems and disorders in adolescent medical patients. The screen can be orally administered, and it has a convenient mnemonic, based on key words in each of the 6 yes or no questions. Substance-related problems and disorders were highly prevalent in the clinic we studied, affecting more than 1 in 4 patients. Studies proposing new intervention strategies for those who screen positive are urgently needed.

pares favorably with other methods of substance use detection.[41,42] The 18-month study recruitment period included 2 summers. Adolescents may use alcohol and other drugs at higher rates when not in school, and recall bias may have resulted in higher reports of past 12-month use by participants recruited during the summer months.

The findings on prevalence may be further limited, in that the study sample, although generally reflective of the clinic population at large, was not selected randomly. Participants were consecutively recruited in approximately half of the 12 clinic sessions conducted each week. We instructed providers to invite all 14- to 18-year-old patients to participate, not only those who had used alcohol or other drugs. However, we cannot assess to what degree they followed this instruction; provider selection bias, resulting in higher than actual prevalence estimates for disorders, remains a possibility. By contrast, healthier and less-affected patients may have been more likely to agree to participate in the study, resulting in self-selection bias and lower than actual estimates of prevalence. Future studies on prevalence should address these limitations and include a larger and more diverse group of clinic settings.

Despite these limitations, this study provides strong supportive evidence for the criterion validity of the CRAFFT test. The CRAFFT test offers pediatricians, nurse-clinicians, family practitioners, internists, and other primary care providers a practical means of quickly identifying adolescent patients who need more comprehensive assessment or referral to substance abuse treatment specialists.

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We have found that laminated pocket cards listing the 6 CRAFFT questions are helpful for administering the screen in actual office practice. Readers who would like a complimentary CRAFFT test pocket card may obtain one by contacting the Center for Adolescent Substance Abuse Research, Children's Hospital Boston, 300 Longwood Ave, Boston, MA 02115; telephone: 617-355-5433; fax: 617-267-9397; Web site: www.ceasar-boston.org.

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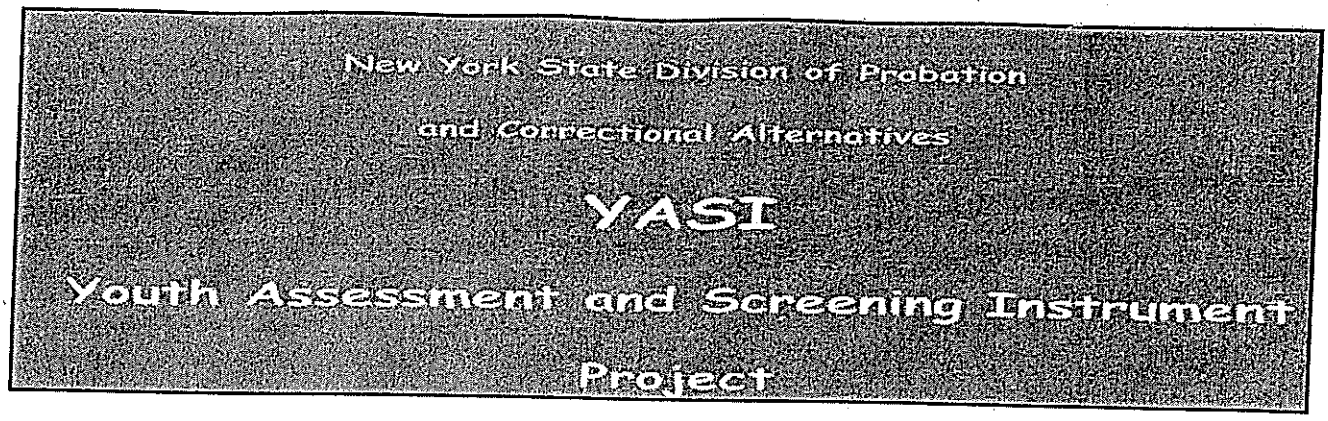
REFERENCES

1. Horgan C, Skwara K, Strickler G. *Substance Abuse: The Nation's Number 1 Health Problem.* Princeton, NJ: Robert Wood Johnson Foundation; 2001.
2. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 1999. *MMWR Morb Mortal Wkly Rep.* 2000;49(SS-5):1-96.
3. Johnston L, O'Malley P, Bachman J. *Monitoring the Future: National Survey Results on Drug Use, 1975-2000. Volume 1: Secondary School Students.* Bethesda, Md: National Institute on Drug Abuse; 2001. Available at: http://www.monitoringthefuture.org/pubs/monographs/vol1_2000.pdf. Accessed March 22, 2002.
4. Substance Abuse and Mental Health Services Administration. *The Relationship Between Mental Health and Substance Abuse Among Adolescents.* Rockville, Md: Substance Abuse and Mental Health Services Administration, Office of Applied Studies; 1999.
5. Aarons G, Brown S, Coe M, et al. Adolescent alcohol and drug use and health. *J Adolesc Health.* 1999;24:412-421.
6. Klitzner M, Fisher D, Stewart K, Gilbert S. *Substance Abuse: Early Intervention for Adolescents.* Princeton, NJ: Robert Wood Johnson Foundation; 1993.
7. Elster A, Kuznets N, eds. *Guidelines for Adolescent Preventive Services (GAPS).* Baltimore, Md: Williams & Wilkins; 1994.
8. American Academy of Pediatrics. *Practices and Attitudes Toward Adolescent Drug Screening.* Elk Grove Village, Ill: American Academy of Pediatrics, Division of Child Health Research; 1997. *Periodic Survey of Fellows No. 31.*
9. Halpern-Felser B, Ozer E, Millstein S, et al. Preventive services in a health maintenance organization. *Arch Pediatr Adolesc Med.* 2000;154:173-179.
10. Love C, Gerbert B, Caspers N, Bronstone A, Perry D, Bird W. Dentists' attitudes and behaviors regarding domestic violence. *J Am Dent Assoc.* 2001;132:85-93.
11. Chamberlain L, Perham-Hester KA. Physicians' screening practices for female partner abuse during prenatal visits. *Matern Child Health J.* 2000;4:141-148.
12. Li C, Olsen Y, Kvigne V, Welty T. Implementation of substance use screening in prenatal clinics. *S D J Med.* 1999;52:59-64.
13. Parsons LH, Zaccaro D, Wells B, Stovall TG. Methods of and attitudes toward screening obstetrics and gynecology patients for domestic violence. *Am J Obstet Gynecol.* 1995;173:381-387.
14. Allen J, ed. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers.* Bethesda, Md: National Institute on Alcohol Abuse and Alcoholism; 1995.
15. Winters K, ed. *Screening and Assessing Adolescents for Substance Use Disorders.* Rockville, Md: US Dept of Health and Human Services; 1999. Treatment Improvement Protocol Series No. 31. DHHS Publication No. (SMA) 99-3282.
16. Ewing J. Detecting alcoholism: the CAGE questionnaire. *JAMA.* 1984;252:1905-1907.
17. Bush B, Shaw S, Cleary P, Delbanco TL, Aronson MD. Screening for alcohol abuse using the CAGE questionnaire. *Am J Med.* 1987;82:231-235.
18. Chung T, Colby SM, Barnett NP, Rohsenow DJ, Spirito A, Monti PM. Screening

adolescents for problem drinking: performance of brief screens against *DSM-IV* alcohol diagnoses. *J Stud Alcohol.* 2000;61:579-587.
19. Knight JR, Goodman E, Pulerwitz T, DuRant RH. Reliabilities of short substance abuse screening tests among adolescent medical patients. *Pediatrics.* 2000;105: 948-953.
20. Knight JR, Shirier L, Bravender T, Farrell M, Vander Bilt J, Shaffer H. A new brief screen for adolescent substance abuse. *Arch Pediatr Adolesc Med.* 1999;153: 591-596.
21. Department of Health and Human Services. *Protection of Human Subjects (Title 45, Code of Federal Regulations, Pt 46).* Rockville, Md: US Dept of Health and Human Services, National Institutes of Health, Office for Protection From Research Risks; 2001. Available at: http://ohrp.osophs.dhhs.gov/humansubjects/guidance/45cfr46.htm. Accessed March 22, 2002.
22. Society for Adolescent Medicine. Guidelines for adolescent health research. *J Adolesc Health.* 1995;17:264-269.
23. Rahdert ER, ed. *The Adolescent Assessment/Referral System Manual.* Washington, DC: US Dept Health Human Services, Alcohol, Drug Abuse, and Mental Health Administration; 1991. DHHS Publication No. (ADM) 91-1735.
24. Knight J, Goodman E, Pulerwitz T, DuRant RH. Reliability of the Problem Oriented Screening Instrument for Teenagers (POSIT) in an adolescent medical clinic population. *J Adolesc Health.* 2001;29:125-130.
25. Latimer WW, Winters KC, Stinchfield RD. Screening for drug abuse among adolescents in clinical and correctional settings using the Problem-Oriented Screening Instrument for Teenagers. *Am J Drug Alcohol Abuse.* 1997;23:79-98.
26. Winters K, Henly G. *Adolescent Diagnostic Interview (ADI) Manual.* Los Angeles, Calif: Western Psychological Services; 1993.
27. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Washington, DC: American Psychiatric Association; 1994.
28. Winters KC, Stinchfield RD, Fulkerson J, Henly GA. Measuring alcohol and cannabis use disorders in an adolescent clinical sample. *Psychol Addict Behav.* 1993; 7:185-196.
29. Winters KC, Latimer W, Stinchfield RD. The *DSM-IV* criteria for adolescent alcohol and cannabis use disorders. *J Stud Alcohol.* 1999;60:337-344.
30. Rutter CM. Bootstrap estimation of diagnostic accuracy with patient-clustered data. *Acad Radiol.* 2000;7:413-419.
31. Carpenter J, Bithell J. Bootstrap confidence intervals: when, which, what? a practical guide for medical statisticians. *Stat Med.* 2000;19:1141-1164.
32. Platt RW, Hanley JA, Yang H. Bootstrap confidence intervals for the sensitivity of a quantitative diagnostic test. *Stat Med.* 2000;19:313-322.
33. Cantor SB, Sun CC, Tortolero-Luna G, Richards-Kortum R, Follen M. A comparison of C/B ratios from studies using receiver operating characteristic curve analysis. *J Clin Epidemiol.* 1999;52:885-892.
34. Nunnally J, Bernstein I. *Psychometric Theory.* 3rd ed. New York, NY: McGraw-Hill; 1994.
35. Bastiaens L, Francis G, Lewis K. The RAFFT as a screening tool for adolescent substance use disorders. *Am J Addict.* 2000;9:10-16.
36. Chan AW, Pristach EA, Welte JW, Russell M. Use of the TWEAK test in screening for alcoholism/heavy drinking in 3 populations. *Alcohol Clin Exp Res.* 1993; 17:188-192.
37. Babor T, de la Fuente J, Saunders J, Grant M. *AUDIT, the Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Health Care.* Geneva, Switzerland: World Health Organization; 1992.
38. Centers for Disease Control and Prevention. Alcohol involvement in fatal motor-vehicle crashes—United States, 1997-1998. *MMWR Morb Mortal Wkly Rep.* 1999; 48(47):1086-1087.
39. Friedman LS, Johnson B, Brett AS. Evaluation of substance-abusing adolescents by primary care physicians. *J Adolesc Health Care.* 1990;11:227-230.
40. Grant BF. Prevalence and correlates of alcohol use and *DSM-IV* alcohol dependence in the United States: results of the National Longitudinal Alcohol Epidemiologic Survey. *J Stud Alcohol.* 1997;58:464-473.
41. Winters KC, Stinchfield RD, Henly GA, Schwartz RH. Validity of adolescent self-report of alcohol and other drug involvement. *Int J Addict.* 1990;25:1379-1395.
42. Babor TF, Kranzler HR, Lauerman RJ. Early detection of harmful alcohol consumption: comparison of clinical, laboratory, and self-report screening procedures. *Addict Behav.* 1989;14:139-157.



In New York State, over 50,000 juvenile cases are seen annually at intake by local probation services. In recent years, there has been growing recognition among probation professionals that a comprehensive assessment protocol is an essential first step toward achieving the goals of public safety, youth accountability, and competency development. Systematic assessment increases outcome predictability while supporting professional judgment, and assists to pinpointing "targets" for service, thereby augmenting the effectiveness of case management.

The Youth Assessment and Screening Instrument (YASI) Project* brings together good probation practice with developments in research regarding assessment, prevention, and effective intervention. The YASI tool was initially developed, field-tested, and validated in Washington State based upon empirical research, and has been customized and enhanced to meet the needs of New York State.

The YASI was developed in Microsoft Access 2000, and is now available in Microsoft Access XP, It is currently being developed in Microsoft Desktop Engine. Having a variety of options better the counties, who have differing software needs. The software offers opportunity to readily gather and analyze data. It synthesizes multiple pieces of assessment information through a "roll-up" function, and provides a picture or profile of the client that can be easily shared on paper. It can assist with information management, including the identification of service gaps.

The YASI tool has two assessment components: a modified initial pre-screen that assesses risk, and a full assessment that incorporates items related to need and protective factors (strengths). Each item offers several response options, allowing for narrative description of the risk, need, and protective factors being assessed. This allows for more detailed and insightful case profiling of the results of the assessment. Additionally, the protocol includes interview material to guide the assessment process. It is directly transferable to client intervention and supervision, and offers excellent potential as a reassessment tool for measuring supervision progress over time. It provides a common language for talking about clients and communicating with other service agencies, and offers more objective criteria for assigning services.

The newest features of the software include an automated case management protocol, an expanded outcomes tab that allows departments to document outcomes in the software, and an increased number of quick report options. The case planning software provides the tools and

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* The Youth Assessment and Screening Instrument Project is conducted by The New York State Division of Probation and Correctional Alternatives, in consultation with Orbis Partners, Ottawa, Canada. It is federally funded under the Juvenile Accountability Incentive Block Grant through a grant from the New York State Division of Criminal Justice Services.

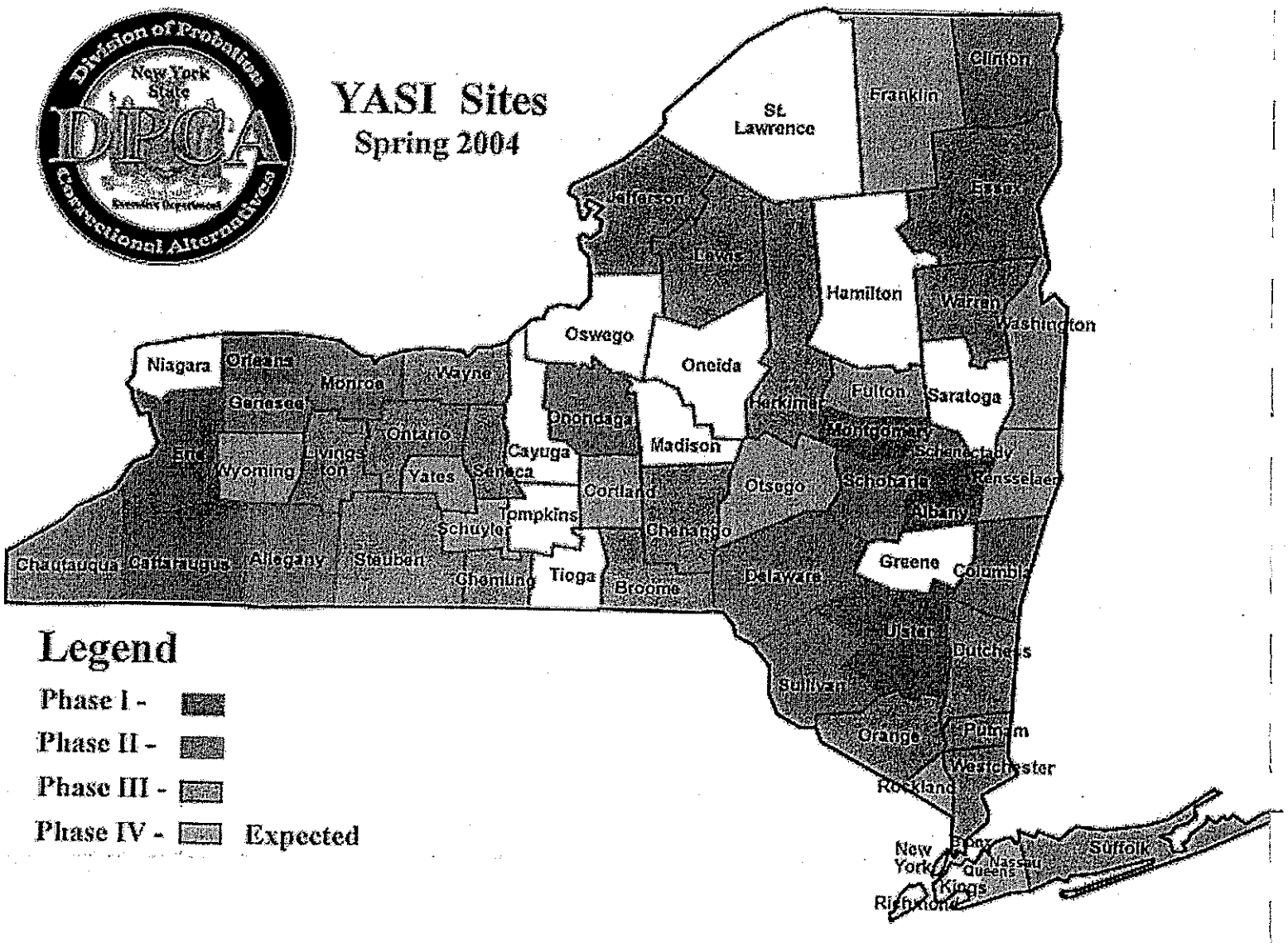
software to assist in the development of specific objectives and action steps to measurably reduce risk and increase protective factors. This software guides the user to target the highest risk factors, identify incentives, specific service interventions, and ensures that roles and responsibilities are clear and documented. In effect, the case management system provide tools to assist probation officers to "connect-the-dots" from assessment to targeted, evidence-based interventions, and to record specific service interventions and case outcomes. Planned is a reworking of the current mental health section. This reworking will separate out mental health concerns from items related to violence and aggression, and a new domain focusing specifically on violence and aggression will be created. The mental health information will remain for responsivity purposes in developing case plans.

Pre-dispositional Investigation and Reports: we are currently in the process of developing software to prepare pre-dispositional reports for the family court. This software will allow probation officers to transfer assessment information into draft narrative reports. This will provide for many new efficiencies in paperwork, standardize the format and comprehensiveness of reports, and ensure that content is consistent with the research in terms of risk and protective factors. It is anticipated that this software will be ready for initial piloting in January 2004.

Detention Tab: This tab is still planned for development. The goal is for this tab to be available to sites seeking to make detention decisions.

For further information, contact Patti Donohue at DPCA at 518-485-5158.

YASI Sites
Spring 2004



Legend

Phase I -

Phase II -

Phase III -

Phase IV - Expected

COUNCIL ON CHILDREN AND FAMILIES
INTERAGENCY WORKGROUP ON OUT-OF-STATE RESIDENTIAL PLACEMENTS

FISCAL SUB-GROUP
JUNE 1, 2005

Introduction:

The Fiscal Sub-Group (FSG) was charged with assembling a comparison of costs between out-of-state schools versus in-state schools serving students with similar disabilities. It cannot be assumed that the characteristics of the out-of-state schools are equal to those of the in-state schools in areas including, but not limited to, programming, staff intensity, and physical plant. One of the perceptions of out-of-state placements is that the out-of-state schools provide some greater intensity of programming than do in-state schools. This has yet to be proven accurate.

The FSG was also directed to determine the economic impact of the flow of State and local dollars out-of-state. As the FSG does not include staff trained in econometric modeling, this analysis was prepared on a very general, but we believe useful, level.

The FSG was also charged with developing an analysis to determine the relative savings or additional costs to NYS to provide services in-state to 100 students that could potentially be placed out-of-state, by expanding existing provider capacity. Also, we were asked to estimate the economic benefits of diverting 100 students into in-state programs.

I. Summary of Funding Sources for Out-of-State Tuition and Residential Costs:

Children placed out-of-state in residential schools or other institutional settings may be placed by local school district Committees on Special Education (CSE) or by social services districts. The first group may be referred to as residential CSE placements and the second group as residential foster care placements.

The State's framework for financing a residential CSE placement involves two funding components: the funding of the child's special education program (tuition), and the funding of the care and maintenance and medical services associated with the child's daily care and supervision (maintenance).

The State's framework for financing a residential foster care placement involves three funding components: the funding of care and maintenance and case management costs associated with the child's daily care and supervision (maintenance); the funding of the child's educational program (tuition); and the funding of medical services (medical).

For foster children placed in residential facilities, the challenge of maximizing Federal Title IV-E or Federal Medicaid reimbursement may be much greater than for in-state settings. This is because New York State does not establish a foster care reimbursement rate for such placements in other states. Whereas the foster care rate setting methodologies within New York State are specifically designed to maximize reimbursement from the available Federal programs, the payment rates used by programs in other states may not be similarly structured. Thus, social services districts

would typically receive a lower percentage of Federal reimbursement for foster care placements in other states.

For additional details on the various funding streams, please refer to Attachment I (page 7).

II. Comparison of In-State and Out-of-state Private School Costs:

Assumptions/Methodology:

- Data for this analysis includes only that related to school district placements as it was determined that placement and cost data for these students was most readily available. The school district data represents 75% of the total out-of-state placements.

- While New York school districts annually place students in 17 approved out-of-state residential programs (See Attachment II), five out-of-state schools account for approximately 75% of the school district placements in approved out-of-state residential programs. Because of this material concentration of placements, only data from these five out-of-state schools were used in this analysis.

- FSG reviewed the general characteristics of the services offered by these five out-of-state schools and then matched these schools to similar programs in-state. Again, we need to use the term similar and not equal.

- The schools were then aligned in a cost matrix to display tuition and maintenance (residential) rates for the out-of-state school and its similar in-state matches. (Exhibit A)

- Total per child costs were then multiplied by twenty (20) hypothetical students in each of the out-of-state and in-state schools to arrive at a total tuition and maintenance cost for both the out-of-state and comparable in-state 100-student sample.

Exhibit A: 5 out-of-state schools and comparable in-state schools

EXHIBIT A

FIVE (5) OUT-OF-STATE RESIDENTIAL PROVIDERS WITH GREATEST NUMBER OF 2003-04 CSE PLACEMENTS
TUITION AND MAINTENANCE COSTS PER STUDENT

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
OUT-OF-STATE PROVIDER	**PROGRAM NAME**	**# OF STUDENTS**	***COST**	****ANNUAL COST PER FT STUDENT**	**COMPARABLE IN-STATE PROVIDER**	**PROGRAM**	**COST**	**# OF STUDENTS**	****ANNUAL COST PER FT STUDENT**
DEVEREUX CENTER-	DCBHC - INTENSIVE	1	$169,896	$169,896	**DEVEREUX NY**	DAY/RESID	$6,109,983	64	$113,763
PA	GATEWAY	2	$275,765	$137,882	**DEVEREUX NY**	CRP	$1,683,938	16	$123,005
	MAPLETON REGULAR	23	$2,960,931	$153,951					
	BRANDYWINE MALE ONLY	29	$3,640,748	$161,288					
	KANNER CTR	17	$2,201,090	$141,668					
Total		**72**	**$9,248,429**	**$153,264**	**TOTAL**		**$7,793,921**	**80**	**$115,640**
JUDGE ROTENBERG EDUCATIONAL CTR-MA	4407:SCH-YR 6:1:2	**157**	**$30,506,239**	**$240,728**	**^HILLSIDE CHILDRENS CTR**	RESID	**$1,935,316**	**13**	**$264,207**
KIDSPEACE NAT'L CTRS FOR KIDS-PA	COMBINED PROGRAM	**177**	**$24,330,495**	**$200,788**	**CHILDREN'S HOME/KINGSTON**	DAY/RESID	$967,716	11	$106,635
					HILLSIDE CHILDRENS CTR	RESID	$1,233,261	13	$168,363
					SUMMIT SCHOOL	DAY/RESID	$14,199,017	157	$107,895
					TOTAL		**$16,399,994**	**181**	**$110,811**
KOLBURNE SCHOOL INC-MA	4407:SCHOOL YEAR	**60**	**$6,549,536**	**$130,339**	**ANDERSON SCHOOL**	DAY/RESID	$11,548,114	102	$127,463
					ANDERSON SCHOOL	CRP	$1,165,529	11	$133,585
					CRESTWOOD CHILDREN'S CTR	DAY/RESID	$1,650,333	17	$129,438
					TOTAL		**$14,363,976**	**130**	**$128,164**
	4407 REG & INTENS								
WOODS SCHOOL-	MOLLIE WOODS	38	$4,762,705	$155,137	**DDI**	CRP	$4,947,211	29	$213,943
MULTI HANDICAPPED	CTR ON CHALLENGING	99	$13,156,065	$149,162	**HILLSIDE CHILDRENS CTR**	RESID	$1,233,261	13	$168,363
PA	BEHAV				**MARYHAVEN**	DAY/RESID	$9,480,535	62	$164,023
					MARYHAVEN	CRP	$2,888,023	19	$166,457
Total		**137**	**$17,918,770**	**$150,705**	**TOTAL**		**$18,549,030**	**123**	**$175,655**
TOTALS					**TOTALS**				
5 OOS PROVIDERS		**603**	**$88,553,469**	**$185,494**	**IN-STATE PROVIDERS**		**$59,042,237**	**527**	**$134,066**

*New York State accepts the host state established rates. **Note**: It would not be reasonable to assume that the out-of-state school characteristics are identical to the in-state schools in areas including, but not limited to, programming, staff intensity, and physical plant.

**FT-Full Time tuition and maintenance. Equals Cost (col 4) divided by FTE # of students (not shown). ^Cost based on Intensive Program tuition and maintenance rates

III. Analysis related to serving 100 students in-state rather than out-of-state:

Assumptions/Methodology:

- The five out-of-state schools from (**II**.) were used as the basis for this analysis.
- The hypothetical 100 students were assumed to be placed in the five schools in equal numbers, 20 from each out-of-state school.
- Each of the 20 subsets were assigned to the correspondingly similar in-state schools in (**II**.)
- If the 100 students were accommodated in currently vacant education and residential space in in-state schools, the cost to New York State to serve these 100 students in-state would be the cost differential between the corresponding in-state and out-of-state schools.
- If the 100 students could not be accommodated in currently existing space and construction was required, a capital construction premium add on rate would need to be developed and included in determining the "cost" to New York to serve these students instate.

The approved per student capital data was analyzed and a weighted average education capital rate of $15,073 was developed, for a cost to NYS of $1.5 million for 100 students. The fiscal impact to New York to serve this hypothetical 100-student sample in-state instead of out-of-state, including construction costs, is ($119,631) (see Exhibit B).

Exhibit B: Cost differential of 100 out-of-state vs. in-state placements

Economic Impact

The Work Group developed an analysis of the economic impact of serving children in-state rather than out-of-state. Since it is unlikely that a proposal could be implemented to serve all 1,400 students currently placed out-of-state, the Work Group considered the impact of serving an additional 100 students in-state and averting the future out-of-state placement. In order to determine the economic impact of serving an additional 100 children and youth in-state, the Work Group compared the cost of serving these children and youth in-state with the cost of serving the children and youth out-of-state. Additionally, the cost of serving the children and youth in-state was then offset by the economic benefits New York State would receive in terms of job creation and additional dollars flowing through the community. These figures assume current salary rates, staff to youth ratios and fringe benefits and do not account for the potential need for more intense levels of service for children and youth with complex and/or multiply-diagnosed needs.

Hypothetical 100 Children and Youth Served In-State

The Work Group's analysis focused on the fiscal impact to NYS of serving 100 out-of-state residential placements in existing in-state residential programs. The Work Group selected the five (5) out-of-state providers with the greatest number of CSE placements, representing 75% of all out-of-state CSE placements in approved programs, to extract the 100-student sample. The

Work Group consulted with SED program staff, who reviewed the characteristics of the program models of the 5 out-of-state schools selected and recommended for each out-of-state school one or more in-state programs that they determined are the most comparable model(s). The Work Group gathered the most recent per student tuition, maintenance, and medical costs for NYS students at the 5 selected out-of-state schools, as well as for students at the comparable in-state schools. The Work Group computed the cost of serving twenty (20) students at each of the five out-of-state schools (100 students in total), and computed the cost of serving twenty students at each of the 5 out-of-state schools' comparable in-state matches. When computing the cost of serving students in-state, additional costs were factored in for capital construction to accommodate the potential need for additional facility space. The Work Group then calculated the cost differential of serving the 100-residential students sample in-state versus out-of-state. Finally, the Work Group determined the economic benefit to NYS of serving 100 additional residential students in-state.

Several assumptions were made by the Work Group in its approach to calculate the fiscal impact of serving 100 students in-state versus out-of-state. One primary assumption is that the characteristics and needs of many NYS students currently being served out-of-state could be met with a similar level of service as currently being offered at the in-state program. (However, in some cases an increase in the intensity of services is needed.) Another assumption made is that each in-state provider is almost at full capacity; thus capital construction costs would have to be incurred at each of the in-state matches in order to accommodate the 100 students. Working under these assumptions, the Work Group determined that the cost of serving the 100-student sample in-state ($17,396,846) was slightly less than the cost of serving this group out-of-state ($17,516,477).

Economic Benefit of Serving 100 Additional Students In-State

Using a model developed by the Empire State Development Corporation (ESDC), the Work Group gathered information on staffing ratios and salaries, construction and rehabilitation costs and the region with the highest number of out-of-state placements. The total staffing ratio was 1.48 direct care workers per child with an average salary of $38,456. The number of new direct care jobs created as a result of serving an additional 100 students in-state is 148. Additionally, it is estimated that 45 new ancillary jobs would be created as a result of this proposal for a total of 193 jobs.

The construction parameters were developed using OCFS, OMRDD and SED data. The analysis included half of the youth being placed in new facilities, which would require new construction and half entering facilities that need some level of rehabilitation. The total construction cost is estimated at about $1.5 million.

The majority of children and youth placed out-of-state originated from the Long Island or the Mid-Hudson region. The economic model included this regional information to provide a geographically sensitive economic benefit model. The table below shows the economic impact related to serving 100 youth in-state compared to the cost of serving them out-of-state.

Economic Impact to Serve 100 Youth In-State as Opposed to Out-of-State

	Cost Benefit Analysis	In-State Cost	Out-of-State Cost	Savings for Serving Youth In-State
1	Annual cost of placing 100 students	$17,396,846	$17,516,477	$119,631
2	Total Economic Benefit	$7,762,151	$0	$7,762,151
3	**Net Economic Impact**	**$9,634,695**	**$17,516,477**	**$7,881,782**

The total cost to serve the 100 out-of-state student sample in-state versus out-of-state is nearly identical, whereas the economic benefit to NYS in terms of an additional 193 jobs created and an infusion of $7.8 million into the local economies makes this proposal fiscally beneficial to NYS.

Previously identified was the issue of the longer lengths of stay for NYS children in out-of-state placements. What has not been prospectively evaluated is the anticipated savings to local social services districts and school districts, if there are shorter lengths of stay at the more expensive residential settings.

EXHIBIT B

2003-04 OUT-OF-STATE RESIDENTIAL PROVIDERS
5 PROVIDERS WITH GREATEST NUMBER OF CSE PLACEMENTS
COST DIFFERENTIAL OF 100 OUT-OF-STATE VS. IN-STATE PLACEMENTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
OUT-OF-STATE PROVIDER	NO. OF STUDENTS	*ANNUAL COST PER FT STUDENT	ANNUAL COST OF STUDENT SAMPLE (Col 2 x Col 3)	COMPARABLE IN-STATE PROVIDER	*ANNUAL COST PER FT STUDENT	ANNUAL COST OF STUDENT SAMPLE (Col 2 x Col 6)	COST DIFFERENTIAL IN-STATE VS OUT-OF-STATE (Col 7 - Col 4)	**ANNUAL COST PER FT STUDENT INCL CONSTR	ANNUAL COST OF STUDENT SAMPLE INCL CONST (Col 2 x Col 9)	COST DIFFERENTIAL IN-STATE VS OUT-OF-STATE INCL CONST (Col 10 - Col 4)
DEVEREUX CENTER-PA	20	$153,264	$3,065,287	DEVEREUX NY	$115,640	$2,312,805	($752,482)	$130,713	$2,614,265	($451,022)
JUDGE ROTENBERG EDUCATIONAL CTR-MA	20	$240,728	$4,814,557	^HILLSIDE CHILDRENS CTR	$264,207	$5,284,140	$469,582	$279,280	$5,585,600	$771,042
KIDSPEACE NAT'L CTRS FOR KIDS-PA	20	$200,788	$4,015,761	CHILDREN'S HOME/KINGSTON HILLSIDE CHILDRENS CTR SUMMIT SCHOOL	$110,811	$2,216,215	($1,799,546)	$125,884	$2,517,675	($1,498,086)
KOLBURNE SCHOOL INC-MA	20	$130,339	$2,606,781	ANDERSON SCHOOL CRESTWOOD CHILDREN'S CTR	$128,164	$2,563,279	($43,501)	$143,237	$2,864,739	$257,959
WOODS SCHOOL-MULTI HANDICAPPED -PA	20	$150,705	$3,014,091	DDI HILLSIDE CHILDRENS CTR MARYHAVEN	$175,655	$3,513,107	$499,016	$190,728	$3,814,567	$800,476
TOTALS 5 OOS PROVIDERS	100	$175,165	$17,516,477	TOTALS IN-STATE PROVIDERS	$158,895	$15,889,546	($1,626,931)	$173,968	$17,396,846	($119,631)

*FT-Full Time tuition and maintenance. Equals Exhibit A Cost (column 4) divided by FTE # of students (not shown).
New York State accepts the host state established rates. **Note**: It would not be reasonable to assume that the out-of-state school characteristics are identical to the in-state schools in areas including, but not limited to, programming, staff intensity, and physical plant.
**Annual construction costs of $15,073 per student based on data from recent SED residential construction projects.
^Cost based on Intensive Program tuition and maintenance rates

ATTACHMENT I

Placement and Payment Responsibilities

A. CSE Placements into Residential Facilities – Responsibilities for CSE Tuition and Maintenance

If a local school district's CSE places a student in a residential facility, the local school district is responsible to pay the education costs and then is reimbursed through State aid for an average of 80 percent of those costs. The social services district for the student is responsible to pay the CSE maintenance cost. Then, the social services district is reimbursed 40 percent of those costs through State aid and 20 percent from the local school district.

B. Foster Care Placements into Residential Facilities – Responsibilities for Foster Care Tuition, Maintenance and Medical Services

If a social services district places a child in a residential facility, the social services district is responsible to pay the foster care maintenance, medical and education costs. The social services district is reimbursed for those costs through a number of Federal and State funding sources.

The primary Federal funding source for foster care maintenance is the Federal Title IV-E program. Statewide, roughly 30 percent of the foster care maintenance costs are reimbursed from this funding source.

The State's Foster Care Block Grant (FCBG) is the source of State funding for all foster care maintenance net of Federal funding, as well as for all educational costs. Each social services district receives an annual share of the State's FCBG appropriation based on its historical expenditures, as well as on its success in reducing the number of foster care placement days. After a social services district exhausts its allocation of the FCBG, it must use local tax levy dollars to fund any balance of foster care maintenance or education costs for foster care placements.

The Federal/State Medicaid program is the funding source for medical services provided to foster children. The Federal share of the medical cost is 50 percent, and the balance is funded by 25 percent State and 25 percent local tax levy dollars.

C. Office of Mental Retardation and Developmental Disabilities (OMRDD)

OMRDD provides several different alternatives for residential services to children based on their individual needs.

Private Residential Schools

OMRDD certifies and licenses 9 private residential schools with a capacity of 593 opportunities for children. OMRDD does not fund the residential or educational cost of children in private residential schools. Children are placed into private residential schools by local committees on special education (CSE), or departments of social

services. Responsibility for education costs rests with the school district where the private school is physically located.

Children's Residential Program (CRP)

Children's residential programs (CRP) are licensed by OMRDD as intermediate care facilities (ICF). OMRDD is responsible for the cost of operation of the residences, even though it does not place children into CRPs. Children are placed into CRPs according to the same procedure as for private residential schools.

Unlike the private residential school, responsibility for the educational costs of a CRP rests with the home school district (where the parents live).

Other

OMRDD, and its network of voluntary providers also operate some unique, special programs that have been developed to satisfy a specific need (technology dependent, autism, severe behavior, sex offender, etc.). OMRDD also receives referrals of children from hospitals, other state agencies, the courts etc. Children may be accommodated in a specialized unit, or in the community based or institutional alternative most appropriate to the child's individual needs.

Other alternatives to serve children include out-of-home OMRDD residential programs such as individual residential alternatives (IRA), community residences (CR), IFC's and family care homes or developmental centers. Home-based services are delivered via the family support services (FSS) program. All of these programs are funded via various Medicaid rates with costs shared amongst local, state and federal sources.

D. Office of Mental Health (OMH)

A very small number of Office of Mental Health recommended out-of-state placements, authorized by the Department of Health (DOH), Bureau of Medical Review and Payment take place each year (average less then six per year). The prior approval process for out-of-state services includes a letter of medical necessity from the referring in-state physician together with documentation that the requested specialized out-of-state medical and psychiatric services are not available in New York State. These requests are subject to review and concurrence at the local governmental unit level, regional and central OMH before they are forwarded to the Department of Health for approval. These placements are ordinarily necessitated by a combination of extremely complex physical and mental health issues requiring very specialized services. DOH provides approval for eligible recipients to use of NYS Medicaid as reimbursement to approved out-of-state facilities on a time limited basis. Referents are required to identify in-state after care services and supports as part of the application process.

Residential Treatment Facilities (RTF) - In-state admissions

There are 539 RTF beds in nineteen facilities throughout New York State. These facilities are classified as a subclass of inpatient services, which provide active psychiatric treatment. Treatment services in RTFs are paid for through the use of

NYS Medicaid (50% federal share / 50% state share) based upon a clinical determination of the child's level of psychiatric disability and the expectation that the child will be separated from their home for 30 days or longer. School tuition during the period of inpatient stay in a RTF is paid through two methods. For children not in the custody of DSS/ACS the Office of Mental Health pays tuition costs and bills Medicaid for partial reimbursement of the expenses. For children in the custody of DSS/ACS the local social services district is charged for the cost of school tuition.

ATTACHMENT II

2003-04 NYS TUITION AND MAINTENANCE COSTS PER STUDENT
OUT-OF-STATE RESIDENTIAL PROGRAMS-CSE PLACEMENTS

	PROVIDER	STATE	# OF CSE PLACEMENTS	ANNUAL COST PER FT STUDENT	ANNUAL COST BY PROVIDER
I.	**APPROVED OUT-OF-STATE RESIDENTIAL**				
	EVERGREEN CENTER	MA	1	$59,761	$59,761
	PERKINS SCHOOL F/T BLIND	MA	7	$94,120	$608,106
	DEVEREUX CONNECTICUT GLENHOLME	CT	43	$106,347	$3,871,567
	BOSTON HIGASHI SCHOOL	MA	17	$107,317	$1,722,545
	PATHWAY SCHOOL (THE)	PA	13	$113,576	$1,378,250
	KOLBURNE SCHOOL INC	MA	60	$130,339	$6,549,536
	BANCROFT SCHOOL (THE)	NJ	25	$133,622	$2,816,222
	WOODS SCHOOL-MULTI HANDICAPPED	PA	137	$150,705	$17,918,770
	DEVEREUX PENNSYLVANIA	PA	72	$153,264	$9,248,429
	MAY INST FOR AUTISTIC CHILDREN	MA	4	$158,002	$607,677
	BERKSHIRE MEADOWS	MA	1	$158,400	$158,400
	MELMARK HOME, INC	PA	17	$197,924	$3,232,686
	CROTCHED MOUNTAIN REHAB CENTER	NH	10	$207,241	$1,657,512
	KIDSPEACE NAT'L CTRS FOR KIDS/	PA	196	$214,217	$26,407,625
	HILLCREST EDUCATIONAL CENTERS	MA	22	$225,299	$2,517,715
	NEW ENGLAND CENTER FOR CHILDRE	MA	26	$227,445	$5,259,663
	JUDGE ROTENBERG EDUCATIONAL CTR	MA	157	$240,728	$30,506,239
	TOTAL- APPROVED OUT-OF-STATE (17)		808	$180,036	$114,520,705
II.	**EMERGENCY INTERIM PLACEMENTS**				
	ELAN SCHOOL	ME	24	$50,139	$988,991
	THREE SPRINGS: NEW DOMINION SC	SC	1	$51,505	$51,505
	LINDEN HILL SCHOOL	MA	1	$52,427	$52,427
	LANDMARK SCHOOL	MA	5	$58,198	$290,991
	GREENWOOD SCHOOL (THE)	VT	1	$62,585	$62,585
	CLARKE SCHOOL FOR THE DEAF	MA	1	$63,395	$60,098
	THREE SPRINGS: PAINT ROCK :AL	AL	2	$64,026	$92,837
	CHAPEL HAVEN, INC	CT	2	$66,360	$132,720
	GREAT EXPECTATIONS	VT	1	$66,360	$66,360
	PINE RIDGE SCHOOL	UT	12	$67,004	$579,584
	MARYLAND SCHOOL FOR THE DEAF	MD	1	$67,067	$67,067
	EAGLE HILL SCHOOL - CONN	CT	1	$68,418	$68,418
	CEDU	CA	1	$69,627	$69,627
	RIVERVIEW SCHOOL	MA	8	$76,460	$611,678
	GROVE SCHOOL INC	CT	27	$78,547	$1,714,279
	VALLEYHEAD, INC	MA	1	$100,033	$100,033
	CARDINAL CUSHING SCH TRAIN CTR	MA	1	$102,421	$102,421
	LITTLE KESWICK SCHOOL INC	VA	1	$103,069	$103,069
	EAGLETON SCHOOL	MA	2	$109,912	$219,824

	PROVIDER	STATE	# OF CASE PLACEMENTS	ANNUAL COST PER FT STUDENT	ANNUAL COST BY PROVIDER
	LAKE GROVE AT DURHAM	CT	5	$113,749	$418,029
	FREDERICK L CHAMBERLAIN CTR IN	MA	15	$119,894	$1,552,625
	LEAGUE SCHOOL OF BOSTON	MA	2	$121,903	$243,805
	KEYSTONE EDUCATION AND YOUTH S	PA	6	$123,041	$608,068
	CRYSTAL SPRINGS	MA	1	$126,606	$101,285
	NEW HOPE MIDLANDS INC	SC	3	$127,063	$381,190
	BENNINGTON SCHOOL INC	VT	11	$127,239	$979,742
	BENEDICTINE SCHOOL FOR EXCEPTI	MD	2	$127,603	$255,205
	DEVEREUX MASSACHUSETTS	MA	1	$128,018	$128,018
	HMS SCHOOL FOR CHILDREN CEREBR	PA	1	$134,622	$134,622
	LAKE GROVE MAPLE VALLEY	CT	4	$135,351	$473,730
	IVY STREET SCHOOL (THE)	PA	1	$147,612	$147,612
	BRADLEY HOSPITAL	RI	1	$158,334	$47,500
	LATHAM CENTERS INC	MA	4	$168,783	$506,349
	LIPMAN HALL EDUCATION AND TRAI	NJ	1	$173,800	$156,420
	YOUTH & FAMILY CTR SERV (TAMPA	FL	1	$177,254	$177,254
	OAK HILL: CONNECTICUT INST F/T	CT	1	$179,469	$179,469
	LEARNING CLINIC OF BROOKLYN CO	CT	2	$181,029	$120,565
	AUSTINE SCHOOL FOR THE DEAF	VT	1	$189,496	$189,496
	WHITNEY ACADEMY	MA	3	$189,708	$569,124
	MAY CTR. F/ EDUCATION & NEURO	MA	7	$194,774	$1,251,421
	ADVOSERV: AU CLAIR OF DELAWARE	DE	8	$201,966	$1,550,086
	LEARNING CENTER DEAF CHILDREN	MA	2	$204,067	$408,134
	NATIONAL DEAF ACADEMY	FL	3	$209,309	$627,926
	AMERICAN SCHOOL FOR THE DEAF	CT	8	$212,744	$1,590,264
	EASTER SEALS OF NH: ROBERT B JO	NH	44	$235,068	$8,785,660
	WELLSPRING FOUNDATION	CT	7	$248,978	$1,058,155
	MENNINGER CLINIC	KS	2	$267,041	$534,082
	BRATTLEBORO RETREAT	VT	1	$267,480	$227,358
	GRAFTON SCHOOL	VA	3	$270,643	$608,947
	LAKEVIEW WISCONSIN REHABILITAT	WI	4	$281,597	$1,126,390
	LAKEVIEW NEW HAMPSHIRE NEURO R	NH	15	$296,923	$3,273,578
	TOTAL - EMERGENCY INTERIM PLACEMENTS (51)		**263**	**$152,218**	**$33,846,626**
III.	**TOTAL - CSE PLACEMENTS (I + II)**		**1,071**	**$172,831**	**$148,367,331**
IV.	**OUT-OF-STATE FOSTER CARE PLACEMENTS**		**355**		**$49,178,714**
V.	**TOTAL - CSE & FOSTER CARE OOS PLACEMENTS**		**1,426**		**$197,546,045**

Notes: FT - Full Time

Cost of Foster Care tuition and maintenance calculated by using CSE placement tuition and maintenance costs
Divided by CSE placements, times the Foster Care placements ($148,367,331/1,071 = $138,531 x 355 = $49,178,714)

INTERAGENCY WORK GROUP ON OUT-OF-STATE RESIDENTIAL PLACEMENTS

RECOMMENDATIONS

Caveat: The enclosed set of goals and the recommendations and objectives enumerated herein are agreed to in principle by representatives of the Interagency Work Group on Out of State Residential Placements and have been reviewed by the respective agency Commissioners. To effectively address the concerns expressed by the Council on Children and Families Commissioners around out-of-state residential placements, it is advised that these recommendations be examined and considered interdependent of each other.

GOAL #1: TO ENHANCE OR IMPROVE ACCESS TO THE STATEWIDE SYSTEMS OF CARE TO PROVIDE FOR CHILDREN WITH COMPLEX OR MULTIPLY-DIAGNOSED NEEDS; INCREASE AND STRENGTHEN PREVENTION AND RESIDENTIAL SERVICES; AND PREVENT, WHERE POSSIBLE, THE PLACEMENT OF CHILDREN OUT-OF STATE.

Recommendation 1.1: *Integrate NYS children and youth in in-state and out-of-state residential care into a comprehensive statewide System of Care, which collaborates to meet all of the child's complex and/or multi-systems needs in the least restrictive settings, as appropriate, within New York State.*

Objective 1.1A: *Strengthen local and regional service coordination and streamline placement processes and access to community-based services, which include or complement existing infrastructures (e.g., Single Points of Access, Hard to Place/Serve Committees and Coordinated Children's Services Initiative counties).*

Objective 1.1B: *Develop a multi-level interagency process, coordinated by an existing single state agency, to guide placements of children with specialized, complex and/or multi-systems needs who may require consideration for residential services outside of NYS. This process should be engaged at the point when a social services district or school district identifies a child who has the potential to be placed outside of NYS. Such process will identify the necessary activities a social services district or school district must engage in prior to a request for an out of state placement for an individual child and must be in compliance with existing federal and state mandates. Key activities are as follows:*

1) *Reinforce and strengthen the use of an interagency three-tiered process on the local, regional and state levels to facilitate treatment and service planning for children at risk of placement as defined in various child-serving systems. Such processes should complement existing initiatives at the local, regional and state levels. Examples of such processes include SPOA, CCSI and Hard to Place committees on the local level, Region II on the regional level and the Hard to Place Committee at the State level.*
2) *Monitor of data on children across service systems who might be referred out of state;*
3) *Create a review process for out-of-state placements referred by either CSEs or LDSS that would explore all available and least restrictive options before a CSE or LDSS out-of-state recommendation is made to SED and/or the*

Family Court judge and identify alternatives to out-of-state residential placements.

Objective 1.1C: *Strengthen SED's (VESID) oversight and coordination of students with disabilities placed or potentially placed out-of-state with technical support from OMRDD, OMH, DOH, and OCFS, including CCF. Also, require consultation between CSE and LDSS by strengthening current law to review all CSE placements to out-of-state facilities, including Emergency Interim Placements (EIPs), and verify that all appropriate in-state options are exhausted.*

Objective 1.1D: *Strengthen the approval process for new and existing schools/residential facilities for children placed through Local Educational Agencies/Committees on Special Education, including Emergency Interim Placement schools. Key concepts for this objective include:*

1) *evaluating and determining NYS oversight licensing/certification criteria with licensing/certification criteria from host states;*
2) *verifying that programs where children are placed out of state meet all licensing and inspection requirements of the home at the time of and duration of the placement of the child;*
3) *exploring the feasibility of requiring all out-of-state facilities providing residential educational services to children or youth who are New York State residents, or interested in providing such services to apply for registration with the State Education Department. Such registration would require the payment of a fee by the facility into a dedicated "Special Revenue – Other" account in an amount intended to cover the costs of review and oversight of such facilities and the placements of New York students in such facilities; this initiative will need to account for the issues related to the Interstate Commerce Clause of the U.S. Constitution;*
4) *confirming consistency of Local Educational Agency and local departments of social service contracts in developing standard language to reflect criteria and require relevant information and reporting obligations (e.g., abuse cases) from approved agencies, , reporting of incidents, appropriate arrangements with receiving state, and notification of relevant program issues, among other information issues.*

Objective 1.1E*: Where appropriate, develop consistent eligibility criteria, discharge planning and service coordination guidelines across systems for children going in and out of residential placements.*

Objective 1.1F*: Include wraparound funding to serve children with complex and/or multiply diagnosed needs and expand upon the success of local initiatives to integrate funds and services to provide for children with these needs. Funding would follow the child and be flexible to serve the child in the least restrictive setting, as appropriate.*

Objective 1.1G: *Reinvest any resources from returning/diverting children, if any, from out of state placements for community-based programs, and residential pilot programs, among other initiatives.*

Objective 1.1H: *Explore funding and program expansion to support least restrictive settings to treat children with multiply diagnosed needs, including children in foster care.*

Objective 1.1I: *Revise local planning procedures to include participation by the local DSS and other service systems representatives in the local CSE placement process[1], where relevant. Through this improved and enforced participation, incorporate permanency-planning concepts in the Individual Education Program for all New York State children, including children with complex and or multiply diagnosed needs who might be at risk of out-of- home or out-of-state residential placements.*

Recommendation 1.2: *Develop and continuously update a set of statewide child and family technical assistance resources such as service directories, assessment tools, referral guides, funding maps, and consulting services.*

Objective 1.2A: *Develop a centralized clearinghouse of research and evidence based practices, and a list of children and youth residential services providers.*

Recommendation 1.3: *Develop recommendations regarding a comprehensive assessment process to address the needs of children placed out of state including children with complex and/or multiply-diagnosed needs.*

GOAL #2: TO COORDINATE A CENTRALIZED/SHARED DATA COLLECTION SYSTEM ACROSS SYSTEMS AND LEVELS OF GOVERNMENT.

Recommendation 2.1: *Improve methods of data collection to provide consistent feedback to systems' stakeholders on the number and needs of children and youth who are hard to-serve and are at risk of future out-of-state placement[2].*

Objective 2.1A: *Identify and define a consistent set of data elements for each student placed out of state by each state agency: name, DOB, disabling condition, prior placements and educational profile (academic, behavioral, physical, social and medical), and anecdotal information on previous interventions, and the reason for a referral for out-of-state placement. Development and sharing of data must comply with OCFS and SED confidentiality provisions.*

Objective 2.1B: *Identify current availability and capacity of in-state residential and nonresidential services varying service needs of each child.*

Recommendation 2.2: *Conduct a statewide cross-systems needs assessment to identify low-incidence/high-need children, identify obstacles to the provision of in-state residential services to meet the specific needs of these children, and design an appropriate response.*

[1] Must be in compliance with IDEA.

[2] Consistent with FERPA, provisions of IDEA, and provisions of federal Part 300 regulations that relate to confidentiality of information concerning students with disabilities.

Recommendation 2.3: *Develop and implement a comprehensive review of individual cases of children and youth placed out-of-state.*

GOAL #3: TO STRENGTHEN THE STATE'S CAPACITY AND RESOURCES IN ORDER TO PROVIDE OPPORTUNITIES TO MAINTAIN CHILDREN IN NEW YORK STATE IN THE LEAST RESTRICTIVE SETTING AVAILABLE THAT CAN ADDRESS THEIR COMPLEX NEEDS.

Recommendation 3.1: *Establish a coordinated development process to determine in-state capacity to address the needs of children placed out of state; define and promote flexibility in rate-setting mechanisms; and streamline licensing procedures so that eligible in-state institutions can apply for and receive multiple licenses in a timely, "fast track" manner.*

Recommendation 3.2: *Strengthen resources to serve children and youth, including but not limited to supervision, classroom staffing, clinical services, security and safety, and physical plant reconfigurations.*

> ***Objective 3.2A:*** *Re-assess all applicable funding mechanisms and rate setting methodologies to determine the need for program intensification or modification to existing funding mechanisms that are responsive to unanticipated cost increases, to the need for enhanced services for the current or anticipated populations, or to the need for structural reconfigurations to meet the specialized needs of the population. This re-assessment would focus on rate setting methodologies to encourage development of programs for children and youth at risk of out-of-state residential placement.*
>
> ***Objective 3.2B:*** *Create flexibility for reimbursing capital costs for building new structures and renovating/adding to existing structures within existing rate methodologies. This includes exploring new bonding/securitizing options beyond the Dormitory Authority of the State of New York (DASNY).*

STATE OF NEW YORK

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S. 5681--B A. 9112--B

2003-2004 Regular Sessions

SENATE - ASSEMBLY

June 19, 2003

IN SENATE -- Introduced by Sen. GOLDEN -- read twice and ordered printed, and when printed to be committed to the Committee on Rules -- recommitted to the Committee on Education in accordance with Senate Rule 6, sec. 8 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

IN ASSEMBLY -- Introduced by COMMITTEE ON RULES -- (at request of M. of A. Millman, Lavelle, Cymbrowitz, Clark, Green, Norman, Gordon, Brennan, Cahill, A. Cohen, M. Cohen, Dinowitz, Gottfried, Grannis, Greene, Grodenchik, Gromack, Hikind, John, Lafayette, Markey, Mayersohn, Mirones, Ortiz, Perry, Sweeney, Weisenberg) -- read once and referred to the Committee on Education -- reference changed to the Committee on Higher Education -- recommitted to the Committee on Higher Education in accordance with Assembly Rule 3, sec. 2 -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the education law, in relation to inspection of out-of-

state residential facilities for mentally impaired individuals

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subdivisions 1 and 2 of section 4407 of the education law, subdivision 1 as amended by chapter 82 of the laws of 1985, paragraph a of subdivision 1 and subdivision 2 as amended by chapter 53 of the laws of 1989, are amended to read as follows:

1. [~~a.~~] When it shall appear to the satisfaction of the department that a child with a handicapping condition is not receiving instruction because there are no appropriate public or private facilities for instruction of such a child within this state because of the unusual

EXPLANATION--Matter in ***italics*** (underscored) is new; matter in brackets [-] is old law to be omitted.

type of the handicap or combination of handicaps as certified by the commissioner, the school district of which each such pupil is a resident is authorized to contract with an educational facility located outside the state, which **is on the register maintained by the department pursuant to subdivision two of this section**, **and** in the judgment of the department, can meet the needs of such child for instruction. **In addition to any other terms and conditions, such contract shall include provisions stating that the department, the school district and parent or person in parental relation to such pupil should be immediately notified of a report of alleged abuse or neglect at such facility, and any action that is being taken with respect thereto.** Contracts, rates, payments and reimbursements pursuant to this section shall be in accordance with section forty-four hundred five of this article.

2. **a.** The [~~**state education**~~] department shall maintain a register **which shall also be publicly accessible via the department's website,** of such educational facilities which are outside of the state which, after inspection **and evaluation as required herein**, it deems qualified to meet the needs of certain children for instruction pursuant to subdivision one of this section.

b. Prior to placing any such educational facility on the register as provided by paragraph a of this subdivision, the department shall:

(i) conduct an evaluation and inspection of each such facility located outside the state which can meet the needs of certain children for instruction in accordance with this section including a site visit by members of the department, or by a member of an entity with whom the department shall contract for such evaluations. Such entity shall be selected by an RFP or RFQ process, as the department shall determine, and shall have recognized expertise in the making of such inspections and site visits.

(ii) determine that such out-of-state facility holds a current license or charter from the state education agency of the state in which the school is located and has been approved, if such approval is required, by the state mental hygiene agency or its equivalent or such similar agency of the state in which the facility is located.

(iii) determine which specific conditions the facility, or a program within the facility, shall be qualified to meet. Such determination shall also be included on the department's website.

(iv) determine that appropriate laws and regulations exist within the state where the facility is located to assure appropriate investigation and prosecution of complaints of abuse or neglect.

(v) enter into appropriate agreements with state and/or local agencies and entities in which the facility is located to ensure in so far as practicable and allowed by law that the department will receive informa-tion of abuse or neglect occurring in facilities listed on the register.

c. Not later than ten days after it shall deem an educational facility qualified to meet the needs of certain children for instruction pursuant to subdivision one of this section, and prior to placing such facility on the register pursuant to paragraph a of this subdivision, the commissioner shall inform the commissioner of the office of mental retardation and developmental disabilities, the commissioner of the office of mental health, the commissioner of the office of children and family services, and the attorney general. The commissioner shall allow such commissioners and the attorney general twenty days in which to comment on such facility prior to placing it on the register. If the commissioner receives an objection from such commissioners, or the attorney general, whether during such twenty day period or after, it shall investigate

such objection and if the commissioner determines that such objection is valid, he or she shall not place such facility on the register, or, if the facility has been placed on the register, it shall immediately withdraw it from the register.

d. The department shall inspect and evaluate each facility on the register at least once every three years and shall address and review each item required prior to initial registration pursuant to this subdivision.

e. When a report of abuse or neglect is made to the commissioner by a state mental hygiene agency or an educational agency or their equivalent, or by a parent, or any credible source involving a facility on the register, the department shall promptly re-inspect and re-evaluate such facility. Such re-inspection and re-evaluation shall include a review of such report. The commissioner shall send a report of abuse or neglect and of any subsequent evaluations and reinspections of approved out-of-state facilities to the office of mental retardation and develop-

mental disabilities, the office of mental health and the office of children and family services within ten days of receipt of the report, and within ten days of completion of the re-evaluation and re-inspection. If the commissioner determines that abuse or neglect has occurred, he or she shall immediately withdraw the facility from the register until and unless the facility has remedied the problem to the satisfaction of the commissioner.

f. The commissioner, after consulting with the commissioner of the office of mental retardation and developmental disabilities, the commissioner of the office of mental health and the commissioner of the office of children and family services, shall report to the legislature and the governor not later than January first, two thousand six, concerning the financial and programmatic feasibility of developing a facility or facilities in New York to provide an appropriate educational program for students placed in residential programs in approved private schools outside the state. Such report shall consider the number of students placed in such residential programs in approved private schools outside the state, the costs of providing education, and possible financial sources for such facility, including grants or other funding from the state, school districts, and the federal government, the ability to maintain a quality learning environment for such students, and such other factors as the department shall deem appropriate, including the feasibility of establishing such a facility under public, not-for-profit, or private auspices.

§ 2. This act shall take effect on the ninetieth day after it shall have become a law.

TO THE SENATE:

I am returning herewith, without my approval, the following bill:

Senate Bill Number 5681-B, entitled:

"AN ACT to amend the education law, in relation to inspection of out-of-state residential facilities for mentally impaired individuals"

N O T A P P R O V E D

This bill would amend the Education Law to provide for greater oversight of out-of-state educational facilities with which school districts contract for the purpose of instructing disabled students from New York State. Specifically, the bill would require the State Education Department (SED) to inspect and evaluate a facility and enter into information-sharing agreements with regulatory agencies in the facility's host state prior to placing the facility on SED's register of approved facilities. The bill would further require SED to: (i) inform the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities (OMRDD), the Office of Children and Family Services (OCFS) and the Attorney General (AG) of its intention to place the facility on the register; (ii) investigate any objections from these agencies; and (iii) decline to place the facility on its register if it determines that any such objection is valid. Thereafter, the bill would require SED to: (a) inspect and evaluate each facility on the register at least once every three years; (b) re-inspect and re-evaluate each such facility promptly after receipt of a report of abuse or neglect at the facility from any credible source; (c) notify OMH, OMRDD and OCFS within 10 days of receiving any such report and within 10 days of completion of the re-inspection and re-evaluation; and (d) immediately withdraw the facility from the register until problems are remedied. Finally, the bill would require SED, in consultation with OMH, OMRDD and OCFS, to report to the Governor and the Legislature no later than January 1, 2006, on the feasibility of developing in-state facilities to replace out-of-state facilities to which disabled children have been referred. The bill would take effect 90 days after becoming law.

I commend the sponsors for attempting to ensure that disabled children, who are among our most vulnerable citizens, receive State-funded services in the safest environment possible. However, I am constrained to disapprove this bill based upon the objections of SED, OMH, OMRDD and OCFS. Each of these interested agencies supports the intent of the bill but urges disapproval of the bill based on serious technical defects.

While the purpose of this bill is laudable, and the sponsors have done an admirable job of attempting to negotiate the substantial legal and practical obstacles to its implementation, there are limits on the ability of New York State to oversee facilities located in other states. While SED inspects the educational component of each out-of-state facility prior to it placement on SED's register of approved facilities, SED relies on the expertise of the regulating agencies in the host state to inspect and evaluate the residential component of such

facilities. Similarly, SED and local school districts work in a cooperative fashion with the applicable regulatory agencies in the host state whenever they receive a report of abuse or neglect in an out-of-state facility since they lack the legal jurisdiction to enforce laws governing such facilities outside New York State.

The sponsors of this legislation assume that out-of-state facilities will agree to contractual amendments to implement the oversight provisions of this bill. However, I am advised that there may be legal limitations on the ability of facilities to agree to such amendments. Moreover, even if a facility were willing to agree to such amendments, the success of the system contemplated by this bill depends on the facility's continued willingness to conform voluntarily to the new regulatory requirements.

I am concerned that facilities may not agree to such provisions, in which case the bill could inadvertently result in the curtailment or reduction of services currently being provided to disabled students. More specifically, if any of the facilities with which school districts currently contract refuse to agree to the requirements of the bill, the bill prohibits students from being placed in those facilities. This could necessitate the relocation of otherwise appropriately placed children in need of specialized services. Since these children generally would not be in out-of-state facilities if suitable placements were available in the State, the result could be children being denied much-needed services.

The best way to address these problems is to ensure that disabled students can receive the services they need in facilities located within New York State. For this reason, the New York State Council on Children and Families, at my request, convened an Out-of-State Residential Placement Workgroup in 2003 to study whether the services provided to students in out-of-state facilities can be provided by facilities within New York in a more effective manner. The Workgroup's final recommendations are expected by the end of 2005. I believe it would be premature to approve this type of legislation without having the benefit of those recommendations.

Nonetheless, I agree with the sponsors that reform in this important area needs to move forward expeditiously. I am therefore directing the Workgroup to issue its final recommendations no later than June 1, 2005. Further, those recommendations should address not only the issue of whether out-of-state placements should continue, but also any necessary changes to the mechanisms by which the State oversees such placements. I am also directing my staff to work with the sponsors to ensure the Workgroup receives the benefit of their considerable insight in regard to this issue. As noted, the goals of this bill are laudable, and the sponsors have attempted to address the significant legal and practical impediments to its implementation in a creative and consistent manner. However, for all the foregoing reasons, I cannot approve the bill at this time.

The bill is disapproved.

Interagency Work Group on Out of State Residential Placements
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