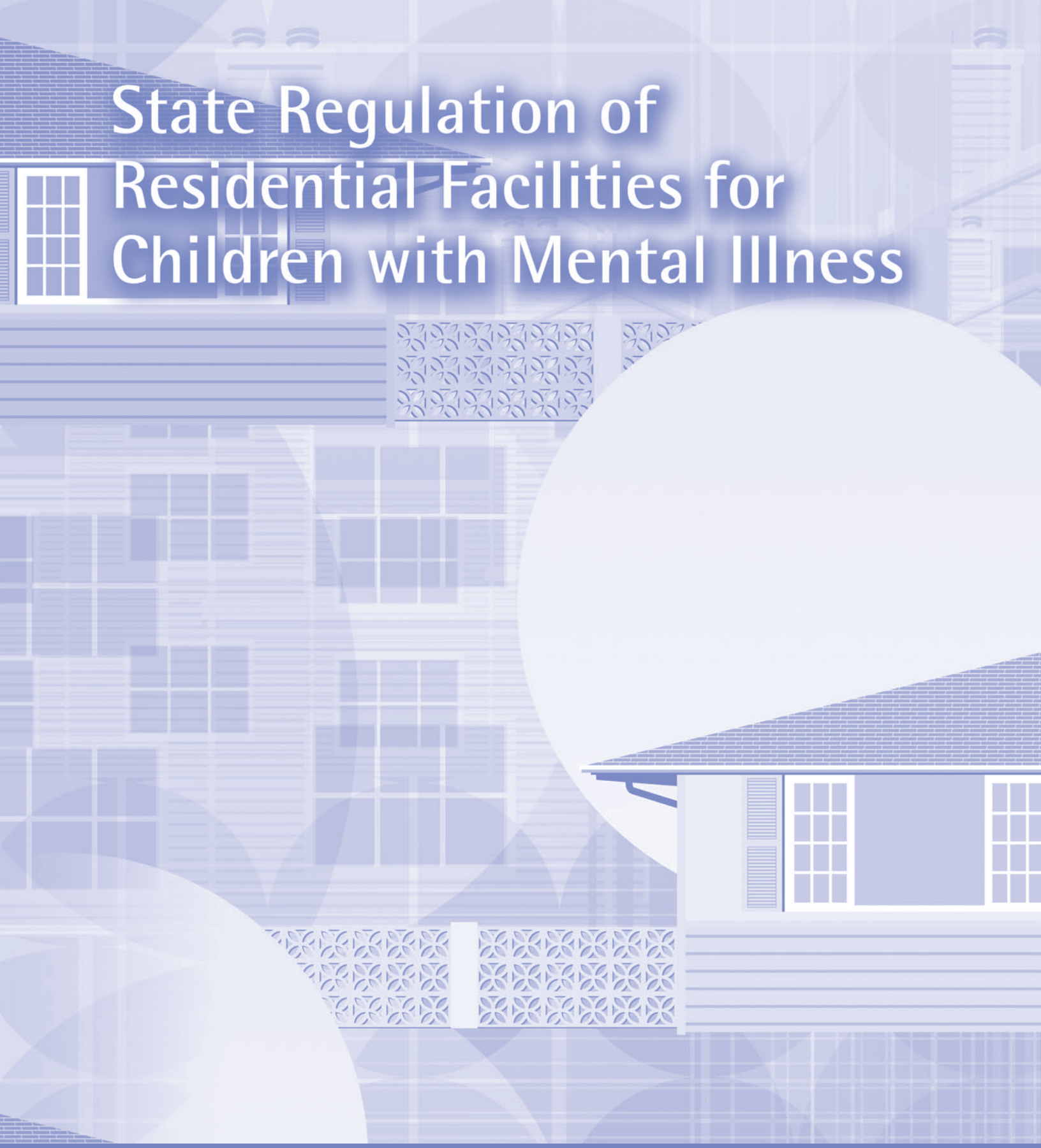
State Regulation of Residential Facilities for Children with Mental Illness



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Executive Summary

There is little national information on the policies and procedures used by States to regulate residential treatment facilities for children with mental illness. As a result, policymakers and program administrators face major difficulties in determining both the effectiveness of current policies and the potential need for new policies that are responsive to emerging trends in child mental health care. Based on a survey of State officials, this report provides the most accurate national data available concerning methods that States use to license and regulate residential facilities for children with mental illness. The information in this report can help Federal and State policymakers improve procedures for monitoring the quality of care provided in these facilities.

The specific purpose of this study was to conduct a national survey of State officials to identify methods that States use to monitor residential facilities for children with mental illness. Officials in departments of mental health, social services, health services, and child and family services responded to structured questions on facility characteristics and programs, licensing and oversight procedures, and sources of financing. The survey was fielded between November 2003 and March 2004. This report presents the results of the study.

Residential Facilities in the Study

To be included in the study, residential facilities for children with mental illness had to be licensed or certified by the State to provide some therapeutic services in addition to room and board. States vary widely in the types of residential facilities that they license or certify, the names of these facility types, and the number of associated facilities.

Because this study focuses on State regulations, *facility type* is the primary unit of analysis, but the study also provides information on the number of facilities in each type and the number of associated beds. Many States license multiple types of residential facilities for children with mental illness. For example, according to officials in one State, two types of facilities meeting study criteria were referred to as "residential care centers" and "group foster homes." The first type included 44 facilities with a total of 1,464 associated beds; the second type included 120 facilities and 900 associated beds.

The study data were derived from officials in 38 States who, in response to a structured survey, provided information on 71 types of facilities. The number of facilities associated with each type varied by State from 1 to more than 800. The number of total beds associated with each facility type ranged from 6 to 7,160. Overall, the 71 types

accounted for 3,628 facilities that, in total, had 50,507 beds as of September 30, 2003. These numbers exceeded counts based on the Survey of Mental Health Organizations (Manderscheid et al. 2004) and data from State mental health agencies (National Association of State Mental Health Program Directors 2005) because the study covered a wider range of residential settings under the auspices of various State agencies.

Major Findings on States' Regulatory Methods

The analysis of survey data led to two major findings. First, States differed in the mix of methods they used to regulate facilities. Typical methods included on-site inspections, documentation of staff qualifications and training, record reviews, resident interviews, critical-incident reports, standards for resident-to-staff ratios, and educational levels of facility directors. All States used at least several of these methods, but few States used all of them.

Second, information provided by State officials indicated that the oversight and regulatory environment for residential facilities for children with mental illness was complex in many States because several agencies, each with a different mission and function, were involved in licensing the facilities, reviewing complaints, funding services, and making inspection visits. For 47 percent of all facility types covered by the survey, licenses or certifications were required from more than one agency. For 22 percent of facility types, complaints were reviewed by three or more agencies. Furthermore, in some States, agencies that provided major financial support may have had substantial reporting requirements but played a minor regulatory role.

Other findings included the following:

- State departments of children and families, departments of health, and mental health agencies all had major roles in regulating residential facilities for children with mental illness.
- To obtain initial licenses, more than 95 percent of all facilities had to be inspected by State personnel and permit a review of staff qualifications; more than two-thirds were required to provide documentation of staff training and permit clinical record reviews.
- To renew their license, more than 85 percent of facilities had to be inspected by State personnel and permit a review of staff qualifications and training along with a review of clinical records; direct interviews with residents were required for less than two-thirds of the facilities.
- In 2002, State agencies made announced and unannounced visits to the majority of facilities for children with mental illness to assess living conditions, safety issues, and services provided; unannounced visits occurred less frequently than announced visits (65 percent of facilities compared with 92 percent).
- More than 60 percent of all facilities had to meet resident-to-staff ratios, and more than 80 percent had to meet minimum education requirements for facility directors.
- More than 90 percent of all facilities were required to report adverse events or critical incidents to the State, but the specific types of adverse events or incidents that had to be reported varied somewhat across facilities.
- Most residential facilities relied on several sources of funding, including Medicaid, State departments of children and family services, and State and local mental health agencies.

1. Introduction

Residential facilities for children with mental illness are owned by a wide variety of public and private entities and are operated under the auspices of various State agencies, including State departments of mental health, child welfare, and juvenile justice (Goldstrom et al. 2001; Pottick et al. 2004). The number of children living in these residential settings has increased during the last two decades in response to the closure of long-term psychiatric hospitals and inpatient institutions (Manderscheid et al. 2001). A total of 474 residential treatment centers for emotionally disturbed children were operated under the auspices of State mental health organizations in 2000, up from 261 centers in 1970; the number of beds in these centers more than doubled during this 30-year period, rising from 15,129 to 33,421 (Manderscheid et al. 2004).

Although States have primary responsibility for regulating residential facilities for children with mental illness to ensure that the facilities meet basic safety, staffing, and service delivery standards, they vary widely in their specific regulatory practices. A few reports have addressed policy questions related to procedures for monitoring residential facilities in selected States (e.g., Colorado Office of the State Auditor 2002; Maryland Task Force 2002; Office of Inspector General 2000), but few national data are available to help policymakers understand the policies and procedures that States use to regulate residential facilities for children with mental illness. As Pottick and colleagues note (2004, p. 324), "[D]eficiencies in knowledge are particularly troublesome in the residential treatment sector, where poor, displaced, and severely impaired youth are the majority."

Several factors underscore the need for better information on this topic:

- In most States, residential care will remain part of the service system for the foreseeable future, and States need better information on methods for regulating residential facilities to ensure that the residential care component of the service system effectively addresses the needs of children with mental illness and their families.
- Many children in State custody are placed in residential settings because no foster or adoptive families are available. State officials are obligated both to ensure that these children receive effective services and to prevent the occurrence of critical incidents that could jeopardize their well-being.
- Residential facilities are costly and, in most States, mental health budgets are sharply limited. Policymakers need information on methods for regulating residential facilities to ensure that public dollars are spent effectively.

Although most States have begun to build the legislative, regulatory, and programmatic foundations for transforming the mental health system for children (Arons et al. 2004), many financial and systemic obstacles remain (Pottick et al. 2004). Children with mental illness continue to enter residential facilities, especially children whose families cannot find or do not have the resources to obtain the community services and supports needed to keep their children at home. As State child mental health service systems continue to evolve, policymakers and facility administrators need to know more about State practices related to licensing, monitoring, and regulating residential facilities.

Based on structured surveys designed for State officials in 50 States and the District of Columbia, the present study aimed to examine methods used by States to license, regulate, and monitor residential facilities for children with mental illness. The purposes of this report are to present the study's findings on State methods for regulating these residential facilities and to provide information that will assist policymakers and facility administrators in understanding the potential role of residential treatment facilities in the evolving system of care for children with mental illness. (A companion report, *State Regulation of Residential Facilities for Adults With Mental Illness*, provides information about residential treatment facilities for adults.) This chapter summarizes existing information on the number of these facilities and the characteristics of their residents. The chapter reviews data on organizations providing residential care, including:

- The 2002 Survey of Mental Health Organizations and General Hospital Mental Health Services (SMHO)
- Reports from the Research Institute of the National Association of State Mental Health Program Directors (NASMHPD) based on 2002 data submitted by the States
- The 1998 Inventory of Mental Health Services in Juvenile Justice Facilities

The chapter also includes data on characteristics of residents from analyses of data from the 1997 Client/Patient Sample Survey (CPSS).

Chapter II provides an overview of the methods used to obtain data from the States and includes the criteria used to identify residential facilities for the survey.

The subsequent three chapters present the study's results in a series of tables, with major findings highlighted in the text. Specifically, these chapters cover the following topics:

- Number of residential facility types, associated facilities, and beds (Chapter III)
- Regulatory methods (Chapter IV)
- Services and sources of financing (Chapter V)

Chapter VI presents conclusions based on the findings. The Appendix includes the survey used to collect data from the States.

A. Organizations Providing Residential Care

The SMHO, conducted every two years by the Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), is a count of specialty mental health organizations and psychiatric services of non-Federal general hospitals and a survey of a sample of these organizations that collects information on services, beds, staffing, expenditures, and sources of revenue. Recent

analyses of data from the SMHO indicate that, in 2000, State mental health agencies operated 474 residential treatment centers for emotionally disturbed children, with a total of 33,421 beds (Manderscheid et al. 2004).

The SMHO focuses specifically on organizations that operate under the authority of mental health agencies and have the provision of clinical mental health services as their primary mission (J. Maedke, personal communication, April 2005). It does not include many other residential facilities that are operated by other State agencies, such as child welfare departments, or that serve as homes to children with mental illness who may need only supportive services, such as case management, vocational training, or medication management.

In addition to the SMHO, some information on the number of individuals in residential treatment beds operated and funded by State mental health authorities is available for selected States through the NASMHPD Research Institute's *State Profile Report* for 2002 (NASMHPD 2005). As Table I.1 shows, States that submitted data reported widely different figures for the average daily

Table I.1 Average Daily Census of Children Under 21 Years and Number of Beds in 24-hour Residential Care Organizations Funded and Operated by State Mental Health Agencies, 2002

State	*Average Daily Census of Clients*	*Number of Beds*
Alabama	51	56
California	1,771	—
Colorado	68	—
Connecticut	10	—
District of Columbia	119	108
Florida	860	—
Hawaii	1	0
Maryland	91	157
Massachusetts[a]	680	—
Minnesota	350	—
Missouri	51	65
Nebraska	—	36
New Hampshire	3	37
New Jersey	438	—
New York	8	16
North Carolina	1,897	—
Oklahoma	2	16
Oregon	209	320
South Carolina	24	37
Texas	45	—
Utah	217	308
Vermont	225	—
Total		1,156

Source: NASMHPD 2005

Notes: Other States did not provide any information for these items or had no residential care organizations funded and operated by the States' mental health organizations. Dashes (—) indicate the State did not respond to the specific item. Average daily census is for fiscal year 2002. Number of beds is as of the last day of fiscal year 2004. Twenty-four-hour residential care is defined as overnight mental health care in conjunction with (1) psychiatric treatment services in a setting other than a hospital, or (2) supervised living and other supportive services in a setting other than a hospital. Examples include halfway houses, community residences, and group homes.

[a] Children 19 years and under

number of children who were in residential settings owned or operated by State mental health agencies and the number of beds. The NASMHPD study defines residential beds as providing (1) overnight mental health care in conjunction with psychiatric treatment services in a setting other than a hospital, or (2) overnight mental health care in conjunction with supervised living and other supportive services in a setting other than a hospital (NASMHPD 2005).

State juvenile justice agencies typically play major roles in providing mental health treatment, rehabilitation, protection, and guidance to youth who commit crimes and who are neglected or abused. Juvenile court judges frequently place these children into residential treatment facilities that are operated by for-profit and not-for-profit entities under the jurisdiction of the States. These facilities include detention centers, shelters, group homes, and live-in treatment centers and camps. Detention centers house only children in the juvenile justice system, but the other types of settings also house children who enter through other agencies, such as psychiatric hospitals or community mental health centers. Group homes, some types of shelters, and other residential treatment centers used by juvenile justice authorities are likely to be included in the present study because they meet the study's criteria; detention centers and certain types of camps are excluded because they do not.

Analyses of data from the 1998 Inventory of Mental Health Services in Juvenile Justice Facilities (Goldstrom et al. 2001) indicate that:

- On a given day in 1998, 673 residential treatment facilities (defined as long-term secure residences where treatment is the basis for placement) used for placement by juvenile justice authorities housed 25,356 youth with mental illness.
- For 257 facilities with funding data, 58 percent received funding from the juvenile justice system, 40 percent from mental health agencies, and 51 percent from social service or child welfare systems.
- Among the 2,798 facilities surveyed (including detention centers, shelters, group homes, and camps), a total of 1,039 provided mental health services to juveniles with mental illness in specially assigned residential arrangements in separate buildings or designated units.

B. Characteristics of Residents

The 1997 CPSS provides information on characteristics of persons served by residential care programs (outpatient settings are excluded). The CPSS included 4,014 youth representing a weighted estimate of 1,314,938 children and adolescents who were admitted to inpatient or residential mental health settings in the United States in 1997 (Pottick et al. 2004). These settings included residential care programs of State and county mental hospitals, private psychiatric hospitals, non-Federal general hospitals, and residential treatment centers for youth that were originally identified in the 1994 Inventory of Mental Health Organizations and General Hospital Mental Health Services (Milazzo-Sayre et al. 2001). Analyses of data from this survey indicate that:

- An estimated 65,949 children were admitted to residential settings in 1997.
- Seventy-six percent of these children were between the ages of 13 and 17.
- Sixty-one percent were male.
- Sixty-five percent were White, 21 percent were Black, and 12 percent were Hispanic.

- Thirty-three percent had diagnoses related to disruptive behaviors, 14 percent had mood disorders, and 8 percent had anxiety disorders.

According to CPSS survey data, youth admitted to residential care were referred from a wide range of sources: 37 percent were referred from social service agencies, 28 percent from the juvenile justice system, and 15 percent from psychiatric inpatient settings (Pottick et al. 2004).

C. Summary

Previous studies provide a foundation for understanding the number and capacity of residential treatment settings for children with mental illness, but the gaps in available information are substantial. In particular, certain types of residential settings have not been included in existing surveys, such as settings that provide a minimum level of therapeutic services beyond room and board and that are not operated under the auspices of State mental health or juvenile justice agencies. Furthermore, existing studies do not address the methods States use to regulate or monitor these facilities.

The present study built on the existing foundation of data by gathering information on State regulatory methods. The types of facilities that States regulate include facilities that do not meet the criteria for inclusion in the SMHO and that have not been included in other surveys. As a result, this study reported on a larger number of facilities than had been included in previous studies.

II. Methods

In the absence of national data on policies and procedures that States use to regulate and monitor residential facilities for children with mental illness, this study required a systematic approach to gathering relevant information from State officials. To accomplish its goals, the study was organized around the following steps:

- Determining the criteria for including residential facilities in the present study
- Developing the survey questionnaire
- Fielding the survey
- Assessing the quality of the data

A. Criteria for Including Residential Facilities

The study used a structured survey to gather information about State-regulated residential facilities that provided some therapeutic service beyond room and board for children with mental illness. In this report, "residential facility" refers to any entity that met the criteria listed in Table II.1.

These criteria were developed with guidance from the project's expert advisory panel following a review of descriptions of State mental health systems and were designed to be broad enough to capture the wide range of State-regulated residential facilities that serve children. As a result, the study included facilities that (1) were regulated by any State agency, including mental health departments, departments of children and families, departments of health, and other agencies; (2) offered various sets of residential services; and (3) focused on diverse subgroups of children and adolescents with mental illness, including children with extreme behavior problems or children with multiple problems (e.g., mental illness and developmental disabilities).

Children with mental illness live in a wide variety of community settings—including detention centers, military-like camps for children with severe behavioral disorders, individual foster care homes, short-stay crisis residences, and their own homes—but this study was not designed to gather information on these settings. Specifically, the study's criteria were designed to exclude facilities for children who were homeless or who had physical disabilities alone, psychiatric hospitals or inpatient facilities of general hospitals, nursing homes, facilities where children stay for short periods (e.g., detention centers, community shelters), residential substance abuse treatment programs (unless the program was specifically for children dually diagnosed with a mental disorder

Table II.1 Criteria for Identifying Residential Facilities for Children with Mental Illness

To be included in this study, facilities had to:

- Specialize in the treatment of children with serious emotional or behavioral disorders, including children who were dually diagnosed (mental illness and substance abuse or mental illness and developmental disability), as long as mental illness was the primary problem.
- Be an establishment that furnished (in single or several facilities) food, shelter, and some treatment or services to three or more persons unrelated to the proprietor.
- Provide staffing 24 hours per day, seven days per week.
- Operate under some State authority, such as a State office granting pertinent licenses or a State mental health authority.
- Include at least 50 percent of residents whose need for placement was based on mental illness.
- Include children with average stays of 30 days or longer.
- Provide at least some on-site therapeutic services beyond housing (e.g., group therapy, individual therapy, medication management, and so forth) either by staff or under contract.

and a substance abuse disorder), and individual foster care homes.

Some States have developed innovative family-based residential arrangements for children with mental illness that would not meet the criteria listed in Table II.1, but that are nonetheless critical to building community-based service systems. For example, some States support children with mental illness in special foster care placements with individual families who receive extra training and compensation. These residential arrangements may play a critical role in a State's overall system of care but would not fall under the purview of the present study. Furthermore, some States are beginning to develop innovative short-term residential options for children with mental illness and their families (e.g., short-stay residential settings for the entire family as part of a crisis-diversion or crisis-intervention service). These arrangements were not included in the study because, in most cases, they involved few children and would require a somewhat different set of regulatory practices than the more traditional types of residential facilities now in place in most States.

As others have noted (e.g., Fleishman 2004), the lack of standard definitions of key terms such as "psychiatric residential facility," "residential treatment center," and "group home" have stymied efforts to develop a national statistical portrait of residential settings for individuals with mental illness. States have adopted widely discrepant terms for essentially similar institutional entities and, conversely, operate facilities with similar names that provide markedly different sets of services and living environments. For example, residential settings with fewer than 16 children are called therapeutic group homes in Maryland and Hawaii, type I residential facilities in Ohio, level 1 residential treatment facilities in West Virginia, residential treatment facilities for youth in Alaska, and supervised independent living programs in South Carolina. Important differences may exist between these institutions in terms of their specific target population and services provided, but knowledge of the official name of these facilities offers little insight into the nature of their differences. The diversity of names has impeded the development of standard categories of facilities for

which national statistics could be developed (Fleishman 2004).

B. Developing the Survey Questionnaire

The goal of the questionnaire was to gather descriptive information on specific aspects of residential facilities for children with mental illness and the methods that States used to regulate them as of September 2003. As a first step, an Internet search of relevant Websites was conducted to obtain information on the specific rules and regulations promulgated by 10 different-sized States in different regions for residential facilities for children with mental illness. This task made it clear that States relied on different regulatory practices for different types of licensed facilities. Accordingly, a survey method was developed that allowed State officials to respond separately for each type of facility.

The review of information available on the Internet also was used to develop specific items in the following five topic areas:

- Program characteristics (including questions on number of residents, beds, average length of stay, and staffing ratios)
- Licensing, certification, and accreditation (including a chart to determine which State agencies provided licensing, certification, and accreditation for each program type)
- Program services (including questions about whether the residential programs were obligated to provide specific services)
- Program monitoring and oversight (including questions about which State agency conducted site visits and responded to critical incidents)
- Financing (including questions about funding sources and per diem rates)

The initial draft of the questionnaire was sent to a selected group of mental health experts for their comments, and changes were made as needed. The survey was tested in three States and, on the basis of respondent feedback, minor modifications were made to ensure that questions were as concise as possible. Appendix B includes the final version of the questionnaire.

C. Fielding the Survey

The survey implementation phase of the project involved the following tasks:

- Web searches were conducted for all States to identify (1) a preliminary list of program types that met the study's criteria, and (2) State officials who potentially could serve as primary contacts (e.g., the director of child services in the mental health department).
- These officials, or a person who was in the same position if the initial contact had left, were contacted by mail and telephone to verify the list of program types, amend the types as needed, and ask the person to serve as the primary contact. (An average of four to five telephone calls or emails per State were made before establishing a primary contact and, after a contact person was identified, an average of three to four telephone or email contacts were needed to verify the list of program types. On average, four hours were needed per State to conduct initial Web searches, identify the contact person, and compile a final list of program types.)
- Each person who agreed to be a primary contact received a formal letter from the project officer at SAMHSA detailing the purpose of the study and thanking the contact person for supporting the project.

- The contact person was sent one or more questionnaires, depending on the number of program types in the State. (The specific name of the program type was included on a cover page and strategically embedded in the questionnaire to ensure that respondents knew to which program type the questions applied. A comprehensive instruction guide assisted respondents in completing the survey.)

Depending on the preference of the contact person, surveys were mailed, faxed, or emailed. Respondents could elect to return the completed questionnaire by mail, fax, or email or to complete the questionnaire in a telephone conversation with an interviewer. Surveys sent by email were based on an Excel spreadsheet so that respondents could reply to the questions on the screen, save the survey, and return it in the spreadsheet format. In all cases, the material included a second cover letter from the project officer at SAMHSA, the list of criteria that defined the types of programs of interest to the study, and specific instructions regarding the survey.

The first questionnaire was mailed in October 2003, and the last completed one was received in March 2004. Most of the questionnaires were sent out and returned by email; most were completed and returned within two to three weeks, although several months were needed to obtain a completed questionnaire from some States. Although a primary contact was available in each State, several individuals typically were involved in responding to the questionnaire because, in most States, no one person was familiar with all topics covered in the questionnaire. For example, one individual was familiar with service requirements while another was familiar with financing. After a survey was received, it was reviewed, and follow-up telephone calls or emails were made to clarify ambiguous responses or fill in missing data, if possible. When all questions were resolved, a questionnaire was considered complete, and a thank-you card was mailed to the respondent.

By the end of March 2004, a total of 89 questionnaires had been mailed to 42 of the 51 States (including the District of Columbia); 38 States returned at least one useable questionnaire. Of the remaining 13 States,

- Nine States did not respond to our request to participate in the survey (repeated calls and emails to the contact person went unanswered, or no primary contact could be located, or State officials indicated that rules were under revision).
- One State indicated that it did not have the resources to complete the questionnaires and instead, provided a brief explanation of the housing options for children with mental illness.
- Three States had programs that did not fit the study's criteria (e.g., the State used only foster home, out-of-State placements, or hospital settings).

Overall, of the 50 States and the District of Columbia, useable information was provided by 41 States (80 percent) including the 38 States completing at least one questionnaire and the three States indicating that they did not license facilities that met our criteria.

Of the 89 questionnaires sent out, 76 were received by the end of the survey period. Several reasons contributed to the fact that 13 questionnaires were not returned: after receiving the questionnaire, some respondents indicated that they did not have the time to complete it; after reading the instructions, some respondents indicated that the program type on which the questionnaire focused did

not fit the study criteria; some respondents did not return a questionnaire and would not return calls or respond to emails.

Of the 76 questionnaires received, 5 were excluded because of missing responses for almost all questions or because close inspection indicated that the program type did not fit the study criteria. Information from the questionnaires was entered into a standard SAS database. Several rounds of detailed data verification with State officials occurred between July and October 2004.

D. Assessing the Quality of Data

The quantitative information presented in this report is drawn entirely from information that staff in State agencies provided in response to the survey questionnaire. Pilot testing of the questionnaire, extensive conversations with selected State and Federal officials, and comments from members of the expert advisory panel showed that States vary widely in whether they have access to statistical information pertinent to the questions in the survey. Consequently, for seven items, the questionnaire asked respondents to indicate whether their responses were premised on experience-based estimates or reviews of specific records or statistical data. Depending on the item, between 13 and 62 percent of respondents indicated that they used estimates (see Table II.2).

Because of the uncertainty in some of the answers provided by some respondents, a final data check was conducted by downloading information from completed questionnaires into two-page templates. These templates were sent back to the appropriate contact person for final verification and a request for any missing information on facility characteristics. Several States suggested minor changes. In some States, officials indicated that they could not provide the data on facility characteristics owing to the

Table II.2 Percent of Respondents Indicating Source of Information for Selected Survey Items

	Percent of Respondents Who			
Survey Item	*Were Unable to Answer Question*	*Used an Estimate*	*Used Record Reviews*	*Answered but Did Not Indicate Whether Response Was Based on Record Review or Estimate*
A1. Number of facilities	0.0	12.7	84.5	2.8
A3. Average number of residents	1.4	62.0	32.4	4.2
A7. Average length of stay	21.1	49.3	26.8	2.8
A14a. Percent of facilities with secure units, if the program was allowed secure units	6.3	34.4	59.4	0.0
D1a. Percent of facilities with an unannounced visit, if the State conducted unannounced visits	8.7	50.0	37.0	4.3
D2a. Percent of facilities with an announced visit, if the State conducted announced visits	4.6	52.3	43.1	0.0
E3. Medicaid per diem, if State had a Medicaid per diem	10.2	44.1	44.1	1.7

Source: Surveys submitted by 38 States

impracticality (i.e., too time-consuming) or impossibility (i.e., the relevant data were not available) of collecting the information.

The quality of the information presented in this report depended on the extent and accuracy of the information available to respondents. Based on extensive efforts to check questionable data through telephone calls and emails to State officials and given that States approved the final data used for the analyses, the report reflects the most accurate national data available on characteristics of the facilities that met the study's criteria and the methods that States used to regulate residential facilities for children with mental illness as of September 2003.

III. Number of Residential Facility Types, Associated Facilities, and Beds

The survey yielded information on 71 types of residential facilities in 38 States. There was considerable variation in the number of facilities associated with each facility type, the average number of residents in a single facility within each type, and the total number of beds in operation in all facilities within a facility type (see Table III.1). Three States illustrate the variation as of September 2003:

- Connecticut operated 3 facility types:
  - — Permanency Diagnostic Centers, a type of facility that included 2 facilities, each with an average of 12 children and a total of 26 beds
  - — Residential Treatment Centers, a type of facility that included 21 facilities, each with an average of 47 children and a total of 1,002 beds
  - — Subacute Facilities, a type of facility that included 4 facilities, each with an average of 12 children and a total of 47 beds
- Wisconsin operated 2 facility types:
  - — Residential Care Centers, a type of facility that included 44 facilities, each with an average of 33 children and a total of 1,464 beds
  - — Group Foster Homes, a type of facility that included 120 facilities, each with an average of 7 children and a total of 900 beds
- Utah operated 1 type of facility:
  - — Residential Treatment Facilities for Children, a type of facility that included 41 facilities, each with an average of 17 children and a total of 843 beds

Overall, the 71 facility types accounted for 3,628 separate residential facilities, which had 50,507 beds as of September 30, 2003. Twenty-three of the 71 facility types (32 percent of all facility types) had 8 or fewer associated facilities, and 7 types (11 percent) had more than 100 associated facilities.

The remainder of this chapter presents information about the characteristics of residential facilities for children with mental illness by describing:

- The number of beds associated with residential facilities,
- Ownership arrangements,
- Average lengths of stay, and
- Number of secured (i.e., locked) units.

Table III.1 Types of Residential Facilities for Children with Mental Illness, Associated Facilities, and Average Number of Residents per Facility, by State, 2003

State	*Facility Type*	*Number of Associated Facilities*	*Average Number of Residents per Facility*	*Total Number of Beds*
Alaska	Residential treatment facilities for youth	36	9	396
	Residential psychiatric treatment centers	5	23	116
	Group homes for youth	8	5	64
Arizona	Juvenile group homes	90	9	849
California	Community treatment facilities	5	27	137
Connecticut	Permanency diagnostic centers	2	12	26
	Residential treatment centers	21	47	1,002
	Subacute facilities	4	12	47
Delaware	Residential treatment centers	6	9	62
	Preadolescent therapeutic group homes	1	5	6
Florida	Therapeutic group care	12	12	163
	Residential treatment centers	14	23	385
Hawaii	Community-based mental illness residential facilities	16	6	115
	Therapeutic group homes	14	5	76
Illinois	Individual care grants	25	12	310
Indiana	Child-caring institutions (long-term care)	78	65	2,500
	Private secure facilities (long-term care)	17	15	170
Kansas	Level V—residential care facilities for children	17	33	660
	Level VI—residential care facilities for children	8	26	233
Kentucky	Psychiatric residential treatment facilities for adolescents	21	8	184
Maine	Residential child care facilities with mental health program	116	6	780
	Residential facilities with secure containment rules	7	3	48
Maryland	Therapeutic group homes—children	23	7	161
Massachusetts	Clinically intensive residential treatment	2	9	24
	Intensive residential treatment facilities for adolescents	5	13	73
	Behavior-intensive residential treatment	2	14	30
	Community residential facilities	24	8	184
Michigan	Child-caring institutions	225	32	7,160
Minnesota	Rule 5 child treatment centers	32	40	929
Mississippi	Therapeutic group homes—children	22	10	220
	Residential treatment—dually diagnosed youth	3	19	56
Missouri	Residential treatment services—children	146	25	3,592
	Family-focused mental illness residential services—children	12	N/A	N/A
Montana	Group homes—children	47	6	304
	Residential treatment facilities for children	3	58	238
Nebraska	Residential treatment centers—children	21	12	368
	Treatment group homes—children	19	8	226

Table III.1 (cont.)

State	*Facility Type*	*Number of Associated Facilities*	*Average Number of Residents per Facility*	*Total Number of Beds*
Nevada	Residential treatment facilities for children	2	37	75
New Hampshire	Child care institutions	40	22	887
New Jersey	Psychiatric community residences for youth	21	8	160
New Mexico	Residential treatment facilities for youth	68	10	796
	Group homes for youth	4	22	86
New York	Community-based mental illness treatment facilities for children	26	8	208
	Residential treatment facilities for children	19	28	539
North Carolina	Residential treatment facilities for children	817	4	3,465
	Therapeutic/foster care camps for children	11	62	681
Ohio	Type I residential facilities	170	5	930
Oregon	Assessment and evaluation psychiatric residential treatment facilities for children	4	13	54
	Subacute treatment facilities for children	2	22	28
Pennsylvania	Residential treatment facilities for children	70	30	2,162
South Carolina	State-operated residential treatment facilities	2	26	31
	Privately operated residential treatment facilities	8	45	284
	High-management group homes	42	20	810
	Moderate-management group homes	20	18	363
	Supervised independent living facilities	11	10	130
South Dakota	Licensed mental illness group care centers	14	25	354
	Residential treatment centers	13	38	499
Texas	Residential treatment centers	85	41	3,487
	Therapeutic foster care group homes	661	9	5,868
Utah	Residential treatment facilities for children	41	17	843
Virginia	Children's group homes	99	6	594
	Children's residential treatment facilities	22	49	1,347
Washington	Children's long-term inpatient facilities	5	19	96
West Virginia	Psychiatric residential treatment facilities	6	20	121
	Level I residential treatment facilities	12	9	108
	Level II residential treatment facilities	19	16	304
	Level III residential treatment facilities	8	31	252
	Shelters	20	10	195
Wisconsin	Residential care centers for children and youth	44	33	1,464
	Group foster homes	120	7	900
Wyoming	Residential treatment facilities	13	34	492

Source: Surveys submitted by 38 States.

Note: The 71 facility types listed in this table were reported by State officials to have had a total of 3,628 associated facilities and 50,507 beds as of September 30, 2003.

A. Number of Beds Associated with Facilities

Overall, the 71 facility types accounted for 3,628 separate residential facilities. As Table III.2 shows, the 3,628 facilities covered in the present study included 50,507 beds as of September 30, 2003. Occupancy rates varied from 50 to 100 percent across facility types, with 12 facility types occupied at less than 80 percent. Information on occupancy rates was unavailable for 16 facility types (23 percent).

Information on the average number of children residing in facilities was reported for 70 of the 71 facility types. The average number of residents ranged from 3 to 65 as of September 30, 2003. Most facilities were small in terms of the number of residents. About one-third of the 71 facility types (23 facility types) had fewer than 10 children on average in each facility; these 23 facility types accounted for 65 percent of all facilities and 31 percent of all beds. Eleven percent of all facility types (8 facility types) had 40 or more residents on average, accounting for 7 percent of associated facilities and 21 percent of beds.

Given that Medicaid defines institutions for mental diseases (IMDs) as residential settings with more than 16 residents, facilities were grouped into those with an average of 3 to 16 residents and those with an average of 17 or more residents. As Table III.2 shows, 37 (52.1 percent) of the 71 facility types included in the study housed an average of 3 to 16 residents in each facility. The 37 facility types accounted for 2,588 associated facilities (71.3 percent of all associated facilities) and 18,598 beds (36.8 percent of all beds).

A total of 33 facility types (46.5 percent) had an average of 17 or more residents in each facility (see Table III.2). The 33 facility types accounted for 1,028 associated facilities (28.3 percent of all associated facilities) and 31,909 beds (63.2 percent of all beds). One facility type could not be classified because the number of average residents in the facilities within the type was not available (see Table III.2).

Overall, the facility types that housed, on average, between 3 and 16 residents accounted for a larger proportion of the facilities but a smaller proportion of beds as compared with the facility types that housed,

Table III.2 Residential Facilities for Children with Mental Illness and Associated Facilities and Beds, by Average Number of Residents, 2003

		Facilities with 3 to 16 Residents on Average		Facilities with 17 or More Residents on Average		Average Number of Residents Not Available	
Survey Results	Total	Number	Percent	Number	Percent	Number	Percent
Results for all facilities							
Facility types	71	37	52.1	33	46.5	1*	1.4
Facilities	3,628	2,588	71.3	1,028	28.3	12	.3
Beds	50,507	18,598	36.8	31,909	63.2	—	—

Source: Surveys submitted by 38 States

*The respondent for this facility type could not provide the number of beds in the associated facilities.

on average, 17 or more residents. Simply put, the number of smaller facilities exceeded the number of larger ones, but the latter accounted for proportionally more beds. It is useful to keep this observation in mind when examining the results of the study.

B. Ownership Arrangements

The ownership of residential facilities for children with mental illness varied widely across States and, in some cases, within facility types. To examine the ownership issue, the questionnaire asked respondents to indicate what percent of the facilities within a particular facility type operated under selected ownership arrangements. For example, within a particular facility type, 75 percent of the associated facilities might be operated by not-for-profit organizations and 25 percent by for-profit organizations. Facility types were classified by the dominant ownership arrangement, whereby dominant was defined as an arrangement that covered 75 percent or more of facilities within a facility type. Thus, in the example, the facility type would have been classified as predominantly owned by not-for-profit organizations.

As Table III.3 indicates, facilities in about two-thirds of the 71 facility types (47 types or 66.2 percent) were wholly or predominantly owned by not-for-profit organizations; these types accounted for 51.9 percent of the facilities and 42.0 percent of the beds. Facilities in most of the other facility types operated under varied ownership arrangements (i.e., no one type of organization owned 75 percent of the facilities within a facility type). Specifically, facilities in 17 facility types had varied arrangements, accounting for 31.6 percent of the facilities and 33.2 percent of the beds.

C. Length of Stay

Length of stay is an important variable because of concerns that long lengths of stay are associated with greater difficulties in returning to family and community after discharge. However, data on length of stay were unavailable for more than one-fifth of the 71 facility types, accounting for 39.1 percent of

Table III.3 Ownership of Residential Facilities for Children with Mental Illness, 2003

	Facility Type		Facilities		Beds	
	Number	Percent	Number	Percent	Number	Percent
Wholly or predominantly operated by not-for-profits	47	66.2	1,884	51.9	21,235	42.0
Wholly or predominantly operated by for-profits	4	5.6	299	8.2	3,155	6.3
Wholly or predominantly operated by government	2	2.8	72	2.0	2,193	4.3
Wholly or predominantly operated by other type of entity	1	1.4	225	6.2	7,160	14.2
Varied ownership	17	23.9	1,148	31.6	16,764	33.2
Total	71	100.0	3,628	100.0	50,507	100.0

Source: Surveys submitted by 38 States

Note: "Varied ownership" indicates that no given type of organization operated 75 percent or more of these 17 types of residential facilities.

all facilities and almost half (46.3 percent) of all beds in residential facilities for children with mental illness (see Table III.4).

In 18 facility types (25.4 percent), average lengths of stay ranged between 1 and 6 months, but these facility types accounted for only about 10 percent of facilities and 10 percent of beds. In about one-third of all facility types (accounting for about the same proportion of facilities and beds), length of stay ranged between 7 and 12 months. In less than 20 percent of facility types (accounting for 12.9 percent of facilities and 7.8 percent of beds), children stayed for longer than a year on average. Analyses of facility types by size indicated that longer lengths of stay were more common in facilities averaging 3 to 16 residents, as compared with facilities averaging 17 or more residents (data not shown).

Few States indicated that they regulated lengths of stay for the facility types included in the study. Maximum lengths of stay were mandated for children in facilities in only 10 of the 71 facility types (14 percent of facility types, accounting for 11 percent of all facilities).

D. Secured Units

Twenty-six types of facilities (37 percent of all facility types) were allowed by State law to have secured or locked units, but State officials indicated that only some facilities within these types actually had locked units. In some cases, facilities within these types did not have such units even though State law allowed them. Specifically, in half of the facility types allowed to have secured units, 50 percent or less of the associated facilities actually had such units. The questionnaire did not ask State officials to report on the number of beds in locked units in facilities that were allowed to have such arrangements.

With respect to this issue, size of facility matters: more than 80 percent of facilities that averaged more than 16 residents were allowed to have locked units, as compared with less than 10 percent of facilities that averaged between 3 and 16 residents.

Table III.4 Average Lengths of Stay in Residential Facilities for Children with Mental Illness, 2003

	Facility Type		Facilities		Beds	
Average Length of Stay	Number	Percent	Number	Percent	Number	Percent
1–6 months	18	25.4	377	10.4	5,415	10.7
7–12 months	24	33.8	1,365	37.6	17,792	35.2
13 or more months	14	19.7	468	12.9	3,929	7.8
Data unavailable	15	21.1	1,418	39.1	23,371	46.3
Total	71	100.0	3,628	100.0	50,507	100.0

Source: Surveys submitted by 38 States

IV. Regulatory Methods

States have available a variety of methods to regulate residential facilities for children with mental illness, including licensure and certification, visits to facilities, review of complaints, and enforcement of important regulations. This chapter presents findings related to the States' regulatory methods. Specifically, it provides information on:

- Licensure and certification
- Complaint reviews
- Critical incident reporting
- Announced and unannounced visits
- Regulations governing selected facility characteristics
- Accreditation

A. Licensure and Certification

Analyses of data from State officials indicated that, depending on the particular State, several agencies licensed or certified residential facilities for children with mental illness. These agencies included:

- State departments of children and families (including welfare agencies)
- State and local mental health agencies
- State departments of health or departments of health and human services
- Various other State agencies, such as the Medicaid agency, the office for child care services, social service agencies, and the department of protective and regulatory services

As Table IV.1 shows, State departments of children and families were involved in licensing or certifying residential treatment facilities for children with mental illness. These departments licensed or certified 30 of the 71 facility types (42.3 percent) in the study, accounting for 19.4 percent of all facilities and 27.1 percent of all beds. State departments of health and State mental health agencies also played a major role in licensing or certifying residential facilities for children with mental illness, each certifying about one-third of the facility types in the study. Five facility types were licensed or certified by departments of health and human services, but these 5 types accounted for 25.3 percent of all facilities (Table IV.1), indicating that these departments were involved with facility types that had a large number of associated facilities. Similarly, 7 facility types were licensed or regulated by other departments and agencies (such as Medicaid agencies or departments of protective services), but these 7 types accounted for 34.5 percent of all beds, meaning that these departments were involved with facility types that served large numbers of residents.

Licensing patterns were influenced by facility size. For example, State mental

Table IV.1 Selected Agencies Licensing or Certifying Residential Facilities for Children with Mental Illness, 2003

	Facility Type		Facilities		Beds	
Agency	Number	Percent	Number	Percent	Number	Percent
Total	71		3,628		50,507	
Department of children and families	30	42.3	704	19.4	13,687	27.1
Department of health	24	33.8	599	16.5	12,781	25.3
State mental health agency	23	32.4	739	20.4	9,294	18.4
Department of social services	14	19.7	625	17.2	15,999	31.7
Department of health and human services	5	7.0	918	25.3	5,575	11..0
Local mental health agency	2	2.8	193	5.3	1,091	2.2
Department of human services	2	2.8	123	3.4	828	1.6
Other departments and agencies	7	9.9	1042	28.7	17,407	34.5

Source: Surveys submitted by 38 States

health agencies licensed 21 percent of facilities that had between 3 and 16 residents on average and 17 percent of facilities that had 17 or more residents on average. In contrast, departments of social service licensed 1 percent of facilities that had between 3 and 16 residents on average and 56 percent of facilities that had 17 or more residents on average (data not shown).

For many facility types, more than one department or agency played a licensing or certifying role (which explains why the percentages in Table IV.1 add up to more than 100). Table IV.2 shows the number of facility types (and associated facilities and beds) that were subject to licensing or certification by more than one agency. As the table shows, 30 of the 71 facility types (42.3 percent) had to respond to two licensing agencies or departments, and 3 facility types had to respond to 3 or more licensing agencies.

Additional analyses indicated the common combinations of agencies responsible for licensing or certifying residential facilities for children with mental illness. The facilities had to obtain licensure or certification from:

Table IV.2 Number of Agencies Involved in Licensing or Certifying Residential Facilities for Children with Mental Illness, 2003

Number of Agencies Involved	Facility Type		Facilities		Beds	
	Number	Percent	Number	Percent	Number	Percent
Total	71	100.0	3,628	100.0	50,507	100.0
One	38	53.5	2,564	70.7	31,786	62.9
Two	30	42.3	813	22.4	11,287	22.4
Three or more	3	4.2	251	6.9	7,434	14.7

Source: Surveys submitted by 38 States

- Departments of children and families and departments of health in the case of 12 facility types
- State mental health agencies and departments of health in the case of 6 facility types
- Departments of social service and departments of health in the case of 4 facility types
- State mental health agencies and departments of social services in the case of 4 facility types
- State mental health agencies and departments of children and families in the case of 3 facility types

In their licensing role, States typically required facilities to complete certain procedures for both initial licensure and certification and renewal: on-site inspections, review of documentation of staff qualifications and training, review of a sample of residents' clinical records, and interviews with residents. As shown in Table IV.3:

- Virtually all facility types (97.2 percent) had to have on-site inspection for initial licensure or certification, and almost all (90.1 percent) had to have such an inspection for licensure renewal.
- Most facility types had to submit documentation of staff qualifications for initial licensure and certification (91.6 percent) as well as for licensure renewal (87.3 percent).
- Documentation of staff training was required for 80.3 percent of facility types at the time of initial licensure and for 85.9 percent at the time of licensure renewal.
- Record reviews had to occur at the time of initial licensure for 67.6 percent of facility types and at the time of licensure renewal for 85.9 percent of facility types.
- Resident interviews were required for far fewer facilities than the other pro-

Table IV.3 Procedures Required by States for Initial Licensure or Certification and Renewal of License or Certification of Residential Facilities for Children with Mental Illness, 2003

		Percent of		
Procedures	Licensure or Certification	Facility Type	Facilities	Beds
On-site inspection	Initial	97.2	98.8	98.9
	Renewal	90.1	73.5	85.1
Documentation of staff qualifications	Initial	91.6	96.6	95.8
	Renewal	87.3	72.4	83.3
Documentation of staff training	Initial	80.3	87.4	88.1
	Renewal	85.9	67.4	78.1
Record review	Initial	67.6	64.1	63.7
	Renewal	85.9	68.4	79.7
Resident interviews	Initial	38.0	14.2	19.1
	Renewal	62.0	26.1	35.8

Source: Surveys submitted by 38 States

Note: Some States permitted provisional licensure or certification, which allowed facilities to begin operations before obtaining an initial license. This meant, for example, that some facilities had records for review at the time of initial licensure or certification.

cedures used in licensing and certification, with only 38.0 percent of facility types (accounting for 14.2 percent of all facilities) required to conduct interviews at initial licensure and 62.0 percent (26.1 percent of all facilities) at licensure renewal.

States rarely revoked licenses or certification. In 2003, respondents in 7 States indicated that licenses or certifications were revoked for 26 residential facilities for children with mental illness, less than 1 percent of all facilities.

B. Complaint Reviews

Just as several agencies provided licensure and certification for residential facilities for children with mental illness, several agencies reviewed complaints filed against these facilities. As Table IV.4 shows, State departments of children and families reviewed 36 of the 71 facility types, accounting for 27.1 percent of the facilities and 31.0 percent of the beds. State mental health agencies also played a role in the complaint review process; these agencies reviewed complaints for 46.5 percent of all facility types, which accounted for 28.9 percent of facilities and 34.5 percent of beds. In comparison, departments of health reviewed fewer facility types (21.1 percent), but such facilities accounted for 36.3 percent of facilities and 29.6 percent of beds. A variety of other departments and agencies (such as the Medicaid agency, department of justice, office of child care services, State commission on quality of care, behavioral health managed care organizations, protection and advocacy offices, and an office of children's affairs) also were involved to a substantial extent in reviewing complaints against residential facilities for children with mental illness. Of the 71 facility types, survey responses indicated that 20 (28.2 percent) were subject to review by one of these other entities, accounting for a substantial proportion of facilities (40.4 percent) and beds (46.5 percent).

Table IV.4 State Agencies Reviewing Complaints Against Residential Facilities for Children with Mental Illness, 2003

	Facility Type		Facilities		Beds	
Agency	Number	Percent	Number	Percent	Number	Percent
Total	71		3,628		50,507	
Department of children and families	36	50.7	983	27.1	15,641	31.0
State mental health agency	33	46.5	1,049	28.9	17,441	34.5
Department of social services	17	23.9	779	21.5	16,435	32.5
Department of health	15	21.1	1,316	36.3	14,942	29.6
Local mental health agency	7	9.9	673	18.6	12,937	25.6
Department of health and human services	3	4.2	90	2.5	1,429	2.8
Department of human services	2	2.8	123	3.4	828	1.6
Other departments and agencies	20	28.2	1,466	40.4	23,482	46.5

Source: Surveys submitted by 38 States

Table IV.5 Number of Agencies Involved in Reviewing Complaints Made Against Residential Facilities for Children with Mental Illness, 2003

Number of Agencies Involved	Facility Type		Facilities		Beds	
	Number	Percent	Number	Percent	Number	Percent
Total	71	100	3,628	100.0	50,507	100.0
One	32	45.1	2,357	65.0	29,961	59.3
Two	23	32.4	497	13.7	7,022	13.9
Three	10	14.1	193	5.3	2,126	4.2
Four	5	7.0	356	9.8	4,238	8.4
Five	1	1.4	225	6.2	7,160	14.2

Source: Surveys submitted by 38 States

For facilities in many facility types, more than one department or agency reviewed complaints against them (which explains why the percentages in Table IV.4 add up to more than 100). Table IV.5 presents the number of facility types (and associated facilities and beds) that were subject to complaint review by more than one agency. As the table shows, 2 agencies or departments reviewed 23 of the 71 facility types (32.4 percent) with complaints against them (accounting for 13.7 percent of facilities), and 3 or more agencies reviewed 16 facility types (22.5 percent) with complaints against them (accounting for 21.3 percent of facilities).

C. Critical Incident Reporting

All of the States in the study required all facilities to report adverse events or critical incidents to the State, but the specific types of adverse events or incidents that had to be reported varied somewhat across facilities. Of the 71 facility types included in the study, more than 90 percent were required to report deaths, suicides, and incidents or allegations of abuse or neglect (see Table IV.6). Suicide attempts had to be reported by 77.5 percent of facility types (accounting for about two-thirds of all facilities), and 63.4 percent of facility types (accounting for about 40 percent of all facilities) had to report hospitalizations of residents. State laws require

Table IV.6 Adverse Events or Critical Incidents Required to be Reported by Facilities for Children with Mental Illness, 2003

Adverse Event/ Critical Incident	Facility Type		Facilities		Beds	
	Number	Percent	Number	Percent	Number	Percent
Total	71		3,628		50,507	
Death	69	97.2	3,571	98.4	49,268	97.6
Allegation of abuse or neglect	67	94.4	3,529	97.3	48,522	96.1
Suicide	66	93.0	3,508	96.7	48,567	96.2
Suicide attempt	55	77.5	2,456	67.7	41,844	82.9
Hospitalization of resident	45	63.4	1,436	39.6	26,947	53.4

Source: Surveys submitted by 38 States

facilities to report other critical incidents as well, including runaways (required for 15.5 percent of facility types and 4.6 percent of all facilities), criminal activities or assaults (required for 15.5 percent of facility types and 3.3 percent of facilities), serious injuries (14.1 percent of facility types and 8.2 percent of facilities), and use of restraints or seclusion (11.3 percent of facility types and 7.3 percent of facilities). Less than 5 percent of facility types are required to report fires, medication errors, and sexual incidents.

D. Announced and Unannounced Visits

State agencies typically visited residential facilities for children with mental illness to assess living conditions, safety issues, and services provided. Visits could have been announced or unannounced. According to survey respondents, most States relied on both methods.

Analyses showed that, in 2002, States made *announced* visits to at least some of the associated facilities in 65 of the 71 types of residential facilities included in the study (91.5 percent). If respondents indicated that States made visits to at least some associated facilities within a particular facility type, they were asked what percent of associated facilities were visited in 2002. In some cases, States visited 100 percent of the associated facilities within a facility type; in other cases, States visited only 1 percent of the associated facilities. For 2 types of facilities, States did not know whether announced visits occurred.

States were somewhat less likely to make *unannounced* visits as compared with announced visits. In 2002, States made unannounced visits to at least some of the associated facilities in 46 of the 71 types of residential facilities included in the study (64.8 percent). In some cases, States made unannounced visits to 100 percent of the associated facilities within a facility type; in other cases, States made unannounced visits to only 5 percent of the associated facilities. For 3 types of facilities, respondents did not know whether unannounced visits occurred.

The same State departments and agencies that were responsible for reviewing complaints against residential facilities for children with mental illness made most of the announced or unannounced visits. As Table IV.7 shows, departments of children and families and State mental health agencies each conducted some type of visit to slightly more than one-third of facility types in 2002. Again, more than one government entity made visits to residential facilities (which explains why the percentages in Table IV.7 add up to more than 100).

E. Regulations Governing Selected Facility Characteristics

Analyses of data from State officials indicated that States varied in the extent to which laws or regulations governed operational requirements for residential facilities for children with mental illness. Two requirements frequently included in laws covering residential facilities involved resident-to-staff ratios and minimum education requirements for facility directors. The survey first asked respondents to indicate whether a State law or regulation required minimum resident-to-staff ratios or a minimum level of education for facility directors; if there was such a requirement, the survey asked respondents to indicate its specific nature.

More than three-quarters (77.5 percent) of all facility types and 61.3 percent of all facilities were subject to required resident-

Table IV.7 Agencies Involved in Conducting Unannounced or Announced Visits to Residential Facilities for Children with Mental Illness, 2003

	Facility Type		Facilities		Beds	
Agency	Number	Percent	Number	Percent	Number	Percent
Total	71		3,628		50,507	
Department of children and families	27	38.0	645	17.8	13,049	25.8
State mental health agency	26	36.6	771	21.3	9,559	18.9
Department of health	16	22.5	1,303	35.9	14,726	29.2
Department of social services	12	16.9	610	16.8	16,074	31.8
Department of human services	2	2.8	123	3.4	828	1.6
Department of health and human services	1	1.4	40	1.1	887	1.8
Local mental health agency	1	1.4	23	0.6	161	0.3
Other departments and agencies	14	19.7	1,231	33.9	22,129	43.8

Source: Surveys submitted by 38 States

Note: Percentages add to more than 100 because States may require facilities to report more than one type of event.

to-staff ratios, which means that about 40 percent of all facilities were not required to maintain any specific ratios (Table IV.8). Slightly more than two-thirds (67.6 percent) of facility types and more than 80 percent of facilities were subject to minimum education requirements for facility directors (Table IV.8). Additional analyses on size of facility type indicated that facilities with an average of 3 to 16 residents were substantially less likely to be subject to either requirement (data not shown).

Survey data provided information on minimum *requirements* rather than on actual resident-to-staff ratios or education levels of facility directors. A separate study would be needed to determine whether residential facilities for children with serious mental illness met or exceeded the requirements.

For those States with requirements governing resident-to-staff ratios and directors' education levels, information on the specifics of the requirements is presented in the following sections.

Table IV.8 Residential Facilities Subject to State Requirements for Resident-to-Staff Ratios and Minimum Education Levels for Facility Directors, 2003

	Facility Type		Facilities		Beds	
Requirement	Number	Percent	Number	Percent	Number	Percent
Total	71		3,628		50,507	
Resident-to-staff ratios	55	77.5	2,223	61.3	35,691	70.7
Minimum education level for facility directors	48	67.6	2,977	82.1	42,571	84.3

Source: Surveys submitted by 38 States

1. Required Resident-to-Staff Ratios

As Table IV.9 shows, of the 55 facility types required to have a particular daytime resident-to-staff ratio, the required minimum ratio fell between

- 2 and 4 residents per staff member for 15 facility types (27.3 percent)
- 5 and 8 residents per staff member for 26 facility types (47.3 percent)
- 9 and 20 residents per staff member for 10 facility types (18.2 percent)

Specific minimum staffing requirements varied by facility size (data not shown). Facilities averaging 3 to 16 residents were subject to State laws that impose lower ratios (i.e., fewer residents per staff member), while facilities averaging 17 or more residents were subject to laws that impose higher ratios (i.e., more residents per staff member). Also, survey responses indicated that nighttime ratios were slightly higher (i.e., a single staff member was responsible for more residents) across most facility types.

2. Required Education Level of Facility Directors

As Table IV.10 shows, of the 48 facility types with minimum requirements for the education level of facility directors, the specific requirement was

- Less than a bachelor's degree for 2 facility types (4.2 percent of all facilities with such a requirement, accounting for 30.3 percent of all facilities and 16.3 percent of all beds).
- A bachelor's degree for 19 facility types (39.6 percent of all facilities, accounting for 22.4 percent of all facilities and 36.6 percent of all beds).
- A master's degree for 15 facility types (31.3 percent of all facilities, accounting for 32.2 percent of all facilities and 22.6 percent of all beds).
- A combination of education and experience for 10 facility types (20.8 percent of all facilities, accounting for 12.0 percent of all facilities and 22.3 per-

Table IV.9 Daytime Resident-to-Staff Minimum Ratios in Residential Facilities with Staffing Requirements, 2003

	Facility Type		Facilities		Beds	
Ratios	Number	Percent	Number	Percent	Number	Percent
Total	55	100.0	2,223	100.0	35,691	100.0
2–4 residents per staff member	15	27.3	1,030	46.3	6,203	17.4
5–8 residents per staff member	26	47.3	756	34.0	17,089	47.9
9–20 residents per staff member	10	18.2	386	17.4	11,389	31.9
Not applicable*	2	3.6	24	1.1	334	0.9
Not available**	2	3.6	27	1.2	676	1.9

Source: Surveys submitted by 38 States

Note: The table includes only facility types that had State requirements for resident-to-staff ratios.

* The item was not applicable for two facility types because the State imposed a staffing requirement that did not correspond to a specific resident-to-staff ratio (e.g., one staff person per living unit).

** Data on specific resident-to-staff ratios were not available for two facility types.

Table IV.10 Minimum Education Requirements for Facility Directors of Residential Facilities with Requirements, 2003

	Of Those with a Requirement, Number and Percentage Requiring					
	Facility Type		Facilities		Beds	
Education Requirements	Number	Percent	Number	Percent	Number	Percent
Total	48	100.0	2,977	100.0	42,571	100.0
Less than a bachelor's degree	2	4.2	902	30.3	6,952	16.3
Bachelor's degree	19	39.6	666	22.4	15,577	36.6
Master's degree	15	31.3	957	32.2	9,634	22.6
Combination of education and experience	10	20.8	358	12.0	9,505	22.3
Experience requirement only	2	4.2	94	3.2	903	2.1

Source: Surveys submitted by 38 States

Note: The table includes only facility types that had minimum education requirements for facility directors.

cent of all beds). For example, in West Virginia's psychiatric residential treatment facilities, the facility director must hold a master's degree and demonstrate two years of experience or hold a bachelor's degree and demonstrate five years of experience.

- Specific experience for 2 facility types (4.2 percent of all facilities, accounting for 3.2 percent of all facilities and 2.1 percent of all beds).

State requirements for minimum education levels for facility directors varied somewhat by size of facilities (data not shown). For example, facility types with a minimum requirement of less than a bachelor's degree for facility directors were more likely to include larger facilities (with an average of 17 or more residents), as compared with smaller ones (with an average of 3 to 16 residents).

F. Accreditation

In addition to requiring licensure or certification, a few states require residential facilities for children with mental illness to be accredited by one of the national accrediting organizations. According to State officials, slightly more than 6 percent of the residential facilities included in the survey were required to obtain accreditation from at least one national accrediting organization. These organizations included the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation for Children and Family Services, the Commission on Accreditation of Rehabilitation Facilities, and the National Committee for Quality Assurance.

V. Services and Sources of Financing

Children with mental illness who are placed in residential settings typically require a broad range of services, from counseling to medication management. Analyses of survey data showed that most residential facilities provided some type of counseling services, but facilities varied substantially in the package of services they were required to provide. This chapter presents data on services that facilities were required to provide to children both during their stay and upon discharge. In practice, facilities might provide more (or less) than they were required to provide. The chapter also discusses findings on sources of financing.

A. Services Provided

As Table V.1 shows, respondents indicated that State law required 90.1 percent of all facility types in the study (accounting for 88.2 percent of all associated facilities) to provide individual counseling and 85.9 percent to provide group counseling. Family counseling was required in 71.8 percent of facility types and financial management counseling in 28.2 percent of facility types. The majority of facility types also provided medication-related services: 81.7 percent were required to manage medications for residents and 73.2 percent to dispense medications.

Between 76 and 82 percent of facility types were required to provide education services and assistance with or training in activities of daily living (ADLs). A smaller percentage of facility types were required to provide vocational training (45.1 percent) or occupational therapy (31.0 percent). States required case management to be provided to residents in 81.7 percent of facility types and client advocacy in 49.3 percent.

As shown in Table V.1, the percentage of facility types required to provide discharge services also varied by specific service. Most facility types (88.7 percent) were required to develop a comprehensive discharge plan, and about half (49.3 percent) were required to provide medications or a medication plan at discharge. About a quarter of facility types (22.5 percent) were required to conduct discharge interviews or satisfaction surveys. A small proportion of facility types (7 percent) were required to provide follow-up home visits after discharge.

B. Sources of Financing

Most facilities relied on several sources of funding (Table V.2). The three most important sources of funding were:

- State Medicaid programs, which provided funds for children in 87.3 percent of

facility types (accounting for 84.1 percent of facilities and 80.9 percent of beds)

- State departments of child and family services, which provided funds for children in 67.6 percent of facility types (accounting for 65.9 percent of facilities and 76.5 percent of beds)
- State and local mental health agencies, which provided funds for children in 57.8 percent of facility types (accounting for 81.3 percent of facilities and 74.8 percent of beds)

Table V.1 Number and Percent of Residential Facilities for Children with Mental Illness Required to Provide Selected Services, 2003

	Facility Type		Facilities		Beds	
Agency	Number	Percent	Number	Percent	Number	Percent
Counseling Services						
Individual counseling	64	90.1	3,201	88.2	39,787	78.8
Group counseling	61	85.9	2,353	64.9	36,557	72.4
Family counseling	51	71.8	1,976	54.5	26,809	53.1
Financial management counseling	20	28.2	1,108	30.5	13,452	26.6
Medication Services						
Medication management	58	81.7	3,030	83.5	39,592	78.4
Dispensing of medication	52	73.2	2,324	64.1	37,517	74.3
Education and Training Services						
Education	58	81.7	3,025	83.4	41,252	81.7
Assistance with ADLs	56	78.9	2,051	56.5	30,253	59.9
Training in ADLs	54	76.1	2,654	73.2	31,656	62.7
Vocational training	32	45.1	1,317	36.3	19,259	38.1
Occupational therapy	22	31.0	1,204	33.2	16,070	31.8
Case Management/ Advocacy						
Case management	58	81.7	3,005	82.8	43,670	86.5
Client advocacy	35	49.3	1,383	38.1	20,599	40.8
Discharge Services						
Comprehensive discharge plan	63	88.7	3,361	92.6	46,962	93.0
Discharge medications or medication plan	35	49.3	806	22.2	13,230	26.2
Discharge interview or satisfaction survey	16	22.5	291	8.0	4,958	9.8
Follow-up visit at home/ other residence	5	7.0	16	0.4	249	0.5
Total	71		3,628		50,507	

Source: Surveys submitted by 38 States

Note: ADLs are activities of daily living.

Other third-party payments, Supplemental Security Income (SSI) payments, and family out-of-pocket payments were sources of funding for between 34 and 47 percent of facility types. Department of education, juvenile justice authorities, State welfare payments, Social Security Disability Income (SSDI) payments, and private grants were sources of funding for between 21 and 28 percent of facility types. Federal grants, State payments supplementing SSI payments, and the Department of Defense were sources of financial support for relatively few facility types (Table V.2).

Overall, 53 types of facilities (or 74.6 percent of facility types, accounting for 45 percent of facilities) reported using a Medicaid per diem rate ranging from $40 to $540. Of the 53 facility types that used Medicaid per diem rates, 29 (54.7 percent) had a rate of $200 or less.

Table V.2 Funding Sources for Services Received by Children with Mental Illness in Residential Facilities, 2003

	Facility Type		Facilities		Beds	
Funding Source	Number	Percent	Number	Percent	Number	Percent
Medicaid	62	87.3	3,050	84.1	40,877	80.9
Department of child and family services	48	67.6	2,392	65.9	38,656	76.5
State or local mental health agency	41	57.8	2,950	81.3	37,752	74.8
Other third-party payments	33	46.5	1,877	51.7	35,078	69.5
SSI payments	26	36.6	1,585	43.7	27,383	54.2
Out-of-pocket family payments	24	33.8	1,929	53.2	30,931	61.2
Department of education	20	28.2	555	15.3	12,531	24.8
Juvenile justice	18	25.4	1,761	48.5	24,996	49.5
State welfare payments	18	25.4	878	24.2	19,426	38.5
SSDI payments	18	25.4	551	15.2	11,136	22.1
Private grants	15	21.1	1,091	30.1	15,845	31.4
Federal grants	8	11.3	323	8.9	4,902	9.7
State supplemental payments	4	5.6	168	4.6	3,182	6.3
Department of Defense	2	2.8	73	2.0	892	1.8
Total	71		3,628		50,507	

Source: Surveys submitted by 38 States

Note: SSI is Supplemental Security Income; SSDI is Social Security Disability Income.

VI. Conclusions

Findings from this study provide information on methods that States used to regulate residential facilities for children with mental illness and underscore the substantial variation across States in their use of regulatory methods in 2003. Analyses of data from State officials indicated that States relied on at least several regulatory methods, but no State used all of the possible methods. These methods included a wide range of specifications and requirements, such as:

- Requirements for announced and unannounced visits
- Mandated staff-to-client ratios
- Requirements for minimum resident-to-staff ratios and minimum levels of education for facility directors
- Specifications for critical-incident reporting
- Specific licensing practices
- Mandated complaint-review procedures
- Accreditation from designated State or national organizations

States also differed widely in the types of residential facilities that they indicated they regulated. Some States, for example, had regulations for a facility type that included small facilities staffed to provide homes for children with mental illness who were in State custody and who may have needed help in developing social skills; children may have stayed in these settings for a year or longer. Other States had regulations for larger congregate settings that focused on short-term rehabilitation (i.e., three months or less) and that offered a full set of counseling and therapeutic activities. The types of facilities that States regulated are different along numerous dimensions, such as mission, administrative structure, size, ownership arrangements, typical length of stay, services provided, and mix of funding sources. States also referred to facilities by different names, making it difficult to identify the extent to which facilities in different States were similar.

The findings further demonstrated that the organizations that operated facilities for children with mental illness typically faced a complex regulatory environment. A wide variety of State agencies with different missions and functions, ranging from State mental health authorities to departments of health to departments of child welfare, oversaw these residential facilities. Furthermore, in most States, several agencies were typically involved in licensing, regulating, and reviewing complaints against residential facilities. For 47 percent of all facility types covered by the survey (accounting for 29 percent of all facilities), licenses or certifications were required from more than one agency, and for 22 percent of facility types (accounting for 21 percent of all facilities), three or more agencies were involved in

reviewing complaints. In addition, facilities may have had administrative reporting requirements from their multiple funding sources.

At the State level, the study showed that some States lacked ready access to important data about residential facilities for children with mental illness. For example, respondents were unable to provide information on the average length of stay for 21 percent of facility types, accounting for 39 percent of facilities and 46 percent of beds. For several key items, respondents indicated that they were relying on administrative estimates rather than specific records or documents to report on certain types of descriptive data, such as average number of residents per facility, frequency of announced visits, or Medicaid per diems.

Although the present study was not designed to provide a national count of residential facilities for children with mental illness, its results on the number of facilities and beds can be compared with data from other studies, such as studies based on SMHO data. These comparisons show that different studies have yielded different counts of residential beds for children with mental illness because the studies used different criteria and methods for identifying residential settings. For example, the present study began from a regulatory perspective and focused on the types of facilities that States regulated, regardless of what organizations operated these facilities. The criteria for the present study included facilities that provided some therapeutic services beyond room and board, but not necessarily a broad set of clinical psychiatric or psychological services. The SMHO, in contrast, focuses specifically on mental health organizations operated under the auspices of State mental health agencies, and gathers information on the number of those organizations that provide major clinical services in a residential venue.

Analyses based on data from the SMHO indicate that there were 474 residential treatment centers for emotionally disturbed children in 2000 and that these centers had a total of 33,421 beds in operation (Manderscheid et al. 2004). The numbers from the present study are substantially higher than these figures because the present study included a larger range of facilities compared with the SMHO. Specifically, the SMHO was developed to provide counts of residential treatment centers for emotionally disturbed children that operated under the auspices of State mental health agencies and that met the following criteria (Manderscheid and Henderson 2004, p. 371):

- It must provide 24-hour residential services.
- It is an organization, not licensed as a psychiatric hospital, the primary purpose of which is the provision of individually planned programs of mental health treatment services in conjunction with residential care for its patients/clients.
- It has a clinical program within the organization that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master's degree or a doctorate degree.
- It serves children and youth primarily under the age of 18.
- The primary reason for the admission of 50 percent of more of the children and youth is mental illness that can be classified by DSM-IV/ICD-9-CM codes other than codes for mental retardation, drug-related disorders, or alcoholism.

In contrast to the SMHO, the present study was designed specifically to examine

methods that States used to regulate residential facilities that met the criteria listed in Table II.1. These criteria led to the inclusion of a wide range of facilities, including facilities that would not be counted in the SMHO.

For example, South Carolina had regulations governing five different types of residential facilities that met study criteria. In one of these types, referred to as supervised independent living programs, facilities were licensed only by the State's department of social services. These facilities housed on average 10 adolescents ages 16 to 21 for an average of one year and provided education, financial management training, occupational therapy, and vocational training, in addition to individual and group counseling. Sources of financial support included the State's Medicaid program and local family and child service agencies, but no mental health agency.

As noted above, the SMHO included residential treatment centers for emotionally disturbed children that operated under the auspices of State mental health agencies and that had as their primary purpose the provision of individually planned programs of mental health treatment services in conjunction with residential care. Because South Carolina's supervised independent living programs were not operated under the auspices of the State's mental health agency and appear to focus on providing education and rehabilitative services, rather than primarily clinical mental health services, they may not be included in the SMHO.

Overall, the criteria used to generate the list of organizations counted in the SMHO would be expected to lead to a count of the number of residential treatment centers for emotionally disturbed children that would be substantially lower than the number of facilities covered by the present study. The present study cast a wider net than the SMHO because its purpose was to conduct a regulatory analysis, rather than to enumerate and describe clinical services offered by residential facilities under the auspices of State mental health organizations.

It is also useful to compare results from the present study (Table III.1) with data from NASMHPD's State profiles (Table I.1). These comparisons show that for all but one State with data in both studies, the number of beds identified in the present study exceeded the number of beds identified in NASMHPD's State profiles. For example, in the present study, the total number of beds in all State-regulated facilities was reported to be 594, 887, and 747 in Nebraska, New Hampshire, and New York, respectively. In the NASMHPD report, the total bed count was 36, 37, and 16 for Nebraska, New Hampshire, and New York, respectively. The difference is likely to result from the fact that the present study included a greater number of facilities (and therefore a greater number of associated beds) because it incorporated facilities beyond those that were funded and operated by State mental health agencies. (Oregon is an exception to the pattern, and the reasons for this finding may involve reporting error, the differences in the time period between the studies, or some other factors.)

As noted in Chapter I, a previous study indicated that 25,356 youths resided in 673 juvenile justice residential treatment facilities in 1998 (Goldstrom et al. 2001). That study included some facilities that were excluded in the present study, such as detention centers, and the present study included facilities that were not placements for individuals in the juvenile justice system.

In addition to extending previous studies of residential settings for children with mental illness, this study's findings also relate directly to the recommendation in the report from the President's New Freedom Commission on Mental Health (2003) that each State develop a comprehensive State mental health plan. As a continuation of the Commission's efforts, SAMHSA, in partnership with key Federal agencies, recently issued *Transforming Mental Health Care in America. The Federal Action Agenda: First Steps* (SAMHSA 2005). One of the five principles outlined in the Action Agenda is to "ensure innovation, flexibility, and accountability at all levels of government." The action steps related to this principle include the initiation of State Mental Health Transformation Grants (first awarded in September 2005) and the provision of technical assistance to help States develop their comprehensive State mental health plans. Incorporating a comprehensive set of methods for regulating residential treatment facilities should help States minimize redundant and potentially conflicting administrative burdens on such facilities, leverage resources across multiple agencies, and foster a coherent continuum of child mental health services.

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Appendix A

Expert Advisory Panel

The authors are grateful to the members of the expert advisory panel who provided thoughtful input into study questions, survey methods, and criteria for the residential facilities included in the study; members of this panel are listed in Appendix A. The authors would like to extend particular thanks to Joy Midman, Sandra Newman, and Tom Harmon for their careful review of an early draft of the survey instrument and for guidance at strategic stages of the study. Jeff Horton of North Carolina, Brenda Harvey of Maine, and Alfred Nichols of California also provided useful feedback during the pilot test of the survey. James Maedke and Nancy Darrow of Social and Scientific Systems, Inc., provided assistance in understanding definitions of mental health organizations used in the Survey of Mental Health Organizations.

At MPR, Debra Draper played an important leadership role in the first phase of the project. Jesse Gregory and Kathy Bencio spent many hours contacting State officials as part of the survey effort. Myles Maxfield gave us insightful comments on an early draft of the report, and Sharon Clark provided unmatched secretarial assistance in producing the report. The authors extend special thanks to the individuals in the various States who took time to complete the survey.

Expert Advisory Panel List of Participants

Panel Members

Karen Saltus Armstrong Senior Public Health Advisor Protection & Advocacy for Individuals with Mental Illness (PAIMI) Program Substance Abuse and Mental Health Services Administration (SAMHSA)	**Collete Croze** Consultant Technical Assistance Collaborative (TAC) Housing Center	**Joe Dziobek** President/CEO Fellowship Health Resources, Inc.
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Deborah Bukoski Survey Researcher	**Lori Achman** Research Analyst	**Ama Takyi** Research Assistant

Appendix B
Survey Questionnaire

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

OMB Number:	0930-0251
Expiration Date:	10/31/2004
Case ID:	
Agency Name:	
Address:	
City, State, Zip:	
Respondent Name:	
Respondent Title:	
Respondent Email:	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

NATIONAL SURVEY OF ADMINISTRATION AND FINANCING OF GROUP HOMES AND RESIDENTIAL FACILITIES FOR PERSONS WITH MENTAL ILLNESS

FACILITY TYPE HERE

INTRODUCTION:

Thank you for agreeing to complete this questionnaire. Your participation is critical to the success of this important project. Instructions for completing and returning the questionnaire are included in a separate document. If you have any questions, please do not hesitate to contact:

Henry Ireys
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Helpful Hints to Complete Your Survey

While there are many types of facilities in your state, this survey is only asking about ***[FILL TYPE]*** *.*

Remember to save often!

- Use the arrow keys to the left of the Section Tabs at the bottom of the page to navigate left to right to see the sections (tabs).
- Click on the Section Tabs at the bottom of the screen to get to that section. *You can skip around between sections and instructions if needed.*
- Follow any skips you see after questions. They may be in one of two formats:

  (after a choice) ➡ GO TO Q3_a
  (at the end of a section) GO TO SECTION C

There are 4 types of questions: Fill-in; Yes/No; Select One; Check All That Apply.
Below are examples of each and how to answer them.

Yes/No:

- (●) Yes
- ( ) No

In this type of question you will move the mouse (which appears as a hand) over the circle next to the response you'd like, and click. Once you do that, the circle will be filled in. If you'd like to change your answer, simply click on the other choice.

Fill-In:

ENTER NUMBER OF HOURS PER YEAR: [ ]

In this type of question, you may be entering a number – such as a percent or you may be typing text for an Other (specify) answer.

Select One:

SELECT ONE

- ( ) High School Diploma
- ( ) Associate Degree
- ( ) Some College
- ( ) Bachelor's Degree
- ( ) Master's Degree
- ( ) Doctorate/Ph.D.
- ( ) M.D.
- (●) Special Certifications
- ( ) OTHER (SPECIFY):

This type of question is similar to Yes/No. Rather than an arrow appearing over the choices, a hand will appear. As with the Yes/No questions,

you may only choose one (by clicking on the circle beside your choice).
You may change your answer by clicking on a different answer.

Check All That Apply:

CHECK ALL THAT APPLY

- [x] Physician
- [ ] Psychologist
- [ ] Nurse
- [ ] Social Worker
- [ ] OTHER (SPECIFY):

For this type of question, you will also see a hand when you move the mouse over the choices. To select the choices you'd like, click your mouse over the box next to your desired answer. Repeat for all your choices.
To change any answer, click again in the box already filled in. It will become blank again.

Assessing Data Quality

We recognize that some items may require you to estimate a number. For a limited number of items, we are asking you to indicate whether your answers are based on an estimate or on actual figures in an existing report or database. This will help SAMHSA evaluate the precision and accuracy of the data. Whenever possible, please use actual figures.

A. FACILITY CHARACTERISTICS

We would like to start by asking some questions about the characteristics of ***[FILL TYPE]*** *in your State.*

A1. How many of these facilities were licensed in your state as of September 30, 2003?

ENTER NUMBER: ____

Please indicate whether this figue is an estimate or is the result of record review.

◯ Estimate ◯ Record Review

A2. What were the total number of beds in operation in all of these facilities as of September 30, 2003?

TOTAL NUMBER OF BEDS: ____

A2_a. Of these beds, what percent were occupied as of September 30, 2003?

ENTER PERCENT: ____

A3. What was the average number of residents in a single facility of this type as of September 30, 2003?

ENTER AVERAGE NUMBER OF RESIDENTS: ____

Please indicate whether this figue is an estimate or is the result of record review.

◯ Estimate ◯ Record Review

A4. Is there a law or regulation in the state that limits the number of beds in a single facility of this type?

◯ Yes ➡ GO TO A4_a
◯ No ➡ GO TO A5

A4_a. What is the maximum number of beds allowed by law or regulation for a single facility of this type?

ENTER NUMBER OF BEDS: ____

A5. What is the usual age range of residents in these facilities?

ENTER AGE RANGE: ____

A6. Is there a state law or regulation that specifies the maximum length of stay for residents in these facilities

◯ Yes ➡ GO TO A6_a
◯ No ➡ GO TO A7

A6_a. What is the maximum length of stay for residents of these facilities?

ENTER NUMBER: ____

SELECT ONE

◯ Days ◯ Weeks ◯ Months ◯ Years

A7. What is the average length of stay for residents of these facilities?

ENTER NUMBER: [ ]

SELECT ONE
◌ Days ◌ Weeks ◌ Months ◌ Years

Please indicate whether this figue is an estimate or is the result of record review.

◌ Estimate ◌ Record Review

A8. Is there a state law or regulation requiring minimum patient-to-staff ratios for these facilities?

◌ Yes ➡ GO TO A8_a
◌ No ➡ GO TO A9

A8_a. What are the minimum patient-to-staff ratios during *daytime* hours?

ENTER NUMBER OF PATIENTS PER STAFF MEMBER: [ ]

☐ Not Applicable

A8_b. What are the minimum patient-to-staff ratios during *evening* hours?

ENTER NUMBER OF PATIENTS PER STAFF MEMBER: [ ]

☐ Not Applicable

A8_c. What are the minimum patient-to-staff ratios during *overnight* hours?

ENTER NUMBER OF PATIENTS PER STAFF MEMBER: [ ]

☐ Not Applicable

A9. What percentage of these facilities are operated by…

State or Local Governmental Units	[ ]
Not-for-Profit Organizations	[ ]
For-Profit/Proprietary Organization	[ ]
OTHER (SPECIFY): [ ]	[ ]
TOTAL	0% ⬅ **MUST EQUAL 100%**

A10. Is there a state law or regulation requiring clinical supervision of direct care workers at these facilities?

NOTE: A direct care worker is defined as an individual who provides active direct care, treatment, rehabilitation or habilitation services to clients.

◌ Yes ➡ GO TO A10_a
◌ No ➡ GO TO A11

A10_a. What is the *minimum* number of hours per month that direct care workers must be clinically supervised?

ENTER NUMBER OF HOURS PER MONTH: ☐

A10_b. What type of individual is allowed to provide this clinical supervision?

CHECK ALL THAT APPLY

- ☐ Physician
- ☐ Psychologist
- ☐ Nurse
- ☐ Social Worker
- ☐ OTHER (SPECIFY): ☐

A11. Is there a state law or regulation that requires a minimum amount of education for facility directors?

- ◯ Yes ➡ GO TO A11_a
- ◯ No ➡ GO TO A12

A11_a. What is the minimum education required for facility directors?

SELECT ONE

- ◯ High School Diploma
- ◯ Associate Degree
- ◯ Some College
- ◯ Bachelor's Degree
- ◯ Master's Degree
- ◯ Doctorate/Ph.D.
- ◯ M.D.
- ◯ Special Certifications
- ◯ OTHER (SPECIFY): ☐

A12. Are facilities required to provide in-service or continuing education for direct care staff?

- ◯ Yes ➡ GO TO A12_a
- ◯ No ➡ GO TO A13

A12_a. What is the minimum number of hours required per year?

ENTER NUMBER OF HOURS PER YEAR: ☐

A12_b. Does state law or regulation require that specific topics (e.g., training on confidentiality issues; first aid training) be covered for all or most direct care staff?

○ Yes ➡ GO TO LIST BELOW
○ No ➡ GO TO A13

Please List Topics:

A13. What agency or entity has the authority to hire and terminate facility directors?

CHECK ALL THAT APPLY

☐ State Mental Health Agency
☐ Local Mental Health Agency
☐ Department of Health
☐ Children and Family Services Agency
☐ Social Services Agency
☐ Board of Directors of Private Entities
☐ Senior Management in Private Entities
☐ No One
☐ OTHER (SPECIFY):

A14. Are these facilities allowed to have locked units?

○ Yes ➡ GO TO A14_a
○ No ➡ GO TO PART B

A14_a. What percent of these facilities have locked units?

ENTER PERCENT OF FACILITIES WITH LOCKED UNITS:

Please indicate whether this figue is an estimate or is the result of record review

○ Estimate ○ Records Review

GO TO PART B: LICENSING, CERTIFICATION, & ACCREDITING

B. LICENSING, CERTIFICATION, AND ACCREDITATION

The next questions are about licensure, certification, and accreditation requirements for ***[FILL TYPE]*** *.*

B1. LICENSURE

Which of the following agencies/departments license these facilities in your state? **CHECK ALL THAT APPLY**	Is this license…? **CHECK ALL THAT APPLY**	What is the duration of the licensure period?
☐ State Mental Health Agency	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Licensure Period (in years)
☐ Local (i.e., city or county) Mental Health Agency	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Licensure Period (in years)
☐ Department of Social Services	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Licensure Period (in years)
☐ Department of Children and Families	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Licensure Period (in years)
☐ Department of Health	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Licensure Period (in years)
☐ OTHER (SPECIFY):	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Licensure Period (in years)

B2. CERTIFICATION

Which of the following agencies/departments certify these facilities in your state? **CHECK ALL THAT APPLY**	Is this certification…? **CHECK ALL THAT APPLY**	What is the duration of the certification period?
☐ State Mental Health Agency	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Certification Period (in years)
☐ Local Mental Health Agency	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Certification Period (in years)
☐ Department of Social Services	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Certification Period (in years)
☐ Department of Children and Families	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Certification Period (in years)
☐ Department of Health	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Certification Period (in years)
☐ OTHER (SPECIFY):	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Certification Period (in years)

B3. ACCREDITATION

Which of the following entities accredit these facilities in your state? **CHECK ALL THAT APPLY**	Is this Accreditation…? **CHECK ALL THAT APPLY**	What is the duration of the accreditation period?
☐ Utilization Review Accreditation Commission (URAC)	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Accreditation Period (in years)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Accreditation Period (in years)
☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Accreditation Period (in years)
☐ Council on Accreditation for Children and Family Services (CACFS)	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Accreditation Period (in years)
☐ OTHER (SPECIFY):	☐ Required to Operate ☐ Required to Receive Public Funding ☐ Optional	Duration of Accreditation Period (in years)

B4. Is there a provisional license process for first-time applicants?

◯ Yes
◯ No

B5. What is required for initial licensure, license renewal, certification, and re-certification?
CHECK ALL THAT APPLY

	On-Site State Inspection/ Visit	Submission of Documentation of Staff Qualifications	Submission of Documentation of Staff Training	Record Review	Resident Interviews	OTHER (SPECIFY)
Initial Licensure	☐	☐	☐	☐	☐	
License Renewal	☐	☐	☐	☐	☐	
Certification	☐	☐	☐	☐	☐	
Re-Certification	☐	☐	☐	☐	☐	

B6. Were any licenses for these facilities in your state revoked or suspended in 2002?

◯ Yes ➡ GO TO B6_a, then B6_b
◯ No ➡ GO TO C1

B6_a. How many?

ENTER NUMBER:

B6_b. What were the reasons?

CHECK ALL THAT APPLY
- ☐ Client Neglect
- ☐ Unsafe conditions
- ☐ Failure to report critical events
- ☐ Lack of qualified staff
- ☐ Fraud
- ☐ OTHER (SPECIFY):

GO TO PART C: FACILITY PROGRAMS & TREATMENT SERVICES

C. FACILITY PROGRAMS AND TREATMENT SERVICES

In this section we'd like you to answer some questions about the services provided to residents and requirements governing service provision in ***[FILL TYPE]*** .

C1. Are these facilities required to develop individualized treatment/service plans for residents?

- ◯ Yes ➡ GO TO C1_a then C1_b
- ◯ No ➡ GO TO C2

C1_a. How often must the individualized treatment/service plans be updated?

ENTER NUMBER: [ ]

PLEASE SPECIFY
◯ Days ◯ Weeks ◯ Months ◯ Years

C1_b. Is the client or parent/guardian required to provide written acknowledgement of the individualized treatment plan?

- ◯ Yes
- ◯ No

C2. Which of the following services does the state *require* these facilities to provide, either by staff or through contractual arrangements?

CHECK ALL THAT APPLY

- ☐ Individual Counseling
- ☐ Group Counseling
- ☐ Family Counseling
- ☐ Assistance with Activities of Daily Living
- ☐ Financial Management Counseling
- ☐ Vocational Training
- ☐ Training in Activities of Daily Living
- ☐ Occupational Therapy
- ☐ Education
- ☐ Client Advocacy
- ☐ Case Management
- ☐ Dispensing of Medication
- ☐ Medication Management
- ☐ OTHER (SPECIFY): [ ]
- ☐ OTHER (SPECIFY): [ ]
- ☐ OTHER (SPECIFY): [ ]

C3. Are these facilities required to provide a minimum number of service/treatment hours to residents?

◯ Yes ➡ GO TO C3_a
◯ No ➡ GO TO C4

C3_a. What is the minimim number of service/treatment hours required per resident?

ENTER NUMBER: _____

PLEASE SPECIFY
◯ Days ◯ Weeks ◯ Months ◯ Years

C4. Are these facilities required to provide any of the following services upon discharging residents?

CHECK ALL THAT APPLY

☐ Comprehensive Discharge Plan
☐ Followup Visit at Home/Other Residence
☐ Followup Treatment or Aftercare Plan Post Discharge
☐ Discharge Interview or Satisfaction Survey
☐ Discharge Medications or Specific Medication Plan
☐ OTHER (SPECIFY): _____

GO TO PART D: FACILITY MONITORING & OVERSIGHT

The following questions involve procedures for monitoring and overseeing ***[FILL TYPE]*** .

D1. Did the state make *unannounced* visits to any of these facilities in 2002?

◯ Yes ➡ GO TO D1_a then D1_b and D1_c
◯ No ➡ GO TO D2

D1_a. What percent of these facilities did the state make unannounced visits to in 2002?

ENTER PERCENT: _____ %

➢ Please indicate whether this figue is an estimate or is the result of record review

◯ Estimate ◯ Records Review

D1_b. What agency or agencies conducted these site visits?

CHECK ALL THAT APPLY

☐ State Mental Health Agency
☐ Local (i.e., city or county) Mental Health Agency
☐ Department of Social Services
☐ Department of Children and Families
☐ Department of Health
☐ OTHER (SPECIFY): _____

D1_c. What is the minimum required frequency of these visits per facility?

☐ No Frequency Rate Required

ENTER NUMBER: _____

PLEASE SPECIFY
◯ Days ◯ Weeks ◯ Months ◯ Years

D2. Did the state make announced visits to any of these facilities in 2002?

◯ Yes ➡ GO TO D2_a then D2_b and D2_c
◯ No ➡ GO TO D3

D2_a. What percent of these facilities did the state make announced visits to in 2002?

ENTER PERCENT: _____ %

➢ Please indicate whether this figue is an estimate or is the result of record review

◯ Estimate ◯ Records Review

D2_b. What agency or agencies conducted these site visits?

CHECK ALL THAT APPLY

- ☐ State Mental Health Agency
- ☐ Local (i.e., city or county) Mental Health Agency
- ☐ Department of Social Services
- ☐ Department of Children and Families
- ☐ Department of Health
- ☐ OTHER (SPECIFY): _____

D2_c. What is the minimum required frequency of these visits per facility?

☐ No Frequency Rate Required

ENTER NUMBER: _____

PLEASE SPECIFY

○ Days ○ Weeks ○ Months ○ Years

D3. What agency (or agencies) reviews complaints and/or grievances about these facilities?

CHECK ALL THAT APPLY

- ☐ State Mental Health Agency
- ☐ Local (i.e., city or county) Mental Health Agency
- ☐ Department of Social Services
- ☐ Department of Children and Families
- ☐ Department of Health
- ☐ OTHER (SPECIFY): _____

D4. Are these facilities required to report adverse events or incidents to the state?

- ○ Yes ➡ GO TO D4_a
- ○ No ➡ GO TO D5

D4_a. What types of adverse events or incidents must be reported?

CHECK ALL THAT APPLY

- ☐ Deaths
- ☐ Suicides
- ☐ Suicide Attempts
- ☐ Hospitalization of a Resident
- ☐ Allegations of Abuse or Neglect
- ☐ Other Critical Incidents: _____

D5. Is there a court order in effect that is influencing any monitoring or oversight procedures for these facilities?

◯ Yes ➡ GO TO D5_a
◯ No ➡ GO TO PART E

D5_a. Please describe the nature of any court orders in place.

GO TO PART E: FINANCING

E. FINANCING

These questions involve financing of services in ***[FILL TYPE]*** *.*

E1. For a typical facility, where does financial support come from? Check all the apply.

- Medicaid ☐
- State/Local Mental Health Agency Funds ☐
- State/Local Family/Child Service Agency Funds ☐
- State Welfare Agency ☐
- SSI Payments ☐
- SSDI Payments ☐
- State Supplemental Payments (SSP) ☐
- Federal Grants ☐
- Department of Education ☐
- Juvenile Justice ☐
- Department of Defense ☐
- Private Grants ☐
- Private 3rd Party Payments ☐
- Self Pay ☐
- OTHER (SPECIFY): _____ ☐
- OTHER (SPECIFY): _____ ☐
- OTHER (SPECIFY): _____ ☐

E2. For these facilities, are there different per diem rates for treatment services applied to different groups of Medicaid patients (for example, a group of residents with more severe problems might be charged a higher rate)?

◯ Yes ➡ GO TO E2_a
◯ No ➡ GO TO E3

E2_a. What is the range?

ENTER THE RANGE: [ ] to [ ]

E3. For a typical facility of this type, what is the Medicaid per diem for treatment services?

ENTER AVERAGE DAILY RATE: [ ]

➢ Please indicate whether this figue is an estimate or is the result of record review.

◯ Estimate ◯ Record Review

<u>THANK YOU</u> FOR TAKING THE TIME TO COMPLETE THIS SURVEY.

PLEASE EMAIL IT TO [RESEARCHER] AT [EMAIL] .
OR
MAIL IT TO [RESEARCHER] AT 600 MARYLAND AVE., SW STE. 550, WASHINGTON, DC 20024

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