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White Paper Community Alternatives to Psychiatric Residential Treatment Facility Services

Commonwealth of Pennsylvania Office of Mental Health and Substance Abuse Services

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Executive summary

The Commonwealth of Pennsylvania, (Commonwealth) Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS) engaged Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to review current issues related to Psychiatric Residential Treatment Facilities (PRTFs) utilization. Mercer was charged to develop recommendations that promote home and community-based alternatives to residential treatment, with a particular emphasis on youth served through the juvenile justice system. This concept paper explores the issues, infrastructure and practices that can better promote a community-based system of care that includes alternatives to PRTFs use.

The Commonwealth spent nearly $234 million on PRTFs in accredited facilities in calendar year (CY) 2006 (the most recent year for which complete data is available). Spending was higher in CY 2006 than in CY 2005 (nearly $206 million), likely reflecting at least in part the implementation of the Integrated Children's Services Initiative (ICSI) in fiscal year (FY) 2006 that added 17 additional accredited PRTF providers across 43 sites. These additional providers increased the number of accredited PRTFs beds within the Medicaid system by 76%, adding 1,394 beds to bring the Statewide total to 3,223.

Information was gathered through interviews with key informants, national experts and a targeted literature review, as well as analysis of PRTFs utilization data from CY 2005 and CY 2006. A draft of this paper was shared with the key informants and edits based on their review of the findings have been incorporated in this final document.

Findings from the literature

PRTFs represent a necessary component of the continuum of care for children and adolescent youth whose behavior cannot be managed effectively in a less restrictive setting. Examples include youth with highly complex needs or dangerous behaviors, such as fire setting (Stroul, 2007), running away from foster care settings, destructive or self-destructive behavior, and step-downs from more restrictive settings (Barth, 2002). The most promising outcomes are associated with family-focused, community-oriented residential programs, which feature structured, intensive interventions that involve the family and focus on building the capacity of the family and community to support the child at home.

Too often children and youth are placed in PRTFs because more appropriate community-based services are not available. Parents, judges and others desperate to meet children's needs often turn to PRTFs because of a lack of viable alternatives. There is growing evidence that, in many situations, children can be effectively served in their homes and communities in lieu of psychiatric residential treatment and that community-based treatment programs are often superior to institution-based programs.

Sources ranging from the 1999 Surgeon General's Report on mental health (MH) to specific studies (Lyons, et al., 2001) have shown residential treatment overall to be ineffective or, at best, mixed in their outcomes for addressing the primary reasons for admission. Furthermore, there is no evidence of a relationship between any outcomes achieved in residential treatment and subsequent functioning in the community (Friesen et al., 2001; Bickman, et al., 2000; Burns, et al., 1998). Research also points to the PRTF milieu itself as problematic because children in PRTFs enter a situation where their only peers are other troubled children – a major risk factor for later behavioral problems (Dishion, et al., 1999).

While residential treatment remains an important component of the system of care, for most youth community-based interventions represent a more appropriate and less costly alternative to residential placement. The range of effective community-based approaches is increasingly broad. As examples, three intervention models have gained strong support through research and represent core elements of effective practice: Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Multidimensional Treatment Foster Care (MTFC). There is also increasing evidence regarding the cost effectiveness of high fidelity Wraparound Care Coordination based on the standards of the National Wraparound Initiative (NWI), relative to services provided through residential treatment facilities (RTFs). While less restrictive than residential services, community-based treatments were found to be equally or more effective in short- and long-term results, while being less disruptive to children and families and less costly to systems of care.

The Commonwealth's current PRTF system

The Commonwealth has made extensive use of PRTFs since the practice of treating youth in state mental hospitals ended in the mid 1990s. An extensive array of private providers has developed over the past 15 years to provide PRTF services. Currently, there are 3,223 accredited PRTF beds across 51 facilities in the Commonwealth, more facilities than in any other state. In addition, the Commonwealth also uses out-of-state PRTFs, with the number varying over time, but generally involving some 200 youth in out-of-state PRTF placements at any given time.

The Commonwealth's child-serving system, like any large state, features a complex interaction of multiple components of the child welfare, juvenile justice and MH systems, including:

- **Probation** – A core function of the juvenile justice system, the county probation department is responsible for youth supervision and implementation of Court dispositions which must provide balanced attention to the protection of the community, accountability for offenses committed, and case management to support the development of competencies to enable children to become responsible and productive members of the community (Pa.C.S. §6301). In addition to traditional probation supervision, the Commonwealth has implemented Specialized Probation Services Programs including school-based probation, community-based probation, intensive probation, and aftercare.
- **Youth Development Centers (YDC)** – YDCs are a component of the juvenile justice system providing residential custody and treatment to youth. YDCs serve approximately 1,500 youth per year through 696 beds in 7 facilities across the state. Approximately, 39% of youth served in YDCs have MH needs by self-report. On average, youth admitted have had 4 placements (including PRTF placements) prior to YDC placement.
- **Juvenile Detention Centers** – Juvenile Detention Centers are county-funded and locally operated. There are 22 facilities across the Commonwealth's 67 counties, each licensed by the State Office of Children Youth and Families (OCYF). Combined, the 22 facilities operate 870 beds. While some informants pointed to indicators of stable median lengths of stay since 2003 of 10 – 12 days, others reported increasing average stays and indications that detention capacity has become increasingly strained.
- **Behavioral Health-Managed Care Organizations (BH-MCOs)** – BH-MCOs manage behavioral services within the Commonwealth's HealthChoices Medicaid managed care program, achieving full Statewide implementation in 2007. Since 2006, BH-MCOs have managed all residential care delivered in PRTFs under the ICSI, including placements for children under the supervision of local juvenile justice and child welfare systems. BH-MCOs bear the financial risk for PRTF services, ensure medical necessity criteria for authorization of access to PRTFs, and operate comprehensive community-based service arrays for Medicaid enrollees.
- **Models for Change** – The Commonwealth's MacArthur Foundation Models for Change (Systems Reform in Juvenile Justice) grant focuses on bringing about

change in three areas: the coordination of the MH and juvenile justice systems; the system of aftercare services and supports; and disproportionate minority contact with the juvenile justice system. This initiative provides opportunities through its functioning multi-agency steering committee for the promotion of empirically supported programming across the juvenile justice, MH and child welfare systems.

Current utilization trends

Mercer analyzed utilization from the two most recent complete calendar years (CY 2005 and CY 2006) to identify trends in PRTF use across counties and BH-MCO areas. As such, the analysis of bed days used by calendar year in this report includes some stays that began prior to the period covered (admissions prior to January 1, 2005) and some stays that continued beyond the period (discharges after December 31, 2006). These bed day averages therefore understate, to some degree, the actual average episode lengths-of-stay by including any partial admissions in the average.

It is also important to note that the time period of CY 2005 through CY 2006 (the most recent years for which complete data are available Statewide) does not fully reflect the important system change undertaken through the ICSI. Therefore, the analyses in this report further understate the amount of PRTF currently delivered under the Medicaid program in the Commonwealth, because the analysis includes both pre-ICSI and post-ICSI placements. Nevertheless, key trends include:

- Overall, 6,848 children and youth received PRTF services Statewide across the two calendar years analyzed (CY 2005 – CY 2006). This included 4,433 children and youth served in CY 2005 and 4,933 served in CY 2006, most of whom were served in both calendar years.
- To control for differences in population, US Census estimates of the population under the age of 21 in each county were used to calculate a statistic of PRTF recipients per 100,000 population under 21. Based on this analysis, the Statewide average is 204.5 recipients per youth population.
- Philadelphia has the highest use of any County with a population under 21 of more than 12,000, with 565.0 recipients per 100,000. Of counties with more than 100,000 residents under age 21, Bucks (61.4) and Montgomery (83.0) had the lowest use. The second largest county by population (Allegheny) had 169.9 recipients per 100,000.
- Youth in PRTF placements also used more days in Philadelphia and other counties. While only 26.3% of youth in PRTFs Statewide stay longer than 270 days, one-third of PRTF recipients in Philadelphia fell into that range. By contrast, only 15.5% of recipients in Allegheny County stay that long. Allegheny County had the highest proportion of episodes under 60 days (31.5%) and the third highest proportion under 90 days (39.9%).
- About one-eighth (13.5%) of recipients received care from out-of-state PRTFs. While 33 counties had no out-of state use and 24 more counties (including Allegheny) had single-digit out-of-state PRTF use, the Southeast Zone had the three highest out-of-state use rates: Chester (26.1%), Philadelphia (24.1%) and Delaware (22.5%).

- In terms of demographics, in CY 2006 most PRTF recipients (73.6%) were 13 –17 years of age. Just over one-third were female (33.5%). A plurality of PRTF recipients were African-American (41.2%).
- In terms of diagnosis Statewide, in CY 2006 the largest proportion of recipients were diagnosed with conduct disorder (36.0%), followed by mood disorders (30.9%), Attention-Deficit Hyperactivity Disorder (ADHD) (12.2%) and adjustment disorders (6.2%). Only two percent (2.0%) of recipients had any diagnosis of Autism Spectrum Disorders (ASD).

Factors underlying current PRTF utilization

We discussed with interview respondents the ways in which youth in the Commonwealth end up being referred and placed in residential facilities and identified the following factors:

- Many youth enter the juvenile justice system and then residential treatment due to a lack of access to appropriate intensive community-based MH services.
- MH service access is currently driven by psychiatric/psychological evaluations and recommendations related to PRTF in the form of a diagnostic evaluation packet. Lack of knowledge on the part of medical providers of how community-based alternatives can be used as an alternative to PRTF, a lack of awareness of local resources, and the tendency to equate restrictiveness of services with service intensity leads to a well-intentioned, but often problematic tendency to refer any youth with complex needs to PRTF.
- The necessary processes and resources for diversion do not exist or are not consistently accessible.
- Relatively scarce inpatient beds and resources are available for youth, combined with a perception that lengths of stay for inpatient psychiatric care are typically brief, leaving PRTF as the only perceived option for intermediate-term stabilization, which can then lead to longer-term stays once the youth is admitted.
- There is a lack of timely crisis intervention services, both community-based and residential.
- There is a lack of services for youth with primarily substance abuse (SA) issues.
- A disproportionate number of minority youth are placed in PRTFs.
- Youth who have lived long-term in child welfare or other placements often move into PRTF as an evolution of service intensity as providers attempt to meet the youth's perceived need for intense services.

Respondents also pointed to a lack of clarity and consensus about the role of PRTF. This leads to longer lengths of stay as residential providers too often have few if any clearly stated goals and parameters within which to work, as well as a lack of proactive discharge planning. Education on services available in PRTFs and effective community alternatives is also seen as needed for courts, which often struggle to find resources that adequately address community safety and treatment needs of youth with behavioral health (BH) problems. This can be compounded by a lack of coordination among responsible youth-serving agencies. Interview respondents highlighted this challenge by

noting that a court order for an "evaluation for placement" can trigger an almost inevitable process toward PRTF placement. This points to the potential benefit of implementing a uniform risk and needs assessment protocol to inform the Juvenile Court Information System and guide disposition decisions and case planning.

Recommendations

An effective MH service system centers around a family-driven and youth guided planning model featuring **Youth and Family Teams** that would design and manage care plans using the Wraparound Care Coordination model. This approach would be supported through the recently established **Youth and Family Institute** that will train family members, providers and stakeholders in key elements of effective practice. In order to be effective, Youth and Family Teams would have access to an **expanded community-based service array** implemented with fidelity to proven practice elements. **Family-centered residential treatment services**, including PRTF, would be an integral part of the system of care and would be coordinated through Youth and Family Teams. In order to ensure the quality of services, **clear performance expectations** should be developed and monitored for PRTF and all other components of the service array.

Case management and effective use of information across the system of care will also require attention. Selection and implementation of **a risk assessment instrument** that is sensitive to the risks and needs of youth in the juvenile justice system represents a high priority for success.

The assessment tool selected should support the development of a **comprehensive case management** and treatment plan for each youth addressing specific risk factors from intake to aftercare. Simultaneously, development of **Statewide standards for screening and assessment** should be a high priority, including a core set of assessment tools that are relevant across the juvenile justice, child welfare and MH systems. Implementation of these complex and inter-related recommendations is most likely to succeed through targeted efforts in **pilot jurisdictions** that demonstrate readiness for this level of change.

Specific recommendations to accomplish this include:

1. **Implement Youth and Family Teams using Wraparound Care Coordination to coordinate services and support family-based services** – To promote more effective interagency coordination and service delivery for high need youth at-risk of PRTF placement, Youth and Family Teams should be implemented following the standards recently established by the National Wraparound Initiative (see Bruns, et al., 2004). Youth and Family Teams will need to have access to a service array built upon empirically supported treatment and focused on strengths, interests, abilities and capabilities, rather than deficits, weaknesses or problems. Specific empirically supported treatments should include MST (Henggeler, et al., 1998), FFT (Sexton, 2004) and MTFC (TFC Consultants, Inc., 2006). Youth and Family Teams can also serve to enhance the effectiveness and mitigate potential drawbacks of residential

treatment if responsibility for care planning remains with the Youth and Family Team during the PRTF episode.

2. **Implement a Commonwealth training and technical assistance center** – Emerging research has revealed the importance of an "evidence-based culture" – a comprehensive effort to develop a culture that values and acts in light of empirically supported findings (Dixon, 2003; Rivard, et al., 2006). In order to build this context and to support high quality implementation of Youth and Family Teams, the Commonwealth has developed a Youth and Family Institute. The Institute will train family members, youth, providers and stakeholders in key elements of effective practice. Central to this effort is training and support for the Youth and Family Teams using Wraparound Care Coordination. The Institute will provide training and quality assurance based on the National Wraparound Initiative's principles and protocols and act as an intermediary organization between demonstration sites and the purveyors of the various empirically supported treatments to be implemented. The Institute will also need to work cooperatively with the Center for Evidence-based Programs and Promising Practices currently being planned in conjunction with Pennsylvania's Models for Change initiative.

3. **Implement a community-based service array –** An array of community-based services, implemented with monitoring and fidelity, can serve as a robust alternative to PRTF placement for many children and youth. An optimal continuum of services will include interventions such as **MST, FFT** and **MTFC** for youth and families at highest risk due to behavior, psychiatric functioning or complex multi-system involvement. In addition to these rigorously evaluated and empirically supported treatments, a fully functioning continuum of services should also include innovative and "home grown" service approaches. If these approaches are defined and fidelity is monitored based on the key elements that underlay the success of proven empirically supported treatments, there is much reason to expect that they also will bring about successful outcomes.

4. **Develop residential options to support an effective continuum of care –** PRTF represents a necessary component of an effective continuum of care. Even with a full array of community-based options, some children and youth will still require residential services. When needed, residential treatment should generally be kept short-term (30 – 90 days) and focus on stabilizing those immediate BH and MH needs that cannot be met in the community. In order to support an effective continuum of services, residential options might include the following program types:

   A. **Crisis residential services** – Residential settings can offer a brief, intensive opportunity to place a youth in a safe setting in which to assess the nature of the crisis and develop an initial treatment approach. These are generally short-term placements.
   B. **Extended sub-acute stabilization** – Acute-oriented PRTFs could serve as an inpatient alternative in which children and youth could be stabilized and treatment begun while transition planning back to a more natural environment takes place.
   C. **Medium-term family-oriented PRTF** – This refers to a specialized PRTF model (referred to by informants we interviewed as “family-based PRTF”) that would meet the needs of youth and community safety while simultaneously working with families intensively and providing empirically supported treatment on an intensive level. In such a model, a child or youth might have a brief placement (30 – 60 days), then return to the community with intensive services in place.
   D. **Longer-term (3 – 12 months) intensive and restrictive PRTF** – Long-term restrictive options will continue to be necessary for a subset of youth with ongoing complex or dangerous behaviors. As these services continue to be needed, it will be important to continue to encourage intensive (as opposed to only restrictive) treatment services, as well as the minimization of restrictiveness by pursuing placement as close to home as practical.
   E. **Small group homes closer to the community** – Less intensive, less restrictive smaller residential facilities can serve as a transition or step-down for youth returning to the community from long-term restrictive placement. They can also serve as a brief placement that allows a higher level of community involvement than traditional PRTF.

5. **Define and monitor performance expectations for PRTF –** System leaders and other stakeholders consistently referred to a lack of clear expectations about the purpose, scope and appropriate lengths of stay for PRTF. Representatives from all three major child-serving systems should build consensus and set performance expectations. Once set, these performance expectations can be implemented through multiple means, including Statewide procurement processes for selective contracting under the authority of Section 1915(b)(4) of the Social Security Act or through the network development activities of individual BH-MCOs that can be required through the BH-MCO contracts.

6. **Monitor implementation quality and treatment fidelity** – The Commonwealth should build into planning and implementation of empirically supported treatment some means to monitor the quality of the changes, and adherence to the standards of program design and delivery (treatment fidelity). Specific empirically supported programs (e.g., MST, FFT, MTFC) have built into their programs a means to monitor treatment fidelity. A Center of Excellence to support empirically supported treatment could serve as the organizing agent to explore and pilot means through which program managers can better monitor the quality of service delivery and adherence to program design.

7. **Select and implement a case management model based on comprehensive juvenile risk/needs assessment –** Selecting and implementing a risk assessment instrument and protocol that is sensitive to the risks and needs of youth in the juvenile justice system represents a high priority for success. The assessment tool selected should support the development of a comprehensive case management and treatment plan addressing specific risk factors from intake to aftercare. The Washington State Juvenile Risk Assessment (Barnoski, 2004) is a widely-used empirically based assessment instrument that provides an overall score related to risk for re-offending and also provides a detailed analysis of the specific risk and protective factors that may contribute to a youth's success or failure under supervision and in response to treatment. State-specific versions of this instrument are in use in over 12 states and it is widely regarded as the current state-of-the-art. The Juvenile Court Judges' Commission and the Pennsylvania Council of Chief Juvenile Probation Officers are currently exploring this issue in conjunction with the Commonwealth's Models for Change Initiative.

8. **Improve information sharing across systems –** Developing Statewide standards for screening and assessment should be a high priority, including a core set of assessment tools that are relevant across the juvenile justice, child welfare and MH systems. This can include exploration of electronic databases that would allow interactive data sharing across systems. Juvenile probation departments participating in the Massachusetts Youth Screening Instrument (MAYSI) pilot screening program have established an information sharing protocol for this initiative. Experiences with this pilot may be informative for a larger scale assessment and screening effort.

9. **Build understanding and consensus among stakeholders** – Judges, administrators and other stakeholders must develop a clear and shared understanding regarding the nature of child MH disorders and treatment alternatives. It will be critical to develop understanding and buy-in among judges and other leaders for assessment-based case management emphasizing "matching" youth to appropriate services based on assessed needs and strengths (as well as risk and protective factors). It will also be important to provide data that demonstrate and explain the potential negative effects of residential treatment on both youth outcomes and recidivism. This type of information could help address concerns among stakeholders who are skeptical of a move towards greater emphasis on community-based alternatives to treatment in restrictive residential placement for high needs children and youth. Likewise, it is critical that human service agencies in general and the BH system in particular gain a thorough understanding of the Commonwealth's juvenile justice system and the principles of balanced and restorative justice.

10. **Start with pilot jurisdictions –** To carry out these comprehensive steps toward reform, we recommend targeted pilots in counties and BH-MCO areas ready to embrace such changes. Change at any level will be difficult, and beginning with those most ready will help promote success. The first year of such a pilot process would be largely devoted to planning, identifying demonstration sites and conducting readiness assessments, consensus building and infrastructure development. The MacArthur Foundation “Models for Change” counties offer a potential starting point, as do counties with more locally-driven change opportunities, such as Judges or Court staff with a special interest in promoting community-based treatment. Such jurisdictions have begun to work through issues of cross system collaboration and information sharing and are further along the pathway of readiness for change.

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Background and methods

Background and purpose

The Commonwealth of Pennsylvania (Commonwealth), Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS) engaged Mercer Government Human Services Consulting (Mercer), a part of Mercer Health & Benefits LLC, to review current issues related to the Psychiatric Residential Treatment Facilities (PRTFs). Mercer was charged to develop recommendations that promote home and community-based alternatives to residential treatment, with a particular emphasis on youth served through the juvenile justice system.

PRTFs in the Commonwealth are non-hospital facilities licensed by the DPW, Office of Children, Youth and Families (OCYF) under Title 55, Chapter 3800 as a Child Residential Facility and certified by OMHSAS as able to provide inpatient benefits to individuals under the age of 21 through the Commonwealth's Medical Assistance Program. The facilities must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). According to a recent analysis of states' PRTF capacity compiled by the Disability Rights Network, over 50 PRTFs operate in the Commonwealth, compared to less than 20 in the states with the next highest numbers (Nebraska, Kentucky and Tennessee).

The Commonwealth spent just under $234 million on PRTFs in accredited facilities in calendar year (CY) 2006 (the most recent year for which complete data is available). Spending was higher than in CY 2005 (just under $205 million), likely reflecting at least in part implementation of the Integrated Children's Services Initiative in fiscal year (FY) 2006 that added 17 additional accredited PRTF providers across 43 sites. This increased the number of accredited PRTF beds within the Medicaid system by 76%, adding 1,394 beds to bring the Statewide total to 3,223 in CY 2006. Informants reported that the number of beds within the Medicaid system has shrunk somewhat in 2007 as some providers decided not to participate.

This concept paper explores the issues, infrastructure and practices that can lead to a community-based system of care that includes alternatives to PRTF use. While the Commonwealth has developed an array of community services for children and adolescents, systematic development of home and community-based services that provide alternatives to psychiatric residential treatment has not taken place. This paper will serve as a focus for additional cross-agency planning regarding the future of the PRTF service system. Eventually, it is the goal of the OMHSAS Children's Bureau to work with DPW and with a full range of stakeholders to develop an integrated cross-agency plan to promote the effective use of PRTF for those youth truly needing such a restrictive level of care and effective, as well as less restrictive alternatives for those who do not.

Methods and data sources

Information for this document was gathered through interviews with key informants and through a targeted literature review. In addition, analysis of PRTF utilization data from CY 2005 and CY 2006 was also included.

Interviews

Interviews were conducted with leaders representing the Commonwealth's juvenile justice, mental health (MH) and child welfare systems including:

- Richard Gold, Deputy Secretary, OCYF
- Stan Mrozowski, Director, Bureau for Children's Behavioral Health, OMHSAS
- Nicole Remsberg, Juvenile Detention Centers of Pennsylvania
- Lourdes Rosado, Juvenile Law Center
- Keith Snyder, Juvenile Court Judges' Commission
- Linda Zelch, Acting Director, Bureau for Community Operations, OMHSAS
- Russ Zemanek and staff, Youth Development Centers (YDC), OCYF
- OMHSAS Children's Advisory Board members

In addition, interviews were conducted with Eric Bruns, PhD and Michelle Zabel, MSS. Eric Bruns, a professor at the University of Washington, is a leading researcher in children's services and one of the developers of the Wraparound Fidelity Index. He is a member of the National Wraparound Initiative and the National Evidence-Based Practices Consortium. Michelle Zabel is the Director of Maryland's Innovations Institute, and Child and Adolescent Mental Health Institute. As Institute Director, Ms. Zabel leads Maryland's efforts to integrate empirically supported treatments into the State's MH system. She also has extensive experience with the Commonwealth's youth and family MH system.

Literature review

The literature search began with the two federally funded research and training centers for children's MH (housed at the University of South Florida and Portland State University). We identified relevant documents and furthered our review by examining articles cited within each. In order to supplement the documents found through this process, we also included the specific literature recommended by the two experts we interviewed.

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Findings from the literature

Residential treatment as a necessary component of the system of care

PRTFs represent a necessary component of the continuum of care for children and adolescent youth whose behavior is not managed effectively in a less restrictive setting. However, PRTFs are among the most restrictive MH services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors, such as fire setting, that may not respond to intensive, nonresidential service approaches (Stroul, 2007). Residential treatment is also seen as appropriate for youth who have run away from foster care settings, who are destructive or self-destructive and who are stepping down from a more restrictive setting (Barth, 2002).

The current national policy stance on the role of PRTF in the children's MH system, supported by the research base, recognizes the value of residential options in the context of a coordinated system of care. While this White Paper primarily addresses the development of community alternatives to the Commonwealth's current PRTF system, it does not advocate the elimination of PRTF services. Instead, residential treatment providers should be embraced as system of care partners and PRTF services should be integrated as part of a complete continuum of services. Under the model set forth in this paper, Youth and Family Teams working with each youth and family using or at risk of restrictive service placements would guide service delivery even when a child is placed in a residential treatment setting, in order to ensure continuity across treatment settings and levels of care. A recent study supports this alternative to traditional PRTF care.

Barth (2002) reports promising outcomes for family-focused, community-oriented residential programs, which feature structured, intensive interventions that involve the family by integrating aspects of family preservation, such as a focus on building the capacity of the family and community to support the child at home, in addition to more typical residential treatment center (RTC) interventions.

Research on PRTF treatment

Too often children and youth are placed in PRTFs because more appropriate community-based services are not available. Parents, judges and others, desperate to meet children's needs, often turn to PRTFs because of a lack of viable alternatives. There is growing evidence that, in most situations, children can be effectively served in their homes and communities in lieu of psychiatric residential treatment and that community-based treatment programs are often superior to institution-based programs. Studies show that, except for youth with highly complex needs or dangerous behaviors, such as fire setting or repeated sexual offenses, programs in community settings are more effective than those in institutional settings, with intensive, community-based and family-centered interventions the most promising.

The 1999 Surgeon Generals' Report on Mental Heath states: "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence." (U. S. Surgeon General, 1999, p. 170)

Looking at all types of residential treatment programs, the Surgeon General's Report indicated areas of concern including:

- Criteria for admission
- High cost of services
- The risks of treatment, including failure to learn behavior needed in the community
- Possibility of trauma associated with the separation from the family
- Difficulty reentering the family and community
- Victimization by PRTF staff
- Learning of antisocial or bizarre behavior from intensive exposure to other disturbed children

In a recent study, Lyons and his colleagues (Lyons, et al., 2001) conducted a review of 285 case records (at multiple intervals) for youth in eight different residential treatment facilities (RTFs) in a western state. Outcomes were mixed as the authors found specific improvements for some youth in some, but not all, of the RTFs examined.

For example, some youth showed improvement for high risk behaviors, such as suicidal ideation, self-mutilation and aggression toward people, while no change was found for aggression toward objects, disobedience, impulsivity and inappropriate sexual behavior (Lyons, et al., 2001). One of the eight RTFs reviewed showed increases in problem behaviors while youth were in treatment. Among youth who showed improvement while in RTF care, the authors specifically note that there was no evidence that the RTFs were successful at improving functioning. In addition, residential treatment may have unintended adverse outcomes on anxiety and hyperactivity (Lyons, et al., 2001). Finally, improvement within an RTF may be unrelated to outcomes in the community. There is no evidence of a relationship between outcomes in residential treatment and functioning in less restrictive environments (Bickman, et al., 2000; Burns, et al., 1998).

As an alternative, community-based services preserve the family's integrity and prevent unnecessary out-of-home placements; put adolescents and their families in touch with community agencies and individuals, thus creating an outside support system; and strengthen the family's coping skills and capacity to function effectively in the community after crisis treatment is completed (Stroul, 1988).

The Bazelon Center for Mental Health Law (2006), in a review of available literature, notes that there is little evidence that PRTF placement has any positive impact at all on children's MH. Further, several studies suggest that any gains made during a stay in a PRTF may not translate well back to the youth's natural environment, creating a cycle where children return again and again to PRTFs. There are many reasons why PRTFs fail to deliver the results they promise, but most are due to type of services provided, their environments and the lack of family involvement; all of which are service elements that can be addressed through attention to evidence-based principles.

Research points to the PRTF milieu itself as problematic because children in PRTFs enter a situation where their only peers are other troubled children – a major risk factor for later behavioral problems (Dishion, et al., 1999). In fact, this research has demonstrated that some children learn antisocial or undesirable behavior from intensive exposure to other disturbed children.

Children are usually sent far from home when placed in PRTFs, sometimes out-of-state. Removed from their families and natural support systems, they are unable to draw upon the strengths of their communities and their communities are unable to contribute to their treatment. Few children thrive when they are confined to facilities sometimes hundreds or thousands of miles from their families, friends, schools and communities. Yet, systems often expect that our most vulnerable and troubled youth will somehow turn around in just such a situation. Instead, this isolation further reduces the efficacy of treatment and increases its cost.

Current literature (Stroul, 2007) increasingly suggests modifying PRTF treatment approaches to be family-centered, smaller in scale and in closer proximity to the youth's home community. The latter issues respond to the common situation in PRTF settings where children and their families must reside far from one another, which creates a host of problems. For one, it often makes family-based interventions difficult or impracticable. As a result, when children leave the PRTF, they too often return to an environment that has not changed. Also, the PRTF environment is inherently artificial – children and youth do not have the opportunity to negotiate the obstacles that occur within their family setting or deal with the difficulties that trigger problematic behaviors in their neighborhoods or schools. As a result, neither the children nor their parents learn better ways to overcome the obstacles that led to the PRTF placement in the first place.

Among children and youth who make gains in placement, few appear to maintain those benefits upon return to the community. In one study, nearly 50% of children were readmitted to an RTC, and 75% were either re-institutionalized or arrested (Friesen et al., 2001). Another study examined outcomes and service utilization among children discharged to their families from an RTF during a three-year period. Consistent with the view that PRTF treatment is frequently associated with continuing placement and dependency, the risk of returning to placement was 32% after one year, 53% after two, and 59% by the end of the third year post discharge (Asarnow, et al., 1996).

Romansky, et al. (2003) found that place of residence, among other factors, was related to three-month psychiatric hospital readmission rates for youth in the child welfare system. Specifically, they reported that youth who had lived in congregate care settings (such as PRTFs) prior to hospitalization had higher re-hospitalization rates over the three-month period than youth in other settings. Similarly, Barth (2002) cites findings from studies where youth in PRTF care have: (1) poorer scores on developmental measures one year following placement, (2) higher re-entry rates back to PRTF after reunification and (3) costs six to 10 times higher than foster care and two to three times higher than treatment foster care.

Effective alternatives to PRTF

While residential treatment remains an important component of the system of care, for most youth community-based interventions represent a more appropriate and less costly alternative to residential placement. As the Surgeon General reported in 1999, "the most convincing evidence of effectiveness is for home-based services and therapeutic foster care," when compared to services in PRTFs. Similarly, the drafters of the Child and Adolescent Service System Program (CASSP) model described effective systems of care as "a comprehensive spectrum of MH and other necessary services, which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families" (Stroul & Friedman, 1994). This model assumes that the needs of children and families are best served through treatment that occurs in the least restrictive, most integrated natural setting possible.

The range of effective community-based approaches is increasingly broad. However, three intervention models have gained strong support through research and represent core elements of effective practice. These three are summarized briefly below.

1. **Multisystemic Therapy (MST)** is an intensive home-based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with low caseloads and varying frequency, duration and intensity levels. MST is based on social-ecological theory where behavior is multi-determined and best understood in the naturally occurring context. MST was developed to address major limitations in services for juvenile offenders and focuses on changing the determinants of youth anti-social behavior (Weiss et al., 2004).

   At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and reducing association with "deviant" peers, primarily through parental mediation (Huey et al., 2000).

2. **Functional Family Therapy (FFT)** was developed by Thomas Sexton (2004) and his colleagues. It is a research-based family program for at risk adolescents and their families targeting youth between the ages of 11 – 18 and has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (service delivery, supervision and organizational support), and quality assurance and improvement.

   FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on risk and protective factors. Intervention incorporates community resources for maintaining, generalizing and supporting family change (Rowland et al., 2001).

3. **Multidimensional Treatment Foster Care (MTFC)** is a type of therapeutic foster care provided to children living with foster parents or for families who require an intensive period of treatment before reunification, as opposed to MST and FFT, which are delivered in community settings to children and youth generally living with their families. This approach is well described in literature disseminated by the developers of MTFC (TFC Consultants, Inc., 2006). The primary goal of MTFC is to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care and MH systems. MTFC is a well-established empirically supported program that has demonstrated outcomes and cost savings when implemented with fidelity (for examples, see Chamberlain et al., 1991; Weisz et al., 2005).

MTFC treatment goals are accomplished by providing close supervision; fair and consistent limits; predictable consequences for rule breaking; a supportive relationship with at least one mentoring adult; and reduced exposure to peers with similar problems. Intervention is multifaceted and occurs in multiple settings. Components include:

A. Behavioral parent training and support for MTFC foster parents
B. Family therapy for biological parents (or other aftercare resources)
C. Skills training for youth
D. Supportive therapy for youth
E. School-based behavioral interventions and academic support
F. Psychiatric consultation and medication management, when needed

Community-based alternatives to residential treatment, such as the three models summarized directly above, have demonstrated reliable short- and long-term results while being less disruptive to children and families. These alternatives provide intensive MH treatment, mobilize community resources and help children and their families develop effective coping mechanisms. Some models emphasize natural supports while others emphasize multi-system and crisis interventions. Randomized clinical trials found greater declines in delinquency and behavioral problems, greater increases in functioning, greater stability in housing placements and greater likelihood of permanent placement in community settings (Bruns, 2003). The Wraparound Milwaukee initiative offers a good example for youth involved in juvenile justice and child welfare systems. Since its inception, use of residential treatment has declined 60%, use of psychiatric hospitalization has declined 80% and average overall care costs for target youth have dropped by one-third (Bruns, 2003).

Other studies show similar findings. For example, Wilmshurst (2002) reported on a random-assignment study where outcomes were compared for youth with severe emotional and behavioral disorders who were treated for three months in either a cognitive-behavioral home-based family preservation program or a residential program. At one-year follow up, youth in the residential program demonstrated clinical deterioration and increased symptoms of anxiety and depression, while those in family preservation programs experienced decreased symptoms of Attention-Deficit Hyperactivity Disorder (ADHD), general anxiety and depression. While less restrictive than residential services, community-based treatments were found to be equally effective in reducing externalizing behaviors, such as the non-compliance often underlying referral to out-of-home treatment.

Mercer's earlier white paper on Wraparound Cost Effectiveness (Mercer, 2006) summarized how emerging research is increasingly demonstrating the cost effectiveness of Wraparound programs relative to services provided through RTFs. Potter and Mulkern (2004) point to one study using a quasi-experimental design conducted by Brown and Loughlin that compared the outcomes and costs of out-of-home placements with community-based services coordinated through a Wraparound Care Coordination model and found that outcomes were at least comparable and costs for those receiving

Wraparound were less ($9,175 vs. $27,748). Potter and Mulkern add that funds to support coordinated community-based planning vary across programs and depend on community assets, youth needs and the population served.

Similarly, a Washington State Institute for Public Policy (WSIPP) report (Aos, et al., 2001) conducted a meta-analysis of the costs and benefits of juvenile criminal programs. The report concluded that community-based programs, such as MST, FFT and MTFC reduced delinquent behavior and returned youth to their home community more quickly and at less cost than residential treatment options. This analysis also included four published studies of unspecified Wraparound approaches being used in the context of services for juvenile offenders. WSIPP found approximately $3,131 in cost savings for each youth. Adding the benefits that accrue to crime victims, the expected net present value increases to $14,831 per participant, which is equivalent to a benefit-to-cost ratio of $25.59 for every dollar spent.

Hewitt Clark and his associates (McDonald et al., 1995 and Clark et al., 1996) at the University of South Florida developed the Fostering Individualized Assistance Program (FIAP) to provide individualized Wraparound supports and services to foster children with emotional/behavioral disturbance (EBD) and their families. The primary program goal was to improve permanency outcomes for foster children. The children served in the FIAP were the most challenging 10% of children within the foster care system and had been in out-of-home placement an average of 2.6 years with an average of four placement changes prior to entering the FIAP study.

A random assignment study was designed to evaluate the effectiveness of the FIAP (Clark, Lee, Prange, and McDonald, 1996). The research design compared children receiving standard practice (SP) services with those who received FIAP. The outcome variables evaluated in this study included: placement settings and behavior change, runaway status, and incarceration. In addition to lower costs, the study found that:

- Children in the FIAP group were significantly less likely to change placements than were those in the SP group during the intervention.
- Both groups showed significant improvement in their emotional and behavioral adjustment over time.
- FIAP boys had significantly lower rates of delinquency and fewer acting out and non-compliant episodes than their SP counterparts.
- Older FIAP youths were significantly more likely than their SP peers to live in permanency settings with their parents, relatives, adoptive parents or living on their own.
- The subset of children in the FIAP group who had histories of incarceration and running away spent fewer days per year, on average, on runaway or incarceration status during the post intervention period than did the SP children.

With a similar program in Vermont**,** Tighe and Brooks (as cited in Kendziora et al., 2001) compared 26 youth receiving Wraparound services through Vermont's Individualized Care Programs with 26 youth referred to out-of-state facilities and found that the average cost of out-of-state treatment facilities was $4,893 per month, while community treatment, demonstrating equal or better outcomes, was 18% less with a savings of $857 a month ($10,284 per year).

The Commonwealth's current PRTF system

This section of this paper provides a brief overview of the Commonwealth's PRTF system. Information comes from key informant interviews and document reviews.

The Commonwealth has made extensive use of PRTFs since the practice of treating youth in state mental hospitals ended in the mid 1990s. An extensive array of private providers has developed over the past 15 years to provide PRTF services. Currently, there are 3,223 accredited PRTF beds across 51 facilities in the Commonwealth, more facilities than in any other state according to a recent analysis of states' PRTF capacity compiled by the Disability Rights Network. In addition, the Commonwealth also uses out-of-state PRTFs, with the number varying over time, but generally involving more than 200 youth in out-of-state PRTF placements at any given time.

The Commonwealth's patterns, while broader in scope than any other state, reflect national trends. Over the past decade in the US, hundreds of private RTFs for youth have been established, described as a $1 billion to $1.2 billion industry that serves 10,000 to 14,000 children and adolescents. The Florida Mental Health Institute's Research and Training Center for Children's Mental Health (FMHI – Friedman et al., 2007) reported this trend, calling it "alarming" because of the limited research support for residential treatment and the strong evidence that community-based treatment and support is effective and indicated for most youth and families, even those with serious problems who need intensive support.

The Commonwealth's child-serving system, like any large state's, features a complex interaction of multiple components of the child welfare, juvenile justice and MH systems. Through interviews with key informants across many of these systems, features of several system components emerged as salient and are reviewed briefly below.

Probation – A core function of the juvenile justice system, the County probation department is responsible for youth supervision and implementation of Court dispositions that must provide balanced attention to the protection of the community, accountability for offenses committed, and case management to support the development of competencies to enable children to become responsible and productive members of the community (Pa.C.S. §6301). As a result of ICSI, County Probation Offices have been working more closely with County Mental Health Offices to address behavioral health needs. Nationally, there is growing support for integrated approaches and for best practice models that suggest use of a single, more intensive service model with low caseloads (25 – 35) and a move away from multi-tier models with high overall caseloads,

supplemented by intensive supervision for a subset of youth (National Advisory Committee for Juvenile Justice and Delinquency Prevention, 1980; National Advisory Committee on Criminal Justice Standards and Goals, 1976).

In addition to traditional probation supervision, the Commonwealth has implemented Specialized Probation Services Programs including school-based probation, community-based probation, intensive probation and aftercare. Under the auspices of Pennsylvania's Models for Change initiative, 21 juvenile probation departments are currently utilizing the MAYSI to screen youth for behavioral health (BH) issues. Additionally, three model counties (Chester, Erie and Allegheny) are being funded to improve coordination between the juvenile justice and mental health systems.

Youth Development Centers (YDC) – YDCs are a component of the juvenile justice system providing residential custody and treatment to youth. YDCs serve approximately 1500 youth per year through 696 beds in seven facilities across the state. Some facilities feature specialized capacities including dedicated MH beds, sex offender programming, programs for female offenders, mental retardation (MR) and drug and alcohol treatment. YDCs feature comprehensive assessment for youth incorporating the MAYSI-2, Problem Oriented Screening Instrument for Teenagers (POSIT) and a range of behavioral assessments. The average age of youth in these facilities is 17.5 years, making transition issues to independence and adult systems of care an important focus. Approximately, 39% of youth served in YDCs have MH needs by self-report. On average youth admitted have had four placements (including PRTF placements) prior to YDC placement.

Juvenile Detention Centers – Juvenile Detention Centers are county-funded and locally operated. There are 22 facilities across the Commonwealth's 67 counties, each licensed by the State OCYF. Combined, the 22 facilities operate 870 beds. While some informants pointed to indicators of stable median lengths of stay since 2003 of 10 to 12 days, others reported increasing average stays and indications that detention capacity has become increasingly strained.

All Juvenile Detention Centers use the MAYSI-2 for screening youth upon entry for MH needs. Based on these screenings, 77% of youth on entry had MH and/or substance use treatment needs. The model of service for Juvenile Detention Centers is to provide a wide range of health services during short-term placements and to serve as a "hub" to link youth to broader array of needed services post-release. Interview respondents perceived that youth often end up in detention when there are no other available placements, generally due to high behavioral needs.

Behavioral Health-Managed Care Organizations (BH-MCOs) – BH-MCOs manage behavioral services within the Commonwealth's HealthChoices Medicaid managed care program. The HealthChoices BH program was first implemented in the Commonwealth's Southeast Zone in 1997, expanding to the Southwest Zone in 1999, the Lehigh/Capital Zone in 2001, and Statewide in 2007. Since 2006, BH-MCOs have managed all residential care delivered in PRTFs under the Integrated Children's Services Initiative (ICSI), including placements for children under the supervision of local juvenile justice and child welfare systems. BH-MCOs bear the financial risk for PRTF services, ensure medical necessity criteria for authorization of access to PRTFs, and operate comprehensive community-based service arrays for Medicaid enrollees.

Models for Change – The Commonwealth's MacArthur Foundation Models for Change (Systems Reform in Juvenile Justice) grant focuses on bringing about change in three areas: the coordination of the MH and juvenile justice systems; the system of aftercare services and supports; and disproportionate minority contact with the juvenile justice system. This initiative provides opportunities for the current initiative through its functioning multi-agency steering committee for the promotion of empirically supported programming across the juvenile justice, MH and child welfare systems. In addition, counties that have participated in the Models of Change Initiative have begun to reform their child-serving systems. These counties may serve as opportune pilot sites.

Current utilization trends

As noted above, the Commonwealth has more PRTF capacity than any other state and not surprisingly, PRTF use is high across the Commonwealth. Mercer analyzed utilization from the two most recent complete calendar years (CY 2005 and CY 2006) to identify trends in PRTF use across counties and BH-MCO areas. Appendix A describes the methodology of the data analysis in detail, but a few key details should be kept in mind by the reader when considering the findings presented below:

- Analysis was conducted looking at the children and youth using PRTF during CY 2005 and CY 2006, focusing on total days used and including two calendar years so that stays lasting longer than one year would be captured more fully. Because of this, the analysis includes some stays that began prior to the period covered (admissions prior to January 1, 2005) and some stays that continued beyond the period (discharges after December 31, 2006). Therefore, reporting on days used by recipient in this report **understates** to some degree the actual lengths-of-stay by including these partial admissions in the analysis.
- It is also important to note that the time period analyzed (CY 2005 through CY 2006) does not fully reflect the important system change undertaken through the ICSI. ICSI integrated funding and management of all PRTF services delivered through the MH, juvenile justice and child welfare systems. Additional PRTF providers began to be enrolled in 2005, and continued to be enrolled into CY 2006, so any encounters for these providers before these dates are not included in the data set analyzed. Therefore, the analyses in this report further **understate** the amount of PRTF currently delivered through the Medicaid program in the

Commonwealth, because the analysis includes only post-ICSI placement days for these providers.

- Only CY 2006 data were used for the calculations of total and out-of-state demographics (age, gender, race and ethnicity) and diagnostic groupings so that the most recent trends for which data is available would be reflected. Both Children in Substitute Care (CISC) and non-CISC episodes were included. For youth with multiple stays, the longest stay was used for purposes of the analysis.

CY 2006 expenditures – Total PRTF expenditures by zone across the Commonwealth are presented in the table below. The table shows total expenditures for CY 2006, as well as average, maximum, and minimum daily rates. The Commonwealth spent just under $234 million on PRTF in accredited facilities in CY 2006.

CY 2006 spending on PRTF by zone

Zone	PRTF Claims Paid	Average Cost Per Day	Maximum County Cost[1] Per Day	Minimum County Cost Per Day
Southwest Zone	$ 44 million	$276	$316	$246
Southeast Zone	$ 115 million	$252	$293	$246
Lehigh/Capital Zone	$ 26 million	$325	$385	$233
Expansion Counties	$ 48 million	$261	$310	$197
Total	**$ 234 million**	**$265**	**$385**	**$197**

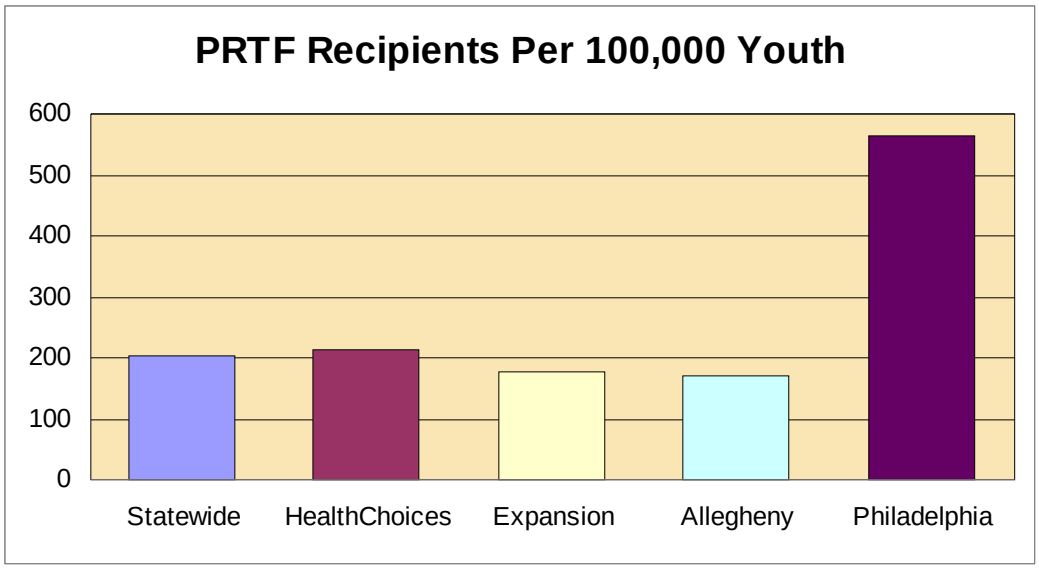
Number of children and youth receiving PRTF – Analysis of PRTF across the children and youth receiving these services yields the following observations (a complete summary of the data by county and zone is provided in Appendix A):

- Overall, 6,848 children and youth received PRTF services Statewide across the two calendar years analyzed (CY 2005 – CY 2006). This included 4,433 children and youth served in CY 2005 and 4,933 served in CY 2006 (most were served in both calendar years). The number of HealthChoices recipients presented in the analysis summary below and the tables in Appendix A by county and zone are unique across Person Level Encounter (PLE) and Fee-for-Service (FFS) claims (that is, recipients with utilization in both PLE and FFS claims have been reconciled and counted only once), however there may be a few recipients who resided in multiple counties during the time period and would have been counted separately in each. Additionally, if youth were in both an in-state facility and an out-of-state facility during the time

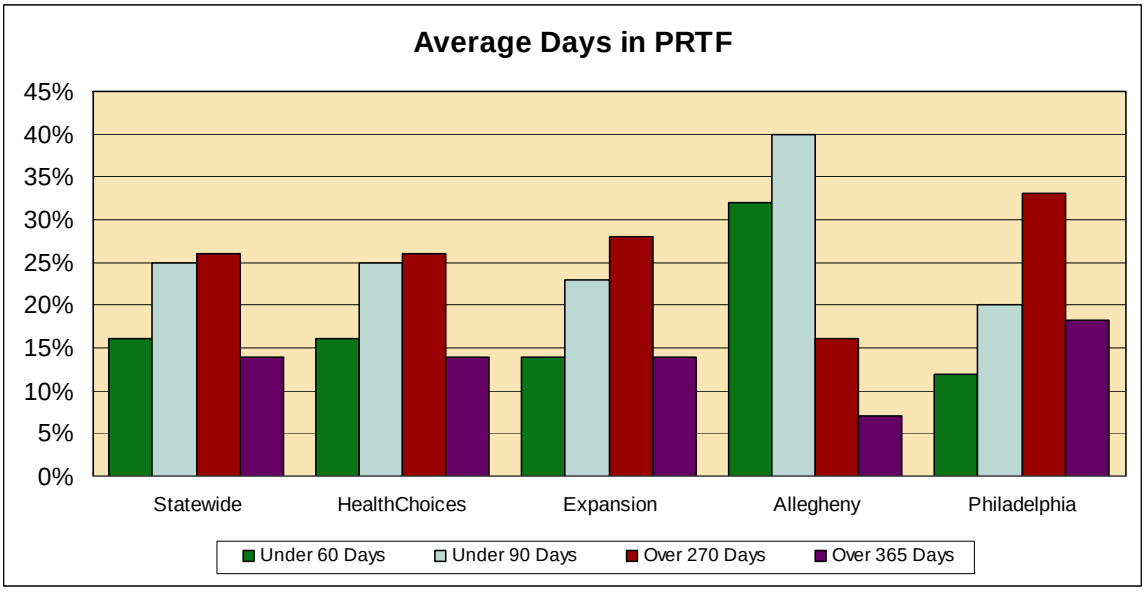
[1] Maximum and minimum costs reported are average costs per county, not the rates lowest and highest rates charged by a specific provider.

period, they would be counted twice. Of these, 5,373 resided in the 25 HealthChoices counties and the remaining 1,475 resided in the remaining 42 counties.

- To control for differences in population, US Census estimates of the population under the age of 21 in each county were used to calculate a statistic of PRTF Recipients per 100,000 population under 21. Based on this analysis, the Statewide average is 204.5 recipients per youth population. The HealthChoices average is 214.1, and the Expansion average is 175.8. Philadelphia has the highest use of any county with more than 12,000 population under 21, with 565.0 recipients per 100,000. Of counties with more than 100,000 residents under age 21, Bucks (61.4) and Montgomery (83.0) had the lowest use. The second largest county by population (Allegheny) had 169.9 recipients per 100,000 youth.



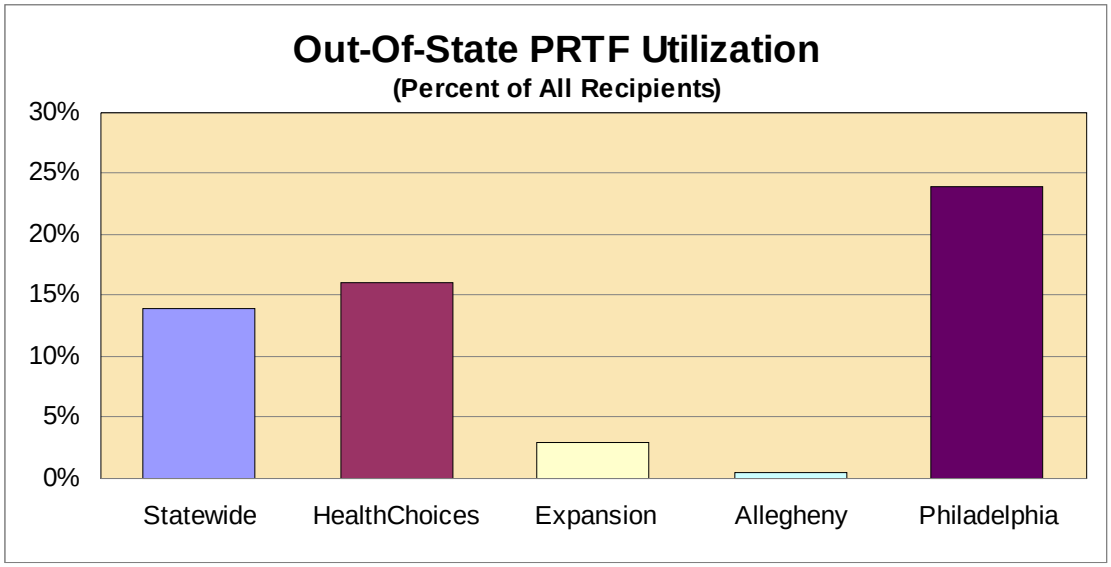
Analysis of average days used by recipient – We also analyzed the average days used by each recipient within each county, differentiating between the proportion of youth with relatively shorter use (under 60 days), moderately long use (under 90 days), and longer use (over 270 days and over 365 days). These results are summarized in the chart below. When reviewing the results below, keep in mind that not all ranges are included in the graph, since the first two categories (under 60 and under 90 days) overlap, and use lasting between 90 and 270 days per youth (nearly half of all use Statewide) are not included (this data is included in the detailed data table in Appendix A). Statewide use was distributed as follows: 15.7% of use under 60 days, 24.8% under 90 days, 26.3% over 270 days and 13.6% over 365 days. Trends were roughly comparable across HealthChoices and Expansion counties, but these averages include wide disparities in such proportions across individual counties, so county-level differences reported in Appendix A may be of more use.



Primary differences across counties regarding **average days used** by recipient include:

- **County comparison with shorter and moderate length use** – Allegheny County had the highest proportion of use under 60 days (31.5%) and the third highest proportion under 90 days (39.9%), statistics that demonstrate lower lengths of stay in PRTFs. Clinton, Forest, Montour, and Sullivan Counties had no short stays (none of their recipients averaged under 90 days), and other counties had few short stays: Clarion had 0% of stays under 60 days and 10% under 90 days and Juniata had 0% of stays under 60 days and 16.7% under 90 days. Philadelphia also had relatively fewer short stays (12.5% under 60 days; 20.4% under 90 days).
- **County comparison of longer-length use** – Those counties with the highest proportion of use over 270 days include Montour (100%, n = 1 recipient), Miflin (52.2%), Snyder (50%, n = 4 recipients), Northumberland (47.1%) and Clinton (46.7%). Philadelphia's proportion of use over 270 days was 33%. Counties with the highest proportion of use over 365 days included Clinton (40%), Juniata (33.3%), Mercer (27.8%) and Somerset (26.7%). Philadelphia's proportion of use over 365 days was 18.3%, also among the highest. Those counties with the lowest proportion of longer term use were Fulton (0% over 270 days; 0% over 365 days), Forest (0% over 270 days; 0% over 365 days), Fayette (10% over 270 days; 2.5% over 365 days), Beaver (10.3% over 270 days; 3.4% over 365 days), Westmoreland (9.1% over 270 days; 4.5% over 365 days) and Lawrence (8% over 270 days; 8% over 365 days).

Out-of-state utilization – The chart below shows that, on a Statewide basis, 13.5% of PRTF recipients received care from out-of-state facilities. The HealthChoices proportion was somewhat larger (16.3%) than the Expansion proportion (3.2%). In reviewing the proportion of recipients within each county who received care from out-of-state PRTFs, 33 counties had no out-of-state recipients and an additional 24 counties (including Allegheny) had single-digit out-of-state use. On the high end, the Southeast Zone had the three highest out-of-state use rates, including Chester (26.1%), Philadelphia (24.1%) and Delaware (22.5%). Other higher proportion counties included Huntingdon (22.2%), Berks (21.1%), Montgomery (19.5%), Northampton (15.8%) and Wyoming (15.4%).



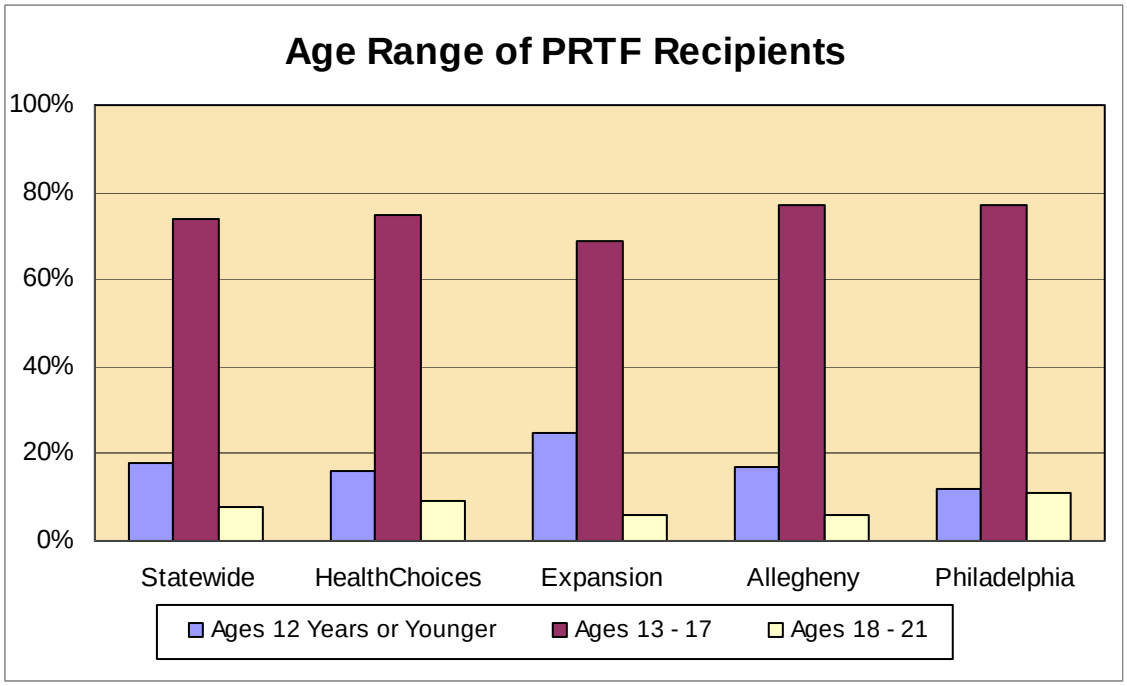
We also examined the demographics of the children and youth using PRTF in CY 2006 (post-implementation of ICSI). Appendix A includes this information for all counties, with trends for out-of-state use reported separately for each county in a separate table. Factors examined include:

- Breakdown of ages served: 0 – 6 years, 6 – 12 years, 13 – 17 years, 18 – 21 years
- Percentage female and male
- Racial and ethnic percentages, including: African-American, Hispanic, White, and Other
- Major primary diagnosis groupings, including Conduct Disorders, Mood Disorders, ADHD, Adjustment Disorders, and Other[2]
- Breakdown for children with Autism Spectrum Disorders (ASD) and MR (counting both primary and secondary diagnoses)

[2] There are some instances in which an individual PRTF recipient is counted in more than one diagnostic group, but these discrepancies from the underlying data were not significant enough to be judged to affect the overall trends of interest to this report.

Analysis of Age Trends – The chart below shows trends by age across PRTF service recipients. Overall, there was not a large degree of variation by age, but key county-level results include:

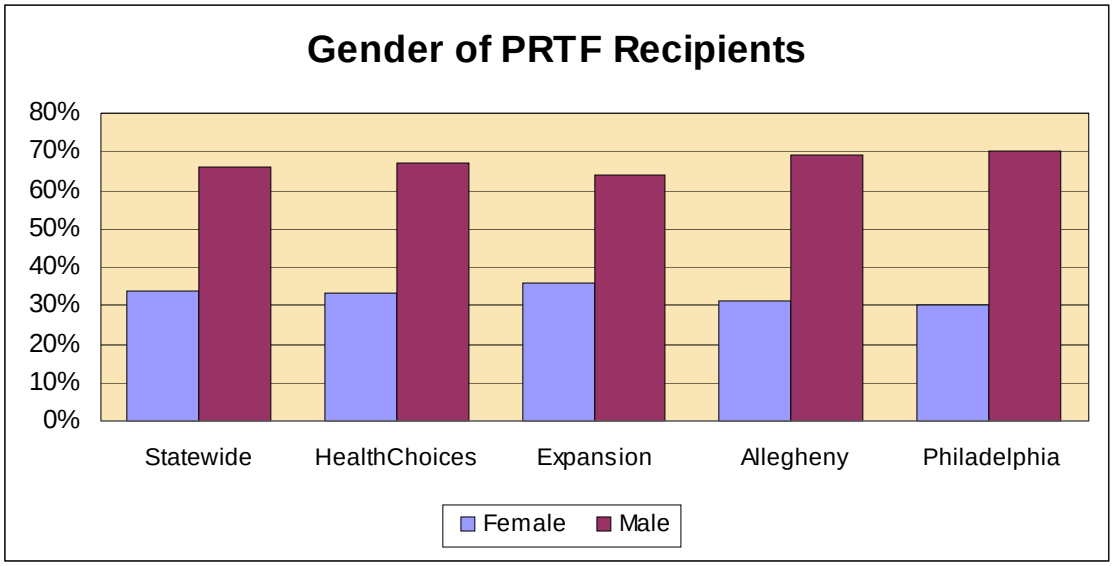
- The Statewide proportion of stays involving recipients ages 12 and younger was 17.9%. The proportion for recipients ages 13 – 17 was 73.6%, and the proportion for recipients ages 18 – 21 was 8.3%. Expansion counties had much higher proportional use by recipients' ages 12 years or younger (25.0%) and lower proportional use by recipients ages 18 – 21 (5.8%).
- Allegheny County had a somewhat lower proportion of recipients' ages 12 years or younger (16.5%) and a somewhat lower proportion of recipients ages 18 – 21 (6.1%).
- Philadelphia had a somewhat lower proportion of recipients' ages 12 years or younger (11.6%) and somewhat higher proportions of recipients 13 – 17 (77%) and recipients age 18 – 21 (11.3%).



Gender – The chart that follows shows the proportion of female and male recipients receiving PRTF services in 2006.

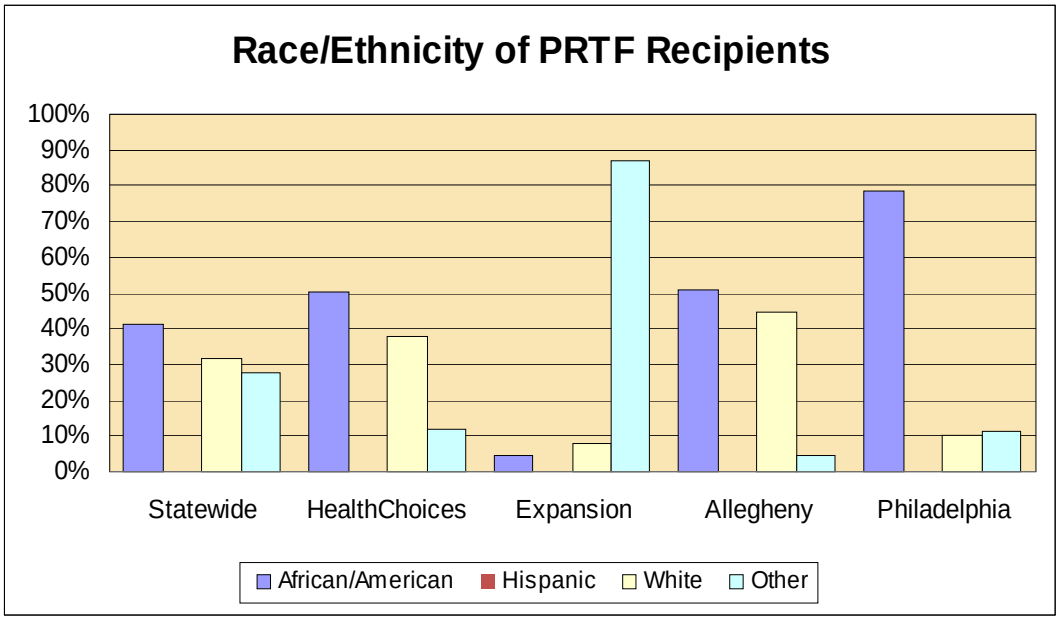
- Statewide the number of female recipients was 33.5%, and tended to be around one-third for both HealthChoices and Expansion counties as groups, with Allegheny (30.7%) and Philadelphia (29.8%) having slightly lower averages.
- Seventeen (17) counties had more than 40% female recipients (Bedford, Butler, Cameron, Chester, Clarion, Clearfield, Delaware, Elk, Erie, Jefferson, Lackawanna, McKean, Monroe, Montgomery, Tioga, Warren and Washington).

- Nineteen (19) counties had fewer than 25% female recipients (Blair, Cambria, Carbon, Columbia, Fayette, Fulton, Greene, Huntingdon, Lebanon, Miflin, Montour, Perry, Potter, Snyder, Somerset, Sullivan, Susquehanna, Union and Venango).

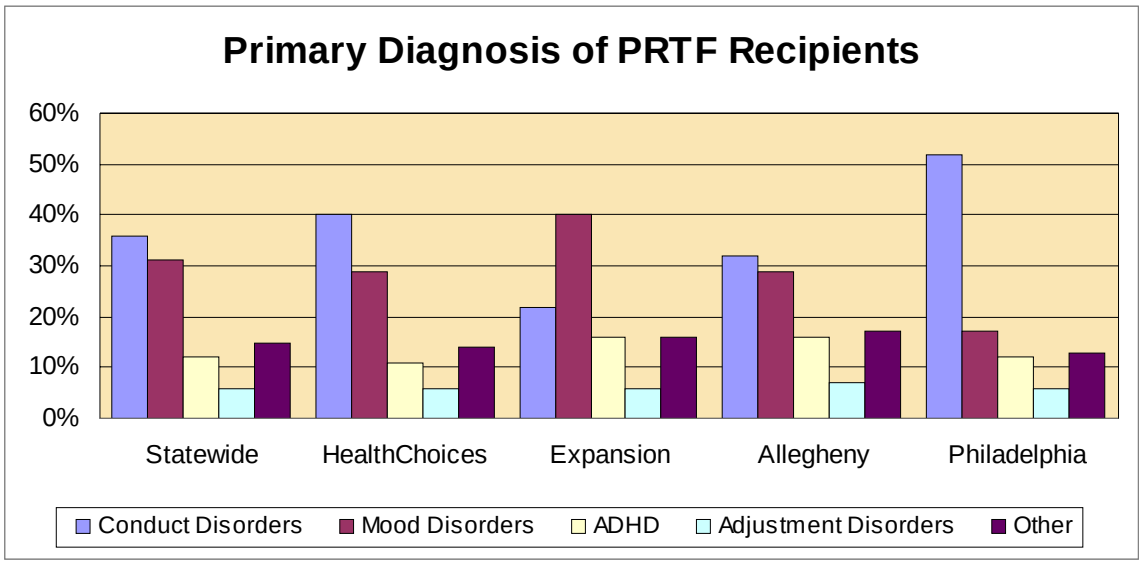


Race and ethnicity – The chart that follows shows the breakdowns across four categories of race and ethnicity: White, African-American, Hispanic and Other. Due to a change in the source from which Mercer received CY 2005 and CY 2006 FFS data, there is concern that the race and ethnicity data reported in CY 2006 may not be accurate (understating the number of White youth and overstating the Other category). Race and ethnicity data for the Expansion Zone may be more accurate in the CY 2005 data. Key findings include:

- **White youth** – Just under one-third of PRTF recipients Statewide fall into the White category (31.9%). However, given the likely understating of the proportion of recipients in Expansion counties who are White, the CY 2005 proportion of 51.4% is likely a more accurate indicator.
- **African-American youth** – The proportion of African-American PRTF recipients Statewide is 41.2%, varying widely between HealthChoices (50.2%) and Expansion (4.7%) counties. Most of this difference was accounted for by Philadelphia (78.5%), but Allegheny, Dauphin and Delaware counties all served over 40% African-American youth.
- **Hispanic youth** – The average proportion of Hispanic PRTF recipients Statewide was 0.2%. Only Pike (7.7%) had more than 5% of its PRTF use attributable to Hispanic youth, and 61 counties in the analysis had no Hispanic PRTF recipients.
- **Other youth** – A large proportion of youth statewide fall into the “other” demographic category, largely because over 87% of PRTF recipients in Expansion counties fell into this category. Based on analysis of CY 2005 data, it is likely that most of these youth are White (in CY 2005, only 2.9% of PRTF recipients in these counties fell into the Other category, and 91.1% were White).



Diagnosis – The chart below summarizes variability in the primary diagnoses of youth receiving PRTF services. Statewide, the largest proportion were diagnosed with conduct disorder (36.0%), followed by mood disorders (30.9%), ADHD (12.2%) and adjustment disorders (6.2%). While these categories represented most children and youth served, the range of diagnoses treated was very broad, with 14.7% having other diagnoses.



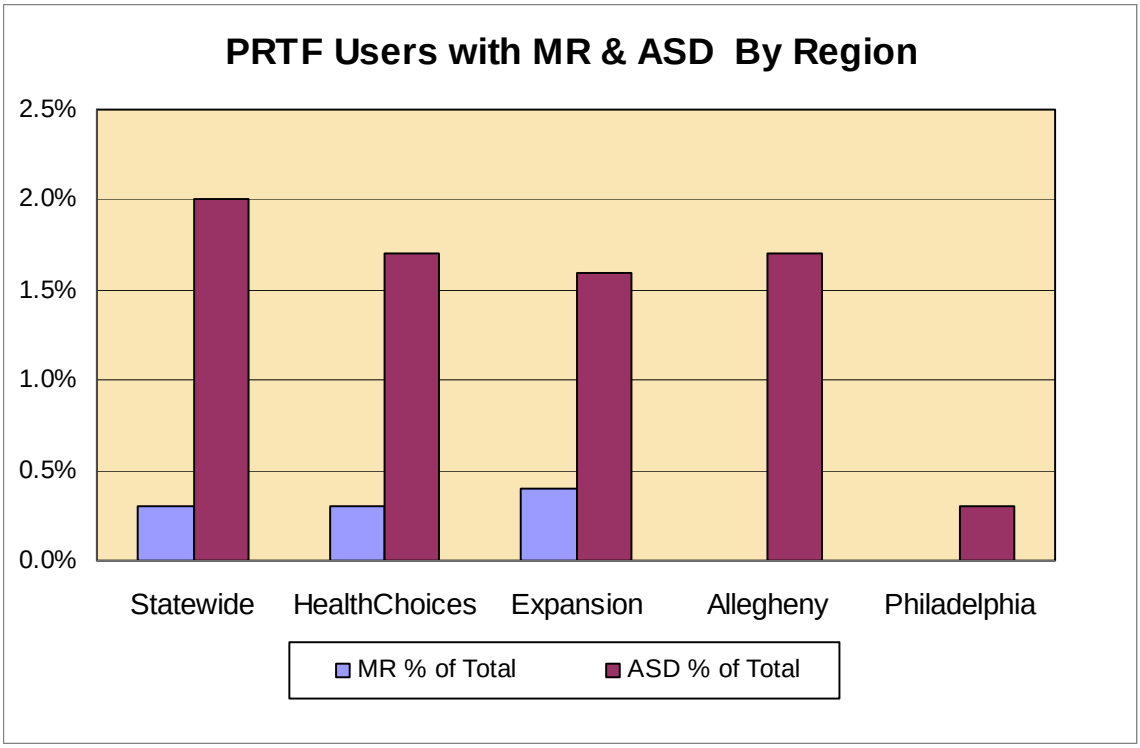
Underlying these averages was significant variability across counties:

- **Youth with conduct disorders** – The average proportion of recipients with primary conduct disorder diagnoses varied widely between HealthChoices (39.5%) and

Expansion (21.9%) counties, largely driven by the high proportion of this diagnosis in Philadelphia (52.0%).

- **Youth with mood disorders** – The average proportion of recipients with primary mood disorder diagnoses showed the reverse pattern between HealthChoices (28.6%) and Expansion (40.4%) counties, with Expansion higher.
- **Youth with ADHD** – The average proportion of recipients with primary ADHD diagnoses Statewide varied somewhat between HealthChoices (11.3%) and Expansion (15.7%) counties. Variation among counties ranged from the highest proportions in Luzerne (30.2%), Somerset (27.3%), Susquehanna (27.3%) and Tioga (26.1%), to the lowest proportions in Armstrong, Bedford, Cameron, Clearfield, Elk, Forest, Huntingdon, and Venango (0% in all).
- **Youth with adjustment disorders –** The average proportion of recipients with primary adjustment disorder diagnoses Statewide was understandably low at 6.2%. Fourteen (14) counties had double digit percentages for these primary diagnoses, with Vernango (27.3%), Clinton (25%) and Wyoming (22.2%) having the highest proportions. The remaining counties had none or only single digit percentages of recipients with these primary diagnoses.

We also looked more closely at diagnoses of Autism Spectrum Disorder (ASD) and Mental Retardation (MR), including PRTF recipients with primary or secondary diagnoses of any of the included diagnoses. Statewide, 2.0% of users were diagnosed with ASD, while less than 1% of users were diagnosed with MR (0.3%). ASD diagnoses were twice as prevalent as a percentage of Expansion county use (3.4%) than of HealthChoices county use (1.7%). The proportion varied widely, though, among, with several over 5%, including Adams (5.7% ASD), Bedford (12.5% ASD), Bradford (8.7% ASD), Cambria (6.8% ASD), Cumberland (7.0% ASD), Greene (9.1% MR), Indiana (5.6% ASD, 5.6% MR), Lawrence (5.6% MR), Lebanon (9.3% ASD), Lehigh (6.0% ASD), McKean (9.1% ASD), Mifflin (6.7% ASD), Perry (6.7% ASD), Somerset (9.1% ASD), Susquehanna (9.1% ASD), Union (22.2% ASD), Venango (9.1% ASD), and Warren (10.0% ASD). Trends regarding days used per recipient for these diagnoses were comparable to overall trends.



Factors underlying current PRTF utilization

Through the key informant interview and document review process, various factors related to PRTF utilization were identified. These are summarized by category in the section below.

Pathways to PRTF placement – Interview respondents were asked to describe the ways in which youth in the Commonwealth end up referred and placed in residential facilities:

- Youth with significant behavioral issues in the PRTF facility are often referred out-of-state because the "typical PRTF" is not able to meet their needs. Multiple respondents noted that current PRTF capacity is too often inadequate to meet the needs of high-need youth.
- Many youth enter the juvenile justice system and then residential treatment due to the lack of appropriate intensive community-based MH services.
- MH managed care is driven by psychiatric/psychological evaluations and recommendations related to PRTF in the form of a diagnostic evaluation packet. Lack of knowledge on the part of medical providers of how community-based alternatives can be used as an alternative to PRTF, a lack of awareness of local resources, and the tendency to equate restrictiveness of services with intensity leads to a well-intentioned but often problematic tendency to refer any youth with complex needs to PRTF.
- The necessary processes and resources for diversion do not exist or are not consistently accessible.

- Relatively scarce inpatient beds and resources for youth were noted, combined with a perception that lengths of stay for inpatient psychiatric care are typically brief (24 – 48 hours), leaving PRTF as the only perceived option for intermediate-term stabilization, which can then lead to longer term stays once the youth is admitted.
- Lack of timely crisis intervention services, both community-based and residential.
- Lack of services for youth with primarily substance abuse issues.
- A disproportionate number of minority youth using PRTF.
- Youth who lived long term in child welfare or other placements often move into PRTF as an evolution of service intensity as providers attempt to meet the youth's perceived need for intense services.

Systemic Issues related to residential placement – Interview respondents voiced concern about varying perceptions regarding PRTF placements across counties and agencies. For example, counties seen as having lower availability of community-based MH services were seen as more likely to turn more quickly to PRTF when MH issues arise. Alternatively, collaboration between MH and the child welfare and juvenile justice systems often inadvertently pulls for PRTF placement as both the latter systems are more often placement-oriented in their approach to youth services.

Respondents also pointed to a lack of clarity and consensus about the role of PRTF. This leads to longer lengths of stay as residential providers too often have no clearly stated goals and parameters within which to work, as well as a lack of proactive discharge planning. Education on services available in PRTFs and effective community alternatives is also seen as needed for Courts, which often struggle to form orders that adequately address community safety and treatment needs of youth with BH problems. In ordering an "evaluation for placement," Courts often start an inevitable process towards PRTF placement. In addition, some Judges and other Court staff do not, in the view of several respondents, have confidence that home and community-based services or even evidence based programs are adequate or appropriate for youth with significant behavioral or MH needs. This can be compounded by a lack of coordination among responsible youth-serving agencies.

Issues related to screening and assessment – Interview respondents noted that the current Juvenile Court Information System has very limited information on risk assessment to guide case planning. Screening and assessment protocols are being reviewed at several levels across the state, with multiple current initiatives across counties and systems. The current absence of an integrated, comprehensive assessment tool that is sensitive to the risks and needs of youth in the juvenile justice and allied systems has significant implications. An effective risk assessment instrument, along with cross-system coordination can support the development of a comprehensive case management approach addressing child-specific risk factors across service systems from intake to aftercare. Such an approach serves as the common thread that weaves the larger child and family service system together, and provides interfaces among the parts of the system.

The MAYSI-2 is being widely implemented as the initial MH screen, but the county-based system poses challenges to standardization of screening approaches across the Commonwealth. MH system representatives reported use of a range of tools including the Child and Adolescent Strengths and Needs (CANS), Child and Adolescent Level of Care Utilization System (CALOCUS) and Child & Adolescent Functional Assessment Scale (CAFAS). However, the availability of qualified staff to perform assessments is a challenge, particularly in rural areas. Finally, there is a lack of consensus related to the relative merits of targeted screening for MH needs versus broader screening and assessment for an array of risk and protective factors that might guide inter-agency case planning. The focus of current initiatives appears to emphasize MH screening using the MAYSI-2 (in 20 counties), the CANS (in limited areas), and the CBCL (post-disposition in Allegheny County).

System concerns – Interview respondents voiced concerns about the lack of an integrated data system in the Commonwealth to evaluate the sufficiency of resources across the system and the appropriateness of the service array to the needs of children and youth (e.g., how do we know what constitutes enough residential treatment beds or slots for community services). There is information in the MH system on service utilization and information in the juvenile justice system on system involvement, but no standard assessment of child-specific risks and needs related to delinquency and greater system involvement is in place. In addition, there is no current capacity to analyze data across MH and juvenile justice databases.

Respondents also expressed a desire to better understand the pathways in which youth who are in need of MH services end up in juvenile justice system placements. There was particular concern noted among judges about PRTF services for youth seen as having more complex needs, including female offenders, youth with severe MH needs, and youth that are charged with sexual offenses.

MH stakeholders described PRTFs as lacking a defined “treatment component,” rendering them “more like an orphanage.” In light of this, these stakeholders expressed concern about taking funds out of the PRTF system too quickly, given the need to enhance the quality of services in PRTF while simultaneously enhancing capacity for community-based services. More effective PRTF programs were seen as offering a cognitive-behavioral treatment approach and being smaller and self-sufficient in terms of treatment resources. Finally, stakeholders noted concerns expressed by PRTFs that their rates do not include payment for coordination and transition with community services.

4

Recommendations: Developing more effective services through community-based alternatives and enhancing coordination for PRTF

Overview

The following recommendations were developed from interviews with key informants, a review of the literature, and descriptions of experience in other states. These recommendations are not offered as definitive, but to represent effective strategies that have been proven in other jurisdictions or are based on converging evidence from multiple sources.

An effective child and family MH service system centers around a family-driven, youth-guided planning model featuring **Youth and Family Teams** that would design and manage care plans using the Wraparound Care Coordination model. This approach will be supported through the **Youth and Family Institute** that will train family members, youth, providers and stakeholders in key elements of effective practice. In order to be effective, Youth and Family Teams would have access to an **expanded community-based service array** implemented with fidelity to proven practice elements. **Family-centered residential treatment services**, including PRTF, would be an integral part of the system of care and would be coordinated through Youth and Family Teams. In order to ensure the quality of services, **clear performance expectations** should be developed and monitored for PRTF and all other components of the service array.

Case management and effective use of information across the system of care will also require attention. Selection and implementation of **a risk assessment instrument** that is sensitive to the risks and needs of youth in the juvenile justice system represents a high priority for success. The assessment tool selected should support the development of a **comprehensive case management** and treatment plan for each youth addressing specific risk factors from intake to aftercare.

Simultaneously, development of **Statewide standards for screening and assessment** should be a high priority, including a core set of assessment tools that are relevant across the juvenile justice, child welfare and MH systems. Implementation of these complex and inter-related recommendations is most likely to succeed through targeted efforts in **pilot jurisdictions** that demonstrate readiness for this level of change.

Specific recommendations

1. **Implement Youth and Family Teams using Wraparound Care Coordination to coordinate services and support family-based services** – There are various models available for supporting coordination of services for high need youth involved in multiple systems, including family group decision-making, person-centered planning and other approaches, but the model that has demonstrated the clearest outcomes for youth in PRTF is Wraparound Care Coordination. To promote more effective interagency coordination and service delivery for high need youth at-risk of PRTF placement, Youth and Family Teams should be implemented following the standards recently established by the National Wraparound Initiative (see Bruns, et al., 2004). In addition, in light of strong evidence that adherence to the principles and protocols of the wraparound process predict future child and family service and functioning outcomes (Bruns, Suter, Force, Burchard, & Dakan, 2003), a fidelity monitoring tool (WFI-4 - Wraparound Fidelity Index-4; Wraparound Evaluation and Research Team, University of Washington) should be used to monitor and support quality.

   Youth and Family Teams will need to have access to a service array built upon empirically supported treatments and focused on strengths, interests, abilities and capabilities, rather than deficits, weaknesses, or problems. Specific empirically supported treatments should include MST (Henggeler, et al., 1998), FFT (Sexton, 2004) and MTFC (TFC Consultants, Inc., 2006). While these interventions come with strong empirical support, there is emerging evidence that Youth and Family Teams, with their emphasis on family engagement, can play a role in further improving outcomes of empirically supported treatments (Bruns, 2004). In this context, the Youth and Family Teams can support empirically supported treatment by helping families to understand the fit and relevance of services and facilitate their engagement.

   Youth and Family Teams can also serve to enhance the effectiveness and mitigate potential drawbacks of residential treatment. Under this model, responsibility for care planning remains with the Youth and Family Team during the PRTF episode and the PRTF joins the team rather than replacing it, so that the PRTF services become simply one of many strategies used by the team over time. Families would be given a choice of residential treatment options and facilities and the team would develop clear, time-limited, measurable objectives for the child while in residential treatment with an emphasis on how strategies and techniques can be used by parents when the child returns to the community. Finally, discharge to the community occurs when the immediate identified needs are met; long-term treatment needs can then be addressed in the community (Stroul, 2007).

2. **Implement a Commonwealth training and technical assistance center** – Emerging research has revealed the importance of an "evidence-based culture" – a comprehensive effort to develop a culture that values and acts in light of evidence-based findings (Dixon, 2003; Rivard, et al., 2006). In order to build this context and to support high quality implementation of Youth and Family Teams, the Commonwealth has developed a Youth and Family Institute. The Institute will train family members, youth, providers and stakeholders in key elements of effective practice. Central to this effort is training and support for the Youth and Family Teams using Wraparound Care Coordination. The Institute will provide training and quality assurance based on the National Wraparound Initiative's principles and protocols and act as an intermediary organization between demonstration sites and the purveyors of the various empirically supported treatments to be implemented.

3. **Implement a community-based service array –** An array of community-based services, implemented with monitoring and fidelity can serve as a robust alternative to PRTF placement for many children and youth. An optimal continuum of services will include interventions such as **MST, FFT** and **MTFC** for youth and families at highest risk due to behavior, psychiatric functioning or complex multi-system involvement. Currently, both MST and FFT are available through the HealthChoices program, but capacity varies across counties. While a variety of therapeutic/treatment foster care models are currently available through HealthChoices, MTFC has not been developed as a standardized model, so inclusion of this within the Medicaid program would require further development. In order to support the success of children and youth in the community, it will also be important to ensure that BH interventions are coordinated with and supportive of school-based efforts, such as Positive Behavioral Interventions and Supports (PBIS). PBIS is a school-based, behaviorally-based approach that combines primary (school-wide), secondary (classroom), and tertiary (individual) systems of support (Adelman and Taylor, 1998; Horner and Carr, 1979; Koegel et al., 1996). It targets improvement in school functioning and other outcomes (personal, health, social, family, work and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant, and desired behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment, (2) comprehensive intervention and (3) lifestyle enhancement.[3]

   In addition to these rigorously evaluated and empirically supported treatments and school-based interventions, a fully functioning continuum of services should also include innovative and "home grown" service approaches. If these approaches are defined and based on the key elements that underlay the success of proven empirically supported treatment, there is much reason to expect that they also will bring about successful outcomes. The Commonwealth's Family-Based Mental Health Services (FBMHS) offers such a model, but implementation can vary widely given the lack of clear fidelity standards, as opposed to the more defined models of FFT and

[3] For additional information, see the Positive Behavior Interventions and Supports website: http://www.pbis.org/main.htm.

MST. The distinction we suggest here is between evidence-based ***programs*** (those discussed above such as MST, FFT, and MTFC with a strong research base) and the broader range of empirically supported treatments. The latter include innovative approaches that are based on the researched elements of success from more established evidence-based programs (Hawkins & Catalano, 1992). These elements include:

A. Concentrating on changing behavior and improving prosocial skills
B. Focusing on problem solving with both youth and their families
C. Employing multiple modes of intervention
D. Goal-oriented treatment
E. Promoting healthy bonds with prosocial members within the child or youth's family, peer, school and community networks
F. Attention to transitions and links to community
G. Training and quality assurance to support quality clinical work
H. Ongoing tracking of child and youth outcomes

If these elements are present, it should be possible for local systems to define their local programs sufficiently to design fidelity tracking protocols and measure their outcomes. Thus, the more traditional or existing practices that have been developed in provider communities may be offered along with the empirically supported treatments if a true culture of evidence-based care is developed around them. Such an approach to a mixed service array, in addition to encouraging choice for consumers and their families, may also help facilitate the buy-in of the provider community and help bring about better overall outcomes than an approach where a small set of empirically supported treatments are exclusively mandated.

A Center of Excellence to promote empirically supported treatment, such as that contemplated by the Commonwealth's MacArthur Foundation Models for Change initiative, could serve as a catalyst for promoting such an evidence-based culture of practice for high-need youth within the juvenile justice system. Implementation is currently targeted by July 2008.

4. **Develop residential options to support an effective continuum of care –** PRTF represents a necessary component of an effective continuum of care. Even with a full array of community-based options, some children and youth will still require residential services. In determining which level of care is most appropriate for youth in need of services, it is important that one makes a distinction between the constructs of restrictive and intensive care. Service **restrictiveness** refers to the extent to which the youth has opportunities to participate in natural activities and community living. **Intensiveness** of services reflects the amount or "dose" of treatment that a youth receives and is unrelated to the setting in which the treatment is provided. If intensive treatment is needed, community-based alternatives generally offer a more cost-effective choice; however, when the safety of a youth or the people around them is of concern, restrictive settings such as an OCYF residential setting or PRTF may be necessary.

PRTFs themselves can vary in terms or restrictiveness. For example, placement of a youth in a PRTF that is close enough to home for the family to participate in regular treatment, or for the youth to engage in graduated transition back to a more natural environment, including school, would make the PRTF less restrictive. Similarly, residential treatment should usually be kept short-term (30 – 90 days) and focus on stabilizing those immediate BH and MH needs that cannot be met in the community. While youth are in residential treatment settings, care should also remain family-focused and youth-centered.

Residential providers should also be invited to develop and provide alternatives to large institutional settings. When residential care is needed, services should be provided to the extent possible in more normalized settings, such as treatment foster homes or therapeutic group homes rather than in large institutions.

Even with formal PRTF settings, facilities should be located as close to home as possible to facilitate family involvement. In order to support an effective continuum of services, residential options might include the following program types. Note that, for all the program types cited below, services should be as family-driven and inclusive of family involvement as possible.

A. **Crisis residential services** – Residential settings can offer a brief, intensive opportunity to place a youth in a safe setting in which to assess the nature of the crisis and develop an initial treatment approach. These are generally short-term placements.
B. **Extended Sub-acute Stabilization** – Acute-oriented PRTFs could serve as an inpatient alternative in which children and youth could be stabilized and treatment begun while transition-planning back to a more natural environment takes place.
C. **Medium-term family-oriented PRTF** – This refers to a specialized PRTF model (referred to by informants we interviewed as “family-based PRTF”) that would meet the needs of youth and community safety while simultaneously working with families intensively and providing empirically supported treatment on an intensive level. In such a model, a child might have a brief placement (30 – 60 days), with the youth then coming back to the community with intensive services in place.
D. **Longer-term (3 – 12 months) intensive and restrictive PRTF** – In keeping with current PRTF practice, long-term restrictive options are needed for youth with ongoing complex or dangerous behaviors. As these services continue to be needed, it will be important to continue to encourage intensive (as opposed to only restrictive) treatment services, as well as the minimization of restrictiveness by pursuing placement as close to home as practical.
E. **Small group homes closer to the community** – Less intensive, less restrictive smaller residential facilities can serve as a transition or step down for youth returning to the community from long-term restrictive placement. They can also serve as a brief placement that allows a higher level of community involvement than traditional PRTF. If they include a treatment component, Medicaid funding may be allowable.

Maintaining or re-building connections to school is another important factor supporting less restrictive, community-based approaches to meeting child and youth treatment needs. For many youth, placement in RTFs sever ties to local schools while providing inadequate educational opportunities that do not transfer back to the school system when a youth returns to the community. This leaves the child alienated from both school and peers and often so far behind that the prospect of catching up with his or her grade level represents an insurmountable barrier to reconnecting to school. Moreover, research has demonstrated clear links demonstrating that connection to school is a powerful protective factor predicting success while disconnection from school has been found to predict a number of negative outcomes including delinquency (Hawkins & Catalano, 1992; Kelley, Loeber, et al., 1997). In light of this, the importance of supporting school connections, both through community-based treatment and better connections to school for youth in residential settings is clear. Similarly, any PRTF placement must be supported by attention to transition back to safe housing in the community. For some youth, especially older teens, supported independent and transitional living settings should be developed.

5. **Define and monitor performance expectations for PRTF** – Related to the discussion in the preceding bullet, system leaders and other stakeholders consistently referred to a lack of clear expectations about the purpose, scope and appropriate length of service for PRTF. Representatives from all three major child-serving systems should build consensus and set performance expectations. In addition, child and family advocacy organizations should be included in this process to ensure that performance expectations and monitoring reflect the needs of families, as well as the needs of agencies and service systems. Similarly, families expressed an interest in access to relevant information from ongoing monitoring and reporting of PRTF performance.

   Once performance expectations are set, the Commonwealth can explore additional contracting mechanisms to develop and maintain the desired array of PRTF and residential services. One way to carry this out would involve a Statewide procurement process for PRTF. Under Section 1915(b)(4) of the Social Security Act, any state can request a waiver of freedom of choice of providers and require enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality and utilization standards which are consistent with access, quality and efficient and economic provision of covered care and services. This is more commonly referred to as selective contracting. When a state chooses to selectively contract with providers, the state will issue a procurement document that identifies mandatory and optional requirements. These requirements may include enhanced provider qualifications, additional services or additional programs for specific populations. In addition, the state may also choose to reimburse the provider under a different basis than authorized in the State Plan.

   In a capitated system such as the Commonwealth's, individual BH-MCOs may choose to selectively contract with a limited number of providers. If the Commonwealth wants to ensure that plans contract with certain types of providers, it

could include specific provisions in the procurement document or contract regarding enhanced provider qualifications, services, and coordination and special programs.

6. **Monitor implementation quality and treatment fidelity** – The Commonwealth should build into planning and implementation of empirically supported treatments some means to monitor the quality of the changes, and adherence to the standards of program design and delivery (treatment fidelity). Some empirically supported treatment (e.g., MST, FFT, MTFC) have built into their programs a means to monitor treatment fidelity. A Center of Excellence for empirically supported treatment could serve as the organizing agent to explore and pilot test means by which treatments can incorporate ways to provide managers of programs with the ability to monitor the quality of service delivery and adherence to program design. A critical element of this effort is to develop a cadre of specialists with expertise in the content of empirically supported treatments who, in the process of organizational change, could work with managers at the state, local and agency level. The end result of these efforts would yield a quality improvement loop of needs assessment, design and implementation, monitoring and evaluation, and feedback to management for periodic program adjustment for better outcomes.

7. **Select and implement a case management model based on comprehensive juvenile risk/needs assessment –** Selecting and implementing a risk assessment instrument that is sensitive to the risks and needs of youth in the juvenile justice system represents a high priority for success. The assessment tool selected should support the development of a comprehensive case management and treatment plan addressing specific risk factors from intake to aftercare. Pennsylvania's juvenile justice system is currently in the process of reviewing various assessment instruments for use in the system, including risk assessments and strengths/needs assessments.

   A case management system is the common thread that weaves the larger child and family service system together, and provides interfaces among the parts of the system. One of the goals of the current system reform should be to ensure that new strategies are implemented in each sector in ways that take into account the inter-dependency of the various parts of the system and to avoid fragmentation of services. Selection and implementation of a comprehensive risk needs assessment, such as the Washington State Juvenile Risk Assessment, would support a system whereby youth involved in the juvenile justice system would receive tailored, coordinated services based on his or her unique pattern of risk and needs factors. Moreover, for a given youth these factors would be addressed in each branch of the system. This systemic perspective is important during the planning stages, and will serve to guide the implementation phase as well.

   For youth who come to the juvenile justice system with multiple problems, case management and treatment across systems would focus primarily upon those risk factors shown by research to be associated with the risk for continuing offending behavior. Some of these risk factors are historical and static, or cannot be changed by treatment, such as prior offense history or age at first offense. Others, such as

antisocial peer networks, poor family relationships or substance abuse, can be improved by treatment and are referred to as criminogenic needs. A related priority, therefore, would be to provide training with regard to these risk factors and their relation to delinquent behavior and treatment. Such training would enhance the system's ability to recognize, assess and treat the core factors underlying problem behavior.

The Washington State Juvenile Risk Assessment (Barnoski, 2004) is a widely-used, empirically based assessment instrument that provides an overall score related to risk for re-offending and also provides a detailed analysis of the specific risk and protective factors that may contribute to a youth's success or failure under supervision and in response to treatment. State-specific versions of this instrument are in use in over a dozen states and it is widely regarded as the current state-of-the-art.

Once a risk assessment tool is selected, it would first be piloted in a small number of pilot jurisdictions, perhaps the Models for Change counties discussed earlier.

8. **Improve information sharing across systems –** Developing Statewide standards for screening and assessment should be a high priority, including a core set of assessment tools that are relevant across the juvenile justice, child welfare and MH systems. This can include exploration of electronic databases that would allow interactive data sharing across systems. Per state and federal statutes, the rights of children, youth and families for access to information and consent prior to sharing protected healthcare information would be protected as protocols are developed.

9. **Build understanding and consensus among stakeholders** – Judges, administrators and other stakeholders must have a clear and shared understanding regarding the nature of child MH disorders and treatment alternatives. It will be critical to develop understanding and buy-in among judges and other leaders for assessment-based case management emphasizing "matching" youth to appropriate services based on assessed needs and strengths (as well as risk and protective factors). It will also be important to provide balanced data that demonstrate and explain both the potential positive and negative effects of residential treatment on both youth outcomes and recidivism. This type of information would address concerns among stakeholders who are skeptical of a move towards greater emphasis on community-based alternatives to treatment in restrictive residential placement for children and youth with severe needs. Likewise, it is critical that human service agencies in general and the BH system in particular gain a sufficient understanding of Pennsylvania's juvenile justice system and the principles of balanced and restorative justice.

10. **Start with pilot jurisdictions –** Given the many complexities involved, the high needs of the youth served, and the need to develop consensus among multiple stakeholders in order to allow for even the possibility of success, targeting change in pilot jurisdictions with a higher likelihood of success is a necessity. The MacArthur Foundation "Models for Change" counties offer a potential starting point, as do counties with more locally-driven change opportunities, such as Judges or Court staff

with a special interest in promoting community-based treatment. Such jurisdictions have begun to work through issues of cross system collaboration and information sharing and are further along the pathway of readiness for change.

11. **Other Implementation Issues –** Other implementation issues to be considered include:

    A. Requiring and providing support for system assessments at a county level to map available resources against needs.
    B. Incentives for BH-MCOs to facilitate participation (such as enhanced administrative reimbursement in rates to manage projects, as well as technical assistance and support of the pilot).
    C. Strategies to track any non-Medicaid savings (e.g., OCYF savings in YDC use, county D&A fund savings, reductions in use of non-accredited PRTF).
    D. Strategies to address services providers' needs to pay for start up and training, including building in up front costs given that implementation of high quality, empirically supported services involves substantial up-front investment.
    E. Providing services in a timely fashion. In order for community-based services to be a meaningful way to divert youth from residential placement, they must be available in a timely fashion (within a couple of days).
    F. Integrating data management across multiple systems.

Time line

To carry out these comprehensive steps toward reform, we recommend targeted pilots in counties and BH-MCO areas ready to embrace such changes. Change at any level will be difficult, and beginning with those most ready will help promote success.

The first year of such a pilot process would be largely devoted to planning, identifying demonstration sites and conducting readiness assessments, consensus building and infrastructure development. The latter would include establishing administrative structures, including: identifying a director for the project, establishing a quality improvement entity integrated with the project evaluation, supporting the continued development of the Youth and Family Institute, coordinating the Institute's activities with those of the MacArthur initiative to promote empirically supported treatment, and working with the purveyors of empirically supported programs more broadly to ensure readiness for implementation. In addition, once demonstration sites are identified, the Commonwealth would need to work with those sites to identify the needs of the youth and families to be served in order to better understand mechanisms by which placement in a PRTF could be avoided or lengths of stay reduced.

Finally, an evaluation design should be developed that features a quasi-experimental approach to address the efficacy and cost effectiveness of the demonstrations. The evaluation should also support a sustainable quality improvement function for the Institute. In addition to tracking measures of fidelity for the Youth and Family Team model (Wraparound) and the empirically supported treatments to be implemented, the evaluation should track functional outcomes using one or a combination of proven

measurement tools, such as the CANS. The CANS was designed to serve as a communication and decision-making tool for psychiatric services. It has demonstrated utility in improving decision-making for residential treatment (Lyons, Mintzer, Kisiel, & Shallcross, 1998) and for quality improvement in crisis assessment services (Lyons, Kisiel, Dulcan, Chesler & Cohen, 1997; Leon, Uziel-Miller, Lyons, Tracy, 1999). Given the focus on juvenile justice populations, the initiative may also find value in adopting part or all of an instrument such as the Washington State Juvenile Risk Assessment (WSJRA). The WSJRA has been validated in its ability to inform level of care decisions for youth in the juvenile justice system (Barnoski, 2004) and has been implemented in multiple states (including New York, Florida, Colorado and Washington) and major cities (Cook County/Chicago, IL).

Appendix A

Appendix A – Detailed PRTF use analysis summaries

The first table in this appendix presents the number of PRTF recipients and their average days used by recipient across counties during the analyzed time period. The number of youth using PRTF over the two calendar years (CY) 2005 and 2006 is noted for each county in the total PRTF users' column.

This table includes CY 2005 and CY 2006 Person Level Encounter (PLE) data from the three HealthChoices' zones in operation for 25 counties,[4] as well as fee-for-service (FFS) data for the same time period from all 67 counties[5] (the remaining 42 Expansion counties and a small amount of continuing FFS delivery in the 25 HealthChoices counties). As noted, the accuracy of the race and ethnicity data reported in CY 2006 is in question (understating the number of White youth and overstating the Other category in the Expansion Zone). Mercer received CY 2006 data from a different source than data received in previous years. As data from the new claims processing system continue to become available, the credibility of the data are evaluated. Race and ethnicity data for the Expansion Zone may be more accurate in the CY 2005 data.

The number of HealthChoices recipients presented in the tables by county and zone are unique across PLE and FFS claims (that is, recipients with utilization in both PLE and FFS claims have been reconciled and counted only once), however there may be a few recipients who resided in multiple counties during the time period and would have been counted separately in each. Additionally, if youth were in both an in-state facility and an out-of-state facility during the time period, they would be counted twice.

[4] This includes all HealthChoices encounters from the time period reported through March 31, 2007.

[5] This includes all FFS claims from the time period received through June 30, 2007

To control for differences in population, US Census estimates of the 2006 population in each county under the age of 21 were used to calculate a statistic of PRTF users per 100,000 population under 21.

The table also looks at trends across average days used, the other primary component of PRTF utilization. Episodes are analyzed in six groupings: (1) episodes under 60 days, (2) under 90 days, (3) 90 to 180 days, (4) over 180 days, (5) over 270 days and (6) over 365 days (note that the first two and last three categories overlap). This analysis was done to identify those counties who have higher average days used. We looked at shorter (those under 60 days), as well as a general benchmark of 90 days as a target for moderate length stays focused primarily on stabilization.

Analysis was conducted looking at the children and youth using PRTF during CY 2005 and CY 2006, focusing on total days used and including two calendar years so that stays lasting longer than one year would be captured more fully. It is important to note that this report provides summaries of average bed days used by recipient across the two calendar year period in order to capture days for any episodes that began in CY 2005 and extended into CY 2006. While only the longest stay for each recipient was included in the analysis, this does not strictly equate to an episode length of stay, because it reflects utilization only during the two calendar years, whereas a strict analysis of length of stay would need to calculate the days only for completed episodes between date of admission and date of discharge (thus excluding days for any episodes beginning prior to or ending after the time period). As such, the analysis includes some stays that began prior to the period covered (admissions prior to January 1, 2005) and some stays that continued beyond the period (discharges after December 31, 2006). Therefore, reporting on days used by recipient in this report **understates** to some degree the actual lengths of stay by including these partial admissions in the analysis.

It is also important to note that the time period of CY 2005 through CY 2006 (the most recent years for which complete data are available Statewide) does not fully reflect the important system change undertaken through the ICSI. ICSI integrated funding and management of all PRTF services delivered through the MH, juvenile justice and child welfare systems. The system change began in CY 2005, with implementation dates of January 1, 2005 in Philadelphia County, April 1, 2005 in Allegheny and York counties, and July 1, 2005 in the remaining HealthChoices counties. Providers began to be enrolled in 2005, and continued to be enrolled into CY 2006, so encounters for these providers before these dates are not included in the data set analyzed. Therefore, the analyses in this report further **understate** the amount of PRTF currently delivered under the Medicaid program in the Commonwealth, because the analysis includes only post-ICSI placement days for these providers.

Total PRTF Use and Use Per Recipient Analysis for CY 2005 and CY 2006										
County	County Population Under 21	PRTF Users/ 100K	Total PRTF Users	Out-of-State Users	Under 60 Days	Under 90 Days	90 - 180 Days	Over 180 Days	Over 270 Days	Over 365 Days
HealthChoices – Southwest Zone										
Allegheny	314,877	169.9	535	2	31.5%	39.9%	29.8%	30.3%	15.5%	7.1%
Armstrong	16,557	126.8	21	1	14.3%	28.6%	38.1%	33.3%	14.3%	4.8%
Beaver	43,203	67.1	29	1	3.4%	13.8%	58.6%	27.6%	10.3%	3.4%
Butler	49,633	74.5	37	-	32.4%	51.4%	21.6%	27.0%	16.2%	5.4%
Fayette	34,919	114.6	40	-	12.5%	25.0%	45.0%	30.0%	10.0%	2.5%
Greene	9,919	171.4	17	-	17.6%	29.4%	29.4%	41.2%	11.8%	5.9%
Indiana	23,890	92.1	22	-	13.6%	27.3%	40.9%	31.8%	22.7%	13.6%
Lawrence	23,366	107	25	2	24.0%	36.0%	24.0%	40.0%	8.0%	8.0%
Washington	50,586	152.2	77	4	18.2%	29.9%	37.7%	32.5%	16.9%	3.9%
Westmoreland	86,269	76.5	66	1	22.7%	36.4%	34.8%	28.8%	9.1%	4.5%
Total for Zone	653,219	133.0	869	11	26.5%	36.7%	32.5%	30.7%	14.6%	6.3%
HealthChoices – Southeast Zone										
Bucks	167,838	61.4	103	15	20.4%	29.1%	33.0%	37.9%	20.4%	7.8%
Chester	137,696	127.8	176	46	14.2%	24.4%	30.7%	44.9%	24.4%	15.9%
Delaware	163,785	127.6	209	47	19.6%	34.9%	34.9%	30.1%	17.2%	11.0%

Total PRTF Use and Use Per Recipient Analysis for CY 2005 and CY 2006										
County	County Population Under 21	PRTF Users/ 100K	Total PRTF Users	Out-of-State Users	Under 60 Days	Under 90 Days	90 - 180 Days	Over 180 Days	Over 270 Days	Over 365 Days
Montgomery	209,719	83.0	174	34	23.6%	33.3%	30.5%	36.2%	20.7%	8.6%
Philadelphia	445,837	565.0	2,519	607	12.1%	20.4%	26.8%	52.8%	33.0%	18.3%
Total for Zone	1,124,875	282.8	3,181	749	13.6%	22.6%	27.9%	49.5%	30.4%	16.9%
HealthChoices – Lehigh / Capital Zone										
Adams	27,176	261.3	71	5	14.1%	18.3%	39.4%	42.3%	22.5%	14.1%
Berks	112,009	190.2	213	45	15.2%	24.2%	28.0%	47.9%	26.5%	13.7%
Cumberland	58,260	128.7	75	-	18.7%	29.3%	34.7%	36.0%	24.0%	9.3%
Dauphin	67,962	206.0	140	3	20.7%	32.1%	27.9%	40.0%	23.6%	10.7%
Lancaster	144,261	130.3	188	13	17.6%	25.5%	30.3%	44.1%	23.9%	9.0%
Lebanon	32,740	189.4	62	4	19.4%	27.4%	27.4%	45.2%	19.4%	8.1%
Lehigh	91,023	171.4	156	19	14.1%	23.7%	35.3%	41.0%	23.1%	9.0%
Northampton	77,247	130.7	101	16	9.9%	17.8%	35.6%	46.5%	15.8%	6.9%
Perry	11,809	194.8	23	-	26.1%	26.1%	34.8%	39.1%	13.0%	4.3%
York	108,910	269.9	294	12	12.2%	23.5%	31.0%	45.6%	21.1%	11.6%
Total for Zone	731,397	180.9	1,323	117	15.4%	24.6%	31.4%	43.8%	22.4%	10.5%
Expansion Counties										
Bedford	12,216	114.6	14	-	14.3%	14.3%	0.0%	85.7%	42.9%	7.1%

Total PRTF Use and Use Per Recipient Analysis for CY 2005 and CY 2006

County	County Population Under 21	PRTF Users/ 100K	Total PRTF Users	Out-of-State Users	Under 60 Days	Under 90 Days	90 - 180 Days	Over 180 Days	Over 270 Days	Over 365 Days
Blair	32,234	170.6	55	-	23.6%	27.3%	18.2%	54.5%	27.3%	7.3%
Bradford	16,501	193.9	32	-	15.6%	21.9%	25.0%	53.1%	31.3%	12.5%
Cambria	35,693	168.1	60	-	16.7%	28.3%	26.7%	45.0%	21.7%	10.0%
Cameron	1,339	298.7	4	-	0.0%	25.0%	50.0%	25.0%	25.0%	25.0%
Carbon	14,518	186.0	27	-	25.9%	33.3%	18.5%	48.1%	22.2%	7.4%
Centre	40,648	71.3	29	1	10.3%	13.8%	20.7%	65.5%	27.6%	6.9%
Clarion	10,726	186.5	20	-	0.0%	10.0%	25.0%	65.0%	25.0%	5.0%
Clearfield	19,555	358.0	70	3	14.3%	18.6%	30.0%	51.4%	28.6%	12.9%
Clinton	9,870	152.0	15	-	0.0%	0.0%	26.7%	73.3%	46.7%	40.0%
Columbia	17,213	52.3	9	-	22.2%	22.2%	22.2%	55.6%	44.4%	22.2%
Crawford	24,244	152.6	37	-	13.5%	18.9%	29.7%	51.4%	29.7%	10.8%
Elk	8,144	282.4	23	-	8.7%	17.4%	30.4%	52.2%	30.4%	13.0%
Erie	79,505	217.6	173	-	11.6%	18.5%	34.1%	47.4%	22.5%	14.5%
Forest	1,356	368.7	5	-	0.0%	0.0%	40.0%	60.0%	0.0%	0.0%
Franklin	36,111	193.8	70	9	18.6%	22.9%	25.7%	51.4%	32.9%	17.1%
Fulton	3,714	188.5	7	-	14.3%	14.3%	28.6%	57.1%	0.0%	0.0%
Huntingdon	11,140	80.8	9	2	11.1%	22.2%	55.6%	22.2%	22.2%	11.1%

Total PRTF Use and Use Per Recipient Analysis for CY 2005 and CY 2006

County	County Population Under 21	PRTF Users/ 100K	Total PRTF Users	Out-of-State Users	Under 60 Days	Under 90 Days	90 - 180 Days	Over 180 Days	Over 270 Days	Over 365 Days
Jefferson	11,245	284.6	32	2	9.4%	12.5%	43.8%	43.8%	21.9%	6.3%
Juniata	6,161	97.4	6	-	0.0%	16.7%	0.0%	83.3%	33.3%	33.3%
Lackawanna	53,330	170.6	91	4	17.6%	28.6%	28.6%	42.9%	23.1%	12.1%
Luzerne	75,943	176.4	134	4	17.2%	30.6%	30.6%	38.8%	17.9%	6.7%
Lycoming	31,231	112.1	35	2	14.3%	22.9%	17.1%	60.0%	42.9%	25.7%
McKean	11,274	656.4	74	1	17.6%	28.4%	23.0%	48.6%	21.6%	14.9%
Mercer	31,259	115.2	36	3	8.3%	13.9%	30.6%	55.6%	44.4%	27.8%
Mifflin	11,872	193.7	23	-	4.3%	8.7%	13.0%	78.3%	52.2%	13.0%
Monroe	46,924	95.9	45	3	13.3%	24.4%	28.9%	46.7%	28.9%	13.3%
Montour	4,608	21.7	1	-	0.0%	0.0%	0.0%	100.0%	100.0%	0.0%
Northumberland	21,135	80.4	17	2	17.6%	23.5%	23.5%	52.9%	47.1%	11.8%
Pike	14,797	121.6	18	-	22.2%	38.9%	5.6%	55.6%	22.2%	16.7%
Potter	4,687	277.4	13	-	0.0%	23.1%	30.8%	46.2%	23.1%	7.7%
Schuylkill	33,038	272.4	90	8	12.2%	22.2%	28.9%	48.9%	28.9%	12.2%
Snyder	10,691	37.4	4	-	25.0%	25.0%	25.0%	50.0%	50.0%	25.0%
Somerset	17,993	166.7	30	-	6.7%	20.0%	13.3%	66.7%	36.7%	26.7%
Sullivan	1,519	197.5	3	-	0.0%	0.0%	33.3%	66.7%	33.3%	0.0%

Total PRTF Use and Use Per Recipient Analysis for CY 2005 and CY 2006										
County	County Population Under 21	PRTF Users/ 100K	Total PRTF Users	Out-of-State Users	Under 60 Days	Under 90 Days	90 - 180 Days	Over 180 Days	Over 270 Days	Over 365 Days
Susquehanna	10,724	149.2	16	-	18.8%	31.3%	18.8%	50.0%	37.5%	12.5%
Tioga	10,750	381.4	41	-	19.5%	22.0%	22.0%	56.1%	34.1%	17.1%
Union	10,992	100.1	11	-	0.0%	18.2%	18.2%	63.6%	36.4%	18.2%
Venango	13,962	114.6	16	-	18.8%	25.0%	25.0%	50.0%	25.0%	6.3%
Warren	10,241	302.7	31	-	16.1%	22.6%	25.8%	51.6%	32.3%	16.1%
Wayne	12,183	295.5	36	1	16.7%	22.2%	36.1%	41.7%	27.8%	19.4%
Wyoming	7,520	172.9	13	2	0.0%	46.2%	15.4%	38.5%	23.1%	23.1%
Expansion Total	838,806	175.8	1,475	47	14.2%	22.7%	26.8%	50.4%	27.8%	13.5%
Overall Totals										
HC Total	2,509,491	214.1	5,373	877	16.1%	25.4%	29.5%	45.0%	25.9%	13.6%
Expansion Total	838,806	175.8	1,475	47	14.2%	22.7%	26.8%	50.4%	27.8%	13.5%
Expansion and HC Total	3,348,297	204.5	6,848	924	15.7%	24.8%	29.0%	46.2%	26.3%	13.6%

We also examined the demographics and primary diagnoses of the children and youth using PRTF, both overall (first table that follows) and focusing just on children and youth in out-of-state facilities (second table that follows). Factors examined include:

- Breakdown of ages served: 0 – 6 years, 6 – 12 years, 13 – 17 years, 18 – 21 years,
- Percentage female and male,
- Racial and ethnic percentages, including: African-American, Hispanic, White, and Other,
- Major primary diagnosis groupings, including Conduct Disorders, Mood Disorders, ADHD, Adjustment Disorders, and Other;[6] and
- Breakdown for children with Autism Spectrum Disorders (ASD) and Mental Retardation (MR) (counting both primary and secondary diagnoses.

Only CY2006 data were used for the calculations of total and out-of-state demographics (age, gender, race, and ethnicity) and diagnostic groupings so that the most recent trends for which data is available would be reflected. Both Children in Substitute Care (CISC) and non-CISC episodes were included. For youth with multiple stays, the longest stay was used for purposes of the analysis.

[6] There are some instances in which an individual PRTF recipient is counted in more than one diagnostic group, but these discrepancies from the underlying data were not significant enough to be judged to affect the overall trends of interest to this report.

CY 2006 PRTF Youth Characteristics for HealthChoices Zones and All Expansion Counties (Percentages of All Recipients)																		
		Age				Gender		Race / Ethnicity				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
HealthChoices – Southwest																		
Allegheny	423	0.0%	16.5%	77.3%	6.1%	69.3%	30.7%	50.8%	0.0%	44.7%	4.5%	31.9%	28.8%	15.8%	6.9%	16.5%	1.7%	0.0%
Armstrong	18	0.0%	22.2%	72.2%	5.6%	66.7%	33.3%	0.0%	0.0%	100.0%	0.0%	22.2%	77.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Beaver	18	0.0%	22.2%	61.1%	16.7%	66.7%	33.3%	0.0%	0.0%	94.4%	5.6%	11.1%	72.2%	11.1%	0.0%	5.6%	0.0%	0.0%
Butler	18	0.0%	16.7%	61.1%	22.2%	55.6%	44.4%	0.0%	0.0%	88.9%	11.1%	11.1%	55.6%	11.1%	0.0%	22.2%	0.0%	0.0%
Fayette	30	0.0%	16.7%	80.0%	3.3%	80.0%	20.0%	13.3%	0.0%	80.0%	6.7%	33.3%	43.3%	6.7%	10.0%	6.7%	3.3%	0.0%
Greene	11	0.0%	18.2%	63.6%	18.2%	81.8%	18.2%	0.0%	0.0%	100.0%	0.0%	54.5%	27.3%	9.1%	0.0%	9.1%	0.0%	9.1%
Indiana	18	0.0%	22.2%	66.7%	11.1%	66.7%	33.3%	0.0%	0.0%	77.8%	22.2%	22.2%	38.9%	11.1%	0.0%	27.8%	5.6%	5.6%
Lawrence	18	0.0%	22.2%	77.8%	0.0%	61.1%	38.9%	11.1%	0.0%	83.3%	5.6%	5.6%	72.2%	11.1%	5.6%	5.6%	0.0%	5.6%
Washington	57	0.0%	21.1%	73.7%	5.3%	52.6%	47.4%	8.8%	0.0%	86.0%	5.3%	21.1%	54.4%	10.5%	5.3%	8.8%	1.8%	3.5%
Westmoreland	53	0.0%	9.4%	83.0%	7.5%	66.0%	34.0%	15.1%	0.0%	83.0%	1.9%	20.8%	39.6%	17.0%	5.7%	17.0%	1.9%	1.9%
Total for Zone	**664**	**0.0%**	**17.0%**	**76.1%**	**6.9%**	**67.5%**	**32.5%**	**35.2%**	**0.0%**	**59.8%**	**5.0%**	**28.2%**	**37.2%**	**14.0%**	**5.9%**	**14.8%**	**1.7%**	**0.9%**

CY 2006 PRTF Youth Characteristics for HealthChoices Zones and All Expansion Counties (Percentages of All Recipients)																		
		Age				Gender		Race / Ethnicity				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
HealthChoices – Southeast																		
Bucks	71	1.4%	23.9%	66.2%	8.5%	74.6%	25.4%	11.3%	0.0%	78.9%	9.9%	28.2%	40.8%	12.7%	7.0%	11.3%	2.8%	0.0%
Chester	133	0.0%	21.1%	75.9%	3.0%	58.6%	41.4%	21.8%	0.0%	64.7%	13.5%	37.6%	38.3%	8.3%	2.3%	13.5%	1.5%	1.5%
Delaware	151	0.0%	14.6%	74.8%	9.9%	51.7%	47.7%	42.4%	0.0%	45.0%	12.6%	33.8%	36.4%	10.6%	2.6%	16.6%	2.0%	0.0%
Montgomery	118	0.0%	25.4%	62.7%	11.9%	52.5%	47.5%	24.6%	0.0%	63.6%	11.9%	37.3%	31.4%	9.3%	6.8%	15.3%	4.2%	0.0%
Philadelphia	1,867	0.0%	11.6%	77.0%	11.3%	70.1%	29.8%	78.5%	0.0%	10.3%	11.2%	52.0%	17.0%	11.6%	5.9%	13.4%	0.3%	0.0%
Total for Zone	**2,340**	**0.0%**	**13.4%**	**75.8%**	**10.7%**	**67.5%**	**32.4%**	**68.2%**	**0.0%**	**20.4%**	**11.4%**	**48.5%**	**20.9%**	**11.3%**	**5.6%**	**13.7%**	**0.7%**	**0.1%**
HealthChoices – Lehigh / Capital																		
Adams	53	0.0%	32.1%	64.2%	3.8%	62.3%	37.7%	1.9%	0.0%	90.6%	7.5%	17.0%	54.7%	3.8%	11.3%	13.2%	5.7%	0.0%
Berks	159	0.0%	25.8%	72.3%	1.9%	62.9%	37.1%	13.8%	2.5%	46.5%	37.1%	32.1%	32.7%	12.6%	2.5%	20.1%	3.1%	0.6%
Cumberland	57	0.0%	29.8%	59.6%	10.5%	71.9%	28.1%	10.5%	0.0%	61.4%	28.1%	21.1%	45.6%	5.3%	7.0%	21.1%	7.0%	0.0%
Dauphin	101	0.0%	19.8%	69.3%	10.9%	67.3%	32.7%	46.5%	1.0%	37.6%	14.9%	14.9%	47.5%	12.9%	10.9%	13.9%	3.0%	0.0%
Lancaster	120	0.0%	17.5%	75.8%	6.7%	69.2%	30.8%	14.2%	2.5%	65.8%	17.5%	21.7%	38.3%	8.3%	13.3%	18.3%	4.2%	0.0%
Lebanon	43	0.0%	14.0%	74.4%	11.6%	79.1%	20.9%	9.3%	0.0%	88.4%	2.3%	25.6%	41.9%	11.6%	4.7%	16.3%	9.3%	0.0%
Lehigh	117	0.0%	23.9%	73.5%	2.6%	64.1%	35.9%	14.5%	0.0%	76.1%	9.4%	32.5%	35.0%	8.5%	3.4%	20.5%	6.0%	0.0%

CY 2006 PRTF Youth Characteristics for HealthChoices Zones and All Expansion Counties (Percentages of All Recipients)																		
		Age				Gender		Race / Ethnicity				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Northampton	76	0.0%	22.4%	68.4%	9.2%	67.1%	32.9%	13.2%	0.0%	68.4%	18.4%	42.1%	32.9%	7.9%	5.3%	11.8%	0.0%	1.3%
Perry	15	0.0%	46.7%	46.7%	6.7%	86.7%	13.3%	6.7%	0.0%	86.7%	6.7%	40.0%	40.0%	6.7%	0.0%	13.3%	6.7%	0.0%
York	211	0.0%	18.5%	75.8%	5.7%	61.1%	38.9%	14.7%	0.5%	73.5%	11.4%	19.0%	48.3%	10.0%	12.3%	10.4%	2.8%	0.0%
Total for Zone	**952**	**0.0%**	**22.4%**	**71.5%**	**6.1%**	**65.9%**	**34.1%**	**16.4%**	**0.9%**	**65.2%**	**17.4%**	**25.2%**	**41.3%**	**9.6%**	**8.1%**	**15.9%**	**4.0%**	**0.3%**
Health Choices Total	**3,956**	**0.0%**	**16.2%**	**74.8%**	**8.9%**	**67.1%**	**32.8%**	**50.2%**	**0.2%**	**37.8%**	**11.8%**	**39.5%**	**28.6%**	**11.3%**	**6.2%**	**14.4%**	**1.7%**	**0.3%**
Expansion Counties																		
Bedford	8	0.0%	50.0%	50.0%	0.0%	50.0%	50.0%	0.0%	0.0%	12.5%	87.5%	0.0%	75.0%	0.0%	0.0%	25.0%	12.5%	0.0%
Blair	30	0.0%	36.7%	63.3%	0.0%	76.7%	23.3%	0.0%	0.0%	6.7%	93.3%	10.0%	56.7%	3.3%	13.3%	16.7%	3.3%	0.0%
Bradford	23	0.0%	30.4%	60.9%	8.7%	69.6%	30.4%	0.0%	0.0%	13.0%	87.0%	26.1%	34.8%	13.0%	4.3%	21.7%	8.7%	0.0%
Cambria	44	0.0%	25.0%	72.7%	2.3%	77.3%	22.7%	2.3%	0.0%	20.5%	77.3%	25.0%	47.7%	11.4%	0.0%	15.9%	6.8%	4.5%
Cameron	2	0.0%	50.0%	50.0%	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Carbon	23	0.0%	34.8%	60.9%	4.3%	78.3%	21.7%	0.0%	0.0%	4.3%	95.7%	43.5%	17.4%	21.7%	0.0%	17.4%	0.0%	0.0%
Centre	13	0.0%	30.8%	69.2%	0.0%	61.5%	38.5%	0.0%	0.0%	7.7%	92.3%	15.4%	61.5%	15.4%	0.0%	7.7%	0.0%	0.0%
Clarion	9	0.0%	33.3%	55.6%	11.1%	55.6%	44.4%	0.0%	0.0%	11.1%	88.9%	22.2%	55.6%	11.1%	11.1%	0.0%	0.0%	0.0%

CY 2006 PRTF Youth Characteristics for HealthChoices Zones and All Expansion Counties (Percentages of All Recipients)																		
		Age				Gender		Race / Ethnicity				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Clearfield	45	0.0%	33.3%	57.8%	8.9%	55.6%	44.4%	0.0%	0.0%	8.9%	91.1%	8.9%	64.4%	0.0%	8.9%	17.8%	4.4%	0.0%
Clinton	12	0.0%	33.3%	66.7%	0.0%	75.0%	25.0%	0.0%	0.0%	0.0%	100.0%	16.7%	16.7%	8.3%	25.0%	33.3%	0.0%	0.0%
Columbia	8	0.0%	37.5%	50.0%	12.5%	87.5%	12.5%	0.0%	0.0%	12.5%	87.5%	37.5%	12.5%	12.5%	12.5%	25.0%	0.0%	0.0%
Crawford	26	0.0%	34.6%	61.5%	3.8%	61.5%	38.5%	0.0%	0.0%	23.1%	76.9%	19.2%	53.8%	7.7%	7.7%	11.5%	0.0%	0.0%
Elk	11	0.0%	9.1%	81.8%	9.1%	45.5%	54.5%	0.0%	0.0%	9.1%	90.9%	18.2%	81.8%	0.0%	0.0%	0.0%	0.0%	0.0%
Erie	122	0.0%	19.7%	74.6%	5.7%	53.3%	46.7%	10.7%	0.0%	2.5%	86.9%	16.4%	45.9%	18.0%	5.7%	13.9%	1.6%	0.0%
Forest	3	0.0%	0.0%	100.0%	0.0%	66.7%	33.3%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Franklin	48	0.0%	29.2%	60.4%	10.4%	66.7%	33.3%	8.3%	0.0%	12.5%	79.2%	16.7%	39.6%	18.8%	8.3%	16.7%	4.2%	0.0%
Fulton	1	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Huntingdon	4	0.0%	0.0%	75.0%	25.0%	100.0%	0.0%	0.0%	0.0%	25.0%	75.0%	50.0%	25.0%	0.0%	0.0%	25.0%	0.0%	0.0%
Jefferson	23	0.0%	30.4%	47.8%	21.7%	56.5%	43.5%	0.0%	4.3%	17.4%	78.3%	21.7%	47.8%	4.3%	8.7%	17.4%	0.0%	4.3%
Juniata	5	0.0%	40.0%	60.0%	0.0%	60.0%	40.0%	0.0%	0.0%	0.0%	100.0%	0.0%	60.0%	20.0%	0.0%	20.0%	0.0%	0.0%
Lackawanna	59	0.0%	25.4%	69.5%	5.1%	50.8%	49.2%	3.4%	0.0%	6.8%	89.8%	27.1%	35.6%	20.3%	3.4%	13.6%	0.0%	0.0%
Luzerne	86	0.0%	17.4%	76.7%	5.8%	66.3%	33.7%	5.8%	0.0%	8.1%	86.0%	15.1%	26.7%	30.2%	10.5%	17.4%	3.5%	0.0%

CY 2006 PRTF Youth Characteristics for HealthChoices Zones and All Expansion Counties (Percentages of All Recipients)																		
		Age				Gender		Race / Ethnicity				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Lycoming	22	0.0%	31.8%	63.6%	4.5%	63.6%	36.4%	0.0%	0.0%	4.5%	95.5%	9.1%	68.2%	9.1%	4.5%	9.1%	0.0%	0.0%
McKean	44	0.0%	18.2%	79.5%	2.3%	56.8%	43.2%	2.3%	0.0%	2.3%	95.5%	34.1%	27.3%	20.5%	4.5%	13.6%	9.1%	0.0%
Mercer	21	0.0%	33.3%	57.1%	9.5%	71.4%	28.6%	9.5%	0.0%	14.3%	76.2%	19.0%	52.4%	9.5%	4.8%	14.3%	4.8%	0.0%
Mifflin	15	0.0%	33.3%	66.7%	0.0%	80.0%	20.0%	13.3%	0.0%	6.7%	80.0%	6.7%	60.0%	13.3%	6.7%	13.3%	6.7%	0.0%
Monroe	34	0.0%	23.5%	73.5%	2.9%	38.2%	61.8%	23.5%	0.0%	2.9%	73.5%	38.2%	35.3%	8.8%	0.0%	17.6%	2.9%	0.0%
Montour	1	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Northumberland	10	0.0%	20.0%	70.0%	0.0%	70.0%	30.0%	0.0%	0.0%	0.0%	100.0%	50.0%	30.0%	10.0%	0.0%	10.0%	0.0%	0.0%
Pike	13	0.0%	30.8%	69.2%	0.0%	69.2%	30.8%	7.7%	7.7%	15.4%	69.2%	38.5%	30.8%	7.7%	0.0%	23.1%	0.0%	0.0%
Potter	5	0.0%	0.0%	100.0%	0.0%	80.0%	20.0%	0.0%	0.0%	0.0%	100.0%	40.0%	40.0%	20.0%	0.0%	0.0%	0.0%	0.0%
Schuylkill	68	0.0%	22.1%	70.6%	7.4%	64.7%	35.3%	1.5%	0.0%	7.4%	91.2%	26.5%	39.7%	10.3%	10.3%	13.2%	1.5%	0.0%
Snyder	3	0.0%	33.3%	66.7%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	33.3%	0.0%	33.3%	0.0%	33.3%	0.0%	0.0%
Somerset	22	0.0%	18.2%	81.8%	0.0%	81.8%	18.2%	0.0%	0.0%	9.1%	90.9%	22.7%	22.7%	27.3%	9.1%	18.2%	9.1%	4.5%
Sullivan	2	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	100.0%	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%
Susquehanna	11	0.0%	18.2%	72.7%	9.1%	90.9%	9.1%	9.1%	0.0%	0.0%	90.9%	36.4%	18.2%	27.3%	0.0%	18.2%	9.1%	0.0%

CY 2006 PRTF Youth Characteristics for HealthChoices Zones and All Expansion Counties (Percentages of All Recipients)																		
		Age				Gender		Race / Ethnicity				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Tioga	23	0.0%	34.8%	56.5%	4.3%	56.5%	43.5%	4.3%	0.0%	8.7%	87.0%	17.4%	34.8%	26.1%	0.0%	21.7%	4.3%	0.0%
Union	9	0.0%	11.1%	88.9%	0.0%	77.8%	22.2%	0.0%	0.0%	11.1%	88.9%	11.1%	11.1%	22.2%	11.1%	44.4%	22.2%	0.0%
Venango	11	0.0%	27.3%	63.6%	9.1%	90.9%	9.1%	18.2%	0.0%	0.0%	81.8%	27.3%	27.3%	0.0%	27.3%	18.2%	9.1%	0.0%
Warren	20	0.0%	25.0%	60.0%	15.%	50.0%	50.0%	5.0%	0.0%	10.0%	85.0%	30.0%	35.0%	15.0%	0.0%	20.0%	10.0%	0.0%
Wayne	29	0.0%	10.3%	79.3%	10.3%	72.4%	27.6%	3.4%	0.0%	3.4%	93.1%	24.1%	31.0%	24.1%	0.0%	20.7%	0.0%	0.0%
Wyoming	9	0.0%	33.3%	66.7%	0.0%	66.7%	33.3%	0.0%	0.0%	11.1%	88.9%	33.3%	22.2%	22.2%	22.2%	0.0%	0.0%	0.0%
Expansion Total	**977**	**0.0%**	**25.0%**	**69.0%**	**5.8%**	**63.7%**	**36.3%**	**4.7%**	**0.2%**	**8.0%**	**87.1%**	**21.9%**	**40.4%**	**15.7%**	**6.1%**	**15.9%**	**3.4%**	**0.4%**
Totals																		
All Health Choices Total	**3,956**	**0.0%**	**16.2%**	**74.8%**	**8.9%**	**67.1%**	**32.8%**	**50.2%**	**0.2%**	**37.8%**	**11.8%**	**39.5%**	**28.6%**	**11.3%**	**6.2%**	**14.4%**	**1.7%**	**0.3%**
All Expansion Total	**977**	**0.0%**	**25.0%**	**69.0%**	**5.8%**	**63.7%**	**36.3%**	**4.7%**	**0.2%**	**8.0%**	**87.1%**	**21.9%**	**40.4%**	**15.7%**	**6.1%**	**15.9%**	**3.4%**	**0.4%**
Overall Total	**4,933**	**0.0%**	**17.9%**	**73.6%**	**8.3%**	**66.4%**	**33.5%**	**41.2%**	**0.2%**	**31.9%**	**26.7%**	**36.0%**	**30.9%**	**12.2%**	**6.2%**	**14.7%**	**2.0%**	**0.3%**

CY 2006 Out-of-State PRTF Youth Characteristics For HealthChoices Zones and All Expansion Counties (Actual Recipients)																			
		Age[7]				Gender		Race / Ethnicity[8]				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African-American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
HealthChoices – Southwest																		
Allegheny	2	-	-	2	-	2	-	1	-	1	-	1	1	-	-	-	-	-
Armstrong	1	-	-	1	-	-	1	-	-	-	-	-	1	-	-	-	-	-
Beaver	1	-	-	1	-	1	-	-	-	1	-	-	1	-	-	-	-	-
Butler	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fayette	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Greene	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Indiana	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lawrence	2	-	-	2	-	-	2	-	-	-	-	-	2	-	-	-	-	1
Washington	4	-	-	4	-	2	2	-	-	3	-	-	3	1	-	-	-	-
Westmoreland	1	-	-	1	-	1	-	-	-	1	-	-	1	-	-	-	-	-
Total for Zone	**11**	**-**	**-**	**11**	**-**	**6**	**5**	**1**	**-**	**6**	**-**	**1**	**9**	**1**	**-**	**-**	-	**1**

[7] Ages 0 – 5 are not shown as they involve less than 1% of admission Statewide.

[8] Since Hispanic Ethnicity includes multiple racial categories, total may exceed 100% across racial and ethnic categories.

CY 2006 Out-of-State PRTF Youth Characteristics For HealthChoices Zones and All Expansion Counties (Actual Recipients)																		
		Age[7]				Gender		Race / Ethnicity[8]				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African-American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
HealthChoices – Southeast																		
Bucks	15	-	1	13	1	9	6	3	-	10	2	5	7	-	-	3	-	-
Chester	46	-	16	30	-	30	16	12	-	24	4	23	18	-	1	4	-	-
Delaware	47	-	9	34	4	19	28	18	-	21	5	24	11	1	-	11	-	-
Montgomery	34	-	7	25	2	15	19	6	-	24	2	14	14	-	-	6	-	-
Philadelphia	607	-	55	480	71	384	222	404	-	56	58	338	128	29	14	106	-	-
Total for Zone	**749**	**-**	**88**	**582**	**78**	**457**	**291**	**443**	**-**	**135**	**71**	**404**	**178**	**30**	**15**	**130**	**-**	**-**
HealthChoices – Lehigh / Capital																		
Adams	5	-	3	2	-	3	2	-	-	3	-	1	3	-	-	1	-	-
Berks	45	-	12	33	-	25	20	8	2	14	15	28	8	1	1	7	-	-
Cumberland	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Dauphin	3	-	3	-	-	2	1	3	-	-	-	2	1	-	-	-	-	-
Lancaster	13	-	5	7	1	5	8	1	-	6	1	4	3	1	3	2	-	-
Lebanon	4	-	2	1	1	4	-	-	-	3	-	2	1	-	-	1	-	-
Lehigh	19	-	7	12	-	15	4	2	-	12	1	13	4	-	-	2	-	-
Northampton	16	-	3	11	2	12	4	-	-	8	2	12	2	-	-	2	-	-
Perry	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

CY 2006 Out-of-State PRTF Youth Characteristics For HealthChoices Zones and All Expansion Counties (Actual Recipients)																		
		Age[7]				Gender		Race / Ethnicity[8]				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African-American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
York	12	-	4	6	2	5	7	1	-	7	1	5	4	-	1	2	-	-
Total for Zone	**117**	**-**	**39**	**72**	**6**	**71**	**46**	**15**	**2**	**53**	**20**	**67**	**26**	**2**	**5**	**17**	**-**	**-**
Heath Choices Total	**877**	**-**	**127**	**665**	**84**	**534**	**342**	**459**	**2**	**194**	**91**	**472**	**213**	**33**	**20**	**147**	**-**	**1**
Expansion Counties																		
Bedford	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Blair	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bradford	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cambria	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cameron	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Carbon	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Centre	1	-	1	-	-	-	1	-	-	-	-	1	-	-	-	-	-	-
Clarion	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Clearfield	3	-	-	2	1	1	2	-	-	-	3	-	1	-	-	2	-	-
Clinton	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Columbia	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

CY 2006 Out-of-State PRTF Youth Characteristics For HealthChoices Zones and All Expansion Counties (Actual Recipients)																		
		Age[7]				Gender		Race / Ethnicity[8]				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African-American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Crawford	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Elk	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Erie	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Forest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Franklin	9	-	-	7	2	4	5	2	-	-	6	5	1	-	-	3	-	-
Fulton	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Huntingdon	2	-	-	2	-	2	-	-	-	1	1	1	-	-	-	1	-	-
Jefferson	2	-	-	-	2	1	1	-	-	-	2	2	-	-	-	-	-	1
Juniata	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Lackawanna	4	-	-	4	-	3	1	-	-	-	4	2	-	-	-	2	-	-
Luzerne	4	-	2	2	-	3	1	-	-	-	4	2	-	-	-	2	-	-
Lycoming	2	-	1	1	-	1	1	-	-	-	2	-	2	-	-	-	-	-
McKean	1	-	-	1	-	1	-	-	-	-	1	1	-	-	-	-	-	-
Mercer	3	-	-	2	1	3	-	1	-	-	2	2	-	-	-	1	-	-
Mifflin	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Monroe	3	-	-	3	-	-	3	1	-	-	1	1	2	-	-	-	-	-
Montour	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

CY 2006 Out-of-State PRTF Youth Characteristics For HealthChoices Zones and All Expansion Counties (Actual Recipients)																		
		Age[7]				Gender		Race / Ethnicity[8]				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African-American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Northumberland	2	-	-	1	-	1	1	-	-	-	2	1	-	-	-	1	-	-
Pike	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Potter	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Schuylkill	8	-	2	6	-	3	5	-	-	-	5	3	4	-	-	1	-	-
Snyder	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Somerset	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Sullivan	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Susquehanna	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Tioga	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Venango	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Warren	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Wayne	1	-	-	1	-	1	-	-	-	-	-	1	-	-	-	-	-	-
Wyoming	2	-	2	-	-	2	-	-	-	-	2	1	-	1	-	-	-	-
FFS Total	**47**	**-**	**8**	**32**	**6**	**26**	**21**	**4**	**-**	**1**	**35**	**23**	**10**	**1**	**-**	**13**	**-**	**1**

CY 2006 Out-of-State PRTF Youth Characteristics For HealthChoices Zones and All Expansion Counties (Actual Recipients)																		
		Age[7]				Gender		Race / Ethnicity[8]				Primary Diagnosis					MR/ASD	
County	Total	< 6	6-12	13-17	18-21	M	F	African-American	Hispanic	White	Other	Conduct D/O	Mood D/O	ADHD	Adjust-ment D/O	Other	Any ASD	Any MR
Totals																		
All Health Choices Total	877	-	127	665	84	534	342	459	2	194	91	472	213	33	20	147	-	1
Expansion Total	47	-	8	32	6	26	21	4	-	1	35	23	10	1	-	13	-	1
Overall Total	924	-	135	697	90	560	363	463	2	195	126	495	223	34	20	160	-	2

Appendix B

Appendix B

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