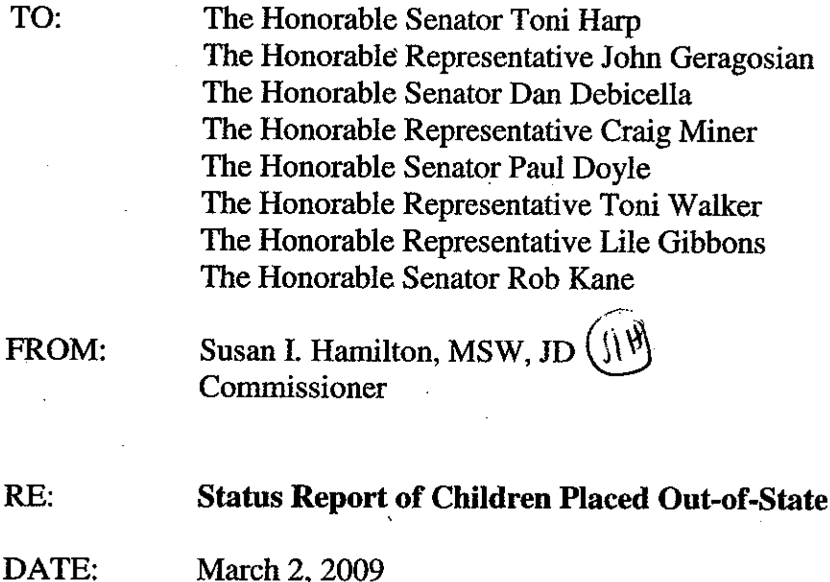
DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Susan I. Hamilton, J.D., M.S.W.
Commissioner

M. Jodi Rell
Governor

MEMORANDUM



TO: The Honorable Senator Toni Harp
The Honorable Representative John Geragosian
The Honorable Senator Dan Debicella
The Honorable Representative Craig Miner
The Honorable Senator Paul Doyle
The Honorable Representative Toni Walker
The Honorable Representative Lile Gibbons
The Honorable Senator Rob Kane

FROM: Susan I. Hamilton, MSW, JD (SIH)
Commissioner

RE: **Status Report of Children Placed Out-of-State**

DATE: March 2, 2009

Attached please find a report pursuant to the requirements of Public ACT 09-1 in which DCF was directed to provide a status report of children and youth requiring residential treatment who would normally be placed in out-of-state facilities and to establish a plan for services for these youth by assessing public and private residential treatment capacity within Connecticut. Additionally, the plan was to include a delineation of costs or savings and offer commentary on the feasibility of implementation of such plan on or before July 1, 2009.

The Department has made every effort to be responsive to the request laid out in the Public Act and to make this submission as comprehensive as possible. However, given the complexity of the needs of those we serve, as well as the complexities associated with treatment planning and the care authorization process, we fully anticipate that there may be follow-up questions. We welcome any continued dialogue.

STATE OF CONNECTICUT
Phone (860) 550-6300 - Fax (860) 566-7947
505 Hudson Street, Hartford, Connecticut 06106-7107
www.state.ct.gov /dcf
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In essence, the report makes four essential points, as follows:

1) Despite a significant decrease in the number of youth placed out-of-state when compared to years ago, there is a steady, and recently increasing, volume of children and youth with particular needs which cannot be met by public or private in-state resources.

2) These in-state resources, even with some unused capacity at any given time, are not currently capable of meeting the clinical needs of the youth being referred out-of-state.

3) In order to minimize out-of-state placements, additional in-state capacity would be required in order to treat children and youth with particular complex behavioral health disorders including significant histories of sexual behavior, fire-setting, uninhibited aggression and/or significant mental retardation or pervasive developmental disorder.

4) Efforts over the last several years to procure these types of services in-state, or enhance existing services, have not been completely successful, and if we are to cease referring children and youth out-of-state, new facilities and resources, in part, would be required.

Thank you for your continued interest in the Department and its work. Please call upon me with any questions regarding this report.

CC: Joan Soulsby, Office of Fiscal Analysis
Thomas P. Sheridan, Senate Clerk
Jennifer Bernier, Legislative Library
Susan Price, Office of Legislative Research
Garey E. Coleman, House Clerk
Kendall Wiggin, State Librarian
Brie Johnston, Human Services Committee
Susan Keane, Appropriations Committee
Ryan O'Neil, Office of Legislative Research

Department of Children and Families
Report on Children Placed Out-Of-State

March 1, 2009

Pursuant to Public Act 09-1

Introduction

Consistent with the requirements of P.A. 09-01 Sec. 27, this document provides both a status report and a plan for the Department of Children and Families (DCF) to establish services for children and youth requiring residential treatment who would normally be placed in out-of-state facilities. As required, this plan includes the integration of existing state facilities to that extent which is clinically appropriate and feasible while also considering available licensed residential treatment capacity in-state. Finally, this report provides a delineation of essential costs and a potential implementation timeframe should resources be made available to DCF through a legislative appropriation which makes implementation feasible.

Background

As of January 1, 2009, 342 children and youth with a nexus to DCF were being treated in out-of state- residential treatment facilities. By way of context, this number represents a significant decrease from the number of youth placed out-of state only eight years ago when 479 youth were being served out-of-state. Significantly, the number also represents an increase from the number of children and youth being treated out-of-state in October of 2006 when only 282 individuals fell in this category.

Of the 342 children and youth who were receiving residential treatment outside of Connecticut in January 2009, 277 had only a Child Protective Service status, 57 had only a Juvenile Services status and 8 had a Dual Commitment status. This is important because, especially for those youth with a Juvenile Services Status, the Courts may have required an out-of-state placement for purposes of public safety or for other reasons entirely at the Judge's discretion. It is also worth noting that of the 342 children being served out-of-state, approximately 75% are being served in neighboring New England States (including 179 in Massachusetts, 34 in Vermont, and 23 in Rhode Island). This is relevant because, despite the geographically small size of Connecticut, it is not uncommon for an out-of-state residential treatment center to be far more proximal to a family living near one of our borders than would be a residential treatment center which is in-state but far from the child and the family's home.

In order to understand why the children and youth are served out of state it is helpful to have an understanding of (1) various considerations that go into referring a youth out-of-state, (2) size and capacity of Connecticut's residential treatment system holistically over time, and (3) unique characteristics of those particular children and youth who are served out-of-state.

Considerations Related to Referring a Youth Out-of-State

Prior to referring a youth out-of-state for residential treatment, a number of issues must be considered. For example:

- **Does the youth require a specialized type of treatment which is not available in Connecticut?** For example, some youth will require specialized treatment for high-risk fire setters for which we do not have programs in Connecticut; other youth may require specialized services for

psychosexual behavior problems, while still other youth may require highly specialized services for Autism and so on.

- **<u>Are specialized services available in Connecticut but not *accessible* in an appropriate timely manner?</u>** We have some capacity to treat youth with significant mental retardation in-state. However, when these beds are full, we have no other in-state providers who are capable of and willing to admit these youth. In some instances (depending on the youth's current placement and the stability thereof) it may be appropriate to wait for a bed to become vacant. In other instances, however, the need for treatment may be of sufficient immediacy that an out-of-state placement becomes the clinically appropriate alternative.
- **<u>Is the out-of-state placement actually closer to the family's residence than an alternative in-state placement?</u>** This is often the case for individuals living in both North Central and Eastern Connecticut. For example, a program in Springfield is far more convenient for a family living in Enfield than would be a program in the Stamford or Bridgeport area. In such a case, where appropriate, we try to place the child as close to the family as is reasonable and clinically appropriate.
- **<u>If a child is to be placed out of state, what is the ability of the out-of-state provider to do what ever family treatment is necessary and appropriate?</u>** Many out-of-state providers have made provisions for this by providing transportation and building in an expectation of frequent and on-going family therapy. Other programs may be less able to accommodate the family's on-going need for therapy. Such programs should only be used in extraordinary circumstances (for example, when there is no viable family connection or when the need for specialized treatment significantly outweighs the negative impact of infrequent family treatment).
- **<u>Does the out-of-state program offer a clinical service which is significantly superior to that which we can offer in Connecticut?</u>** A variety of out-of-state programs offer specialized services of high quality which are inadequately available in Connecticut. While we may have some capacity in-state for quality treatment of a specific type, our capacity may be limited. Accordingly, we must confront the dilemma of whether to send the child out-of-state in order better to meet his or her treatment needs or to place the child in a less appropriate in-state program simply because it is closer.
- **<u>Has the family specifically requested an out-of-state provider?</u>** On occasion, families have requested specific programs to meet the needs of their children. Such requests ought to be decided solely on their merits. If the program identified appears to be one which can best meet the needs of the child, it may be reasonable and appropriate to accommodate the family's request.

- **<u>Has a Judge ordered a residential placement for which there are no beds available now or in the foreseeable future in-state?</u>** In such instances, out-of-state placements must be considered. However, all of the considerations identified above (proximity to family, appropriateness of quality treatment, etc.) must also be considered.
- **<u>Is the child currently in detention awaiting discharge to a residential bed for which no in-state bed is available?</u>** As with a judicial order for residential placement, in such instances out-of-state options certainly are appropriate to consider.
- **<u>Has the child him or herself requested an out-of-state placement?</u>** From time to time, children have requested out-of-state placement predicated on their belief that being more distant from local friends and family will be better for them. Such requests are evaluated and decisions made based on the individual case assessment.
- **<u>Has the child been rejected for admission by all appropriate in-state providers?</u>** Providers are not required to accept children who are outside of their promulgated eligibility criteria (for example, programs are not required to take fire setters when they clearly state in advance that such youth are not appropriate for their programs). When a youth has been rejected by all appropriate in-state providers, out-of-state providers must be considered.

It should be noted that in order to assure that these questions have been asked and satisfactorily answered, any out-of-state referral to residential treatment must be approved by the Director of Behavioral Health and Medicine or, for committed, delinquent youth, by the Bureau Chief of Juvenile Services.

The Size and Capacity of Connecticut's System

As described in Chart 1 there are currently approximately 433 licensed residential treatment beds in Connecticut that are utilized by DCF. The number of beds utilized differs from the number of beds licensed since some providers have a licensed bed capacity significantly in excess of that which is utilized by DCF. That additional capacity may be used by the provider to serve youth from other states and/or to serve youth who are referred from school districts or DDS, or who are not eligible for services from the public sector. The instances in which that occurs are characterized by the specialty nature of the provider such as The American School for the Deaf or the preference of the provider for diversified funding streams as exemplified by Wellspring and Devereux Glenholm.

Chart 1:

In-State RTCs	General Psych Total Beds	In-State RTCs	JJ Total Beds	In-State RTCs	Substance Abuse Total Beds	In-State RTCs	MR/PDD Total Beds	
Children's Center of Hamden	38	Mount St. John	32	Rushford	12	Learning Clinic	6	
Klingberg	42	CJR	60 *	MCCA	15	CHOC-Jordan	12	
CHOC	49	Touchstone	26	New Hope	20	JRI	6	
Grey Lodge	18	Stepping St.	24					
Wellspring	26	Natchaug	13					
Waterford	40							
GRAND TOTAL	**213**		**155**		**47**		**24**	
High Meadows	16		0				20	
CCP	39		9				0	**GRAND TOTAL**
GRAND TOTAL	**268**		**164**		**47**		**44**	**523**

* CJR - RTC to close April 2009 - JJ beds reduced to 95.

While the number of children served in contracted Residential Treatment Centers has significantly declined over the past 5 years, Chart 2 shows that the average cost per child served has increased by almost 46% over the same period

Chart 2: Number of Children Services in RTC 2003-2008

Year	Total Dollars	Children Served	Average Cost Per Child Served
2003	$73,232,985	1087	67,371
2004	$89,401,963	1201	74,439
2005	$87,986,038	970	90,707
2006	$80,769,969	874	92,414
2007	$80,514,462	810	99,400
2008	$78,575,651	800	98,219

Over the past several years a variety of factors have contributed to a decrease in the utilization of residential treatment. Of those factors, the most salient are (1) a dramatic increase in the availability of more intensive community based behavioral health services, (2) the implementation of the Connecticut Behavioral Health Partnership and a corresponding emphasis on utilization management, and (3) the implementation by DCF of Structured Decision Making with a valid and reliable Safety Assessment instrument along with the utilization of other standardized assessment instruments including the Child and Adolescent Need and Strengths (CANS) and the Global Appraisal of Individual Need. In this context it is important to note that concurrent with the reduction in the number of children removed from their home, the rate of recurrence of maltreatment has also been reduced to the point where it is now below the national median for all child welfare agencies indicating that the decisions made by DCF regarding removal are not jeopardizing the safety of children.

As far as the increase in more intensive and extensive community-based, behavioral health services is concerned, DCF expenditures for community based behavioral health services have increased from approximately $14 million in 2001 to over $101 million in 2008. This increase included the development of 54 new Therapeutic Group Homes which allow children and youth to be served in home-like settings in residential communities, as well as the expansion of intensive home-based services, crisis stabilization and emergency mobile psychiatric services, and other community-based services. Increasingly, children are remaining in local communities, and children and families are receiving evidence-based treatment interventions. There is increased access to community services, and improved accountability has led to improved care and outcomes.

It is important to note that under the terms of *Juan F.* Exit Plan, DCF is required to have no more than 11% of all children in care in placement in residential treatment. In large measure because of the aforementioned initiatives and activities, the DCF has continued to meet this *Juan F.* Exit Outcome Measure. Comparing December, 2007, with December, 2008, we have 6% fewer total children in care, and of those children the percentage that are placed in residential treatment has been reduced from 11% to 10%. The development of Therapeutic Group Homes, the full implementation of use of the CANS instrument to make level of care determinations, the full implementation of a concurrent review process by the Administrative Services Organization (ASO) to assess the continued need for a residential level of care for each child, and the implementation of a protocol by the DCF area offices to prevent children from being on discharge delay status all seem to have been significant factors in the reduced utilization of and need for residential care.

Our analysis further suggests that if the average length of stay for all children in residential treatment is reduced by only two months, almost 90 additional children could be served within the existing in-state residential treatment capacity. To this end, we expect the average length of stay to continue to decline, and we believe that this will create additional capacity for in-state, residential providers.

The Role and Capacity of State-Operated Facilities

Before proceeding, it is important to establish both the role and capacity of State-Operated Residential Treatment Facilities. In addition to licensing in-state residential treatment center beds operated by private providers, DCF itself manages and operates two residential treatment centers: Connecticut Children's Place (CCP) and High Meadows. (See Chart 3, below)

Chart 3: State Operated Residential Treatment Centers

Name	Capacity	Cost
Connecticut Children's Place	48	$18,902,204
High Meadows	36	$17,898,586

The overall number of beds operated by DCF is comparatively small, and the per-diem cost of those beds is comparatively high (Appendix I). By virtue of these facts, these facilities serve several unique and specialized roles in the overall DCF continuum of care. First, they are the primary step-down discharge option from Riverview for children who cannot immediately and safely return home and who are not accepted by private residential treatment centers by virtue of either their acuity or instability. Second, they serve other children and youth who can not currently be served by private residential treatment centers either because of their acuity, their risk, or their specialized clinical and/or medical needs. Third, they serve the Judicial System by providing the only residential treatment centers to which children may be court-ordered. Finally, they serve the DCF system as a whole by providing a safe, intensively staffed emergency placement setting for youth with complex clinical needs who present in crisis and who are in need of immediate placement.

As will be discussed later, the two residential facilities operated by DCF have a finite capacity both by virtue of their staffing allocations and their physical plants. Because of this, any expansion of those facilities to serve other populations would require additional resources and/or modification of the private provider system in myriad ways.

Characteristics of Children and Youth Treated Out-of-State

As indicated in the earlier discussion, children and youth are generally served out-of-state for one or more of the following reasons:

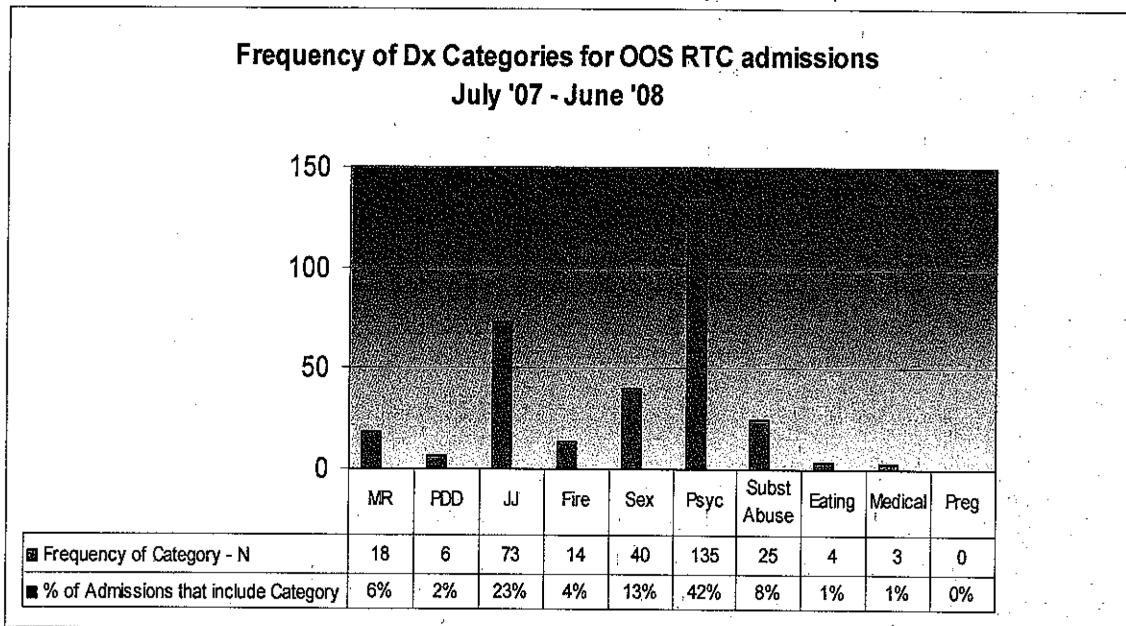
- The child has been referred to and "rejected" by all clinically appropriate in-state residential providers, or
- There is no currently available in-state capacity for a child with the particular clinical problem(s) requiring treatment; for example, there are no programs in Connecticut that provide residential treatment for youth who are fire setters or aggressive sex offenders, or

- There is in-state capacity but that capacity which exists is being fully utilized with the result that the youth must be sent out of state in order to receive timely clinically appropriate treatment, or
- The youth is ordered out of state by a Judge, or
- The youth requests an out of state placement in order to attend a specialized residential treatment center or to be proximal to family, or
- The youth's permanency plan calls for reunification with an out-of-state relative and placement out-of-state is used to facilitate and expedite the permanency plan.

For purposes of this report, we will focus only on the first three reasons articulated above since those account for the vast majority of out-of-state placements.

Children and youth referred out-of-state typically fall in one or more of several distinct diagnostic categories. As reflected in Chart 4 (below), the child or youth generally has a co-morbid psychiatric problem and a psychosexual behavior problem or he or she has a significant behavior problem that has led to adjudication by the Juvenile Justice System, and/or he or she engages in dangerous behavior associated with fire-setting, and/or he or she is diagnosed with mental retardation. While a number of these youth have substance abuse problems, it is generally the case that this is a co-occurring problem and not the primary reason for out-of-state treatment.

Chart 4: Frequency of Diagnostic Categories
Out of State RTC Admissions
Total OOS admissions for time period below = 173



	MR	PDD	JJ	Fire	Sex	Psyc	Subst Abuse	Eating	Medical	Preg
Frequency of Category - N	18	6	73	14	40	135	25	4	3	0
% of Admissions that include Category	6%	2%	23%	4%	13%	42%	8%	1%	1%	0%

Ex: Substance Abuse; This category occurred 25 times of the 173 admissions, 8% of the 173 admissions included this category
Categories above are NOT mutually exclusive, categories above show frequency

Legend: MR = Mental Retardation
PDD = Pervasive Developmental Disorder
JJ = Nexus to Juvenile Services
Fire = History of firesetting
Sex = Psychosexual Behavior Problem
Psyc = Axis One Psychiatric Disorder
Substance Abuse = Axis One Substance Abuse Disorder
Eating = Clinically significant eating disorder
Medical - Medical Problem Requiring out-of-home residential treatment
Preg = Pregnant

In reviewing these data, it becomes clear that several things will required in order to eliminate the necessity for out-of-state placements:

1. The capacity and role of state-operated facilities must be re-examined and provisions must be made in either the public or private sector to accommodate those children and youth whom private providers currently decline to serve or are unable to serve.

2. Private providers must re-align their available capacity to better serve the clinical needs and level of acuity of the youth currently being referred out-of-state by DCF. This cohort of youth is far more challenging than was the case several years ago, and, in some cases, the development of this capacity will require staffing modification, additional training, and modification to the facilities' physical plants.

3. The utilization of existing capacity must be maximized. There is clear and demonstrable relationship between the average length of stay in residential treatment and the number of children and youth who can be served in a finite number of beds. (See Chart 5). In addition, length-of-stay targets must be tied to the attainment of measurable and appropriate clinical outcomes and goals.

4. Finally, additional specialized in-state capacity must be developed for specific cohorts of youth. For example, if Connecticut is not going to send youth with significant aggressive or predatory psychosexual behavior problems out-of-state then we must develop programs in-state to meet this need. This capacity can be developed in either the public or private sector and there are advantages and disadvantages to both approaches. Ultimately, however, we believe that the optimal approach is one which relies upon a *mix* of public and private services (both residential and community-based) to treat Connecticut youth in-state.

Chart 5: Relationship between ALOS and number of Youth served

Reducing ALOS (Days)	MONTHS	Youth Served	# Additional Youth Served w/decreased ALOS
365	12	433	
334	11	473	40
304	10	520	87
274	9	578	145
243	8	650	217

This Chart represents the number of additional youth who could be served in relationship to decreased LOS

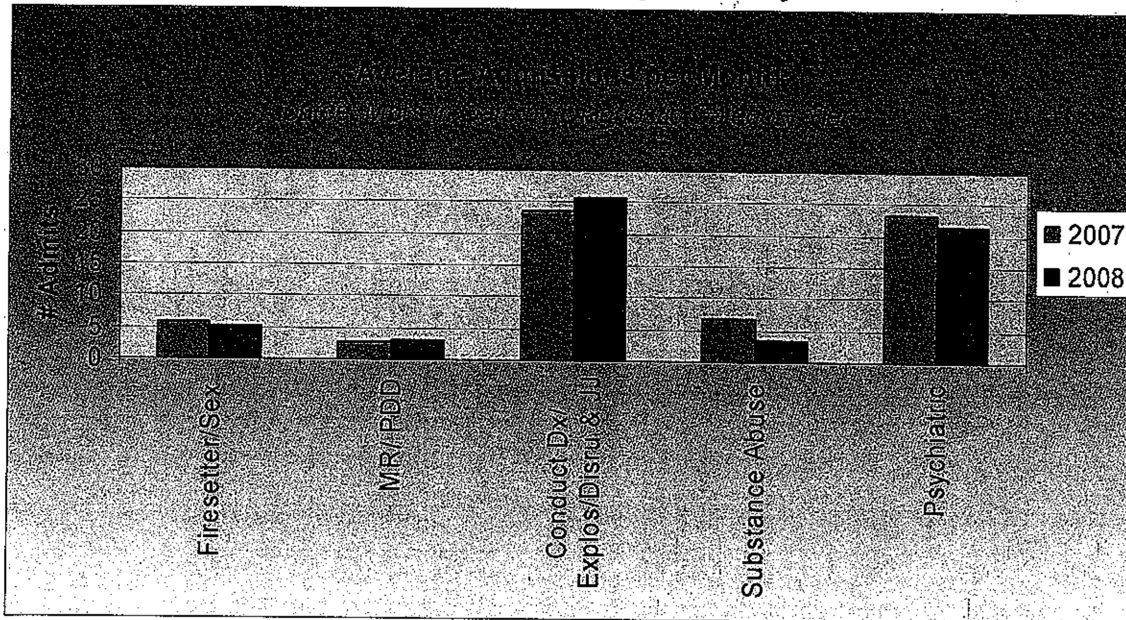
Utilization of Existing In-State capacity

A review of current utilization indicates that the majority of residential treatment is provided to youth between the ages of 13 and 16; although the rate of admissions has remained fairly flat over the past 18 months, there has been a downward trend in the average length of stay. When we look at the number of youth with clinical presentations of a type which generally necessitate out-of-state placement, we find that despite a small decrease, there is a fairly stable volume of youth whose clinical needs cannot currently be met in-state (See Chart 6 and Chart 7)

Chart 6: Bed Occupancy
Source: Diagnostic Category Tier Data

RTC AVERAGE POINT-IN-TIME BED OCCUPANCY		
	2007	2008
Firesetter/Sex Reactive	**100**	**111**
MR/ PDD	**67**	**62**
Conduct Dx/ Explosive/Disruptive & JJ	**282**	**274**
Substance Abuse	**54**	**40**
Psychiatric	**312**	**293**

Chart 7: The average rate of admissions per month has not fluctuated greatly for two years



Again, in looking at the preceding charts, it is important to remember that the categories "psychiatric" and "substance abuse" generally reflect co-occurring diagnoses. More specifically, those children and youth with only a diagnosis of a psychiatric disorder or a substance abuse disorder may be served in-state, whereas those youth with a psychiatric disorder and fire setting or highly sexualized or aggressive behaviors may currently require placement out-of-state or in a DCF-operated facility.

Chart 8 sheds further light on our analysis of the characteristics of youth served in-state and out-of state.

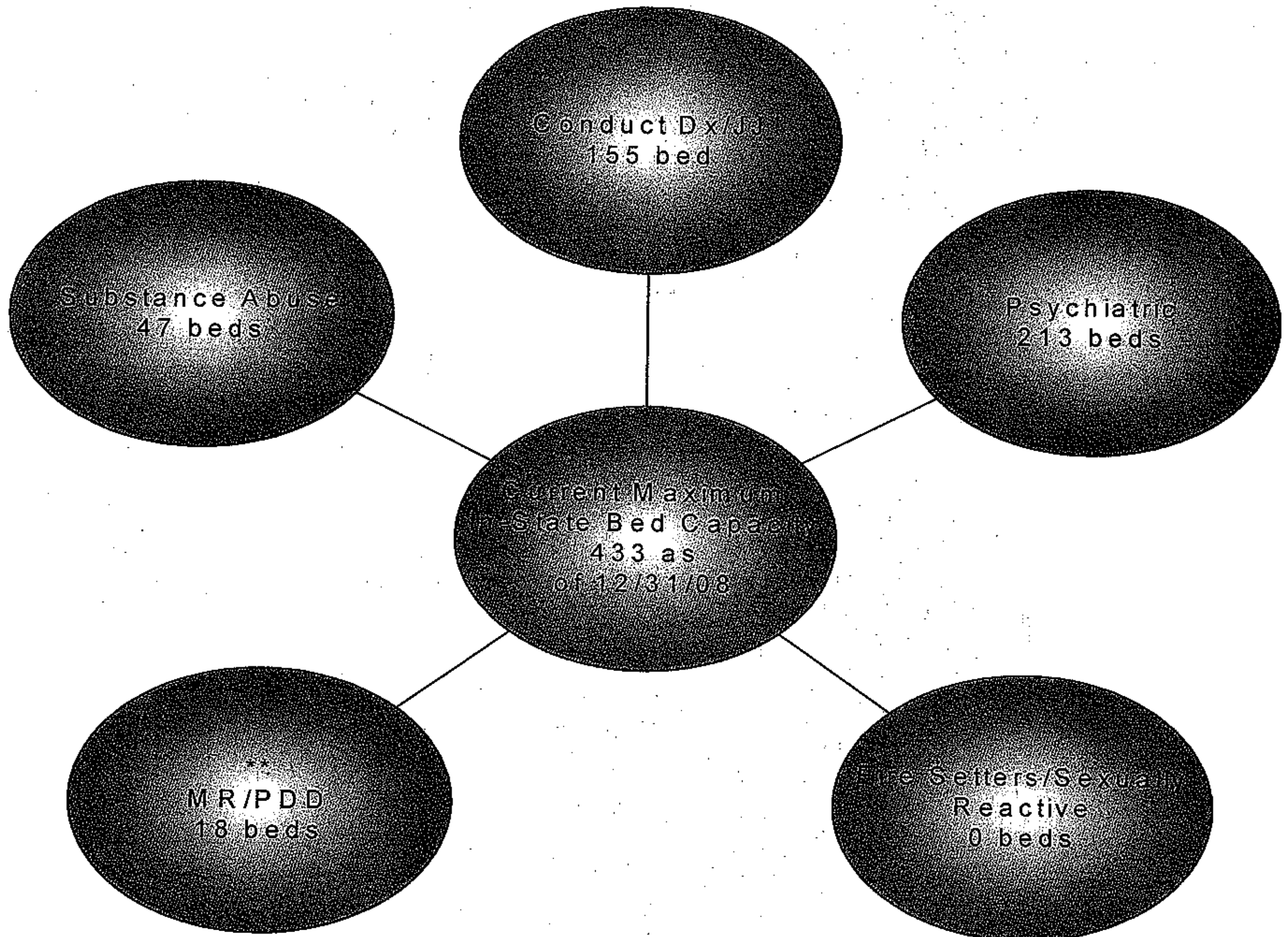
Chart 8: RTC location (in-state & out-of-state) of unduplicated youth during Q3 & Q4.

Q3 & Q4 '08	In State	OOS	Total	% In State	% OOS
Fire/Sex	**0**	**137**	***137***	**0%**	**100%**
MR/PDD	**26**	**55**	***81***	**32%**	**68%**
ConductDx/JJ	**294**	**77**	***371***	**79%**	**21%**
Sub Abuse	**41**	**10**	***51***	**80%**	**20%**
Psych	**277**	**117**	***394***	**70%**	**30%**
TOTALS	***638***	***396***	***1034***	***62%***	***38%***

An analysis of our data clearly indicates that simply looking at the raw number of existing residential treatment "beds" provides an inadequate understanding of the scope of the issue. Obviously, the "specifics" of demand when allocated across gender and primary diagnostic categories is much more informative, and we find that for certain diagnostic categories the in-state capacity is inadequate to meet the demand whereas for others the reverse is true. For example, from 07/07 through 09/08, of the 951 children referred for in-state residential care, 109 were not accepted by our in-state providers. The reasons and percentages for each decision not to accept are varied. Nevertheless, as a result of in-state denials for care, it was necessary to place those children in out-of-state settings.

Chart 9 depicts the in-state private provider residential treatment bed capacity as of 12/31/08.

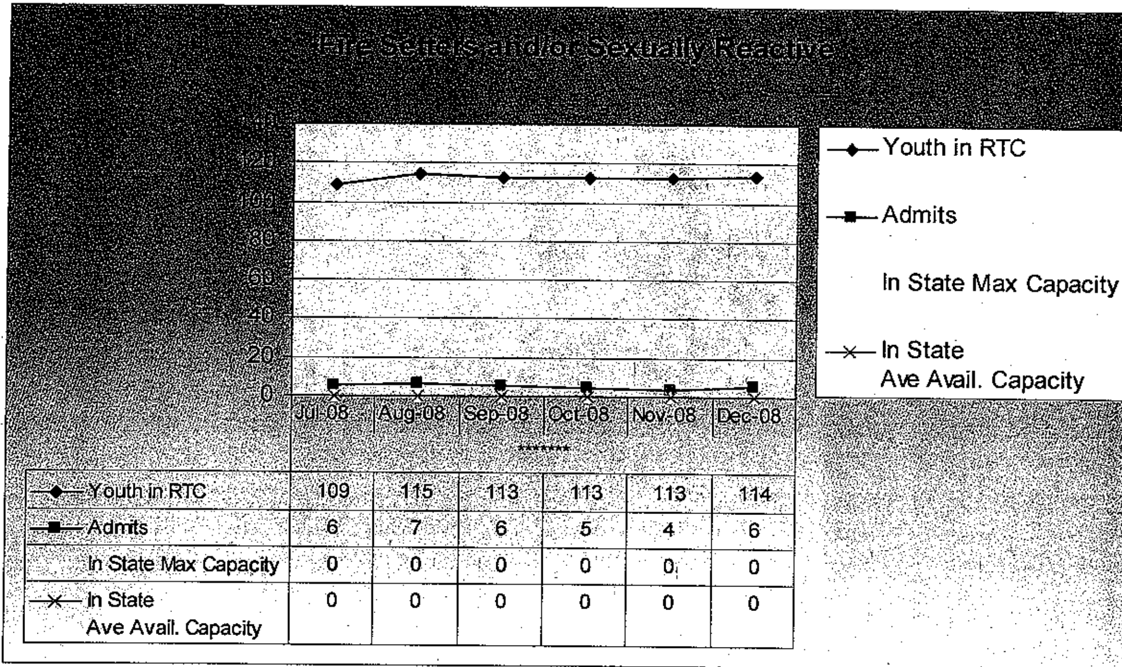
Chart 9: CT's current In-State private provider system as of 12/31/08



** The above 6 Additional beds to serve MR/PDD youth brought online January 09 are not reflected in count

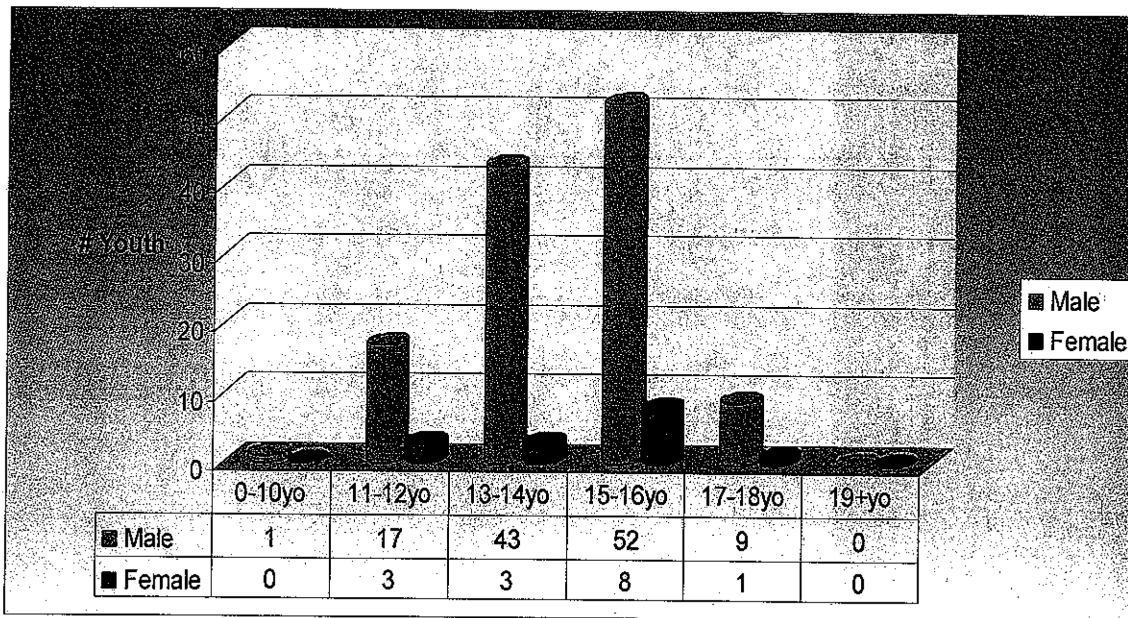
Charts 10 and 11 provide information relative to the supply and demand for in-state RTC beds for youth with fire-setting or highly sexually reactive behaviors, along with basic demographic characteristics of the youth who require such services.

Chart 10: Fire Setters &/or Highly Sexually Reactive
Q3 & Q4 '08



	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Youth in RTC	109	115	113	113	113	114
Admits	6	7	6	5	4	6
In State Max Capacity	0	0	0	0	0	0
In State Ave Avail. Capacity	0	0	0	0	0	0

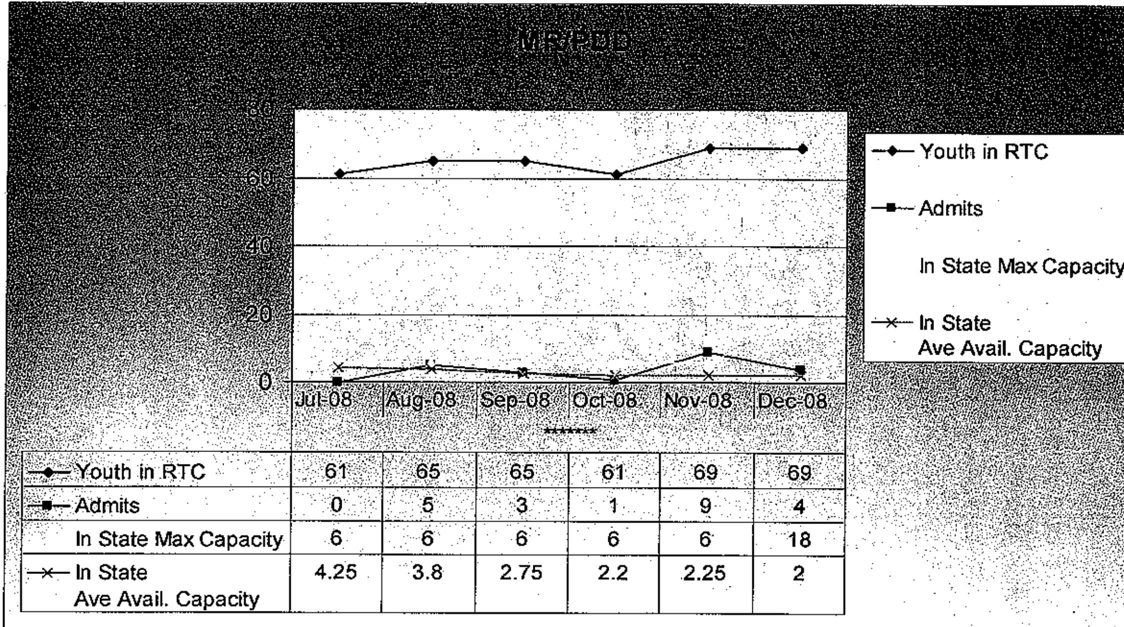
Chart: 11 Fire Setters and/or Highly Sexually Reactive (con't)
Gender and Age



	0-10yo	11-12yo	13-14yo	15-16yo	17-18yo	19+yo
Male	1	17	43	52	9	0
Female	0	3	3	8	1	0

Charts 12 and 13 provide information related to the supply and demand for in-state RTC beds for youth with mental retardation and/or severe pervasive developmental disorders, and basic demographic characteristics of the youth who require such services.

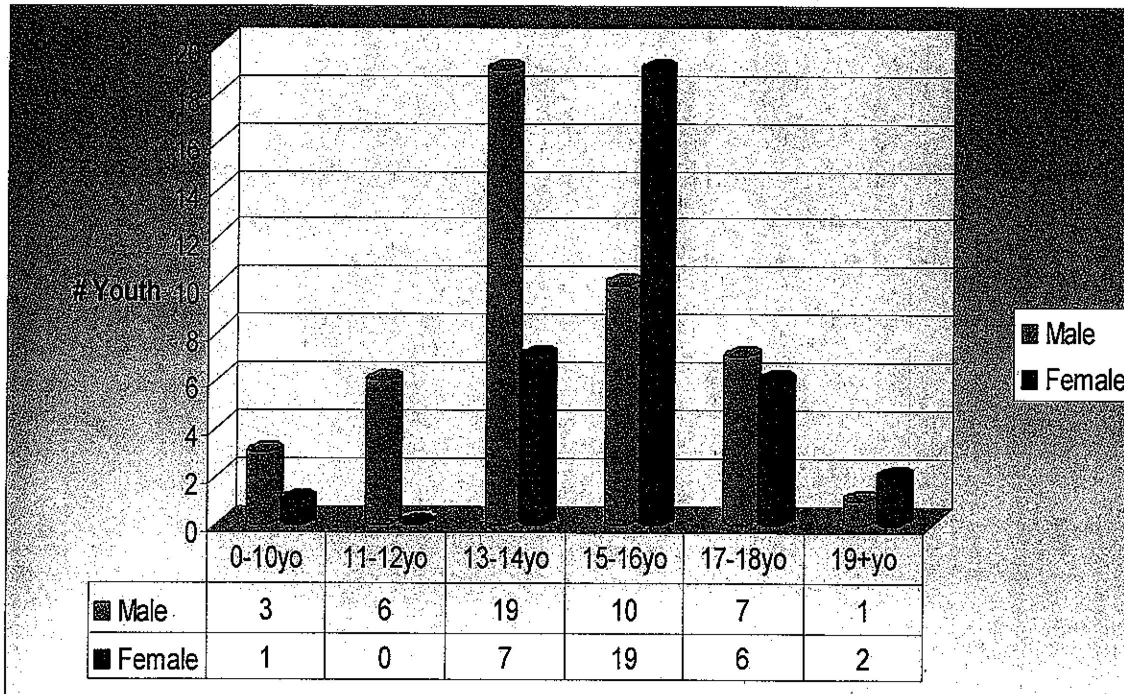
Chart 12: MR/PDD
Q3 & Q4 '08



	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Youth in RTC	61	65	65	61	69	69
Admits	0	5	3	1	9	4
In State Max Capacity	6	6	6	6	6	18
In State Ave Avail. Capacity	4.25	3.8	2.75	2.2	2.25	2

First youth admitted 12/24/08 to CHOC-Jordan; therefore in-state maximum capacity not reflecting Jordan House until Dec '08. (Jordan House vacancies reported under Psych during these 2 quarters)

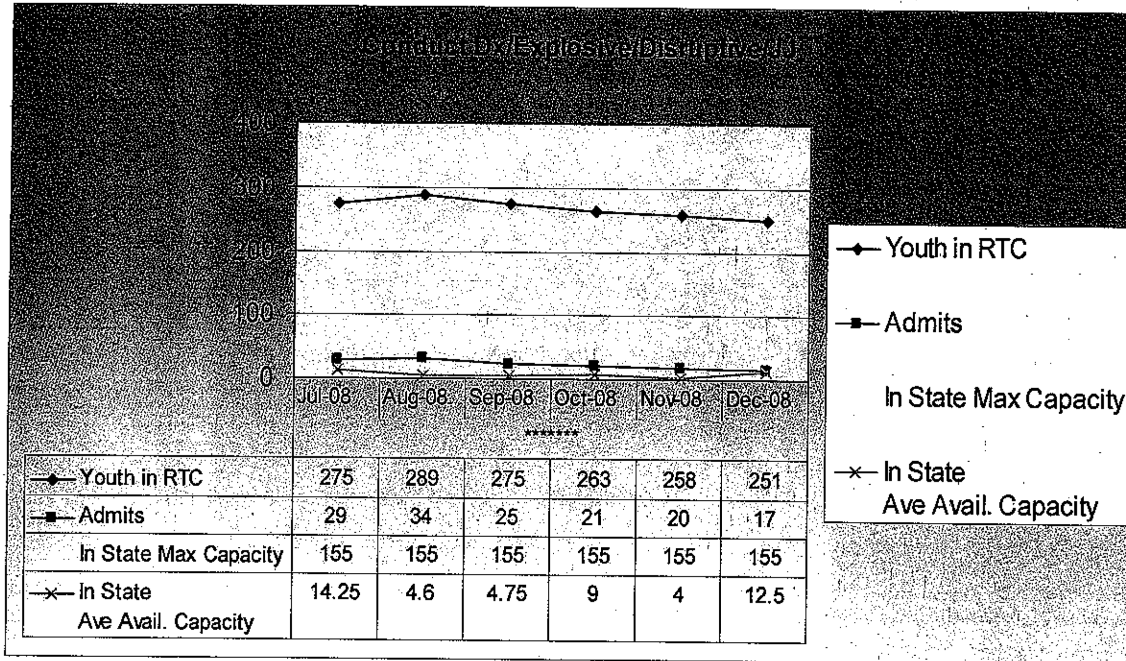
Chart 13: MR/PDD (con't)
Gender and Age



	0-10yo	11-12yo	13-14yo	15-16yo	17-18yo	19+yo
Male	3	6	19	10	7	1
Female	1	0	7	19	6	2

Charts 14 and 15 provide information related to the supply and demand for in-state RTC bed for youth with extreme aggressive and/or unlawful behaviors, and basic demographic characteristics of the youth who require such services. It is important to note here that with the planned closing of residential treatment services provided by The Connecticut Junior Republic, the "supply" will decrease from 155 beds to 95 beds by the spring of 2009.

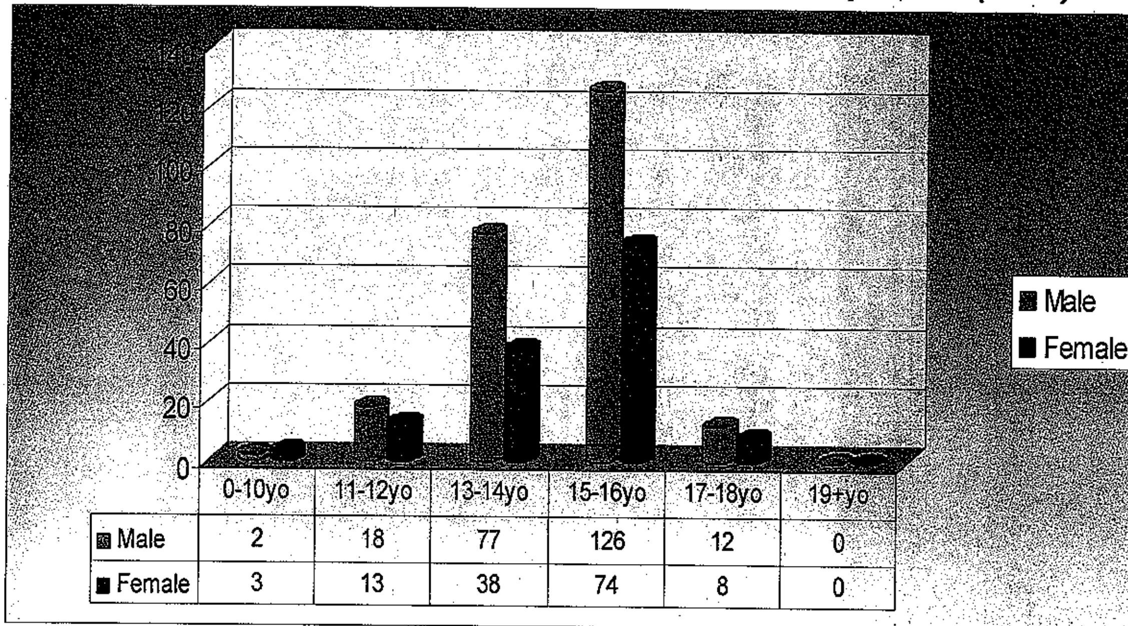
Chart 14: Conduct Disorder/Explosive/Disruptive/JJ Q3 & Q4 '08



	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Youth in RTC	275	289	275	263	258	251
Admits	29	34	25	21	20	17
In State Max Capacity	155	155	155	155	155	155
In State Ave Avail. Capacity	14.25	4.6	4.75	9	4	12.5

As of July 1, 2008 CJR dropped to 60 beds from 84 beds

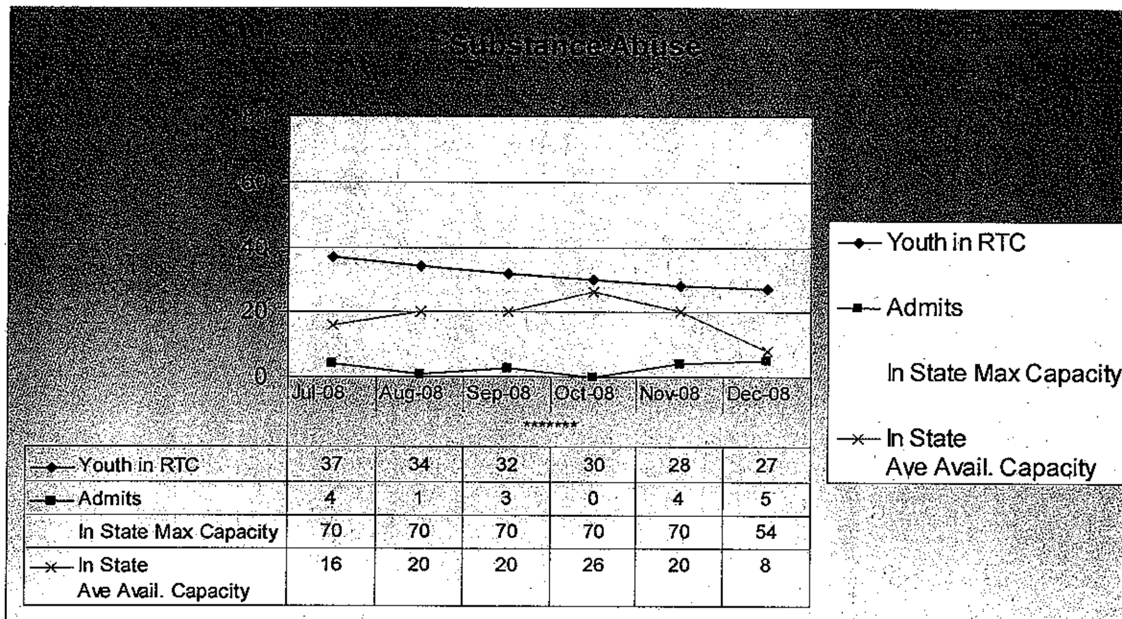
Chart 15: Conduct Disorder/Explosive/Disruptive/JJ (con't)



	0-10yo	11-12yo	13-14yo	15-16yo	17-18yo	19+yo
Male	2	18	77	126	12	0
Female	3	13	38	74	8	0

Charts 16, 17, 18, and 19, which depict supply and demand for substance abuse and psychiatric residential treatment services, are provided for context and informational purposes only; again, these are relevant to this discussion only insofar as the children and youth in one of the previous categories present with a co-occurring psychiatric or substance abuse diagnosis, which, of course, is typically the case.

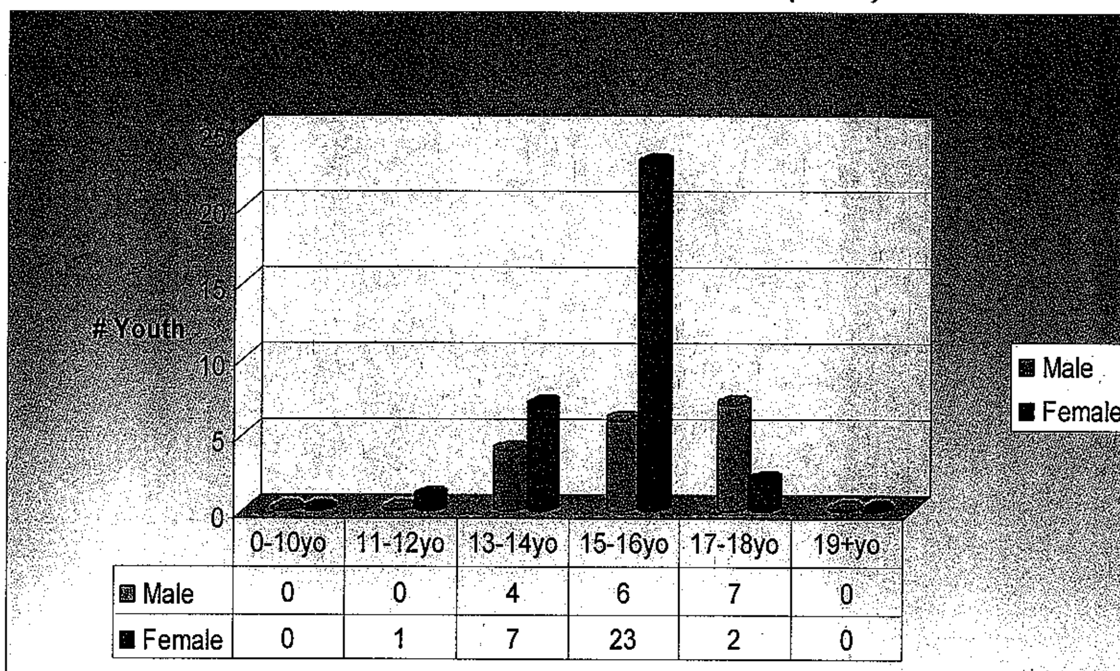
Chart 16: Substance Abuse
Q3 & Q4 '08



	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Youth in RTC	37	34	32	30	28	27
Admits	4	1	3	0	4	5
In State Max Capacity	70	70	70	70	70	54
In State Ave Avail. Capacity	16	20	20	26	20	8

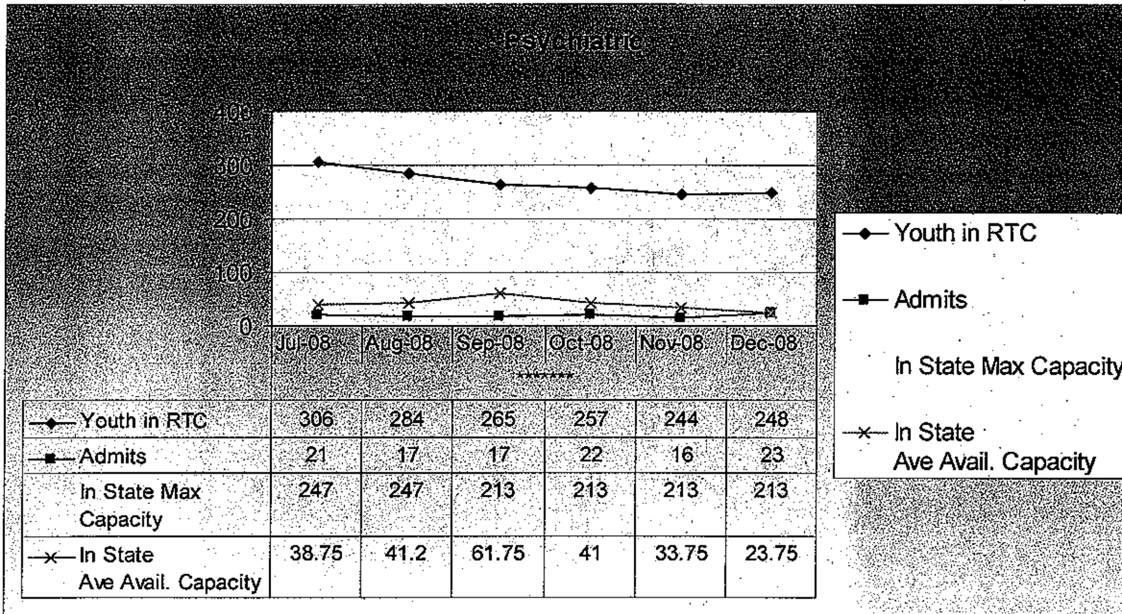
Stonington: closed 12/9/08; pro-rated bed capacity for Dec. Quality of care issues led to decreased use prior to Dec. It is noted that Q3 & Q4 Youth in RTC w/Sub Abuse Dx is less than Q1&2- due to several factors: 1) On site CCMs clarifying sub abuse dx 2) When SA beds not avail, youth admitted to other facilities and sub abuse dx may not be listed/reported as primary

Chart 17: Substance Abuse (con't)



	0-10yo	11-12yo	13-14yo	15-16yo	17-18yo	19+yo
Male	0	0	4	6	7	0
Female	0	1	7	23	2	0

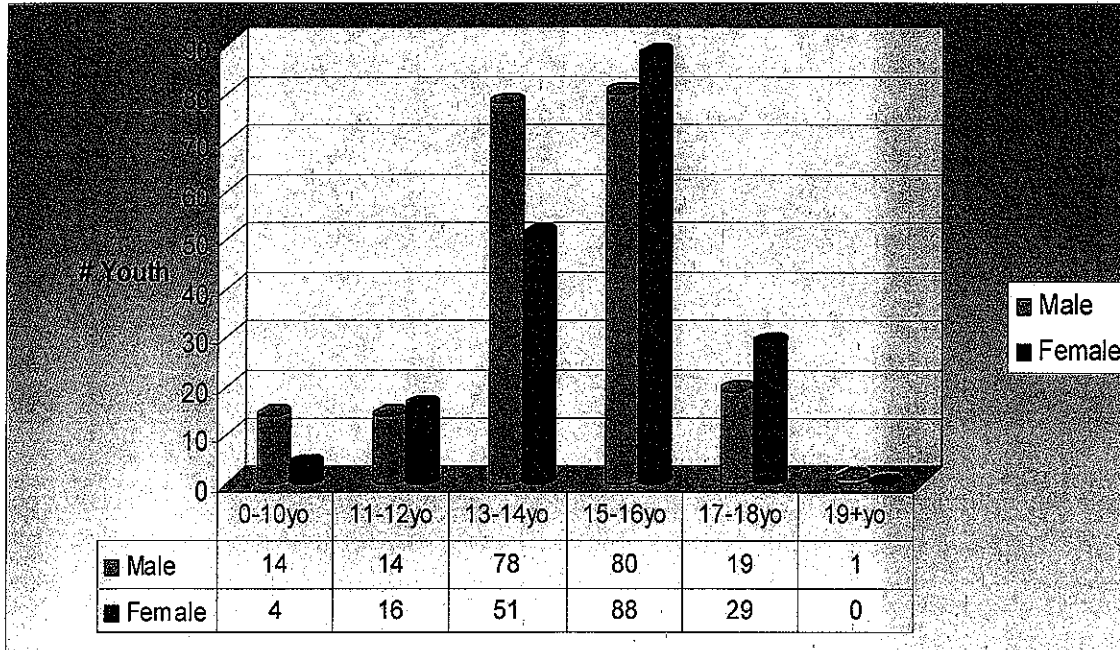
Chart 18: Psychiatric
Q3 & Q4 '08



	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Youth in RTC	306	284	265	257	244	248
Admits	21	17	17	22	16	23
In State Max Capacity	247	247	213	213	213	213
In State Ave Avail. Capacity	38.75	41.2	61.75	41	33.75	23.75

Maximum Capacity- dropped to 213 beds due to closing of CREC 8/22/08.
Average Available Capacity markedly higher these 2 quarters compared to past 12 months. This is primarily due to vacancies at CREC prior to their closure and CHOC vacancies during transitioning of psych beds to prepare for MR/PDD population at Jordan House and Waterford as they transitioned from 4 cottages to 3 cottages (same total beds however)

Chart 19: Psychiatric (con't)



	0-10yo	11-12yo	13-14yo	15-16yo	17-18yo	19+yo
Male	14	14	78	80	19	1
Female	4	16	51	88	29	0

Gross Summary of In-State Capacity and Needs

Chart 20 provides a gross summary of capacity, supply and supply deficits for identified diagnostic categories.

Chart 20: 2009 Projected In-State Over/Under Utilization by Diagnostic Category

RTC AVERAGE Monthly BED OCCUPANCY			2009 - TWELVE MONTH PROJECTION Against Existing In-State Capacity					
All Children- In State & Out of State	2007 Total Occup.	2008 Total Occup.	2009 Ave Bed Occup	% Male Beds Needed	% Female Beds Needed	% Priority Age Range	In-State # of Current '09 Available Maximum Capacity (assuming capacity as of 12/31/08)	In-State BED Gap Under/Over Utilization
Firesetter/Sex	100	111	117	89%	11%	13-14 34% 15-16 44%	0	-117
MR/ PDD	67	62	64	57%	43%	13-14 32% 15-16 36%	18	-46
Conduct Dx/ Explos/Disrup & JJ	282	274	278	63%	37%	13-14 31% 15-16 54%	155	-123
Substance Abuse	54	40	41	34%	66%	13-14 22% 15-16 58%	47	+13
Psychiatric	312	293	302	52%	48%	13-14 33% 15-16 43%	213	-89

If these supply deficits are to be ameliorated so that all children and youth can be treated in Connecticut, several things must happen:

- First, the utilization of current in-state private providers' capacity must be maximized. This will require that private providers have both the willingness and the resources to provide care to youth who are currently being referred for treatment out-of-state.
- Second, current in-state capacity will need to be expanded. Whether this is done in the public or the private sector, new capacity will need to be developed in order to meet the needs of children and youth who are currently being referred out-of-state.

Our current estimate, based upon the foregoing analysis and summarized in Chart 20, above, suggests that we will need additional beds if we are to serve all children and youth in-state. Residential providers currently have, in aggregate and on average, an available "unused" capacity of 35-45 beds. We currently have within our state a significant number of beds which ideally could and should be used to provide services to youth who are being sent out-of-state. However, even if this "unused" capacity were to be used to serve youth who are currently being referred out-of-state, we would still need a net increase of approximately 100 beds given current residential lengths of stay. (Please see calculations on page 23 for additional explanation.)

Importantly, however, as we know from Chart 5, there is a relationship between average length of stay and the number of beds required to serve a finite number of youth. As illustrated on Chart 21 the number of beds required for the primary population served out-of-state will decrease with the attainment of shorter lengths of stay.

Chart 21: ALOS by Diagnostic Category

Q3 & Q4 '08	# Discharges	ALOS (based on d/c)	Bed Days	If ALOS 350 Days	Then # Add'l Youth Served	If ALOS 300 Days	Then # Add'l Youth Served	If ALOS 270 Days	Then # Add'l Youth Served	If ALOS 250 Days	Then # Add'l Youth Served
Fire/Sex	**30**	**594**	**17820**	**10500**	*21*	**9000**	*29*	**8100**	*36*	**7500**	*41*
MR/PDD	**18**	**555**	**9990**	**6300**	*11*	**5400**	*15*	**4860**	*19*	**4500**	*22*
CondDx/ JJ	**167**	**340**	**56780**	***N/A***	*N/A*	**50100**	*22*	**45090**	*43*	**41750**	*60*
Sub Abuse	**24**	**282**	**6768**	***N/A***	*N/A*	***N/A***	*N/A*	**6480**	*1*	**6000**	*3*
Psych	**170**	**420.5**	**71485**	**59500**	*34*	**51000**	*68*	**45900**	*95*	**42500**	*116*

Capacity and the Utilization of State-Operated Facilities

The preceding analysis is necessarily related to Legislative questions regarding the increased utilization of state funded residential facilities because those facilities already typically operate at maximum available capacity.

Chart 22 depicts the average daily vacancy rate and the average monthly vacancy rate at High Meadows, the capacity of which is 36. If we were to look only at the number of "vacant" beds we would deduce that the facility is operating at approximately at 93% of capacity; however even this figure is misleading. No facility operates at 100% capacity because there is always at least some lag between the time and date of a discharge and the time and date of the admission which fills the vacated

bed. More importantly, Chart 22 does not reflect the fact that the "empty" beds at High Meadows are often empty precisely because they are being temporarily "held" for a youth being discharged from Riverview or from another hospital or returning from an out-of-state placement.

Chart 22:

Month	Average Daily Vacancy	DD Bed	Non DD
July-07	3.9	3.0	0.9
August-07	4.8	4.0	0.8
September-07	7.2	3.5	3.7
October-07	3.9	3.4	0.5
November-07	2.0	1.9	0.1
December-07	0.6	0.4	0.2
January-08	0.4	0.4	0.0
February-08	1.4	0.9	0.5
March-08	0.6	0.4	0.2
April-08	1.0	0.1	0.9
May-08	1.6	0.3	1.3
June-08	2.4	0.2	2.2
July-08	3.6	2.4	1.2
August-08	4.3	4.0	0.3
September-08	5.8	4.5	1.3
October-08	3.3	3.3	1.4
November-08	3.2	2.8	0.4
December-08	0.8	0.3	0.5

High Meadows Average Daily Vacancy Report

Average Bed Vacancy per Calendar Year (08) = 2.5
(DD bed vacancy = 1.6) (Non DD bed vacancy = .9)

Average Bed Vacancy per Fiscal Year 7/08 = 2.4
(DD bed vacancy = 1.5) (Non DD bed vacancy = .9)

Notes:

- High Meadows admits males age 12-20. The maximum allowable census is 36 (20 DD beds, 16 non DD beds)

- July 07 - October 07 reflects the time period which High Meadows discharged all female residents and younger males in order to accommodate the cohort of developmentally disabled youth as a result of the closing of Lake Grove, hence the higher vacancy averages for those months.

Chart 23 depicts the average daily and monthly vacancy rate at CCP, the capacity of which is 48. Of this capacity, it is essential to note that 9 beds are reserved for utilization by Juvenile Parole Services, and of the 9 beds, two are intentionally held vacant to the maximum feasible extent for purposes of the emergency placement of youth taken into custody. As with High Meadows, once one inserts into the calculation those beds to which a youth is "matched" (even if he or she is not yet currently in the bed) the available capacity is essentially exhausted.

Chart 23 Connecticut Children's Place
Average Daily Vacancy Report

Month	Average Daily Vacancy	Girls	Boys		Parole Vacancies
July-07	4.80	2.20	2.60		2.20
August-07	1.40	0.40	1.00		0.40
September-07	1.40	1.00	0.40		1.00
October-07	2.50	1.75	0.75		1.75
November-07	4.00	0.83	3.16		0.83
December-07	3.25	2.33	1.00		2.00
January-08	2.50	2.25	0.25		2.25
February-08	4.60	3.60	1.00		2.60
March-08	4.00	2.00	2.00		1.66
April-08	2.20	1.11	1.11		0.88
May-08	1.50	0.75	0.75		0.75
June-08	2.75	2.25	0.50		1.00
July-08	3.40	2.42	0.97		1.50
August-08	2.50	1.19	1.29		0.50
September-08	4.00	1.76	2.27		1.00
October-08	1.20	0.35	0.87		0.35
November-08	2.10	0.00	2.07		0.00
December-08	3.25	0.29	2.97		0.00

Average per Calendar Year 08 = 2.83
(Girls = 1.50) (Boys = 1.34)

Average per Fiscal Year 08 = 2.91
(Girls = 1.71) (Boys = 1.21)

Discussion

Several conclusions can be drawn from our analysis thus far. First, there is currently insufficient available "surplus" capacity in the private non-profit, residential treatment center system to treat all of the youth currently referred out-of-state. As indicated earlier, 342 children and youth are currently being treated out-of-state. The available unused capacity in the private provider RTC system is approximately 35-45 beds on a monthly basis. Parsing out beds that were vacant as a result of facilities closing, from July 08 through January 09, the number of vacant beds at in-state private residential treatment centers typically utilized by DCF ranged from a high of 73 in September 08 to a low of 20 in January 09. On average, approximately 46 beds were vacant every month during this period. However, since this number has trended consistently down over the past five months, we estimate available unused capacity to be in the range of 35-45 beds. Most importantly, despite that available unused capacity there is a clear mismatch between the clinical needs of the youth being referred out-of-state and the residential placement services available through in-state by providers with empty beds.

Second, there is, for all practical purposes, no currently available capacity at DCF's state operated residential facilities: CCP and High Meadows. In light of the Governor's proposal to close High Meadows, the overall capacity of state-operated residential facilities may be reduced. Such a reduction could be offset by the additional development of specialized residential programming in the private sector.

Third, there is a great deal of "stability" to the volume of need for children and youth with particular diagnostic profiles that are referred out of state. As indicated in Charts 6 and 7, we need additional in-state capacity to treat youth with complex psychiatric problems and significant histories of sexually dyscontrolled behavior, fire-setting, uninhibited aggression and/or developmental disabilities.

Fourth, expanded in-state capacity, in either the public or the private sector, cannot be achieved without an infusion of new resources. It should be noted that over the past several years DCF has issued several RFPs to expand in-state private-provider residential capacity, and, at the same time, supported several private provider initiatives to reorganize residential care better to serve youth with complex behavioral health disorders. Staffing patterns have been intensified, daily rates have been raised and training initiatives have been implemented. Yet our system has still not yet evolved to the point where it is no longer necessary to refer children for out-of-state placement.

As an aside, these points, taken in combination, raise a key question: If there is so much unmet demand, why are residential treatment centers electing to get out of this business? Over the past year we have seen CREC opt-out of the provision of residential care, and the Stonington Institute and Connecticut Junior Republic have or are following suit. The answer, unfortunately, may not be particularly complicated. Several factors appear to contribute. With the increased availability of in-home and community-based services, only the most complex youth with difficult to manage behaviors are now receiving residential treatment. Further, the "mix" of youth is not as variable as it once was, and today every youth in residential treatment is difficult to treat. Consequently, serving youth in large program settings are increasingly difficult unless the facility has an appropriate physical plant and well-trained staff. That is an expensive

proposition, and there has not been the infusion of new resources into residential treatment centers commensurate with the needs of private providers to treat the increasingly difficult population being served. Furthermore, as various in-state providers have increased their range of community-based services, some are finding that the provision of residential care is simply not sufficiently remunerative, or the financial risk and community pressures associated with treating an increasingly difficult to manage population are not commensurable with the rewards.

Chart 24 below, outlines the per-diem rates paid to various in-state providers, as well as the per-diem rate for CCP and High Meadows. (See Appendix I for additional details.)

Chart 24:

IN-STATE RESIDENTIAL PROGRAM RATES Provider-Basic Residential	SFY' 09 LBC	Dec 08 Per Diem	Jan 09 Per Diem
American School for the Deaf (Paces-5)	30	$304.09	$304.09
American School for the Deaf (Paces-7)	30	$411.52	$411.52
Children's Center of Hamden	38	$247.96	$247.96
Children Home of Cromwell	63	$274.54	$274.54
Connecticut Junior Republic	60	$304.47	$304.47
Justice Resource Institute, Inc. (Susan Wayne Center)	15	$479.64	$479.64
Klingberg	42	$233.00	$233.00
Learning Clinic	38	$177.73	$177.73
Midwestern Ct. Council On Alcoholism	15	$257.53	$257.53
Mount Saint John	32	$362.72	$362.72
Natchaug Hospital, Inc.	12	$538.11	$538.11
New Hope Manor	20	$183.69	$183.69
No.Amer.Fam.Inst.(Stepping Stone)	22	$437.04	$437.04
No.Amer.Fam. Inst.(Touchstone)	26	$304.85	$304.85
Rushford Center (Portland SA Program.)	12	$301.41	$301.41
Shelter For Women (Grey Lodge)	18	$220.62	$220.62
Stonington Institute	45	$314.46	$314.46
Waterford Country Sch.	52	$216.63	$216.63
Wellspring	26	$323.06	$323.06
CCP	48	$1,294.05	$1,294.05
High Meadows	36	$1,529.82	$1,529.82

As mentioned earlier, of the children placed out of state, nearly 75% are in New England and more than half in Massachusetts. A comparison of rates reveals that 42% of in-state programs cost less than $250 per day while 52% of out of state programs cost less than $250 per day (Appendix I). In general direct care staffing and clinical ratios are comparable, and to date we have not been able to determine to our satisfaction why some out-of-state facilities seem more willing than some in-state providers to serve some of our children.

Chart 25:

Residential Rate Comparison			
In State		**Out of State**	
(19 Providers)		(61 providers/87 programs)	
<$200/day	3 (16%)	<$200/day	26 (30%)
$200-$250	5 (26%)	$200-$250	19 (22%)
$250-$300	5 (26%)	$250-$300	12 (14%)
>$300/day	6 (32%)	>$300/day	30 (34%)
Range: $168-$535/day		Range: $106-$939/day	

Next Steps: The Plan, Costs, and Contingencies

In calendar year 2008 an average of 13 children and youth were sent out-of state for treatment every month (exclusive of those placements made by Parole Services or CSSD).

Chart 26:
Cohort Categories

	Mental Retardation/ PDD	Problem Sexual Behavior/ Fire-Setting	Psychiatric	Juvenile Justice	Substance Abuse	Other	Total Placements by Month
January	2	0	2	0	0	0	4
February	1	6	6	0	0	1	14
March	0	5	3	0	0	1	9
April	3	10	12	0	0	1	26
May	6	3	6	0	0	0	15
June	1	3	5	0	0	0	9
July	3	4	8	2	0	1	18
August	4	5	3	0	0	3	15
September	7	4	4	0	0	0	15
October	0	4	5	0	0	1	10
November	3	2	2	1	1	1	10
December	2	3	5	0	3	1	14
Total for Cohort Category	32	49	61	3	4	10	159

As noted previously, P.A. 09-01 Sec 27 requires DCF to develop in-state capacity to eliminate the need to refer children out of state. Contingent upon the availability of resources, our plan to cease referring children out of state (except under unique circumstances when such placement is demonstrably in the best interest of the child or is court-ordered) could be initiated commencing July 1, 2009 with the goal of ceasing to refer children out-of-state by July 2011.

Several steps would be required to meet this objective:

First, DCF would need to complete its analysis of what specific types of services must be available in Connecticut, and in what volume, to ameliorate the need for new out-of-state placements. This analysis is already underway but would need to be completed by May 1, 2009 so that a final, master project plan would be completed no later than July 15, 2009.

Second, DCF would continue a series of meetings with individual providers to determine their willingness to modify their programs to treat specific populations of children for whom there is evident in-state need. In some instances those conversations are at an early stage. In others (for example the Children's Home of Cromwell), collaboration has already resulted in the conversion of a unit to serve children with developmental disabilities. These discussions with providers could be concluded within 180 days.

Third, while these discussions are occurring, we would continue to make efforts, within available resources, to improve existing practices including providing the necessary resources to bring direct care staffing ratios across our in-state provider network to a 4:1 ratio and clinical ratios to approximately 6:1. To date, we have worked with some providers to reduce their licensed bed capacities to better address various behavioral management concerns they were experiencing due to having too many children per room. In a limited set of circumstances we have worked with providers to reduce their licensed bed capacity due to reduced demand for their specific service. We have also worked with the providers to reduce the period of time between a discharge and the next placement.

Fourth, DCF, through its partnership with the Department of Social Services (DSS) and the Connecticut Behavioral Health Partnership (CT BHP), would continue to manage length of stay in residential treatment. While individual lengths of stay will always be predicated upon the unique needs of the child, on aggregate DCF would reduce the average length of stay in residential treatment centers in-state to 320 days by December 31, 2009. Subsequent to attainment of that goal, DCF, in collaboration with DSS and the CT BHP, would implement a 10% average length of stay reduction target on an annual basis.

Fifth, DCF would continue to attempt to utilize state-operated residential capacity to the maximum feasible extent by assuring that children and youth are served there only when residential treatment services are not available to them in-state in the private sector. Processes to assure that this objective is met would be put in place by April 1, 2009.

Sixth, contingent upon the availability of funds, DCF will expand the capacity of state-operated facilities to treat those youth who would otherwise be referred to out-of state programs. Because, as indicated earlier, CCP and High Meadows generally operate at full or near-full capacity, and because this would in all probability remain true even if the private sector increased its ability to serve youth in-state currently referred

out-of state, eliminating the need for out of state residential placement would require some combination of the following:

- An expansion of the number of state-operated beds and a modification of the campus and the physical plant of one or both state-operated residential facilities; or
- The development of at least two new facilities, one for youth with dyscontrolled psychosexual behavior problems, and one for youth with developmental disabilities. These facilities could be either state-operated or contracted residential treatment centers; and
- A reduction in the average length of stay in the residential treatment; and
- An increase of the number of staff commensurate with the increase in bed capacity, and appropriate new training and programming for youth with highly aggressive behavior disorders, dyscontrolled sexual behavior disorders and/or fire setting behaviors.

Assuming that some out-of-state referrals can and will be absorbed through modifications in the in-state private sector's ability and willingness to serve an increasing number of youth in-state whom they have previously not accepted, and assuming that the average number of youth sent out-of-state for treatment continues to hold more or less stable, and assuming that the average length of stay in residential treatment is 320 days, and assuming that the size of the private provider pool of available and clinically appropriate beds remains stable, then the number of new beds required to be established at new or expanded facilities would be approximately in the range of 92 to 102 new beds.

This calculated as follows:

- 156 referrals out of state per year
- Average LOS is 320 days
- 137 beds required
- 35-45 beds to be absorbed through existing private provider capacity
- Net new beds required: 92-102
- Note: The cost would be partially offset through savings associated with the corresponding decrease in out-of-state placements.

One area in which the Department can maximize its existing state-operated capacity is by capitalizing on the decreased number of children who require the state's most intensive level of care at Riverview Hospital. The hospital's current census is approximately 65 although the facility has the capacity to serve up to 88 youth. By converting one unit to a less acute level of care, the facility could serve 12 to 20 additional youth with mental retardation and/or other developmental or Autistic Spectrum Disorders. Such a conversion would require little additional resources and the facility's cost would be spread across a larger number of residents resulting in an approximately 20% decrease in average cost per day, blended across both the acute and less acute levels of care.

However, if we are to cease referring youth out-of-state at least two new facilities must be envisioned in addition to converting some of Riverview Hospital's currently vacant beds to a residential level of care. These facilities would be required in order to accommodate at least 80 youth with psychosexual behavior problems and/or youth with histories of fire setting and/or dyscontrolled aggressive behaviors as well as

a small number of youth with developmental disabilities. The construction of two state-operated facilities the size of the existing CCP campus would likely require $60 - $80 million in capital costs for construction, together with combined operating costs of approximately $40 million per year. Alternatively, this capacity could be sought through the expansion of private provider capacity within state although there would likely be a need for capital cost associated with additional private, non-profit, residential treatment centers as well.

While steps 1-5 above can occur independently of step 6, it is important to state that without step 6 the target of placing no children out-of-state and serving them exclusively in-state will not be achieved without expanding clinically appropriate and viable in-state capacity. This can be done in the public sector, or it can be accomplished through an expansion of services in the private sector. Such an expansion would, in all likelihood, require establishing new providers to serve specialized populations through the appropriate RFP and CON processes and the ability to site new programs for high-risk populations in our local communities.

Contingencies

The preceding plan is based upon several contingencies which must be explicit:

First, the analysis is predicated on the premise that High Meadows will remain open. Our analysis was completed this way simply because at this point there is no date certain for the closing of High Meadows. Should High Meadows close the ability of DCF to serve children and youth currently served out-of-state in Connecticut at state-operated residential treatment centers will be impacted directly in proportion to the number of beds which will be eliminated; in this eventuality a growth in private provider capacity and a concomitant ability to site programs would be necessitated.

Second, the analysis presumes that DCF continues to purchase residential services going forward in the same way as it has heretofore. It is important to note, however, that alternate funding mechanisms may be considered, and DCF is actively collaborating with private providers to conceptualize and concretize alternative ways of working together to more effectively and economically serve children and youth.

Third, the analysis presumes an ability to establish and site at least two new programs in Connecticut, and at least one of them would be for youth with dyscontrolled psychosexual behavior problems. There will predictably be community opposition to the siting of programs in Connecticut that treat individuals with dyscontrolled psychosexual behavior problems and/or histories of fire setting.

Finally, this analysis presumes that the number of residential treatment center beds currently available in-state will remain stable. Over the past several years the number of appropriate and available in-state residential treatment beds in Connecticut has decreased. Any further loss of in-state beds in the private sector would increase the pressure to refer children and youth out-of-state care in order to meet their needs.