Report Card: DCF Region 3 Placement of Children in OOS Treatment

Update 9/4/13

Quality of Life Result: Connecticut Children grow up stable, safe, healthy and ready to lead successful lives.

Contribution to the Result:

DCF - All children served by DCF grow up healthy, safe, smart and strong.

Strategic Plan:

This contribution to the Quality of Life Result is directly related to DCF Strategic Plan OM: *'HEALTHY - Optimal receipt of health services from prevention through treatment; Good mental health; and Age-appropriate development'.* Also this Contribution is related to Strategic Plan OM: *SAFE - Parental Functioning.*

DCF Region 3 - All children requiring treatment in a congregate setting are able to receive that treatment effectively in Connecticut.

Our Partners: The following entities are Region 3's most critical partners in this work - Regional Resources groups from each Area Office; Regional Foster Care staff; CFTM Staff; Regional Program Management; Voluntary Units; CO units including: Community Psychiatry , Congregate Care; Licensing; Fiscal and Rate Setting, Behavioral Health and Wellness, Education; DMHAS YAS; Parole Services; DSS - ABI/TBI Waiver; Community Transition Program; the legacy of Life Long Family Ties; case work SW's and SWS'; Community Psychologists; Office Directors who made this a priority and supported this effort; BGV Safe Haven Program; Adelbrook's Shiloh House; Regional USE Liaison and the statewide USE team; MSS members;

Special Credit: Mark Dumais and Ladwana Jenkins; T'Kai Howard; Mark Frankinburger; Jeanine Griffin; Jon Jacaruso, Pam Kelley and Kathleen Maxfield; Skye Garofalo, Jim Gannotti, Socorro Cortijo, Denise Morell, Monica Smith; Shelly Brodsky; Dr Lesley Siegel; Amy Marracino; Thomas Ranallo and Sara Lourie; Ken Secchiaroli and Wayne Mundell; Dorian Long; Kym Banton and Dr. Bill Anderson; Mary Ann McGuire; Jessica Bessette; Dr. Michael Schultz; Mary Cummins; Dr. Linda Dixon; Connecticut Behavioral Health, Inc.; Kitty McCue and Pam

How Much Did We Do?

# of children or youth in DCF care that are in OOS treatment baseline is report of January 1, 2012.

Children in OOS Placement - Region 3

As of January 1, 2012

Area Office	01/01/2012
Middletown	2
Norwich	14
Willimantic	11
Total	27

Data Source - Dr. A. Trasante: Monthly Report on children in OOS placements

Story behind the baseline:

The Barriers:

- Until recently there has been no in-state treatment for children or youth with: problem sexual behaviors, aggression related to Autism Spectrum Disorders or Alcohol Related Neurodevelopmental Disorders. There is quite limited treatment options for boys or girls with severely aggressive behaviors and/or severe psychiatric disorders;
- Finding appropriate, timely placements for children/youth with no kin available.
- Resistance by OOS treatment facilities to discharge youth (e.g. Gage G, Matt O and Nicole C); 'failure' or 'lack of progress' of a youth in the treatment program often results in recommendations for longer stay not different treatment; Our failure is not making consistent requests for the facility's plan to address lack of progress thru program, content and design modifications.
- Lack of effective family treatment in 'treatment' facilities.
- Minimal effective treatment for child or youth with complex trauma disorders in CT.
- Very limited amount of home based, highly skilled and individualized services for child and family.
- Value Options = Lack of integrated oversight of treatment planning on child and family. Lack of program quality/quantity improvement standards that reflect meaningful measures of child & family health and wellbeing. (e.g. school attendance, enduring connections with family/kin)
- Persistent vacancies on R/ARG staff which have limited travel to OOS facilities with staff.
- Insufficient focus by all on deterring children/youth from CC.
- USE plan challenges
- No alternate funding strategies.
- TFC system inadequate to meet needs posed by radical downsizing of number/type of children/youth formerly placed in treatment facilities.

How Well Did We Do It?

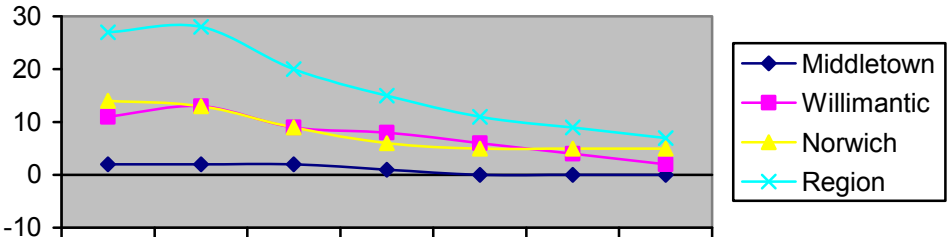
Children in OOS Placement - Region 3
20 month retrospective

	01/01/2012	05/01/2012	10/01/2012	01/01/2013	05/01/2013	08/16/13	Est. 9/1/13
Area Office							
Middletown	2	2	2	1	0	0	0
Norwich	14	13	9	6	5	5	4
Willimantic	11	13	9	8	6	4	2
Total	27	28	20	15	11	9	6*

Data Source - Dr. A. Trasante: Monthly Report on children in OOS placements

* all youth are placed in Massachusetts = or < 30 miles of Ct border.

Region 3 Youth OOS Placement Trend 1/1/12 to 9/1/13



	1/1/12	5/1/12	10/1/12	1/1/13	5/1/13	8/16/13	9/1/13
Middletown	2	2	2	1	0	0	0
Willimantic	11	13	9	8	6	4	2
Norwich	14	13	9	6	5	5	5
Region	27	28	20	15	11	9	7

Many Thanks to April Brenker for this chart ☺

How Much Remains to be Done?

Remaining youth in OOS

Names and Table deleted

Trend: ▼ ☺

Story behind the change in baseline:

Identify, Persist and Collaborate Strategy

- **Persistent focus** of PM, SWS/SW, A/RRG, CFTM staffs
- **Prioritized TDM's on all OOS youth**. Do follow ups when necessary.
- **Assigned R/ARG primary staffer to OOS and Congregate Care project in each AO.** Both AO's with children in Congregate Care and OOS have weekly discharge planning review processes. Middletown is the example and the exception. By the time this RBA was developed no Middletown AO youth remained in OOS treatment.
- **Persistent focus** transitioning youth to DMHAS/DDS by case work staff, R/ARG liaison. CPD prioritizing this activity. Middletown is the example here again where the PM took the lead on this and the results are obvious.
- **Identify** youth in need of treatment and deter from OOS placement unless absolutely necessary. Only one child (VS DCF adoption) since spring 2012 has been referred OOS. She is slated to return in December 2013 to adoptive family.
- **Collaboration** with FASU Manager, TFC Liaison to actively pursue TFC follow up and improve the matching process. TDM staffers were assigned to attend TFC and STAR/Safe home meetings in respective offices to assist staff in discharge and planning. They were assigned follow up with difficult to place children and youth.
- **Identify and highlight critical role of foster/kin care/TFC/FACT** in achieving this goal. As a result decision was made to establish a regional CSWA position to work

directly with regional matching team, kinship staff and TFC agencies. In place by 10/1/13.

- **Persistent focus** on joint development with Systems PD and FASU PM of CHR FACT program. Assign ARG to lead contact role with weekly meetings (JG). Do same with new JRI's new TFC & Diversion program (TH).
- **Identify need for unique services** to maintain children in their homes, with kin and/or foster homes. Identify current contracted services as generally unable to serve this 'new' population of children and families due to insufficient intensity, design and/or skill.
- Develop, deliver and monitor USE plans
- **Collaborate** with credentialed providers, DCF contractors and specialized providers to provide or expand community services that fit the unique need of each family. For example CBH in Middletown Area, Adelbrook new in-home services with behavioral expertise, TEEG and the new JRI Intensive Diversion Program among others.
- **Persistent focus** on financing strategies to implement needed services including requests for individualized child rates and other mechanism available. Explore TFC-Enhanced.
- **Persistent focus** on referrals for appropriate programs in CT with Value Options.
- **Persistent focus** on effective treatment of child/youth and family within the context of their complex trauma, impact of acquired (e.g. ARND) or traumatic brain injury (fall or auto accident), genetic disorder and the resources of a child/youth's family/kin system as a focus of intervention and source of permanent connection.
- **Development** of in-state treatment placements for PSB (BGV) and children on spectrum with severe dysregulation (Adelbrook). Attention to establishing & maintaining effective relations with these providers.
- One youth has been placed OOS at the Region's request during the 20 month period: Nicole C on 8/28/12. She will be reunified by December 2013. Dr Siegel made one of her last visits OOS to visit JRI's Walden Street treatment program. She determined that an extension from September to December for discharge was appropriate. Rae E was placed OOS in March by DMHAS and his case will fully transition to DMHAS hopefully by year's end depending on Education issues.

Are these Youth Better Off?

Questions remain - How do we determine this?
Areas of further Inquiry:
Children/youth discharged from OOS - how many were discharged to a family/kin/community placement (normalized)? How many were discharged to same LOC (positive or negative move)? How many remained in family and community placements in 12 months?

Story behind the baseline:

- CPD determined from the start of this effort that each OOS child/youth would not be moved if it were clearly in the child's best interest to remain in treatment where they were.
- Each child/youth is assessed monthly by CPD as to the youth and family's progress/lack there of. If no progress was being made there were 2 questions that must be answered -
  - What is the treatment program's plan to modify or individualize their program to meet the child/family's need that would justify extending the LOS?
  - Are there instate options to better meet the child/family's needs and what are they?

Trend: OOS treatment ↓

Proposed Actions to further Turn the Curve:
Strategies = coherent collections of actions that have a reasoned chance of improving results. Best thinking about what works and includes contributions of partners.

- Hire specialized CSWA regional staffer to focus & collaborate on all levels of family care from kin to DCF foster to TFC to FACT and JRI. Goal is to minimize permanent disruptions, maximize initial assessment and support of child and family, maximize recruitment support, identify and troubleshoot system issues in collaboration with FASU PM and PD.
- Collaborate with WCS on S-FIT Program with 10 WCS Safe Home beds = (Short term) Family Intensive Treatment . Utilize advanced skill of CFTM staff and R/ARG liaisons. Use this intervention as possible template for future change projects with community & CC providers.
- "Priority Destination kids" project - tracking and intervention strategy
- Develop expertise in Family Based treatment. Bring in consults.
- ARND and other Acquired Brain or Traumatic Brain Injuries. Work with Statewide team to develop screening process or adapt tool for R/ARG implementation.
- Define is youth/family better off - Why, How, How long, etc?
- Target VO ICM for problem solving, trouble shooting role as opposed to problem identification role they have assumed.

Research Agenda: a disciplined way of pursuing unanswered questions that arise from RBA process.

- Answering the question "Is This Child Better Off?"

Data Development Agenda: prioritized list of areas in which data development work is needed.

- Defining the data and sources necessary to answer the question "Is This Child Better Off?"