DCF Community Behavioral Services and Transition from DCF to DMHAS

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Putting DCF Community Behavioral Health Services in the Larger Context

- There is a large array of community behavioral health services funded by DCF
- Services are offered by community providers who have a contract with DCF
- The community behavioral health services are primarily provided by local not-for-profit mental health organizations
- Services provided are available to children and youth in DCF care (child welfare, juvenile justice, voluntary services)
- Services provided are available to children and youth in the general population within limits of available resources
- Children in DCF legal custody or families working with DCF Voluntary Services often have priority access

DCF Voluntary Services

- The Voluntary Services program is a DCF operated program for children and youth with serious emotional disturbances, mental illnesses and/or substance dependency and who are in need of services that they do not otherwise have access to. Parents do not have to relinquish custody or guardianship under this program

- The Voluntary Services Program emphasizes a community-based approach and coordinates service delivery across multiple agencies.

- Parents and families are critical participants in this program and are required to participate in the planning and delivery of services for their child.

1,569 families (unduplicated count) were served in SFY12.

Community-Based

- Crisis Intervention
- Clinic or office based
- Extended Day Treatment
- Intensive in home Treatment
- “Non-traditional” or Credentialed fee for services

Crisis Intervention Services Home School and Community

Emergency Mobile Psychiatric Services (EMPS)

- EMPS Crisis Intervention Service is Connecticut's crisis intervention service for children and their families. More than 90% of children are seen at their home, at school or in the community and 85% within 45 minutes of receiving the crisis call.

- More than 13,814 calls to the EMPS system SFY2012, which developed into 10,560 episodes of care.

Office and clinic setting

- **Outpatient Psychiatric Clinics for Children**
  - A multi-disciplinary team of psychiatrists, psychologists, APRNs, clinicians and case managers at 26 contracted outpatient clinics provide psychosocial assessments, psychiatric evaluations/medication management, and clinical treatment through individual, family and group therapies
  - In SFY 2012, the outpatient clinics served 22,402 children and their caregivers.
- **Extended day treatment**

  A multi-disciplinary team of psychiatrists, APRNs, clinicians and direct care staff at 19 program sites deliver an array of integrated behavioral health treatment through individual/family/group therapies, therapeutic recreation, and rehabilitative support services, for a minimum of 3 hours per day/5 days per week through a milieu-based model of care.

  In SFY2012, this program served 1,134 children/youth and their caregivers.
- **Integrated family violence program**

  Clinic and In-home--- based services for families where domestic violence has been identified. Core services include safety planning for survivor and child, trauma focused work with children, interventions focused on repairing and healing relationships, and batterer interventions. Annual capacity: 360 families

  Adolescent substance abuse outpatient

  -Substance abuse screening/evaluation, individual, group and family therapeutic interventions in a clinic based setting. 358 adolescents received services in SFY2012.

Intensive In Home Services

- **Intensive In-Home Service array:**

  - An array of Evidence Based Practices (EBPs) or promising practices that serve specific target populations and have a criteria for referrals.

  e.g. IICAPS, FFT, MDFT, MDFT spec. pop., FBR, JOTLAB, MST, MST spec. pop., Community Bridge etc…

Intensive In Home Services

- **Intensive In Home Child & Adolescent Psychiatric Services (IICAPS)**

  - A 6-month home-based intervention addressing psychiatric disorders of the child, problematic parenting and other family challenges that affect the child and family's ability to function. Teams of professionals average 4 to 6 hours per week of intervention with the child and caregivers to prevent hospitalization or to return the child to community based outpatient care.

  - Serves approximately 2,000 families annually.

Intensive In Home Services

Family Treatment Services – a range of evidence based models including:

- **Functional family therapy**
  An empirically grounded, family-based intervention to improve family communication and supportiveness while decreasing negativity, delivered within the family setting by 4 providers, 5 teams that are grant-funded. 519 youth and their caregivers received services in SFY2012.

- **Multi-dimensional family therapy (MDFT), including "special population"**
  Family-based intensive in-home treatment for adolescents with significant behavioral health needs and either alcohol or drug related problems, or who are at risk of substance use. Provides individual, caregiver and family therapy, and case management. 713 families received services in SFY2012.

Intensive In Home Services

- **Re-entry and family treatment**
  -MDFT for parole youth with substance abuse treatment needs. An estimated 75 youths received services in SFY2012.

- **Recovery case management for families with substance abuse**
  -Intensive recovery support services for families with children at risk for removal or at the point of removal. Annual capacity: 330 families

- **Family-based recovery**
  -Intensive in-home family treatment combining evidence-based substance abuse treatment with a preferred practice to enhance parenting and parent-child attachment. Annual capacity: 144 families

- **Juveniles Opting To Learn Appropriate Behaviors (JOTLAB)**
  -Rehabilitative treatment for youth with problem sexual behaviors that provides comprehensive clinical evaluation, individual psychotherapy, family counseling, psycho-educational therapy groups, and social skills building groups. In SFY2012, 99 children and their caregivers received services.

Intensive In Home Services

- **Multi-systemic therapy (MST)**
  Intensive family- and community-based treatment program that addresses environmental systems that impact chronic and violent juvenile offenders -- their homes and families, schools and teachers, neighborhoods and friends. 215 families received services in SFY2012.

- **Multi-systemic therapy (MST) for special populations**
  Special populations include problem sexual behavior, transition age youth, and parole youth re-entering the community. 112 youth and families received services in SFY2012.

- **Multi-systemic therapy (MST) "Building Stronger Families"**
  Intensive in-home treatment for families with maltreatment and substance abuse issues. 24 families received services in SFY2012.

Intensive In Home Services

- **Community Bridge**

This prototype run by the Village for Children and Families in Hartford has provided clinical interventions to 20 youth and families in its first five months of operation.

Youths and families receive intensive in-home therapeutic support on a 24/7 basis from a clinical team of licensed clinicians and paraprofessional mental health support workers. The clinical team engages with family members and provides necessary support to the youth in all aspects of community functioning for up to 2 years. Youth without adequate family resources are served in foster homes. The community based service is supplemented by the availability of brief residential placement for purposes of assessment and behavior stabilization.

Home and community services

(for non-system involved children and families)

- **Care coordination**

  Care coordination uses an evidenced-based child and family wraparound team meeting process to develop a plan of care that uses both the formal and informal network of care to meet the identified needs of the child and family.

  Serves about 1,200 families annually.

- **Family advocacy**

  Family advocates provide support and assistance to the parent/caregiver of a child with a serious mental or behavioral health need. The family advocate works with the care coordinator (above) in the child and family wraparound team meeting process and focuses on providing support to the parent/caregiver. Capacity to serve more than 400 families annually.

- **Respite care**

  Respite care is a non-clinical intervention, which provides stress relief to parents of children and youth who have serious mental or behavioral health needs. Community or home-based respite is provided for up to 4 hours per week for 12 weeks. Annual capacity: 250 children

Discretionary

- 60% on 9 Credential services 40% on variety of “non-traditional”
- Top 3 credentialed services
  1. Therapeutic Support Staff
  2. Supervised visitation
  3. Transportation

Transition Planning and Linkages Between DCF and DMHAS

- The transitional population include youth in the direct care of DCF who need continuing support beyond the age of 18
- They are some of the most vulnerable youth in the DCF system;
- A high proportion of them have experienced significant trauma through exposure to abuse, neglect, domestic violence, substance abuse, community violence and other traumatic events;
- In addition to trauma they have the overlay of serious mental health conditions and the resulting need for specialized services and supports;
- They are anticipated to need long term supports into adulthood; and
- They are typically utilizing higher levels of care within the system (see below)

Transition Planning and Linkages Between DCF and DMHAS (con't.)

Current Residence For Youth Referred To DMHAS (Pending/Accepted)								
	Ages							
Residence	16	17	18	19	20	21+	Grand Total	%
Residential Treatment/Group Home (both in and out-of-state)	30	68	53	14	8		173	38.9%
Foster Care (Relative/Non-relative)	21	42	32	16	6	2	119	26.8%
Home	8	28	25	4	3	1	69	15.5%
Adolescent Child Welfare Transition Programs (From group home to independent living)	8	12	18	15	8	1	62	14.0%
Other	2	5	3	2	1		13	2.9%
Children's Psychiatric Hospital	3	3	2				8	1.8%
Grand Total	72	158	133	51	26	4	444	

Transition Planning and Linkages Between DCF and DMHAS (con't.)

Without a systemic and collaborative approach the "hand off" from the child to the adult mental health system is likely to be ineffective and increase the likelihood of poor outcomes including homelessness, jail, unnecessary hospitalizations, etc.

National Collaborative on Workforce and Disability (2009) stated that:

"The absence of a coordinated system of service delivery also presents significant challenges for youth and young adults with mental health needs as they age out of youth services. They may be either shunted down an inappropriate service tunnel that does not address their specific needs, or they may "fall off a cliff" as they age out of youth services and have to navigate the complexities associated with the adult service system."

The Transition Process Starts with Screening

- Identify the target population through a formal screening process
- DCF begins screening at age 15; screenings are completed by clinical staff in the Region in collaboration with the staff who know the individual best
- Provide criteria and protocol for staff to follow
- Take a broader view of youth in the system - go beyond the diagnosis to get a full picture of the youth with particular regard to their trauma and treatment history
- Determine if a referral for adult services is needed (DMHAS, DDS)

DCF Clients Screened for DMHAS/DDS	
FY	# Screened
2007	759
2008	1936
2009	1022
2010	793
2011	741
2012	663
2013*	478
Grand Total	6392

*7/1/12 to 4/15/13

Referral from DCF to DMHAS

- A centralized referral process with dedicated staff;
- Clearly communicated and monitored time frame for referral;
- Agreement between DCF and DMHAS around what is needed for a complete referral; and
- A process to track and monitor referrals through disposition at DMHAS.

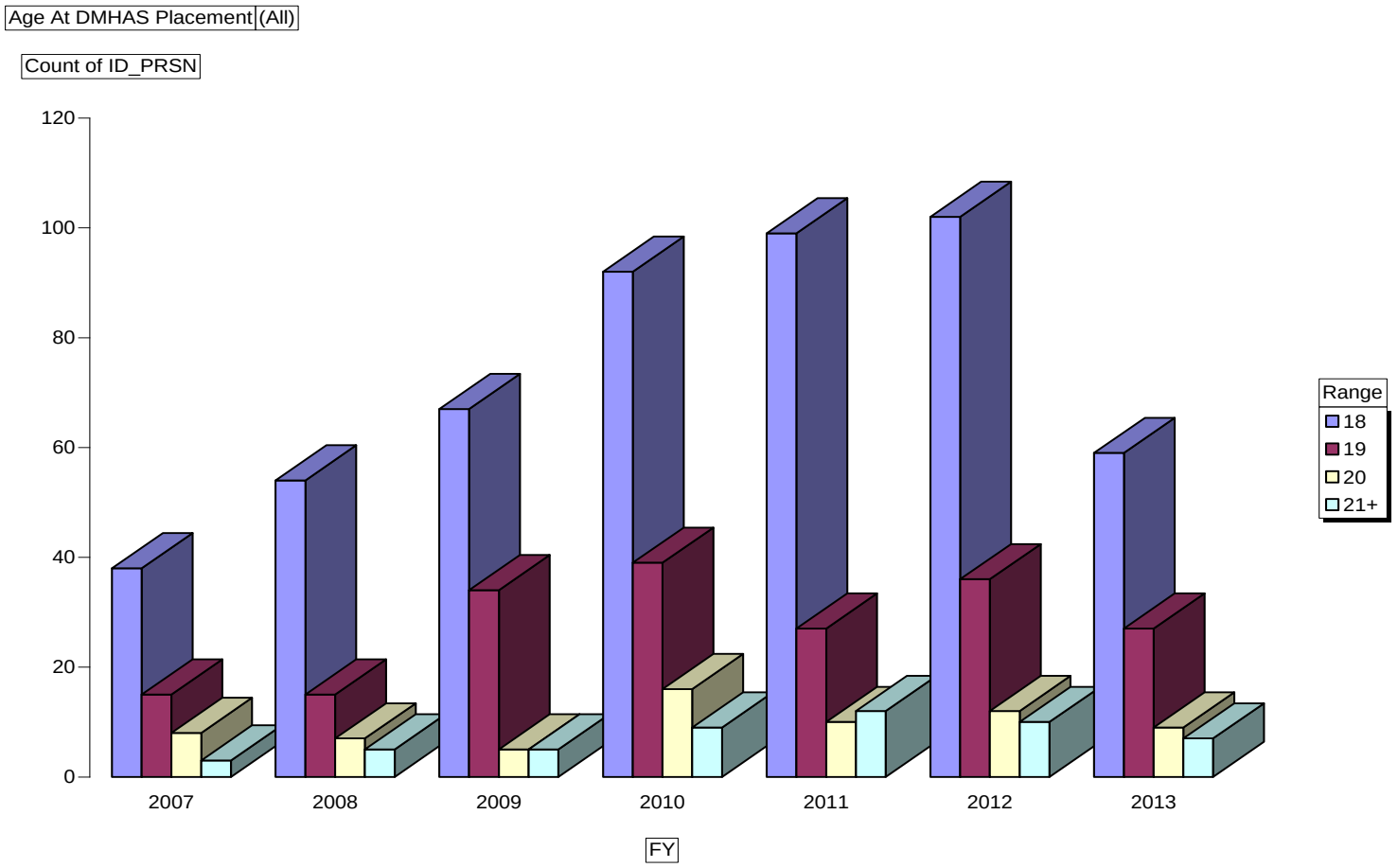
Number Of Referrals Submitted To DMHAS From The DCF	
FY	Total
2007	200
2008	382
2009	429
2010	373
2011	332
2012	223
2013*	180
Grand Total	2119

*7/1/12 to 4/15/13

Transition Timing

- Defined as the time frame between when the determination of eligibility is made and when the youth turns 21
- When a youth goes from DCF to DMHAS depends on these variables:
  - DCF educational and legal status
  - The individual needs, interests and willingness to continue with DCF
  - Resources available within the 2 systems.
- Most youth transition from DCF to DMHAS at age 18 or 19

Transition Timing (con't.)



Transition Activities

- Joint planning between DMHAS and DCF staff
- Providing information to the youth around available resources and options
- Developing a transition plan with the youth and relevant stakeholders that:
  - Identifies where the youth wants to live
  - Outlines services and supports needed and available
  - Identifies the work to be done to make the transition happen and who is responsible
  - Defines the time frame with projected transition date

Administrative Support for Successful Transitions

- This is a shared collaborative process – it takes both agencies to make it work
- Staff need to have sufficient time for transition activities
- There needs to be a common list – so there is agreement – about who is transitioning
- There need to be regular communication between local DCF and DMHAS staff to assure there is a forum for planning and problem resolution (monthly meetings)
- The agencies need to track transitions to keep them moving
- There needs to be the option of joint case conferencing to address complex clinical issues or when next steps are unclear
- Administrators in both agencies need to be available to handle issues that can't be resolved at the local level:
  - Day to day problem resolution – the little glitches
  - Formal administrative meeting – the bigger glitches

Challenges

- At 18 the youth goes from being a child to an adult
- Need to prepare youth for adult roles and responsibilities
- What about youth who don't meet DMHAS criteria but still need services – multi-agency involvement
- Bridge any differences between the child and adult system so that it doesn't become a "gap" to fall between
- Assure there is continuity of treatment and supports for an individual during the transfer