DCF Residential Care November 15th, 2010

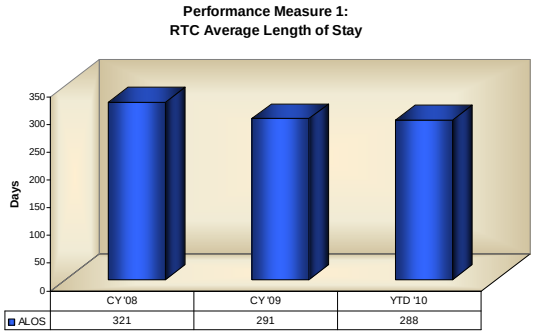
Quality of Life Result: All youth in Connecticut live happy and healthy lives.

Contribution to the Result: DCF youth who receive treatment in residential treatment centers (RTCs) will be provided with a comprehensive array of behavioral health services (individual, family, group, and milieu therapies) that will enable them to transition to less restrictive settings successfully without the need for further institutional care.

Actual SFY 10 Total Program Expenditures: $32,766,753	*State Funding:* $32,766,753	*Federal Funding:* $0	*Other Funding:* $0
Estimated SFY 11 Total Program Expenditures: $30,765,295	*State Funding:* $30,765,295	*Federal Funding:* $0	*Other Funding:* $0

Partners: Families, non-profit provider association groups (CAN, CLOC, CCPA), the Department of Social Services, the Department of Developmental Services, the Department of Mental Health and Addiction Services, local communities, local police, faith based organizations, and advocates.

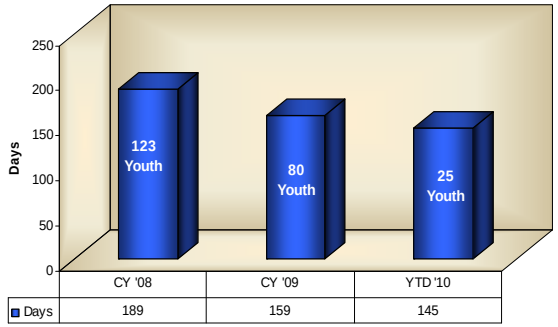
Performance Measure 1: Statewide average length of stay (ALOS) in days for RTCs.



Story behind the baseline: Ideally, children and youth should receive psychiatric care in a community setting whenever clinically possible. When the acuity of the child is of such a magnitude that institutional care becomes necessary, the duration of that care should be only as long as is necessary to effectively treat the child. Children are better off when the time that they spend in institutional environments is as brief as possible. Since 2008, length of stay in RTCs has declined. In 2008, DCF developed timeframes for discharge planning for youth in residential care. Also in 2008, the Behavioral Health Partnership began tying authorization for residential treatment to payment. This means that when a child no longer meets criteria for residential placement or continuing care, payment to the provider may not be authorized and the child is placed in discharge delay status. After an initial placement is authorized, continued stays in residential care are reviewed at a minimum of 30 day intervals. As a child approaches discharge, the interval for reviewing treatment progress becomes shorter. In addition, training in focal treatment planning for residential providers occurred throughout 2009. We expect this downward trend to continue.

Proposed actions to turn the curve: DCF will continue to use a child specific clinical outcome tool at RTCs and in other state funded treatment settings. This measure will assist in guiding the treatment process. In July, 2010, DCF established parameters for reduced lengths of stay in therapeutic group homes (TGHs) in order to increase TGH access for youth who are ready to move from residential to community based settings. In addition, DCF is promoting the use of evidence-based treatment interventions in order to accelerate the attainment of clinical outcomes. Contingent upon the availability of funding, DCF will utilize performance-based incentives beginning in FY '11 to support program improvement initiatives for providers who successfully decrease length of stay.

Performance Measure 2: The average number of days youth remain in RTCs beyond clinical necessity.

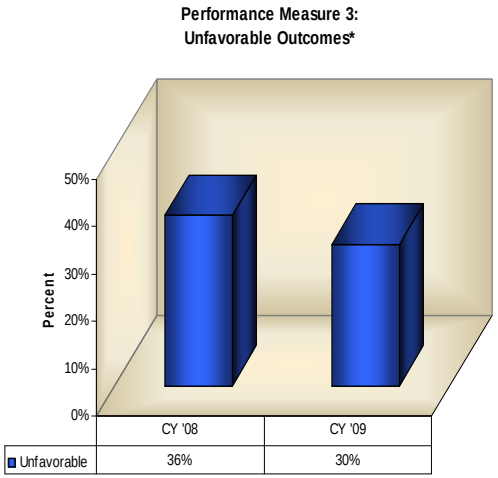


Story behind the baseline: As indicated in Performance Measure 1, youth are expected to remain in residential treatment for only as long as clinical necessity dictates. Performance Measure 2 focuses on the length of time youth remain in institutional care *after* they are clinically ready to return to family and community settings (whereas Performance Measure 1 focuses on the total amount of time required to effectuate discharge). This is an important measure of how well we are doing in assisting youth to return to home and community based care. Different cohorts of youth have different average lengths of stay. Discharge delay appears to be a by product of variations in provider practice and systems resources as well as diagnostic characteristics of the youth themselves. The Department currently leads discharge planning meetings for youth in residential care. Meetings involve both providers and Area Office staff and provide a forum to resolve barriers which delay discharge. We expect the average number of days in which youth remain in residential care beyond clinical necessity to decrease except for cohorts of youth for whom few community based resources are available in Connecticut.

Proposed actions to turn the curve: DCF has established targets for shorter lengths of stay in TGHs to provide increased access to these homes for youth in residential care. DCF will also use W.R. funds and wraparound funds to provide community based supports for youth discharged from residential care to community based settings. DCF will continue to use Local Managed Service System meetings between Area Offices and providers. These meetings offer collaborative opportunities to plan for youth who are transitioning out of RTCs. In addition, DCF has re-designed its foster care system and established standard timelines for matching a youth to a foster family, which again is

intended to reduce discharge delays. Contingent upon the availability of funding, DCF will also utilize performance-based incentives beginning in FY '11 to support program improvement initiatives for providers who successfully reduce the number of days a youth remains in residential care beyond clinical necessity.

Performance Measure 3: Percent of youth re-institutionalized or experiencing an unfavorable outcome within 90 days of discharge from an RTC.

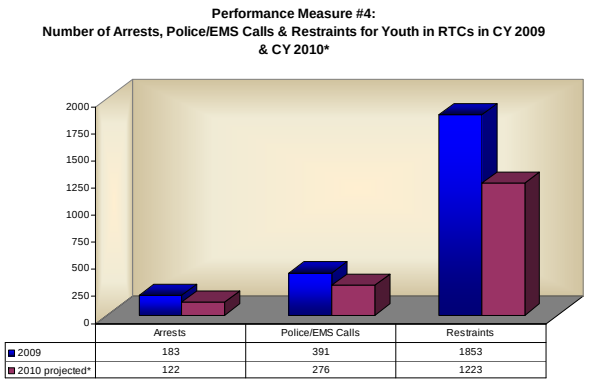


*Unfavorable outcomes include hospitalization, return to RTC, return to other higher level of care, or "other" unfavorable outcomes such as incarceration.

Story behind the baseline: The expansion of community based services has diverted less complex youth from RTCs to home and community based services and consequently residential care is only used by those children with high levels of acuity. That notwithstanding, the percentage of youth with unfavorable outcomes is an important indicator of a successful intervention and of how well we are doing at achieving post placement success. DCF began collecting data on post-RTC reinstitutionalization in 2009 and currently collects outcome data quarterly. It is our belief that with increased focus on post-placement stability, fewer youth will have unfavorable outcomes after discharge. Due to the impact of multiple intervening variables which impact post RTC discharge (e.g., family and community economic conditions, school success, developmental maturation, etc.) it would be erroneous to tie long-term life outcomes solely to this intervention. However, maintaining stability after discharge is related to family involvement during treatment, aftercare stability, support in post-treatment environment, and linkages between residential treatment and community services. Staff training, small program size, trauma informed services, a shorter length of stay, involvement of families, and improvements in educational achievement have been associated with positive outcomes. We predict a decline in unfavorable outcomes.

Proposed actions to turn the curve: Multiple interventions are required to impact this outcome: Providers will be incentivized to implement evidenced based treatment modalities and to establish linkages with community based providers and services. DCF's trauma initiative will continue to provide consultation to providers so that programs can offer trauma informed services that lead to enhanced post placement stability. Importantly, providers will be directed to make RTCs more family centered. Providers will be incentivized to increase family engagement and to focus on family readiness to support post-placement stability success. Contingent upon the availability of funding, DCF will utilize performance-based incentives beginning in FY '11 to support initiatives for providers who demonstrate greater post-placement stability for youth discharged from their care.

Performance Measure 4: The number of arrests, police/EMS calls, and restraints for youth in RTCs.



Story behind the baseline: At times, coercive interventions and police involvement are utilized to assure the safety of the child and others. Children are better off when these interventions are not utilized. When the police are called to assist a provider in maintaining safety the outcomes of that intervention are often outside of the provider's control. However, alternative non-coercive approaches and interventions are available. By using non-coercive interventions treatment outcomes should generally improve. We expect that the use of coercive interventions will continue to decline as providers develop new skill sets and competencies in the utilization of non-coercive interventions; there has already been a substantial decline is all three areas within the past 22 months. We currently project a 33% decline overall in arrests for youth in RTCs, a 30% reduction in police/EMS calls, and a 34% reduction in restraints.

Proposed actions to turn the curve: DCF sponsored a conference for providers in January, 2010 to spearhead a three year initiative to reduce coercive interventions. DCF asked providers for a 30% reduction in these areas from their calendar year 2009 baseline. In 2011, we will seek a 50% reduction from the 2010 target. This translates into a 65% reduction over a two year period. In calendar year 2012, we are seeking an additional 50% reduction from the 2010 target. This is an 83% reduction over a three year period relative to the 2009 baseline. Our goal is to come as close as possible to the elimination of these events. Residential providers submitted agency-specific strategic plans in March, 2010. These plans outlined initiatives to achieve the reductions. A follow up conference which focused on skill-building was conducted in July, 2010. We expect to see continuing reductions in the use of coercive interventions.