2012 Program Report Card: DCF Residential Treatment (RTC)

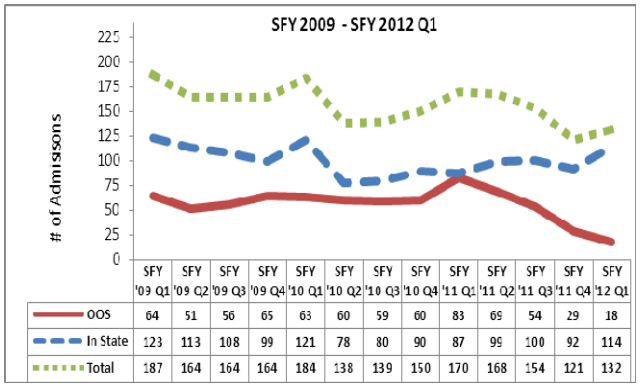
Quality of Life Result: Connecticut children grow up safe, healthy, and ready to lead successful lives
Contribution to the Result: Children and youth receive residential treatment through the DCF network of care, when community-based services have been exhausted, and as part of comprehensive and individualized treatment plans. Services include individual, group, and family treatment that is trauma-informed, and which contributes to each child's ability to function and thrive in the community, and in a family setting whenever possible, without the use of further residential treatment services.

Program Expenditures	State Funding	Federal Funding	Other Funding	Total Funding
Actual FY 11	$30,528,383	0	0	$30,528,383
Estimated FY 12	$37,439,919	0	0	$37,439,919

Partners: Families; CT Association of Non-Profits, The Children's League of CT, the CT Community Providers Association and their member agencies; the DSS; DDS; DMHAS; DCF; local communities; local police; faith-based organizations; advocates; the Behavioral Health Partnership.

How Much Did We Do?

Residential Treatment Admissions



	SFY '09 Q1	SFY '09 Q2	SFY '09 Q3	SFY '09 Q4	SFY '10 Q1	SFY '10 Q2	SFY '10 Q3	SFY '10 Q4	SFY '11 Q1	SFY '11 Q2	SFY '11 Q3	SFY '11 Q4	SFY '12 Q1
OOS	64	51	56	65	63	60	59	60	83	69	54	29	18
In State	123	113	108	99	121	78	80	90	87	99	100	92	114
Total	187	164	164	164	184	138	139	150	170	168	154	121	132

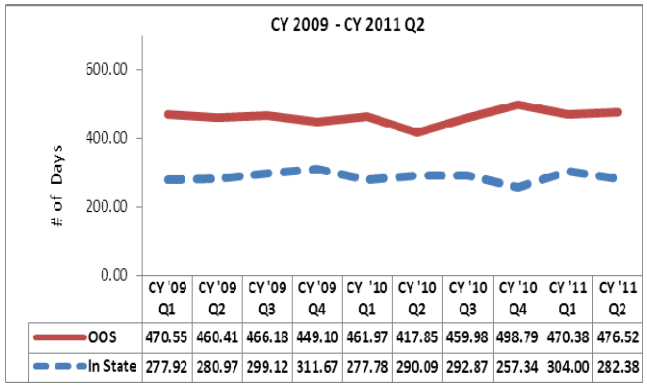
Story behind the baseline:

A concerted effort over the last 3 SFYs has reduced the reliance on RTC, in particular out of state treatment. Additionally, there have been tremendous efforts to limit children 12 and under from being treated in congregate care settings. For children ages 12 and under, in-state admits have decreased 72% and OOS admissions have decreased 83% when SFY Q1'09 is compared to SFY Q1'12. The monthly total of children in OOS placement as of 12/1/2011 represents a 37% decrease when compared to 12/1/2010 (232 vs. 367 children).

Trend: ▲

How Well Did We Do It?

RTC Average Length of Stay (ALOS)



	CY '09 Q1	CY '09 Q2	CY '09 Q3	CY '09 Q4	CY '10 Q1	CY '10 Q2	CY '10 Q3	CY '10 Q4	CY '11 Q1	CY '11 Q2
OOS	470.55	460.41	466.18	449.10	461.97	417.85	459.98	498.79	470.38	476.52
In State	277.92	280.97	299.12	311.67	277.78	290.09	292.87	257.34	304.00	282.38

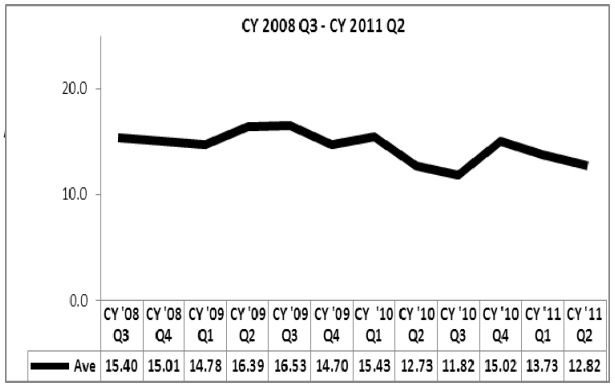
Story behind the baseline:

The average length of stay (ALOS) for Residential Treatment has remained stable for both In and OOS RTC facilities from CY Q1'09 to CY Q2'11. ALOS for children in OOS treatment is consistently longer than In-State ALOS. Average length of stay remains stable as the acuity of children and youth that are approved for admission to RTC remains high. Although the ALOS remains consistent, it is important to note that the actual number of children admitted to RTC has decreased dramatically as shown in the previous measure.

Trend: ◄►

How Well Did We Do It?

Physical Restraints per 1000 Client Days



	CY '08 Q3	CY '08 Q4	CY '09 Q1	CY '09 Q2	CY '09 Q3	CY '09 Q4	CY '10 Q1	CY '10 Q2	CY '10 Q3	CY '10 Q4	CY '11 Q1	CY '11 Q2
Ave	15.40	15.01	14.78	16.39	16.53	14.70	15.43	12.73	11.82	15.02	13.73	12.82

Story behind the baseline:

As we treat more children in the community than in congregate care settings, the acuity of those children treated in RTC increases. One factor that affects performance is the number and complexity of risks/challenges that clients remaining in RTC experience. Despite this, efforts to decrease the use of physical restraints continue. We have seen a downward trend in Physical Restraints per 1000 Client Days; with a 17% decrease in use of restraints when CY Q3'08 is compared to CY Q2'11.

Trend: ▲

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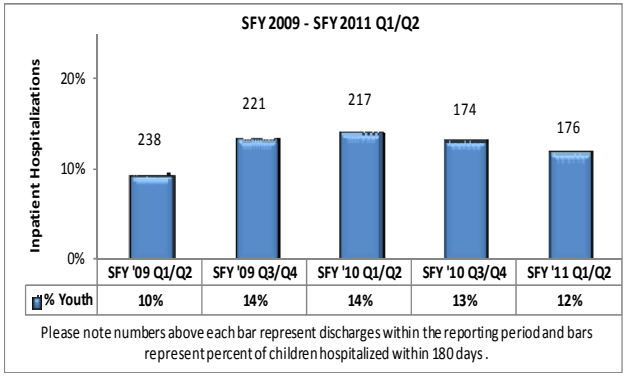
Quality of Life Result: Connecticut children grow up safe, healthy, and ready to lead successful lives

Is Anyone Better Off?

Children and Youth Experiencing Inpatient Hospitalization within 180 days of Discharge from RTC



Please note numbers above each bar represent discharges within the reporting period and bars represent percent of children hospitalized within 180 days.

Story behind the baseline:

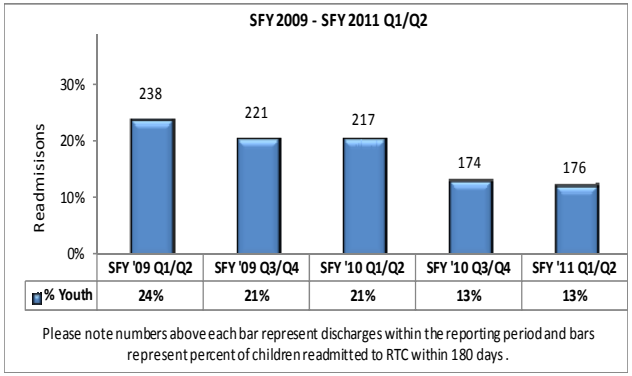
Children and youth treated in RTC were often psychiatrically hospitalized multiple times prior to their RTC stay. Thus, one measure of the efficacy of the RTC treatment is whether they require hospitalization following the RTC stay. The percentage of children and youth experiencing Inpatient Hospitalization within 180 days post RTC discharge has decreased 14% when SFY '09 Q3/Q4 is compared to SFY '11 Q1/Q2.

The goal is to increase community based services and supports in order to reduce possible hospitalizations of children after discharge from RTC. However, hospitalizations can often serve as an intervention to maintain a child in the community and avoid return to RTC. This is especially true for the smaller, but more acute population admitted to RTC.

Trend:, ▲

Is Anyone Better Off?

Children and Youth Experiencing Re-Admission to RTC within 180 days of Discharge from RTC



Please note numbers above each bar represent discharges within the reporting period and bars represent percent of children readmitted to RTC within 180 days.

Story behind the baseline:

Another measure of efficacy is whether or not children and youth require a return admission to RTC within 180 days of their discharge. The percentage of children and youth experiencing a re-admission to RTC within 180 days of discharge from RTC has decreased 46% when SFY Q1/Q2'09 is compared to SFY Q1/Q2'11.

To improve outcomes, DCF plans to implement a system of performance management, built upon the principles of RBA and the literature of "Implementation Science." This will involve a heavy focus on training as well as data collection, use and reporting.

Other areas that DCF will address to impact this measure are: improved transition plans as children and youth leave the RTC; and active family involvement and preparing families to more successfully handle crises post RTC stay.

Trend: ▲

Proposed Actions to Turn the Curve:

DCF has developed two targeted work groups to increase the effectiveness of Residential and community-based services. These groups will lead initiatives to: Implement performance incentives focused on improved outcomes for children; increase effectiveness of transition from congregate care to family and community-based care; increase community-based service outcomes for children and families. Specific steps include implementing a strength based, family-focused service model across the RTC's to improve outcomes, and a "Team Decision Making" model that empowers parents in making decisions around services and supports to successfully return and maintain their child in the family and the community.

Data Development Agenda:

DCF is working on: measuring multiple types of success in the community, at different time intervals, post discharge from RTC (reduction in recidivism, reduction in substance use, school success); a model to project future need for congregate and foster care. Utilization projection data is needed to ID ages, gender and service needs of children in the near future; data on regional needs for congregate and foster care to serve as many children as close to their homes, as possible; using contractor reporting system data (the PSDCRS) and chart audits to accurately ID providers that are effectively meeting the needs of children and families, including performance outcomes; working to analyze restraint and seclusion data, including specifics re: gender, age, days/times, & situations most prone to restraints and seclusions, in order to focus on prevention and reduction initiatives. These data can also be used to focus on specific providers.