

CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES



Congregate Care Rightsizing and Redesign: Young Children, Voluntary Placements and a Profile of Therapeutic Group Homes

A REPORT IN THE "FOSTERING THE FUTURE" SERIES

August 4, 2011

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Message from the Commissioner

All children and youth in the State of Connecticut deserve the opportunity to grow up as members of a family, to succeed in school and to participate in their communities in a positive and character-building way. It is my goal, as Commissioner of the Connecticut Department of Children and Families, to ensure that youngsters in the care and custody of this department share in these kinds of normative childhood opportunities as well.

Unfortunately, many children and youth on the department's caseload have not had and currently do not have these opportunities. In fact, in June of this year there were 1433 youngsters in congregate care settings within and outside of Connecticut. While this represents 28% fewer congregate care placements than in 2004, it nonetheless means that too many children and youth are not growing up with family and community ties.

The department's policy goal of reducing our reliance on congregate care placement is anchored in several key principles:

1. We will not place children ages six and younger in congregate care, except under a very few exceptions that I will authorize personally. This will require attention to the neuroscience of early childhood development and a stronger set of relationships with families, foster families (including relative and kinship families) and community providers.
2. We will work to dramatically reduce the numbers of children ages 7 through 12 who are placed in congregate care, beginning with those whose permanency goal calls for reunification with their families, placement in a foster family or adoption. To accomplish this will require increased supports for families and increased foster and adoptive family resources.
3. For those 1200 youngsters ages 13 through older adolescence now in congregate care settings (including group homes), we will conduct a thorough review to determine how best to ensure their return to a family or kinship-based setting as close to their families of origin as reasonable.
4. When any congregate placement is made, we will expect and require the facility to include the child's family or foster family (and other key adults in the child's life) as full participants in the admission, treatment and discharge process.
5. We will work with the congregate care sector within the State of Connecticut to gradually implement a brief treatment model in all cases in which that is appropriate. In the department's own behavioral health facilities, we are also moving to a brief treatment model that will be generally limited to 120 days or less. The average stay in private residential treatment and therapeutic group homes is now close to a year, or more.

6. We will work with families, providers and young people themselves focus on outcomes for all aspects of the department's work. This means that we will expect child and family plans to include both treatment and normative outcomes to be accomplished within a timeframe specific to each child.

Over the past four months, we have taken the time to look at the data and the lives of children currently being served by the department's foster family and congregate care systems. We find much room for improvement. Our challenges and the direction we propose to take over the next 24 months are outlined in this report and its companion paper *Advancing Foster Family Care in Connecticut*.

The practice changes listed in this report, coupled with improved partnerships with a broad variety of stakeholders and the development of performance markers, are all essential to achieving our goals for the children and youth that we serve. We look forward to a renewed partnership with Connecticut's foster families and with the state's community and congregate care sectors as we work together to implement the principles articulated here and improve outcomes for children and families.

Justice Joette Katz, Commissioner
Connecticut Department of Children and Families
August 1, 2011

Executive Summary: Goals and Levers of Change

The New Direction

The Connecticut Department of Children and Families currently serves just over 1400 children and youth in congregate settings. Slightly fewer than 200 of the youngsters are ages 12 and younger and 21 are under the six years old or younger.¹ Many of these youngsters, especially those ages 12 and younger, have discharge plans that call for reunification with their families or other family-settings.

The continually evolving research literature makes it very clear that congregate care placements for children can have significant negative impacts on children's overall development. These impacts include disengagement from a consistent primary caregiver and resulting attachment problems, the loss of familiar and individualized support systems, including extended family, school and peers, and lapses in formal learning, and difficulties readjusting to life in the community. In addition, the neuroscience of early development indicates that congregate and multiple placements in the very early years may impact the actual structure and functioning of the brain.

Other work now ongoing at the Connecticut Department of Children and Families points to the under-utilization of the state's current foster families as an essential alternative to congregate care. Kinship and relative families constitute a particularly under-used resource. Foster families receive little fiscal and therapeutic support as compared with providers in the congregate care system. In fact, the department's per diem for therapeutic group homes is ten times greater than the rate for foster families (\$361 to \$631 per day versus \$28 to \$50).

Services that can prevent congregate placements and aid in the return of children to family settings include intensive in-home services for the child and family, child-specific treatment services, day treatment, enhanced foster family care and respite.

Following a period of intensive internal analysis, the Department of Children and Families is utilizing this report to propose a new direction that will reduce our reliance on congregate care and make important adjustments in the use of our Voluntary Placement and Therapeutic Group Home Programs.

Implementation Partnerships

The Department of Children of Families will, as promised, re-engage with families, the private sector, and youth themselves as we move to the implementation phase of this work. Focus groups with youth are being scheduled, and we will work to obtain family input in partnership with the department's State Advisory Council, Behavioral Health Partnership and other family-based organizations.

¹ As of July 27, there were just 10 children ages six and younger in Safe Homes.

We will also formalize a series of working engagements with private congregate care providers to clarify policy issues, explore trend data on outcomes, quality and utilization, and develop strategies to support those facilities who wish to modify their programs to bring them in line with the needs of children and youth as documented in this and other recent reports.²

Four Goals for Congregate Care Rightsizing and Redesign

1. Reduce the numbers of children ages 12 and younger in congregate care and eliminate, to the greatest possible extent, congregate placements for children ages six years or younger.
2. Gradually reduce the length of stay in congregate placements through the department's Voluntary Services Program to a period of 6 to 9 months, aligned as much as possible to the school year. Approval of Voluntary Placements will also require family involvement, and the application of a financial means test. In addition, the Department will seek insurance payment where available.
3. Review and repurpose therapeutic group homes now in use. This may include conversion of homes now serving younger children to enable them to serve youth who are now or could be placed in out-of-state residential treatment programs.
4. Implement a system of performance management, built upon the principles of Results Based Accountability and the literature of "Implementation Science." This will involve a heavy focus on training as well as data collection, use and reporting.

Levers of Change

Policy Change (by January 2012)

By January 2012, the department will issue the following new or revised agency policies:

- Children ages 12 and younger are to be served in family settings and returned from current congregate care to family settings. Family settings are defined as biological homes, relative or kin placements, or other foster family care.
- No children age six or younger will be placed in congregate care without formal authorization by the commissioner.
- Length of stay for children placed in congregate care through the Voluntary Services Program and the Therapeutic Group Home Program will be reduced, with a target of 6

² See the Future of Riverview Report (April 2011), for example, which documents specific cohorts of young people with complex needs not now being met by in-state residential providers. This report is online at -- www.ct.gov/dcf/lib/dcf/latestnews/rvh_final_report_webmed.pdf

to 9 months in accord with a child's needs. Note: A similar policy shift to shorter lengths of stay in residential treatment will also be explored.

- When a family enters the Voluntary Services Program seeking placement of its child(ren), family dynamics and functioning will be formally assessed.
- Parental failure to participate actively in placement planning, treatment and discharge planning for a child in the DCF Voluntary Services Program is grounds for termination from the program.

Practice Changes

Over the coming 12-18 months, department practice will be modified as follows:

- By mid-September 2011, establish an internal DCF Congregate Care Team to provide system oversight for all congregated care programs serving CT children, youth and families.
- By mid-September 2011, establish a public-private Congregate Care Learning Community composed of a multi-stakeholder partnership that meets regularly to frame strategies for redesign congregated care settings and development of strategies for achieving those goals.
- Continue the department's statewide implementation of the Strengthening Families Practice Model with statewide implementation by December 30, 2012.
- Implement procedures to better manage the length of stay of children and youth in Therapeutic Group Homes and move them into families more quickly.
- Partner with Connecticut institutions of higher education and the private provider sector to implement joint trainings for DCF staff, foster families, and community and congregated care providers that address the following: family-centered care; trauma-informed practice; the neuroscience of child and adolescent development; strategies for building partnerships with communities; and improvements in leadership, management, supervision and accountability. (Ongoing)
- Utilize learning from the WR program and from evidence-based wraparound service models to assure appropriate supports for biological, adoptive and foster families. (Ongoing)
- Review information currently required by the Voluntary Services Program application packet related to family financial and insurance information. Level of care requirements

should be included in the application package when placement is sought. (By January 2012)

Improved Access to Child-Specific and Family-Supportive In-Home and Community Services

Over the next 24 months, the Department will partner with a broad array of stakeholders to:

- Support the expansion of community-based autism services and respite programs for families seeking voluntary services and placements from the Department of Children and Families. This will involve joint work with the Connecticut Department of Developmental Services and other stakeholders.
- Plan for and guide an increase in the number and diversity of evidence-based substance abuse and domestic violence treatment services for both parents and their children
- Increase the use of foster family settings (including kinship) as an alternative to congregate placements
- Utilize the learning from the WR Program and from evidence-based wraparound models to assure appropriate supports for biological, adoptive and foster families.

Performance Management

Develop and implement measurement strategies to ensure that all policies and practice changes are applied uniformly across all regions and area offices.

Establish clear parameters and guidelines for the types, quality and quantity of services provided by the Therapeutic Group Homes, including a marked increase in family participation and in community involvement.

Evaluate the provision of clinical and other services to determine which of these services can be offered by community providers during placement in support of a successful transition of the child back to his or her family or subsequent to discharge to the community.

With Value Options and others, establish performance management outcomes, criteria, measures and timelines for assessing outcome progress and success in keeping children in families and moving children in congregate care into families. For congregate care providers, this should measure family engagement, length of stay, planning and activities to support return of a child to his or her home, and the number of children discharged to families.

To best meet the data needs of the Department, convene a working group including DCF and Value Options staff to execute a reliable, congruent dataset that can be ready for data mining by June 2012. Fully leverage the capacity of Connecticut Behavioral Health Partnership data-reporting capacities, PSDCRS, and other data collection and reporting systems to collect data

for congregate care settings, regularly analyze and report these data back to providers, and use these data for the purposes of quality improvement and management decision-making.

Build the capacity for enhanced use of data by beginning with key DCF Area Office staff members, with a plan for extending this capacity to additional stakeholders. Focus departmental efforts on a core set of key performance indicators that are closely related to service quality discharge outcomes among children in congregate care settings.

Financing

With The Annie E. Casey Foundation's Child Welfare Strategy Group explore ways of supporting a period of redevelopment and conversion for therapeutic group home providers willing to modify their programs to serve youngsters currently refused by in-state residential treatment providers.

Explore a cost model for therapeutic group homes that would allow clinicians currently serving specific children to provide transitional services to the same child upon return home or to a foster family setting. Determine if a similar model could be applied to the congregate sector more broadly.

Consider consolidating the training allocation in each provider's budget to support training across all providers. Joint training opportunities would be developed and presented by the DCF Academy for Family and Workforce Knowledge and Development in partnership with adjunct faculty from the private sector. This will help to support consistent, family-centered, trauma-informed practice and training on the neuroscience of development for all providers.

Develop a monitoring and feedback system for congregate care providers to monitor the achievement of performance targets. Develop an "early warning system" for those providers experiencing signs of failure. Establish a period for the collaborative development of a time-limited corrective plan of action.

Part I: Changing Direction in Connecticut

Change and Realignment in the Department of Children and Families

Since the appointment of Justice Joette Katz as Commissioner of the Connecticut Department of Children and Families (DCF) in January 2011, the agency has been engaged in a period of dramatic change and realignment. These changes are all built around a revised vision for children and youth served by the Department. This expanded view moves the Department from a dominant focus on “safety and placement” to one that also embraces children’s health and learning within the context of a family-centered framework:

In partnership with families and the community, children and youth served by the department will grow up healthy, safe and learning, and will experience success in and out of school. The department will advance the special talents of the children it serves and will make opportunities for them to give back to the community.

To advance this vision for children and youth in the care and custody of the Connecticut Department of Children and Families, agency leaders are implementing a series of structural changes within the context of five cross-cutting themes. At the same time, the Department is developing a series of policy directives designed to promote the delivery of services to children within the context of their families (including foster families) while at the same time reducing the use of congregate care. This entire effort is called Fostering the Future.

Structural Changes and Cross-Cutting Themes

Over the period, February through July 2011, the Department has created a collaborative team framework to replace the silos of bureau operations in its Central Office, realigned regional operations to build toward a comprehensive children’s services system, consolidated two agency institutions, and established the Academy for Family and Workforce Knowledge and Support. Early in August, the Commissioner will name six Regional Directors and the leadership of the Central Office Clinical and Community Support Team and the Child and Adolescent Development and Prevention Team.

In addition, the Department has identified five cross-cutting themes that serve to align our work agency-wide:

- A family-centered approach to all service delivery, reflected in development and implementation of a Strengthening Families³ Practice Model and the Differential Response System

³ Information on the national Strengthening Families initiative is online at -- www.cssp.org/reform/strengthening-families/resources

- Trauma-informed practice as related to children and families but also to the workforce that serves them
- Application of the neuroscience of child and adolescent development to agency policy, practice and programs
- Development of stronger community partnerships
- Improvements in leadership, management, supervision and accountability.

Emerging Policy Directives

In support of this new direction, the Commissioner has begun to craft and issue policy directives that promote practice change across the agency. These include:

- A directive to agency area office staff to make announced, rather than unannounced, visits with parents and families
- A directive that relative foster care will be the presumed placement for children rather than the exception
- A policy direction under development that (with rare exceptions authorized by the Commissioner only) children ages six years and younger will not be placed in congregate care settings
- The expectation that over the next 18 months many fewer children ages 12 and younger will be placed in congregate settings
- A move to the use of a brief treatment model in the department's mental health facility units on the North and South Campus of the consolidated Children's Psychiatric Center.

Other Work to Advance the New Direction

In addition to this report on congregate care right sizing, the Department of Children and Families is completing a series of brief but intensive examinations of policy, practice and program across the placement continuum, as summarized below:

- *Future of Riverview Report: Ten Steps Forward*: A review and analysis resulted in the recommendation for consolidation of the Riverview Hospital for Children and Youth with the Connecticut Children's Place, creation of six brief treatment units across the consolidated facility, integration of pediatric services across the new facility and the Connecticut Juvenile Training School, and seven other action steps.⁴ An Interim Consolidation Report was issued to the Implementation Steering Committee on June 21, 2011.⁵ A final Implementation Report will be issued no later than October 1, 2011.

⁴ *The Future of Riverview Report: Ten Steps Forward*, published on April 13, 2011, is online at -- www.ct.gov/dcf/lib/dcf/latestnews/rvh_final_report_webmed.pdf

⁵ The *Interim Consolidation Report*, published on June 21, 2011, is online at -- www.ct.gov/dcf/lib/dcf/latestnews/pdf/rvh_ccp_consolidation_report6_23_11.pdf

- *Advancing Foster Family Care*: An examination of the department's current and desired foster family system with the support of The Annie E. Casey Child Welfare Strategy Group and the Connecticut Association of Foster and Adoptive Parents. This thought paper outlines a series of steps needed to increase the effectiveness of recruitment and outreach efforts, better utilize existing licensed foster families and support them to improve child outcomes and foster family retention. In addition, the paper addresses issues in relative, kinship and therapeutic foster family care, calls for a focus on child outcomes, and the resolution of data, policy and fiscal issues. This report will be released later in August 2011.
- *Strengthening Families Practice Model*: The department's Strengthening Families Practice Model, in development for the past two years with support from Casey Family Programs and Casey Family Services, has been launched in two of the agency's regions with training provided by Partners in Change. Over the coming 18 months, training and implementation will occur in the department's remaining four regions.⁶

The Strengthening Families Practice Model incorporates a focus on family strengths and protective factors and draws on the Strengthening Families framework being implemented across the nation.⁷ Core elements of the Connecticut Practice Model include family-centered practice, purposeful visits, family assessment and a family teaming model of engagement.

- *Differential Response System*: In January 2012, the Department will launch a new system to support families who have been referred for child welfare services but whose child safety risk level is low. Also in development for several years, the Differential Response System serves as a non-protective services gateway to services for vulnerable children and families. It will utilize state funds appropriated in the departments' budget.

Effective implementation requires a new level of partnership with local agencies and natural supports in the community. Other states that have already implemented a Differential Response System have found improved service delivery for vulnerable families. As one example, Ohio reports improved child safety, a reduction in court caseloads and a 42% reduction in the need for out-of-home placements over a five year period when child welfare referrals actually rose.⁸

⁶ Note: The Connecticut Department of Children and Families will operate with six rather than five regions beginning in the fall of 2011.

⁷ This work is led and supported nationally by the Center for the Study of Social Policy. Information and materials are accessible online at -- www.cssp.org/reform/strengthening-families.

⁸ *Morning Musings: Strengthening Families and Differential Response*, May 10, 2011. Online at -- www.ct.gov/dcf/cwp/view.asp?A=3623&Q=482766

Purpose of the Congregate Care Rightsizing and Redesign Study

The Department of Children and Families is committed to serving an increased number of the children and youth on its caseload in family-based settings and in their own communities to the greatest extent possible. To begin to develop strategies for “rightsizing” its reliance on congregate care, the department’s Congregate Care Rightsizing Workgroup was established in May 2011 and was tasked by the Commissioner with:

- An analysis of all children in congregate care who are ages 12 and younger, with a special focus on children 6 and younger
- An analysis of all children and youth in the Voluntary Services Placement Program (hereafter, the Voluntary Placement Program), and
- A review of the Therapeutic Group Homes including policy, practice and outcome data.

This study process was undertaken after the examination of data on all youngsters in residential treatment, within and outside of Connecticut. At that time (March and April 2011), there were about 700 children and youth in residential treatment. The study summarized here includes all children in all forms of congregate care, defined as settings that operate on a 24/7 basis with shift-based staffing.

The types of congregate care funded through departmental grants, contracts and/or purchase of service for individual children are listed below. Descriptions of each type of congregate care setting are provided in Appendix A of this report.

- Residential Treatment Centers
- Therapeutic Group Homes
- STAR Homes
- Safe Homes (including those programs previously identified as Permanency Diagnostic Centers)
- Psychiatric Residential Treatment Facilities
- Crisis Stabilization Units
- PASS Group Homes
- Maternity Group Homes, and
- Supportive Work, Education, and Transition Program.

In order to effectively achieve systems change in congregate care, the Department is utilizing the following framework for action:

1. Create an internal analytic process to collect and analyze data
2. Prepare a public report of findings
3. Establish a standing internal workgroup to manage the department’s work relative to both community and congregate services

4. Design a collaborative public-private process with the community and congregate provider sector to create solutions that advance the department’s vision
5. Establish a Results-Based Accountability process to report on progress and challenges
6. Prepare regular public progress reports.

Leveraging Change: Progress in Four Jurisdictions

A recent report of the Annie E. Casey Foundation outlines successful efforts by several states to reduce their reliance on congregate care as part of the systematic reform of their state child welfare system. In *Rightsizing Congregate Care: A Powerful First Step in Reforming Child Welfare Systems*, the Casey Foundation identifies five systemic levers for change, and notes that change occurs “when at least two of the five levers are targeted...” Many of Casey’s congregate care rightsizing initiatives began by targeting one or two levers of change, then expanding to more. Not all levers were targeted for each project, although front-line practice was a targeted change in every site.”⁹

Levers of Change that Promote Congregate Rightsizing	
Lever	Actions
Composition of Services	<ol style="list-style-type: none"> 1. Reduce congregate beds 2. Increase community foster homes 3. Increase community-based services 4. Increase the use of kinship placements
Front-line Practice	<ol style="list-style-type: none"> 1. Engage young people in talking about their placement preferences 2. Increase the engagement of parents and family 3. Identify potential kinships homes earlier
Finance	<ol style="list-style-type: none"> 1. Create financial disincentives for congregate care (e.g., require local contributions for institutional placements) 2. Redirect savings from decreased cost of congregate care to community-based services
Performance Management	<ol style="list-style-type: none"> 1. Use permanency and well-being outcomes to evaluate congregate care providers 2. Phase out contracts with providers that have poor performance
Policy	<ol style="list-style-type: none"> 1. Mandate family-base concurrent planning for all children and youth 2. Limit use of independent living as a case goal 3. Identify potential kinships homes earlier 4. Encourage youth to consider open adoption arrangements that permit birth-family contact 5. Require prior authorization and utilization reviews for entry into congregate care

⁹ *Rightsizing Congregate Care: A Powerful First Step in Reforming Child Welfare Systems* (undated). The Annie E. Casey Foundation. Online at -- www.aecf.org/~media/Pubs/Topics/Child%20Welfare%20Permanence/Foster%20Care/RightsizingCongregateCareAPowerfulFirstStepin/AECF_CongregateCare_Final.pdf, p. 2

The Annie E. Casey rightsizing report describes efforts in four jurisdictions to reduce reliance on congregate care: the New York City Administration for Children's Services; the Maine Bureau of Child and Family Services; the Louisiana Office of Community Services; and the Virginia Department of Social Services. Over a relatively brief period of time, each of these jurisdictions substantially reduced its use of congregate care. A brief summary of each follows.

New York's Results

New York reduced its congregate care population by 27% from 1996 to 2001. In addition, the number of congregate care beds decreased from 4,178 in 2002 to 2,192 in 2008. This reduction in the use of congregate care saved more than \$41 million, "a portion of which was reinvested in supportive and aftercare services." Finally, when this initiative began one-third of all teens entering the Administration for Children's Services were served in family settings compared with two-thirds today.¹⁰

Maine's Results

From 2004 to 2009, Maine reduced its use of congregate care by 73%. The use of kinship foster family care increased from 12% to 30%, and 40% of children "discharged to adoption spent less than two years in congregate care as compared with 26.8 percent of children in similar circumstances nationally."¹¹ Finally, \$10.5 million was saved as the result of congregate care rightsizing, of which \$4 million was reinvested into community programs.

Louisiana's Results

Over a two year period, 2006 to 2008, Louisiana reduced its use of congregate care by 33% and increased its use of foster family homes from 496 to 700. In addition, by engaging directly with youth being served in the congregate care system, Louisiana learned that the "main reason many youth languished in congregate care (the average length of stay was two years) was that no one had assessed whether they could live in a family setting."

Virginia's Results

After determining in 2007 that nearly one-third of all children in the state's child welfare placement system were in congregate care, the Virginia First Lady undertook a dramatic reform effort. Despite a state fiscal deficit, the Virginia assembly passed a reform agenda that included an increase in funding (\$1.8 million) to recruit, train and support foster and adoptive families, a 23% increase in foster care and adoption caseworkers and \$800,000 for training them, and a "new state funding formula with incentives for community-based placements."¹²

¹⁰ Ibid, pp. 3-4

¹¹ Ibid, p. 5

¹² Ibid, p. 7

The City of Richmond was identified as a first pilot site, including implementation of the Team Decision Making model for “all children for whom step-down from congregate care was considered.” As part of the pilot, three court mediators were loaned to the child welfare offices and trained to serve as Team Decision Making facilitators. Additionally, the state created a Council on Reform (called CORE), consisting of 13 localities, 100 volunteer representatives from the state department’s of social services, mental health, and comprehensive services as well as representatives from provider and parent organizations.

In just five months, the court facilitators held 250 team meetings, “resulting in a 30% decrease in the number of Richmond youth in congregate care. Birth families, never before included in meetings related to their children, were central participants...”¹³ Statewide by March of 2009, Virginia experienced a 27% reduction in congregate care, an overall drop in the placement population (congregate and foster family care), and an increase of 14% in CORE localities and 5% statewide.

The bottom line... As will be seen throughout this report, Connecticut has already taken several of the steps noted in the *Rightsizing Congregate Care* report by The Annie E. Casey Foundation. With expanded partnerships with community and congregate providers, increasing numbers of youngsters will be served more appropriately and less expensively in their own families, in other family and kinship settings, and in their own communities.

Summary of Connecticut’s Rightsizing and Redesign Goals

The DCF Congregate Care Rightsizing Work Group has identified a series of goals and levers of change to “rightsizing” the department’s reliance on congregate care and to review and redesign some of its continuum of settings. A summary of these goal statements follows.¹⁴ The reader is directed to each of the sections of this report for further detail.

1. Reduce the numbers of children ages 12 and younger in congregate care and eliminate, to the greatest possible extent, congregate placements for children ages six years or younger.
2. Gradually reduce the length of stay in congregate placements through the department's Voluntary Placement Program to an average of 180 days or less, require family involvement, require the application of a financial means tests and secure insurance payment where available.
3. Review and repurpose therapeutic group homes now in use. This may include conversion of homes now serving younger children to enable them to serve youth who are now or could be placed in out-of-state residential treatment programs.

¹³ Ibid, p. 7

¹⁴ Note: These statements are included verbatim within the Executive Summary as well.

4. Implement a system of performance management, built upon the principles of Results Based Accountability and the literature of “Implementation Science.” This will involve a heavy focus on training as well as data collection, use and reporting.

Implementation Partnerships¹⁵

The Department of Children of Families will, as promised, re-engage with families, the private sector, and youth themselves as we move to the implementation phase of this work. Focus groups with youth are being scheduled, and we will work to obtain family input in partnership with the department's State Advisory Council, Behavioral Health Partnership and other family-based organizations

We will also formalize a series of working engagements with private congregate care providers to clarify policy issues, explore trend data on outcomes, quality and utilization, and develop strategies to support those facilities who wish to modify their programs to bring them in line with the needs of children and youth as documented in this and other recent reports.¹⁶

Acknowledgements

The Department gratefully acknowledges the contributions of the following individuals who worked together over the period from May through July to collect and analyze data and then prepare the *Congregate Care Rightsizing Report*. In addition, the Department acknowledges the data support provided by Value Options through the Connecticut Behavioral Health Partnership.¹⁷

The working group identified below has been co-chaired by Arnold Trasente and Nancy DiMauro. Individuals are listed alphabetically along with their agency affiliation.

- Dr. Karen Andersson, DCF lead on the Connecticut Behavioral Health Partnership
- Nancy DiMauro, DCF lead on the Child Welfare Policy Unit
- Dr. Linda Dixon, DCF Residential Treatment Consultant and member of the DCF Academy on Family and Workforce Knowledge and Development
- Elisha Gilliam, Annie E. Casey Foundation Child Welfare Strategy Group
- Elizabeth Graham, Deputy Commissioner DCF
- Dr. Janice Gruendel, Deputy Commissioner DCF
- Giselle John, Annie E. Casey Foundation Child Welfare Strategy Group
- Dr. Bert Plant, DCF Interim Team Leader, Clinical and Community Consultation

¹⁵ This section is repeated verbatim in the Executive Summary.

¹⁶ See the Future of Riverview Report (April 2011), for example, which documents specific cohorts of young people with complex needs not now being met by in-state residential providers. This report is online at -- www.ct.gov/dcf/lib/dcf/latestnews/rvh_final_report_webmed.pdf

¹⁷ Online at -- www.ctbhp.com/about.htm

- Dr. Brett Rayford, DCF Interim Team Leader, Child and Adolescent Development, and Prevention
- Gretchen Test, Annie E. Casey Foundation Child Welfare Strategy Group
- Dr. Arnold Trasente, DCF Supervising Consulting Psychologist, Program Review and Evaluation
- Dr. Jeff Vanderploeg, Connecticut Center for Effective Practice

Part II: An Overview of Congregate Care

A Brief Summary of the Research

In a brief monograph entitled “Redefining Residential Treatment,”¹⁸ the American Association of Children’s Residential Treatment Centers advocates for a limited, although necessary, role for residential treatment in the service continuum. The monograph also acknowledges that residential care must be re-conceptualized as a specialized intervention that is more family based, better aligned with community care, utilized only when needed, and employed for as brief a period as necessary.

While residential treatment and other forms of congregate care have their place within the service continuum, their negative effects on children’s development warrant mention. These include:

- Disengagement from a consistent primary caregiver and resulting attachment problems
- The loss of familiar and individualized support systems, including extended family, school and peers, and lapses in formal learning
- Difficulties readjusting to life in the community.

In short, institutional care often lacks many of the characteristics that lead to healthy emotional and cognitive development. Coupled with the stress associated with abusive and/or neglectful situations, removal from a family can create significant biochemical sequelae that impact normal brain development in a negative way. These problems are especially significant among very young children when brain development and attachments are being rapidly built.¹⁹

Young children’s brain development and functioning are impacted – positively or negatively – by the nature of the relationships that they have with caregivers. Optimal development occurs when that care giving is richly interactional, stimulating and positive.²⁰ Importantly, placement in a congregate care setting – with caregivers who change with each of three shifts – is likely to interfere with the development of healthy attachments in infants and toddlers. In addition, multiple placements may also “result in disruptions in care giving and the development of a healthy attachment, which in turn may evoke feelings of loss and abandonment, deprive

¹⁸ American Association of Children’s Residential Treatment Centers: Redefining Residential Care – Series One through Eight. Online at – www.aacrc-dc.org

¹⁹ Significant research addresses the developmental challenges of children and youth in the child welfare system and the neurologic sequelae of trauma, abuse and neglect. Recent research on brain development is beginning to identify the impact of chronic stress (as experienced in abusive and/or neglectful family circumstances) and complex trauma (often associated with repeat episodes of abuse, neglect and repeated placements) on brain growth and functioning at various stages of children’s development. For example, *Understanding the Effects of Maltreatment on Brain Development*, online at – www.childwelfare.gov/issue_briefs/brain_development. Additional references can be found at the Just Beginning website online at – www.justbeginning.org

²⁰ See materials available from the Harvard Center on the Developing Child, online at -- [//developingchild.harvard.edu](http://developingchild.harvard.edu)

children of the consistent relationships that foster a sense of belonging, and threaten their ability to master age appropriate tasks. These children may be less able, or unable, to form positive attachments to other adults, experience high levels of anxiety and guilt, engage in displays of socially unacceptable behaviors or experience emotional distress.”²¹

Research has also focused on identifying characteristics of congregate care that can mitigate its negative impacts. In general, factors associated with better child outcomes include: smaller size of the program,²² staff training, family involvement, systemic interventions, and trauma-informed systems and interventions.²³ Most of the recent literature on positive outcomes related to residential care has focused on the impact of "family centered" care.²⁴ Emerging best practices in the delivery of congregate care include:

- Addressing family issues as well as child-specific challenges
- Accommodating care to meet the scheduling needs of the family, foster family or other adults involved in the life of the child
- Frequent phone calls and visits to family and other involved adults
- Sufficient transition planning that includes extended stays at home with home-based interventions initiated prior to formal discharge.²⁵

Finally, some authors have noted that diagnostic presentation is important in considering congregate care's usefulness. For example, in one study of responses to residential treatment, researchers concluded that children who demonstrated oppositional, defiant, or generally conduct-type symptoms seemed to do the most poorly in a residential treatment setting.²⁶

A Summary of Previous Departmental Initiatives Related to Rightsizing

For over ten years, the Connecticut Department of Children and Families has been committed to reducing its reliance on congregate care. Recognizing the restrictive and costly nature of this treatment modality and its limited documented efficacy, the focus of DCF's behavioral health

²¹ Attachment and Recovery: Caring for Substance Affected Families (2005). Connecticut Center for Effective Practice. pp. 17

²² Ryan, J.P., et al., (2008). Juvenile delinquency in child welfare: Investigating group home effects. Children and Youth Services Review doi: 10.1016/j.chilyouth.2008.02.004

²³ Pumariega, A.J. (2007). Residential treatment for children and youth: Time for reconsideration and reform. American Journal of Orthopsychiatry, 77(3), 343-345

²⁴ Barth, R.P. (2002) Institutions vs. foster homes: The empirical base for the second century of debate. Chapel Hill, N.C.: UNC, School of Social Work, Jordan Institute for Families.

²⁵ Dupree, D., & Stephens, S.A. (2002) Foster care and Early Child Development: Implications for Child Welfare Policy and Practice. Center for Assessment and Policy Development; Nelson, Charles A, (2007) A Neurobiological Perspective on Early Human Deprivation. Child Development Perspectives, Vol. 1, No. 1, pp. 13-18; Curtis, P.A., Alexander G., & Lunghofer, L.A. (2001). A literature review comparing outcomes of residential group care and therapeutic foster care. Child and Adolescent Social Work Journal, 18, 377-392.

²⁶ Joshi, P.K., & Rosenberg, L.A. (1997). Children's behavioral response to residential treatment. Journal of Clinical Psychology, 53(6), 567-573.

program development has been to foster and support community-based care/intervention, in tandem with reducing reliance on congregate care.

Connecticut Community KidCare

A blueprint for reform within the publicly-funded children's behavioral health system was introduced in 2001 when the Department and its partner, the Connecticut Department of Social Services launched *Connecticut Community KidCare*. Based upon the federally-endorsed System of Care model,²⁷ *KidCare* was based on the premise that all care should be child centered, family focused, culturally competent and community based.

To support the initial efforts to launch a community-based children's behavioral health system, the Connecticut General Assembly appropriated approximately \$34 million dollars to DCF (SFY 2002-2004). This funding was intended to promote the development and delivery of much-needed services including:

- Emergency Mobile Psychiatric Services
- Care Coordination
- Extended Day Treatment
- Family Advocacy, and
- Home-Based interventions.

Dollars allocated to the Department by the Mental Health Strategy Board in 2004 to 2006 also helped to initiate Yale's intensive in-home psychiatric services model (IICAPS), funding for which was eventually absorbed in DCF's budget.

Currently, the department's budget for community-based services is approximately \$55 million. Additional dollars from federal grants and state and national foundations have helped to support these efforts, as have dollars for flexible funding from the department's child welfare accounts.

The Juan F Consent Decree

As DCF began to implement this shift toward a community-based treatment philosophy, several additional initiatives were concurrently implemented that had a significant impact on the use of congregate care and residential treatment. *Juan F Consent Decree* Exit Outcome Measures stipulated, among other targets, that no more than 11% of youth in care and custody of the Department could be placed in residential treatment (all youth 0-18 committed to DCF) at any given quarter (Outcome Measure #19).

²⁷ SAMHSA is the federal Substance Abuse and Mental Health Service Administration, online at -- www.samhsa.gov

Development of Therapeutic Group Homes

Therapeutic group homes, designed as an intensive, clinically informed alternative to large congregate care settings, were procured between 2004 and 2008. These 5-6 bed facilities were created to provide a structured environment in which youth could reside while attending school in the community and participating in a wide variety of community-based activities (i.e., sports, music). There are currently 52 therapeutic group homes in CT serving about 240 youngsters at any given time. Previously most, if not all, of these young people would have been placed in larger residential facilities.²⁸

Connecticut Behavioral Health Partnership

In 2005, the Connecticut Behavioral Health Partnership was established. The Partnership is a statutorily-created collaboration that supports joint planning, funding and oversight of the publicly-funded behavioral health network for HUSKY A and B recipients and other DCF involved youth.²⁹ The statute also required the Department of Social Services (as the state Medicaid agency) and the Department of Children and Families to procure the services of an Administrative Services Organization (ASO) to provide utilization management, clinical management and quality assurance activities for the services covered through the Partnership, including residential treatment and other types of congregate care.

Processes initiated under the Partnership provided new Level of Care Guidelines³⁰ based on medical necessity criteria by which all referrals to residential care and other types of congregate care are reviewed and approved (or denied). This provides a level of “gate keeping” not previously available. Centralized databases were also created to capture demographic, clinical and placement information on each child placed in residential treatment and other types of congregate care.

Through the initial authorization process and routine concurrent reviews by the Partnership, each child's progress in treatment is being tracked, and discharge planning is prompted and facilitated when clinically appropriate. This new level of clinical oversight and provider management has supported the department's desired joint goals of diverting children from congregate care to community based care whenever appropriate and shortening lengths of stay whenever possible for those youth who enter congregate care. Through the compilation of aggregate data on youth specifically in residential treatment, numerous reports are prepared to highlight trends in the use of residential and other types of congregate care. These reports have served to heighten awareness throughout the system regarding the use and challenges of this level of care.

²⁸ See A Profile and Recommendations Related to Therapeutic Group Homes. A Report in the Fostering the Future Series (July 2011). Connecticut Department of Children and Families. Available online at the department's website.

²⁹ See Public Act 05-280, Section 92.

³⁰ Online at -- www.ctbhp.com

Reductions in Congregate Care Use and Services

The Department of Children and Families has been steadily reducing the overall number of placements into congregate care since 2004.³¹ On June 1, 2004, there were 1996 youngsters placed in all types of congregate settings. On June 1, 2011, 1433 youngsters on the department's caseload were placed in congregate care, a reduction of 563 or 28%.

Trends vary over time, however, for various types of congregate care placements. For example, over the same period of time, therapeutic group home placements have *dramatically increased* while residential treatment placements *have declined*.

- On June 1, 2004, 233 youngsters were placed in therapeutic group home beds as compared with 461 on June 1, 2011. This represents an increase of 98%.
- On June 1, 2004, 1231 youngsters were placed in residential treatment (in and out of state) on June 1, 2004. On June 1, 2011, half as many youngsters (626) were placed in residential beds, a decline of 605 youth (49%).

Reductions in the use of congregate care have had a significant impact on Connecticut's *in-state* congregate care provider network. During the last seven years, there has been a reduction of over 450 in-state residential beds for children in the DCF system. This includes the closure of a number of programs and significant census reductions at other programs.³² Most recently, two therapeutic group homes have been closed due to low utilization levels.³³

³¹ For further detail, contact Fernando Muniz, Chief of Planning and Quality Improvement, Connecticut Department of Children and Families at – Fernando.muniz@ct.gov

³² In most instances program closures or census reductions were driven by three factors: (1) Quality of service or treatment concerns identified by the Department; (b) Agreement between the Department and the provider that the provider no longer wished to serve the increasingly complex population of children and youth being referred; (c) *Fiscal challenges*.

³³ *A Profile and Recommendations Related to Therapeutic Group Homes*, op. cit.

Part III: Meet Some of Connecticut's Younger Children in Congregate Care

Meet Ron, Age 12

Ron is a 12-year-old boy who enjoys sports and art work. He is an eager and spirited student who loves to learn new things. Ron has lived in a therapeutic group home since November 2009. He has a significant history of impulsivity, self-injurious behavior, and aggression. Ron's current psychiatric diagnoses include Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder. He is on four different psychotropic medications.

Ron was subjected to severe and prolonged physical abuse and neglect by his parents throughout his infancy and toddler hood. Following removal from his home at age three, Ron and his siblings were placed with relative caregivers. Parental rights were eventually terminated. Prior to Ron's group home placement, he required several psychiatric hospitalizations, including two at the Riverview Hospital for Children and Youth, one placement in a sub-acute residential setting, and two stays in residential treatment. While residing with family members, Ron and the family participated in intensive community-based clinical services including respite, extended day treatment, in-home programs, and clinical day school placements. Ron no longer has any contact with his relative caregivers and siblings as they relocated to another country and rejected a continued relationship with him.

Despite very high levels of therapeutic support in the current treatment setting, including 1:1 staffing, individual, art, group, and milieu therapies, a sensory program and frequent meetings with a psychiatrist, Ron continues to display impulsive and aggressive behavior. At times, he requires brief acute psychiatric hospitalizations for behavioral and pharmacological stabilization. He is prone to explosive outbursts when faced with situations that require intimate interpersonal engagement. His discharge goal is therapeutic foster care.

Meet Peter, Age 9

Peter is a nine year old boy who has been residing in a Safe Home for the past 12 months. Peter is very physically active and quite well coordinated. He is a creative child who loves to draw and paint. He has an infectious smile and laugh, and can be most charming when calm and engaged. However, he also exhibits some challenging behaviors that require specialized interventions. Peter is committed to the Department and did not experience success in the two foster home placements that preceded his current placement. He has been exposed to chronic domestic violence, and has been the victim of physical abuse.

Peter carries a diagnosis of autism with mild mental retardation. His language skills are quite limited, and he makes poor eye contact with others. He has frequent toileting accidents and is prone to running away or "bolting" when frustrated or angry. He has an array of other challenging behaviors that include tantrums and physical aggression toward both peers and adults. Physical restraint is frequently used to protect him from harming himself or others.

Peter has been involved in various early intervention programs to address his developmental delays. He currently attends a specialized educational program close to the Safe Home. In addition, the Department has procured the services of a behavioral analyst to help develop a set of targeted behavioral interventions (called Functional Behavioral Analysis) designed to decrease the number and frequency of Peter's aggressive behaviors and to teach Safe Home staff how to implement this individualized program. Because Peter's behavior is so impulsive, and due to the highly specialized nature of his daily treatment and physical care needs, Peter's stay at the Safe Home has been supported through the constant engagement of a one-to-one support staff member.

Despite previous efforts to reunite Peter with his mother, safety issues remain prominent and -- at this time -- reunification is not possible. Peter's father is currently incarcerated. An earlier placement with an aunt and uncle ended due to his challenging behaviors. He was subsequently referred to a therapeutic foster home. A potential home was identified but the caregivers ultimately declined the placement. A professional foster home was identified but, again, the potential foster parent declined after observing Peter in the Safe Home.

Specialized recruitment has been discussed with three additional agencies. No home has been identified, and Peter has now spent over a year in the Safe Home. Another aunt was identified as a potential relative placement in April, and Peter has begun weekly visits with her, but she notified DCF in June that she and her husband will not serve as a permanent placement for Peter. The department is not considering a referral to residential treatment for Peter given his young age. He remains in the Safe Home while therapeutic foster family placement is created.

Meet Michael, Age 12

Michael is a 12-year old boy currently placed in an intensive residential treatment program in Massachusetts. Michael is a warm and engaging child. He is a great artist, insightful and well mannered. He is a bright and intelligent 6th grade special education student. He was placed in Massachusetts in August of 2009 following a three-month stay at Riverview Hospital for Children and Youth. Prior to his stay at Riverview, Michael lived at home with his mother and three siblings. Michael was committed to the Department as uncared for with specialized needs since his mother was not able to effectively manage him at home. Michael's mother and four siblings are still actively involved with the Department as a Child Protective Services in-home case with protective supervision.

Michael has a history of aggression toward others, difficulty accepting limits and mood lability. He is diagnosed with Impulse Control Disorder and Attention Deficit Hyperactivity Disorder. Childhood neglect, inconsistent parenting, divorce and being a witness of repeated violence characterized Michael's early developmental years. He required physical intervention almost daily when first placed in the residential treatment program, despite numerous interventions and medication trials. Michael has remained in this program and is on a complex medication regimen.

Since his placement in congregate care, Michael's mother has visited him just four times and has participated in only a few family therapy sessions despite the department's offer of assistance with transportation, child care and other associated needs. In contrast, Michael's father has attended 24 family therapy sessions and visits twice monthly. Michael's father wants him to live with him following treatment and has remained steadfast in his commitment to his son. Unfortunately, a bitter divorce and on-going parental conflict has made this difficult for mother to accept.

The initial discharge recommendation for Michael was for a therapeutic group home placement before reunification with his father. While Michael has made significant progress in his treatment, he has not been able to reach the bar of "no physical restraints for three months" that is required in order to be placed in a therapeutic group home back in Connecticut. He has been able to remain free of physical restraints for up to 75 days, but not for the required 90 days.

Michael goes home to stay with his father twice a month without incident. Since it appears that a therapeutic group home may not be an option for Michael, the residential treatment program is now recommending another residential treatment facility closer to Michael's home in Connecticut. DCF area office staff members have been informed that, because of his restraints and occasional need for medication, no residential treatment program in Connecticut will accept Michael.

Part IV: Keeping Younger Children in Families and Out of Congregate Care

In the process of obtaining data for children in congregate care, it quickly became apparent that a lack of consistency exists in the data available across the sources (e.g. from the Department's internal data systems and from reports available from Value Options through the Behavioral Health Partnership). These inconsistencies created challenges in ensuring that the data reported below is both valid and complete. In order to present the most complete information on young children in congregate care, this section of the report includes a combination of data from both the department's LINK data system and Value Options.

As will be evident, the number of children we report on for the analyses below varies by the source of the data. Specifically, some of the information is based on 188 children in congregate care in late June of this year. Other information is based on a subset of these children (n=165). We are very careful to identify the data sources in each analysis presented below as findings will vary by source. Finally, to gather more detailed information, we also surveyed the department's area offices. Data acquired in that June survey is based on 146 children for whom responses were provided.

Children Ages 12 and Younger in Congregate Care

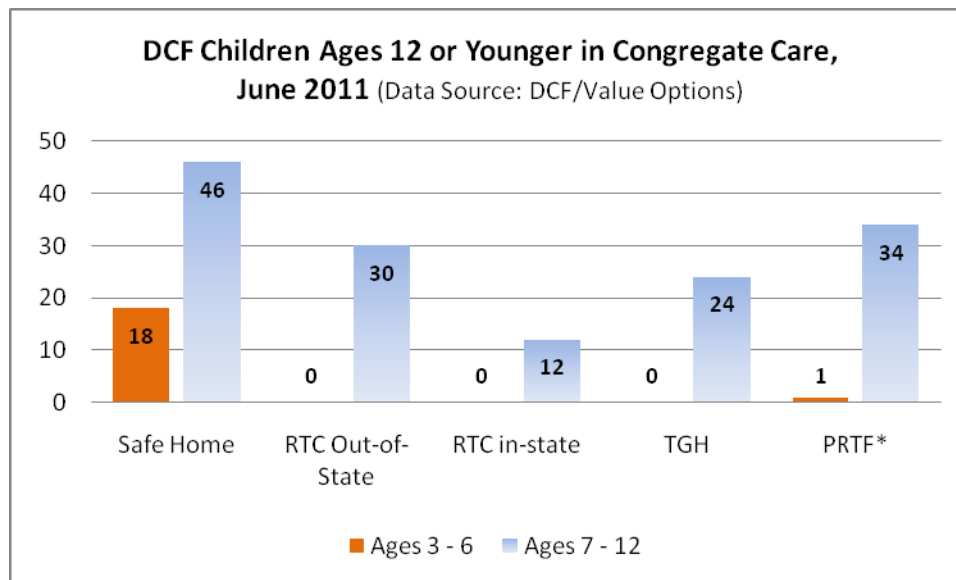
Based on data analyzed from both the DCF LINK data system and from Value Options, 188 children ages 12 and younger were served in congregate care settings as of late June 2011. These congregate care settings vary significantly in their level of restriction, the treatment services they provide to children and families, and their geographic locations. The following chart provides current data on the numbers of children placed in each congregate care type of setting:

Children ages 12 and younger in Congregate Care Setting (late June 2011) (n=188)		
Type of Setting	Number	Percent of Total
Residential Treatment, In-State	12	6%
Residential Treatment, Out-of-State	30	16%
DCF Facilities	5	3%
Psychiatric Residential Treatment Programs (PRTF)	35	19%
Safe Homes (expected stay of 45 days or less)	64	34%
Therapeutic Group Homes	24	13%
Group Homes	11	6%
Shelters and Crisis Stabilization Programs	4	2%
Hospital, Medical and Psychiatric Units	3	2%

Among these 188 young children, nearly all (88%) were placed in the following settings: Safe Homes, Residential Treatment Facilities (in-state and out-of-state), Therapeutic Group Homes,

and Psychiatric Residential Treatment Facilities (PRTF). At the time this data was drawn, there were a total of 165 children ages 12 and younger in these four types of facilities. Data reported below provides further detail for this subset of children.

The chart below shows the type of placement for two groups of children, those younger than seven and those ages 7 through 12 years. This analysis reveals two important facts. First, there are many fewer very young children in congregate care (that is, under the age of 7 years) than slightly older children. Second, the most frequently utilized placement type for both age groups is the Safe Home model which was originally intended as a 45-day placement but now serves children for much longer periods of time.



Demographic and Geographic Data for Children Ages 12 and Younger

Slightly more than half of children 12 and younger (55%) placed in congregate care settings were male. Boys outnumber girls in each placement setting except for in-state residential treatment centers. The proportion of young children of color in congregate setting is about equal to that of white children – 48% to 46%. Among children of color, 21% were African American children and 27% were Hispanic.

The data presented below are based on 165 of the 188 children ages 12 and younger in congregate care in late June 2011. Case responsibility for children ages 12 and younger in congregate care is relatively equally distributed across the department's area offices.

Children Ages 12 and Younger in Congregate Care by DCF Region, June 2011						
Region/Area Office	Safe Homes	RTC Out-of-State	RTC In-State	TGH	PRTF	Totals
Hartford, Manchester	10	6	4	3	4	27
New Haven, Milford	18	3	2	4	4	31
Willimantic, Middletown, Norwich	15	6	1	4	6	32
Torrington, Waterbury, Danbury	9	7	4	4	6	30
Stamford, Norwalk, Bridgeport	3	3	0	3	10	19
New Britain, Meriden	9	5	1	6	5	26
Totals	64	30	12	24	35	165

Legal Status of Children in Placement

These findings are based on data for the 188 children in placement in late June 2011 gathered from the DCF LINK data system and from Value Options.

Among the 188 children 12 and younger, 53% were committed to the Department of Children and Families for abuse or neglect. In 20% of the remaining cases, children were in the care of the Department under an Order of Temporary Custody. For another 14%, the Department is the statutory parent. Safe Homes had the highest number of children whose legal status was either an Order of Temporary Custody or statutory parent.

Discharge Planning and Barriers to Returning Children to a Family Setting

The following data is the result of an ad hoc survey of DCF staff in June 2011 conducted by the Congregate Care Work Group. At the time of the survey there was 195 children ages 12 or younger in congregate care. Data is included on 146 of these children. The survey focused on discharge planning for each specific child and anticipated barriers for returning each child to a family setting.

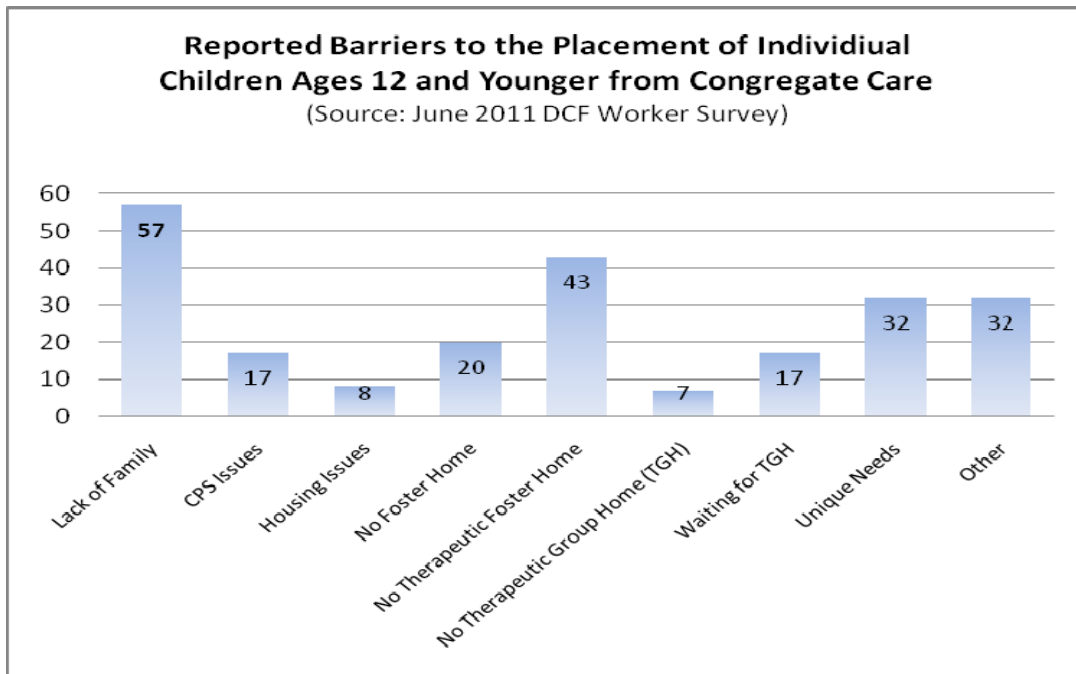
Permanency Goals and Discharge Planning

Sixty-two percent of the 146 children whose records were examined as part of this survey had a permanency goal of reunification with their families. Another 26% had a goal of adoption. Just over one in ten had what is called an APPLA goal – Another Planned Permanent Living Arrangement.

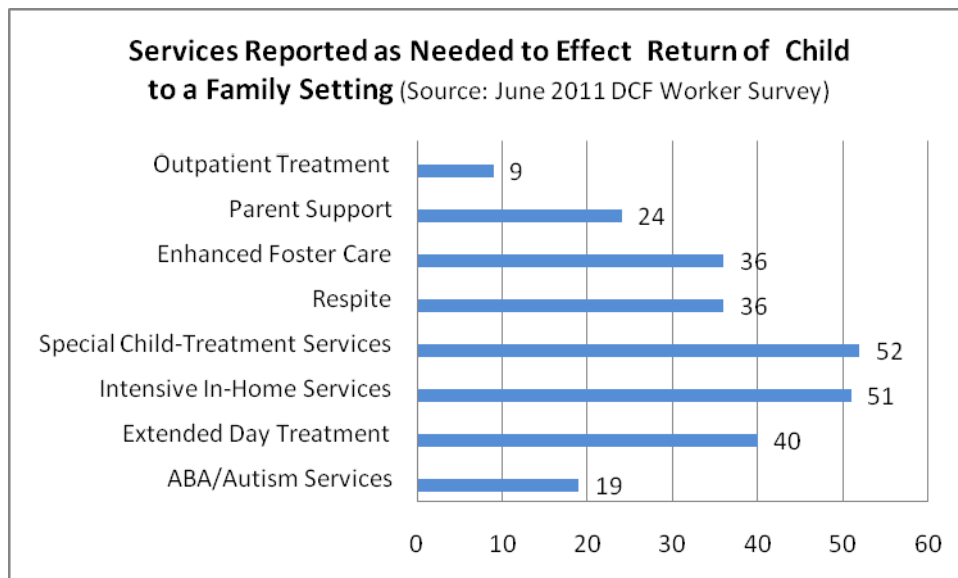
One third of these 146 children (32%) had a primary discharge plan calling for return to their home (26%) or to a relative (6%). Nearly half (45%) were to be placed with a foster family or in a therapeutic foster family home (17% and 28%, respectively). Fifteen percent (15%) had a discharge plan calling for placement in a therapeutic group home.

Perceived Discharge Barriers and Necessary Services

The survey also sought information on current or anticipated discharge barriers and the services that would be needed to accomplish the discharge plan. When identifying multiple barriers for a child’s discharge from congregate care, the lack of a family or foster family home was the most frequently mentioned barrier. Accessing services to meet the unique needs of children is also mentioned frequently.



When asked to indicate the services most needed to accomplish the return of individual children to a family setting, workers most frequently noted the need for intensive in-home services for the child and family, child-specific treatment services, day treatment, enhanced foster family care and respite.



What Do We Know about the Very Youngest Children in Congregate Care?³⁴

No DCF-involved children ages six years and younger are currently served in out-of-state facilities or in DCF-operated facilities. The 21 children in this age range are currently served in four types of congregate settings:

- Safe Homes
- Maternity Group Homes³⁵
- Psychiatric Residential Treatment Facilities (PRTF), and
- Hospitals (Psychiatric and Medical Units)

Data drawn for the analyses that follow are from the DCF LINK system and from Value Options.

Placement Types and Change over Time

On June 29th, 2011, twenty-one (21) DCF-involved young children were placed in Connecticut congregate care settings. Over the past three years, congregate care placements of children ages six years and younger declined by two-thirds, from 76 in May of 2008 to 21 in June 2011.

Children Ages Six and Younger in Congregate Care Placements						
Date	Total	Safe Home	Group Home Settings	Medical Group Home	PRTF	Hospital (Psych/Med)
May 2008	76	66	1 in a Therapeutic Group Home	2	Unknown	7
June 2011	21	15	3 in Maternity Group Homes	0	2	1

Most of these young children are placed in Safe Homes (15 of the 21). The three children in maternity settings were in placement with their biological mothers while under the care of the Department of Children and Families due to abuse/neglect issues. The two children in the PRTFs and the one child in the hospital were placed to meet the psychiatric needs of the children. All had a primary diagnosis of Post Traumatic Stress Disorder. The ages of these children are shown below by setting:

³⁴ During the 2011 session of the Connecticut General Assembly, a bill was introduced to prohibit the Connecticut Department of Children and Families from placing any child ages six or younger into a congregate care setting. Language was included to permit the Commissioner of the Department waiver authority in very limited circumstances including extreme medical or health conditions of the young child. The bill did not pass, but the Department is committed to implementing its intent through agency policy and practice within the coming year, July 2011 through June 2012.

³⁵ Through 2008, the Department of Children and Families utilized therapeutic group homes as placement settings for mothers with babies. These families are now served exclusively in maternity homes.

- Safe homes: 3.5 to 6.9 years
- Maternity group homes: 0.4 to 0.9 years
- PRTF: 6 to 6.9 years
- Psychiatric Hospital: 6.5 years

Among the 15 children ages six and younger in Safe Homes, there were only two sibling groups and each included two siblings. Analysis of other data indicates that the frequency of sibling groups of more than two children in Safe Homes has not been significant. This is noteworthy since one of the model components for Safe Homes was the expectation that larger sibling groups would constitute a major referral category.

Also among children now in Safe Homes, the average length of stay is 154 days – three and a half times longer than intended by the model (that is, a maximum of 45 days).

Diagnostic Information

Nine of these children have experienced prior placements, but the records of just six of the children provide a DSM diagnosis.

Children 6 and younger in Safe Homes as of 6-29-11: DSM Diagnoses	
9 Children	Had no DSM diagnosis identified
2 Children	Adjustment Disorder
1 Child	Reactive Attachment Disorder & Post Traumatic Stress Disorder
1 Child	Pervasive Developmental Disorder
1 Child	Anxiety Disorder
1 Child	Attention Deficit Hyperactivity Disorder

Legal Status, Permanency Goals and Discharge Plans

Data on the 15 children in Safe Homes reveal that all are in the legal custody of the Department and all but one have a goal of family care. Specific discharge plans vary, however.

Legal Status	Permanency Goals	Discharge Plans
<ul style="list-style-type: none"> • Committed Abuse/Neglect/Un cared for: 9 children • Order of Temporary Custody: 4 children • DCF as Statutory Parent: 2 children 	<ul style="list-style-type: none"> • Reunification: 9 children • Adoption: 5 children • Unknown: 1 child 	<ul style="list-style-type: none"> • Family reunification: 2 children • Adoptive home: 2 children • Relative home: 3 children • Therapeutic Group Home: 6 children • No plan: 2 children

Child Welfare Strategy Group Data: Initial Placements by Age from 2006 through 2010

As part of its support for the Congregate Care Work Group, the Child Welfare Strategy Group conducted a study of placements of children entering DCF care from 2006 through 2010. While this study covered all placement types including both foster family and congregate care, only data on congregate care placements are reported here.³⁶ These data are reported according to slightly different age groups: birth through five years and six through 11 years.

Nonetheless, several findings of the Child Welfare Strategy Group's analysis are important for the present report. First, while the average length of stay for children ages five and younger was 80 days for a first placement, children re-entering congregate placement had stays that averaged 44 days longer. Second, children ages six through 11 years remained in their congregate care placements for a dramatically longer period of time -- 228 days.

Debunking Myths

Information often cited as "fact" when justifying the placement of young children in congregate care do not appear to be valid. Data examined and presented below show these facts to be myths.

- Myth #1. Children in Safe Homes are more psychiatrically complex than children being maintained in a family setting. Based on data reported and in the *Advancing Foster Family Care* paper, this does not appear to be true.
- Myth #2. Placement of large sibling groups is a primary function for Safe Homes. Based on young children now in these settings, this is not the case.
- Myth #3. Only children placed in Safe Homes will get good assessments to determine subsequent placement needs. Data from children's records do not support this assertion. Children can get assessments without having to reside in congregate care.

Data on diagnoses, legal status, placement goals, discharge plans and other indicators all reveal that younger children placed in congregate care settings are not notably different from their peers who are either maintained in their family of origin or placed into another family or kin setting during a time of family crisis.

³⁶ The Child Welfare Strategy Group utilized department data collected by Chapin Hall at the University of Chicago for this study. The data is based on individual placements along with the age of the child at the beginning of each placement. These data do not represent unduplicated counts of children in placement. That is, a child who is placed more than one would be counted more than once. Thus, the data represent placement counts, not individual child counts.

Practice Challenges, System Barriers, and Needed Culture Change

Several important themes can be identified in the data presented for children 12 and younger in congregate care settings. These themes both identify challenges and suggest action steps. The themes can be grouped into the following categories: Practice Challenges, System Barriers, and Needed Culture Changes. These themes are not mutually exclusive and are elaborated below.

Practice Challenges: Stepping Down and Bumping Up

While the majority of children 12 and younger have reunification as a permanency goal, the results of the congregate care survey as well as DCF LINK case narratives indicate a reliance on the practice of "stepping down" children from Residential Treatment to another congregate care setting prior to being transitioned to their family. This includes stepping children down to a therapeutic group home or the department's Therapeutic Foster Care Program.

This practice is supported by residential treatment providers who recommend that the child needs "more work, more time, more structure and more practice" before they can be successful with their family. For the DCF area office staff, this step down plan generates less risk than returning the child directly home or with relatives. Parents as well have been acculturated to this belief and are requesting more treatment before accepting children home, particularly parents involved in the Voluntary Services Program.

The practice of stepping down has potentially significant ramifications for children. Long stays in Residential Treatment, followed by long stays in Group Homes can potentially result in a child being institutionalized and dependent upon a high level of external structure. It becomes more difficult to transition the child to the family and community, and the family adapts to life without the child in the home. Research has shown that long length of stays in congregate care settings can also lead to heightened emotional and behavioral problems for children.

The practice of some children needing to step down to another level of care also suggests that the residential treatment services provided did not adequately prepare either the child or their family for reunification and community living. This can occur when residential treatment centers focus heavily on managing the child's behavior and symptoms, as opposed to strengthening the child and -- equally importantly -- strengthening the family's ability to care for their child in their home.

Another practice issue involves "bumping up." When lower levels of care cannot be identified and made available for a child they can be bumped up to higher levels of care, even though they may not require that higher level of care. For example, if a therapeutic foster home cannot be found, a Comprehensive Assessment of Need and Strengths (CANS) is submitted for placement to a therapeutic group home. If there are no openings in a group home, the level of care is bumped up to Residential Treatment. This practice is contrary to providing services in

the "least restrictive environment" and leads to children being "placed by default" in to higher levels of care.

System Barriers

The congregate care survey identified the lack of a family or foster home as the primary barrier to discharging children from congregate settings. The first report in the *Fostering the Future Series – Advancing Foster Family Care*³⁷ – addresses all aspects of the department's foster care and adoption systems including: Regulations and licensing; recruitment and retention; Training; Kinship care; Fiscal connections to congregate care; and Placement decision making. The goal of this work group is to provide an analysis that both explains the current system and provides recommendations for increasing the numbers of foster and relative homes available for children throughout the state.

The congregate care survey results also indicated that respite services, enhanced foster care and intensive in-home treatment were the most needed services for a child to be successfully transitioned to a family setting. Respite services for families (biological, kin and foster) in particular were identified as a significant service for the child's success in remaining in a family. In addition, home based services for youth on the autism spectrum also need to be developed.

Mindset Changes

The majority of recommendations/referrals for children 12 and younger to be placed in congregate care settings are generated from the Connecticut provider network. This includes hospitals, the Therapeutic Foster Care Program, in-home services, Safe Homes, and mental health clinics. DCF area office staff members are often reluctant to challenge these recommendations generated by psychiatrists, psychologists and other licensed practitioners.

Special Challenges for Children 12 and Younger with Developmental Disorders

A review of the data clearly points to the challenges the Department faces in meeting the needs of children 12 and younger with developmental disabilities, including those on the autism spectrum. Neither the child welfare system nor the children's behavioral health system was designed to specifically address the unique and complex needs of these specialized populations. However, through the child welfare system or the Voluntary Services program, the Department of Children and Families often becomes responsible for providing comprehensive care to this group of children. Once community-based and in-home resources have been exhausted, congregate care is usually sought for these children.

Other state agencies, including the Department of Developmental Disabilities (DDS) and the Department of Social Services (DSS) offer some specialized programming for children with

³⁷ *Advancing Foster Family Care: A Thought Paper in The Fostering the Future Series* (July 2011). Connecticut Department of Children and Families. This paper is accessible from the department's website – www.ct.gov/dcf

cognitive challenges as do local Boards of Education. *However, a comprehensive and coordinated network of care does not exist in a fashion that is commensurate with the behavioral health services available to assist children and the families of children with serious emotional disturbances.*

This service challenge is amplified when addressing the needs of children with pervasive developmental disorders, as no state agency within Connecticut is currently mandated to provide comprehensive care for this group, and there are limited evidenced based practices available for the treatment of autism and PDD. As a result, several state agencies have established an intra-agency workgroup to address the service needs of this population. Together with the Office of Policy and Management, the Department of Mental Health and Addiction Services, Department of Developmental Services, Department of Children and Families, and the Department of Social Services are currently researching best practices for these children and youth, and identifying the services currently utilized. The potential for expanding the DSS Autism Waiver and procuring a Center of Excellence for Youth with Autism Spectrum Disorders is being considered, but remains in the planning stages.³⁸

The Way Forward: In-Home and Community Based Services for Children 12 and Younger

Over the last 10 years, Connecticut has made significant improvements in the array of community-based services for children and families, summarized in the 2009 departmental report "Behavioral Services for Children and Families: A Framework for Planning, Management, and Evaluation."³⁹ These services are critical to serve children and families in their homes and communities, especially when circumstances of the child or family create conditions where placement is considered. In-home and community services are also critical to the successful return and re-integration of children and youth to their own homes or alternative family settings in their communities.

The Behavioral Services report documents significant progress in improving access, enhancing program quality and expanding the service array. Examples of *expanded access* include an enhanced Medicaid Rate for clinics that meet access and program improvement standards, and an increase in Medicaid enrollment. Examples of *quality improvements* include the implementation of defined program standards and workforce development for care coordination, redesign of the Emergency Mobile Psychiatric Service System, and the implementation of Risking Connections, Evidence Based Family Engagement Strategies, and therapeutic recreation within the network of extended day treatment programs.

³⁸ The DCF contact person for this work is Sara Lourie. She can be reached at – sara.lourie@ct.gov

³⁹ This report includes information on current issues, progress made and challenges remaining that were organized into the following seven topic areas: (1) Service Capacity, Access and The Service Array; (2) Service Effectiveness and Quality; (3) Stakeholder Involvement in Planning and Oversight; (4) Management of Systems and Services; (5) Cultural Competence; (6) Public Awareness and Policy; (7) Funding and Revenue Maximization.

Perhaps most significant has been the introduction of an array of in-home and outpatient evidence based practices. These include the introduction of Trauma Based Cognitive Behavioral Therapy at 16 outpatient clinics and development of a variety of evidence based/best practice, family focused in-home services. At the current time, these programs include:

- Multi-Systemic Therapy (including several variations for problem sexual behavior, child welfare engaged families, and youth re-entering from incarceration)
- Functional Family Therapy
- Multi-dimensional Family Therapy
- Intensive In-Home Child and Adolescent Psychiatric Service, and
- Family Based Recovery.

Gaps in In-Home and Community Services for Young Children

These services focus on preserving children in their homes and communities and helping to reunify and re-integrate children who have been placed out of the home and community. Given this initial focus, the majority of service and system development has focused on children and youth between the ages of 12 and 17, where there were the highest numbers of children in congregate care.

Although these programs have helped to reduce the state's reliance on congregate care, analysis conducted in the course of the congregate care review reveals that the development of services for children birth to 12 has not kept pace. In fact, very few DCF funded programs have been specifically designed to serve children 12 and younger.

In Connecticut, the bulk of services for children 12 and younger are funded by other entities such as state and local school district initiatives (e.g. school readiness programs), DDS (e.g. Birth to Three), federal programs (Head Start and Early Head Start), grants and private foundations (Child First) and DSS (child care subsidies and EPSDT). Despite the presence of these programs, few have been brought fully to scale, have sufficient capacity, or are well coordinated with departmental programs and services. Appendix B describes the programs funded or supported by the Department that serve children 12 and younger.

With the exception of the Early Childhood Consultation Partnership, Family Based Recovery, and some selected Extended Day Treatment programs, most of these services were not specifically designed to serve a younger population (although they will and do provide care to children 12 and younger). However, in order to maintain all children in this age group in their homes and communities in the presence of serious emotional disturbance, there will need to be a more robust array of services for younger children from screening and detection, through prevention, early intervention, and intensive community based services.

In February of 2009, the Child Health and Development Institute published *Promoting Early Health and Learning: A Profile of Two Connecticut Communities*.⁴⁰ The report describes the coordination of an early childhood system of care in two communities (Middletown and Groton/New London) funded by the Graustein Foundation. Each community engaged in one year of planning and three years of implementation to improve the health of children ages birth to five years. A number of programs were implemented in each community focusing on social and emotional health, oral health, and physical health, nutrition, and exercise.

Many of the lessons learned from this initiative are relevant to the department's efforts to better serve young children and prevent the use of out-of-home and congregate care. For example:

- Training local members of the early childhood community as spokespersons and champions helps to spread the word and promote sustainability.
- Hiring or designating a key staff person as a coordinator for early childhood in each community is highly recommended.
- Collaborations across agencies are important in order to implement systems approaches to problems such as expulsions from preschool.
- Connecting with state initiatives is critical.

In order to enhance the existing array of community-based services for those children that would otherwise be placed in congregate care, the Department must collaborate with other national, state and local initiatives and coordinating bodies. These include Zero to Three⁴¹, the Connecticut Early Childhood Cabinet⁴², Local School Readiness Councils⁴³, the William Caspar Graustein Memorial Fund's Discovery Initiative (in 54 communities)⁴⁴ and Child Health and Development Institute of Connecticut⁴⁵.

Using W.R. Services to Prevent Congregate Care Placements

The W.R. lawsuit was filed March 2002 seeking to improve services for children and youth with mental illness. The settlement agreement, reached in May 2007, became effective July 1, 2007 and was completed in July 2011. The department has used this work "to focus greater attention on the potential to divert younger children from residential placements and to provide targeted support to older youth who need special assistance in leaving long-term congregate placements."⁴⁶ The *Final Evaluation Report* of the W.R. Settlement Agreement, published in

⁴⁰ Simpson, G., Griffin, A., Kaufman, J. and Meyers, J., *Promoting Early Health and Learning: A Profile of Two Connecticut Communities* (2009). Farmington, CT: Child Health and Development Institute of Connecticut.

⁴¹ Online at – zerotothree.org

⁴² Online at – www.ctearlychildhood.org

⁴³ See a description of School Readiness Councils at –

www.sde.ct.gov/sde/lib/sde/PDF/DEPS/Readiness/sroverview.pdg

⁴⁴ Online at -- [//discovery/wcgmf.org](http://discovery/wcgmf.org)

⁴⁵ Online at – www.chdi.org

⁴⁶ *Final Evaluation Report. Individualized Community Based Options*. W.R. Settlement Agreement, July 2011.p. 1

July 2011, provides substantial insights in the types and costs of in-home and community services needed to avert congregate placement and support families – including relative families -- in the care of their children and youth.

Overall, the WR program developed individualized plans for 356 children and youth through the end of May 2011. To date, half of the youngsters served with these wrap-around services were functioning at a higher level or maintaining appropriate stability in their lives, 69% remained in the same community-based placement for the duration of the WR plan, and 88% continued to live in community-based settings.

Annualized costs for the WR program ranged from \$528 to \$316,342. The median annualized cost of these plans is \$21,998, or \$60.22 per day. The actual average cost of active WR plans is \$28,585 for an average of 9.2 months of service.

A review of services provided through the WR program to 74 WR children ages 12 and younger and living with families reveals that the most frequent services were therapeutic support staff (provided in 52% of the cases) and behavior management (42%). All of the 74 families received at least one service. Nearly half of these families (46%) needed two services and a third of the families received three services. The chart below shows the type of service and its frequency of use.

Services Utilized by 74 WR Families with Younger Children	
Therapeutic Support Staff	39 cases (52%)
Behavior Management	31 cases (42%)
In-Home Therapy	18 cases (24%)
After School Program	15 cases (20%)
Assessment/Evaluation	10 cases (14%)
Difficulty of Care	7 cases (9%)
Applied Behavior Analysis	6 cases (8%)
Respite	6 cases (8%)
Summer Camp	4 cases (5%)
Transportation	4 cases (5%)
Parent Training	3 cases (4%)
Medication Management	3 cases (4%)

Meet Two Young Children Served through the WR Program

Edgardo is a seven-year-old Hispanic boy who had been in the care and custody of DCF for the past three years. Eduardo had been placed a total of eight times. He carries the diagnosis of Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder and Oppositional Defiant Disorder. He is aggressive, impulsive and had been described as treatment resistant. He

required multiple levels of care and support and was eventually reunified with his mother following placement in a Therapeutic Group Home.

Services were provided to Edgardo and his mother through the WR program, including a clinical day treatment program, 15 hours of in-home behavioral management, in-home therapy for Edgardo's mother, in-home therapy for Edgardo, and YMCA membership. The annual cost for all these services is \$69,760.

Jakim is a nine-year-old boy who required a three week psychiatric hospitalization in September of 2007 due to out-of-control and aggressive behavior. He was hospitalized again a month later for biting his counselor and for displaying other aggressive behaviors. Following this hospitalization, Jakim was transferred to a PRTF where he stayed until April, 2008. He was then placed in a Safe Home where he continued to show aggressive behaviors to both staff and other children. Jakim was able to demonstrate improved functioning while with his grandmother. He was subsequently discharged to live with his grandmother in December of 2008.

Services have been provided through the WR program to support Jakim and his grandmother. These include therapeutic support through a Post Traumatic Stress Center, medication management and an in-home applied behavioral specialist and child intervention specialist. The total annual cost of these programs was \$112,320

Part V: A Profile of Voluntary Services Placements

Eligibility and Characteristics of the Voluntary Placement Program

The Department of Children and Families' Voluntary Services Program was known initially as the "non-committed treatment program" serving children who needed a residential level of care and whose parents did not have sufficient insurance or financial resources to cover the costs of that care. Over the last 20 years the Voluntary Services Program has become a means of largely providing in-home supports to families. At present, 674 Voluntary Services cases provide resources for in-home services, while 106 cases receive support for out-of-home care. Since January of 2006 there has been a 38% decline in the number of open Voluntary Services cases.

Many of the families that seek Voluntary Services have children with behavioral health, emotional and behavioral issues who need services that they would not otherwise have access to. At the request of the family, the Department provides services such as management services, community referrals and treatment services for children who were *not* referred based on allegations of abuse or neglect and who are not committed to the Department.

The department's area offices determine whether the family's application for Voluntary Services will be approved. If the application is approved, the Department is responsible for identifying treatment needs with the family, developing a case plan with the child and family, assisting the family to secure needed treatment, providing case management services to families, coordinating out of home placement materials if required, providing referrals to community services and evaluating progress through the department's Administrative Case Review process and Probate Court hearings.

DCF policy and regulations dictate eligibility criteria for the program:

- The child has an emotional, behavioral or substance abuse disorder diagnosable under the most recent issue of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
- The child has an emotional, behavioral or mental health disturbance resulting in the functional impairment of the child or youth, which substantially interferes with, or limits, his or her functioning in family, school, or community activities.
- The child has a substance abuse disorder as determined by a trained substance abuse professional and the disorder disrupts the academic or developmental progress, family or interpersonal relationships of the child/youth or is associated with present distress or disability or a risk of suffering death, pain or disability.
- The child with a developmental disorder or mental retardation, as defined in the DSM-IV, shall only be eligible if the child/youth also has an emotional, behavioral or substance abuse disorder and the alleviation of such is the primary purpose of the request for voluntary services.

- The child's behavior, due to the emotional disturbance, can be treated within the resources available to the Department at the time of application.
- The child's treatment needs cannot be met through existing services available to the parent/guardian, and
- The child has not reached the age of eighteen (18) years at the time of referral.

A child who has been committed to the Department as a juvenile delinquent and who will require the extension of placement or services on a voluntary basis upon the expiration of the commitment may also be admitted to the Voluntary Services program at the discretion of the Commissioner or designee.

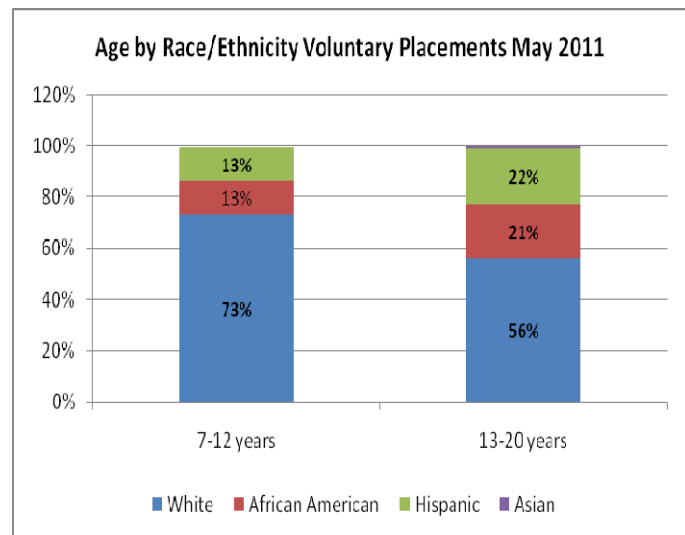
Department policy and regulations specify conditions of eligibility for placement under the Voluntary Services Program:

- An appropriate, Department approved, treatment program or facility is available.
- There is a reasonably healthy parent-child relationship, and it is anticipated the parent/guardian will continue to maintain a relationship with the child while the child is participating in the Voluntary Services program and continue to be active in the planning, treatment and discharge process.
- There is the reasonable expectation that the child will return to the family when the treatment is completed.

Child, Family and Participation Data

In May 2011, 106 children and youth were placed through the Voluntary Placement Program. These children were placed predominantly in residential treatment facilities with one child placed in a therapeutic group home. The majority (85%) of Voluntary Placement children were between the ages of 13 and 17, with just 15% between the ages of 7 and 12 years.

Boys outnumbered girls, 62 to 44 in the Voluntary Placement Program.



Among the 15 children ages 7 through 12, 73% were white. In contrast, among the 91 older children ranging in age from 12 to 20, 56% were white, 21% were African American and 22% were of Hispanic origin.

Diagnosis and Length of Stay

The majority (51%) of children and youth in voluntary placements had psychiatric disorders as their primary reason for placement, with 36% having mental retardation and/or autism spectrum disorders as their primary reason for placement. Problem sexual behavior or fire settings accounted for 13% of the recorded diagnoses of children in the Voluntary Placement Program in May 2011.

For calendar year 2010, children in the Voluntary Placement Program remained in residential treatment facilities an average of 47.5 days longer than other children in residential treatment. As of June 2011, Voluntary Placement Program children remained 74 days longer.

A Comparison of Voluntary Placements and Non-Voluntary Placements in Residential Treatment Facilities		
	Calendar 2010	2011 Year to Date
DCF RTC Voluntary Services Placements	393.6 Days	421.7 Days
DCF RTC Placements Excluding Voluntary	346.1 Days	347.6 Days
All DCF RTC Placements	350.7 Days	356.5 Days

Parental Engagement

For the 15 children ages 12 and younger, records indicate that parents were engaged in 5 cases (that is, one third), were not engaged in 5 cases, and in 5 cases we could not determine parental engagement from the records. Of note, all of these younger children had reunification as their goal; however, a review of each child's case narrative suggests a somewhat different picture. The parents of 5 of these children were strongly questioning whether they wanted to have the child return home. Three of these families were not engaged in treatment.

Ensuring that Insurance Company Obligations are Met

The Connecticut Department of Children and Families is participating with the Office of the Attorney General and several partner state agencies in a Commercial Insurance Maximization Work Group. The goal of the work group is to improve processes for the Department and other state agencies to recoup costs for voluntary services provided to children and families who are covered through private, commercial insurance. Over the course of the next six months, the Department will maximize claiming for children currently enrolled in the Voluntary Services Program as well as develop mechanisms for maximizing insurance claiming for new cases.⁴⁷

In addition to this effort, the Joint Task Force of the Connecticut Chapter of the American Academy of Pediatrics and the Connecticut Chapter of the American Academy of Child and Adolescent Psychiatry has called for dramatic changes in the way that mental health services

⁴⁷ For additional information, contact Fernando Muniz, Connecticut Department of Children and Families at -- fernando.muniz@ct.gov

are funded by commercial insurance companies. The report, entitled A Mental Health Blueprint for Connecticut's Children, proposes eliminating "profit-driven behavioral managed care subcontractors for commercially insured families, and replacing them with Connecticut's Behavioral health Partnership model of not-for-profit care with professional oversight."⁴⁸ The groups assert that implementing this type of model "will increase the money available for mental health care and provide care that is more efficient and more effective, while not spending any additional money. The Joint Task Force has recently received outside funding to prepare a cost model for the proposal."⁴⁹

⁴⁸ Online at --
www.ctmirror.org/sites/default/files/documents/Mental%20Health%20Blue%20Print%20FINAL%20FINAL%202%20%283%29.pdf

⁴⁹ See Mental Health Advocates have a Blueprint for Children's Care. CT Mirror (October 22, 2010). Online at --
www.ctmirror.org/story/8129/childrens-mental-health-blueprint-1021

Part VII: A Profile of Therapeutic Group Homes and the Youngsters They Serve

A Therapeutic Group Home is a community-based four to six bed program located in a neighborhood setting with intensive staffing and in-house clinical services. Connecticut's therapeutic group home model is expected to create a physically, emotionally, and psychologically safe environment for children and adolescents with complex behavioral health needs. Therapeutic group homes serve a same-gender population, with the exception of one mixed-gender home, and specific age ranges (pre-latency, latency or adolescent).⁵⁰ The majority of the therapeutic group homes serve children and youth with psychiatric issues but several specialized cohorts -- children and youth with developmental delays or problem sexual behavior -- are also served.

As of July 1, 2011, there are 52 therapeutic group homes in Connecticut with a current total capacity of 268 children and youth. Until the recent closing of two group homes, there were 54 homes with a total capacity of 279 children and youth. Data reviewed below is for the years when there were 54 total therapeutic group homes. The utilization of these group homes has averaged between 86% and 89%.

In the last fiscal year, the Department of Children and Families expended \$52,057,409 for services provided by therapeutic group homes. Per diem rates for these homes range from \$336.48 to \$631.88, resulting in annual costs per child ranging from \$122,815 to \$230,636. See Appendix C for a listing of the Therapeutic Group Homes, their respective budgets and per diem rates.

Therapeutic Group Homes and the Populations They Serve	
Age Group/Service Cohort	Number of Programs
Pre-Latency Male Psychiatric	1
Pre-Latency Mixed Gender Psychiatric	1
Latency Male Psychiatric*	5
Latency Female Psychiatric	3
Latency Male Psychiatric/Pervasive Developmental Disorders (PDD)	1
Latency Male Psychiatric/Problem Sexual Behaviors (PSB)	1
Adolescent Male Psychiatric	10
Adolescent Female Psychiatric	16
Adolescent Male Psychiatric/Developmental Disabilities (DD)	6
Adolescent Female Psychiatric/DD	1
Adolescent Male Psychiatric/PSB	5
Adolescent Female Psychiatric/PSB	1

⁵⁰ Of note, the Department of Children and Families also funds other types of group homes and supervised living serving less complex youngster in a more normative context.

Adolescent Male Psychiatric/PDD	1
Adolescent Female Psychiatric/JJ	3
Adolescent Male Psychiatric/PSB/DD	1

Understanding the Cohorts

Youngsters with Psychiatric Needs: These youngsters experience complex psychiatric and mental health disorders and typically carry one or more major psychiatric diagnoses (including trauma, psychotic, and affective disorders). Most have experienced significant trauma and multiple unsuccessful placements. The majority of youth in these homes have received intensive mental health services at various levels of care including outpatient, inpatient, and other congregate care, prior to admission.

Youngsters with Psychiatric Needs and Developmental Disabilities: These youngsters exhibit comorbid complex psychiatric and mental health disorders and developmental disabilities. Most youth present with mild to moderate mental retardation and neuro-cognitive impairments and have experienced some form of trauma. The majority received intensive mental health services prior to admission to the group home, including community-based and in-home services, outpatient treatment, inpatient hospitalizations, and other congregate care placements.

Youngsters with Psychiatric Needs and Pervasive Developmental Disabilities: These youngsters have experienced some form of trauma and some carry primary diagnoses of Post Traumatic Stress Disorder. The majority received intensive mental health services prior to admission including community based and in-home services, outpatient treatment, inpatient hospitalization, and other congregate care placements.

Youngsters with Psychiatric Needs and Problem Sexual Behavior: These youngsters have experienced sexual and physical trauma and have completed formalized residential treatment for psychosexual behavior problems. Most of these youths present with trauma-reactive behaviors. However, some have engaged in sexual offending behaviors and have accrued legal charges related to the offenses. Some of the youths in this cohort received mental health services prior to treatment for their problem sexual behavior.

Youngsters with Psychiatric Needs, Developmental Disabilities and Problem Sexual Behavior: These youngsters present with mild to moderate mental retardation and have experienced sexual and physical trauma. All of these youths have completed formalized residential treatment for problem sexual behavior. Some of the youths in this cohort display trauma-reactive behaviors. However, others have engaged in sexual offending behaviors and have accrued legal charges related to these offenses. The majority of these adolescents received prior mental health services in different levels of care but the treatment was not necessarily related to psychosexual behavior problems.

Youngsters with Psychiatric Needs with Juvenile Justice Involvement: These youngsters with psychiatric needs also have juvenile justice involvement including placement in detention

and/or adjudication for delinquent behavior. Two of these homes require parole involvement. Most of the youth in these homes have received intensive mental health services in various levels of care including outpatient, inpatient, and other congregate care, prior to admission. Many of youth in these homes have experienced some form of trauma and carry trauma-related and behavioral disorder diagnoses.

Program Characteristics

Connecticut's Therapeutic Group Home model is intended to involve each child or youth in naturally-occurring community support systems and supports the development of personal resources (e.g. assets, protective factors, and existing coping skills). Therapeutic techniques/strategies are utilized in the relationship with the child/family, primarily through group milieu experiences. These strategies emphasize individualized interventions for specific skill acquisition that will enable the child or youth to achieve or maintain the most realistic and highest level of independent functioning. Children and youth served by therapeutic group homes are at serious risk of regression without this level of treatment intervention.

Therapeutic group homes are expected to provide an intensive corrective relationship with children focused on assisting them to improve their relationships and success at school, at work and/or in community settings. Specific skills addressed include: Development and maintenance of daily living skills; Anger management; Social skills; Family living skills; Communication skills, and Stress management.

Individualized and intensive supervision in the structured setting is designed to minimize behaviors related to functional deficits, ensure safety during episodes of out-of-control behavior and maintain an optimal level of functioning. Intensive crisis management and de-escalation strategies are employed.

Clinical/Treatment Services

Children and youth in a therapeutic group home are expected to receive a minimum of one hour per week of individual therapy and two hours per week of evidenced-based group therapy. One hour a week of family therapy is required for all youngsters who have any type of discharge plan of reunification. Group homes serving youth with problem sexual behaviors must also provide specialized relapse prevention treatment for these youngsters. Psychiatric services, including medication management, are provided on site. Three hours per week on-site (contracted) psychiatric services must be provided at the group home along with 15 hours per week of on-site nursing services.

Examination of the chart below reveals that while individual therapy sessions were provided at or above the levels required by and paid for through the group home per diem rate, family therapy was very limited. Also, several types of group homes provided less service than required across the various types of therapy required.

Average Clinical Hours per Week Provided per Child Across by Type of Therapeutic Group Home (Source: December 2010 Audit) ⁵¹				
Types of Group Homes	Individual Therapy Req'd: 1 hour	Group Therapy 2 hours	Family Therapy 1 hour	Bridgework⁵² Services 1 hour
Pre-Latency Male Psychiatric	1.0	0.0	0.5	0.6
Pre-Latency Mixed Gender Psychiatric	3.0	2.7	0.0	0.2
Latency Male Psychiatric	1.7	1.8	1.0	1.9
Latency Female Psychiatric	1.2	3.6	0.9	2.0
Latency Male Psychiatric/PDD	1.1	0.5	0.6	0.2
Latency Male Psychiatric/PSB	2.3	3.3	1.3	2.2
Adolescent Male Psychiatric	1.6	1.5	0.2	0.5
Adolescent Female Psychiatric	2.1	3.6	0.5	2.7
Adolescent Male Psychiatric/DD	1.2	0.4	0.1	0.6
Adolescent Female Psychiatric/DD	2.2	2.0	0.7	2.9
Adolescent Male Psychiatric/PSB	2.8	3.4	0.6	1.2
Adolescent Female Psychiatric/PSB	2.3	3.0	0.8	0.0
Adolescent Male Psychiatric/PDD	1.7	0.7	0.0	0.1
Adolescent Female Psychiatric/JJ ⁵³	2.7	3.0	1.5	0.3
Adolescent Male Psychiatric/PSB/DD	1.4	2.1	0.0	0.0

Clinical staff members also provide case management and aftercare services including, but not limited to:

- Initial multi-disciplinary assessments and monthly review of the master treatment plan, therapy and milieu progress notes
- On-line bed tracking, initial and continued stay reviews with Connecticut Behavioral Health Partnership
- Phone contact with DCF, families, and community providers

⁵¹ Data was obtained from an audit of children and youths' case records in therapeutic group homes. The audit covered the period 12/6/2010 to 12/20/2010 and included the records of children and youth of all ages.

⁵² Bridge Work was calculated for all youth, regardless of resource. Bridge Work is defined as any activity, that actively engages the youth in preparing him/her for the next lower level of care.

⁵³ Two of these homes are only available to youth on juvenile parole. Chart audits were not completed for these two parole homes due to low census; thus no data is provided.

- Participation in child specific team meetings and PPT's, and discharge planning meetings.

Clinical staff can make recommendations for other services (i.e. substance abuse screening) and provide linkage to such services and are expected to coordinate their clinical interventions with community providers delivering services to the child and/or family. Finally, clinical and/or milieu staff may provide home-based outreach and visitation, parent education, instructional modeling, support groups and family activities.

Milieu Treatment

Connecticut's model for therapeutic group home milieu treatment requires, but is not limited to: Crisis management; Therapeutic recreation and enrichment (e.g., ropes or challenge course) activities; Social skills development; and Tutoring/academic mentoring. Staff members assess each youth's competency in the area of life skills, provide ongoing education and training to improve life skills, and monitor and assess the development of competencies for each youth. Daily community based activities (recreational, vocational, social development) serve as a focus for clinical and rehabilitative intervention. Creative and non-traditional mental health opportunities, which reflect the culture, customs and needs of the specific population, are offered. These opportunities are offered in consideration of peer socialization, skill building/enhancement and personal enrichment of the youth served.

In addition, program staff are expected to work with all children and youth (especially those who do not have a resource to participate in family therapy) for a minimum of one hour per week on "bridge work". Bridge work is defined as any activity that actively engages the youth in preparing him/her for the next lower level of care. Any group home staff member may complete bridge work. Examples of bridge work include age appropriate life skills, budgeting and shopping, taking public transportation, vocational experiences, money management and banking.

Educational and Vocational Programming

Therapeutic group homes are expected to provide opportunities for youth to receive training, information and to gain skills as they pertain to employment and educational options. Activities include, but are not limited to, workshops, training, presentations and field trips, linkages to local businesses (coaching), post-secondary institutions, and mentoring. Therapeutic group homes are also expected to ensure that each child or youth is enrolled in and attends an approved full-time educational program. Support and assistance includes participation in educational planning and other related meetings. Children and youth can attend community schools or clinical day schools, as determined by the local education authority (LEA).

Average Length of Stay Data for Therapeutic Group Homes, 2009 and 2010

The average length of stay in therapeutic group homes, across all youngsters and types of homes was 488 days in 2009 and 500 days in 2010. Children ages 12 and younger remained longer in these homes than did older youngsters in both years: 618 days in 2009 and 564 in 2010. Boys generally experience longer average lengths of stay than do girls.

Children and youth with combined psychiatric and developmental disabilities, or psychiatric and problem sexual behaviors had the longest lengths of stay in Therapeutic Group Homes.

Average Length of Stay in Therapeutic Group Homes, 2009 and 2010				
Age/Cohort	2009 ALOS	2009 Number of Youth Discharged	2010 ALOS	2009 Number of Youth Discharged
Pre-Latency Male Psychiatric	549	3	422.8	6
Pre-Latency Mixed Gender Psychiatric	543.5	2	244.7	3
Latency Male Psychiatric*	550.0	21	420.1	22
Latency Female Psychiatric ⁵⁴	515	1	513.3	8
Latency Male Psychiatric/PDD	436.7	3	426	1
Latency Male Psychiatric/PSB	849.5	2	1067.7	3
Adolescent Male Psychiatric	431	20	499.7	27
Adolescent Female Psychiatric	395.9	53	442.5	55
Adolescent Male Psychiatric/DD	689.3	10	995.5	8
Adolescent Female Psychiatric/DD	705.3	3	365.5	4
Adolescent Male Psychiatric/PSB	654.2	10	733.8	17
Adolescent Female Psychiatric/PSB	388.7	3	572	4
Adolescent Male Psychiatric/PDD	NA	None	NA	None
Adolescent Female Psychiatric/JJ	255.8	15	195.7	23
Adolescent Male Psychiatric/PSB/DD	181	2	391	2
Totals	488 days		500 days	

Average Length of Stay by Age and Gender in Therapeutic Group Homes, 2009			
2009	Ages 0-12	Ages 13-16	Ages 17+
Females	650 days	371 days	396 days
Males	578 days	696 days	490 days
2010			
Females	550 days	455 days	312 days
Males	578 days	664 days	584 days

⁵⁴ Pendana Home was a Mixed Gender home prior to 2010. The discharge shown for 2009 was a male; thus Pendana was categorized in 2009 data as part of the Latency Male Psychiatric cohort. The discharge reported for 2010 was a female; thus Pendana was categorized in 2010 Latency Female Psychiatric.

Discharge Outcomes

Cohort	Lower Level of Service	Other Therapeutic Group Homes	Higher Level of Service
General Psychiatric: 12 and younger	65% to home, foster home, pre-adoptive homes	19%	16% to residential treatment, hospitals, PRTFs
General Psychiatric: Adolescents	25% to home 30% to apartment thru DCF/DHMAS/DDS 9% to DCF Pass Group Homes	13%	23% to residential treatment, hospital, detention/ incarceration, shelter or signed themselves out at age 18
Psychiatric w/ Developmental Disabilities: Adolescent Males	23% to home 54% to supervised apartment thru DCF/DMHAS/DDS		23% to residential treatment, hospital, detention/prison
Psychiatric w/ Developmental Disabilities Adolescent Females	33% to home 50% to supervised apartment thru DCF/DHMAS/ DDS		1 youth was discharged to a hospital
Psychiatric w/ Pervasive Developmental Disabilities: Latency Age Males	1 went home	2 to therapeutic group homes	
Psychiatric w/ Problem Sexual Behavior: Latency Males	75% to foster homes		25% (n=1) to hospital
Psychiatric w/ Problem Sexual Behavior: Adolescent Males	18% to home 73% to apartment thru DCF/DMHAS/ DDS		1 signed out at age 18, 1 to residential treatment, 1 to hospital
Psychiatric w/ Problem Sexual Behavior: Adolescent Females	1 to DMHAS apartment		2 signed out at age 18, 1 to hospital
Psychiatric w/ Developmental Disabilities and Problem Sexual Behavior	1 to home 1DHMAS apartment		1 signed out at age 18, 1 to residential treatment
Psychiatric with Juvenile Justice Involvement	53% to home or foster home	1 to therapeutic group home	41% to residential treatment

Part VIII: Implementation and Fidelity

The successful implementation of new practices and initiatives in congregate care and other settings will be greatly enhanced by embedding this work in sound implementation practice. Support for this work include the creation of learning communities for training and technical assistance and the effective use of existing and new data to support both practice and management decision making. This section describes a critical role for "Implementation Science" to achieve better outcomes from congregate and community-based services.

Implementation Science

There are a number of effective practices and interventions available to children and families involved in the child welfare and mental health systems; yet few of these services have been received by the children and families that need them the most. In addition, when new and effective practices or interventions are identified and introduced into real-world settings, stakeholders experience "model drift," or gradual compromises in the degree to which actual service delivery practices match the ideal. Fidelity to well-specified models helps increase the likelihood of observing the best possible outcomes, whereas model drift produce less-than-desired results.

Empirical investigation and practical experience illustrates that simply identifying new practices and mandating their incorporation into existing service delivery systems is not enough to ensure these services are fully incorporated, or that they result in the desired effect. A growing body of research demonstrates that effective *implementation* practices are needed just as much as effective interventions^{55 56 57} Fixsen et al. define implementation as a specified set of activities designed to put into practice an activity or program of known dimensions. The emerging science and practice of implementation suggests a number of factors related to effective implementation.⁵⁸

These factors include, but are not limited to:

- Fidelity to the model as opposed to "reinvention"
- Assimilation of the new practice into "business as usual"
- Having a "culture of learning" within participating organizations

⁵⁵ Domitrovich, C. E., & Greenberg, M. T. (2000). The study of implementation: Current findings from effective programs that prevent mental disorders in school-aged children. *Journal of Educational and Psychological Consultation, 11*, 193-221.

⁵⁶ Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation Research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

⁵⁷ Mihalic, S.F. & Irwin, K. (2003). Blueprints for violence prevention: from research to real-world settings-factors influencing the successful replication of model programs. *Youth Violence and Juvenile Justice, 1*, 1-23.

⁵⁸ Fixsen et al, op cit.

- Having dedicated resources to implementing the new practice
- A system for monitoring implementation efforts and outcomes
- Availability of technical assistance
- Good relationships with intermediary organizations facilitating implementation, and
- The presence of demonstrable outcomes.

Many of these implementation factors can be grouped together into two domains: Training and Technical Assistance, and Data Collection, Reporting and Quality Improvement.

Training and Technical Assistance

Training and technical assistance can be used to support many of the above factors including monitoring fidelity, assimilating a new practice, establishing a culture of learning, and providing technical assistance. Training and technical assistance must go beyond the “one-shot training” model, which is known to be far less effective than the establishment of a learning culture that integrates the perspectives and influences of multiple stakeholders including funders, managers, providers, researchers, and families.

For example, the Learning Collaborative methodology (Institute for Healthcare Innovations, 2005) has been used to install and sustain evidence-based practices across the country, including Connecticut. Learning Collaboratives engage multiple partners in an intensive process that is designed to support learning and implementation. The focus is not just to train individuals in a new practice, but to create a learning culture that pervades an entire system, that constantly addresses barriers to implementation, and that can be sustained over time.

It is important to note that there have been several attempts to establish a learning community around congregate care. However, these efforts have not been fully sustained over time to yield the intended effect on system reform. New strategies are needed.

Data Collection, Reporting, and Quality Improvement

The routine use of data for the purposes of monitoring, accountability, quality improvement, and management decision-making is a critical component for ensuring that new programs and initiatives are fully implemented in complex settings. Nationally and in Connecticut, anecdotal evidence suggests that “what gets measured gets done,” particularly if what is measured is also analyzed, reported, and incorporated into the learning community. In the last several years, the child welfare and mental health fields have vastly increased the degree to which data are collected and available. Many (but not all) programs and services collect data, but fewer have the ability to analyze and report that data, and fewer yet have the ability to systematically use that data for quality improvement and management decision-making. In Connecticut, entities such as the Behavioral Health Partnership have collected tremendous amounts of data; however, there is a need to ensure that the right data are in the hands of the right people: the decision-makers and practitioners who can put the data to practical use.

Research has clearly identified that having well-articulated goals and expectations supported by data that can be regularly analyzed and reported has the power to transform services and service systems.⁵⁹ In Connecticut, there are now a number of programs and services that regularly use data for these purposes and have yielded the kind of “demonstrable outcomes” that are so important to fully implementing new and existing programs and services.

The successful implementation of new practices and initiatives in congregate care and other settings will be greatly enhanced by embedding this work in sound implementation practice supported by core implementation supports such as learning communities for training and technical assistance and the effective use of existing and new data to support practice and management decision-making.

A Final Note

The Department of Children and Families looks forward to working with families, the provider sector, members of the Connecticut General Assembly and other key stakeholders to improve children's life outcomes through family-centered policy, practice and programs. The work outlined in this report represents a vital contribution to that goal.

⁵⁹ Garland, A.F., Bickman, L. & Chorpita, B.F. (2010). Change what? Identifying quality improvement targets by investigating usual mental health care. *Administration and Policy in Mental Health and Mental Health Services Research*, 37, 15-26.

Appendix A: Descriptions of Congregate Care Services

Safe Homes

Safe Homes and Permanency Diagnostic Centers (PDC's) are intended for children requiring stabilization and assessment after removal from home. These programs are intended for children in need of short-term out-of-home care due to abuse or neglect. Currently, there are 17 Safe Homes (run by 13 providers) with a total bed capacity of 178. The contracted length of stay is 45 days but children remain in Safe Homes for much longer periods of time.

Therapeutic Group Home

A Therapeutic Group Home (TGH) is a community based four to six bed program located in a neighborhood setting with intensive staffing and clinical services offered 24 hours, seven days a week. It is a structured highly intensive treatment program that creates a physically, emotionally, and psychologically safe environment for children and adolescents with complex behavioral health needs who need additional support and clinical intervention to succeed in either a family environment or in an independent living situation. A TGH is designed to serve as a step-down from inpatient care, or as a step down from or an alternative to residential level of care. Group Homes are designed by cohort and serve a same gender age range (i.e. pre-latency, latency or adolescent) population. There are also several specialized cohorts for children and youth with Developmental Disabilities, problem sexual behavior (with and without DD), and youth involved with the Juvenile Justice system.

Youth are offered an array of culturally competent, trauma informed and gender responsive services including individual, group and family therapy, crisis management, case management, as well as milieu therapy. In addition, staff members assess each youth's competency in the area of life skills, provide ongoing education and training to improve life skills, and monitor and assess the development of competencies for each youth. Psychiatric services, including medication management, as well as nursing care are provided on-site. Community based activities (recreational, vocational, social development) serve as a focus for clinical and rehabilitative intervention. Youth attend community schools or clinical day schools, as determined by the local education authority.

Placements to Therapeutic Group Homes are determined by the Connecticut Behavioral Health Partnership, based on level of care guidelines. Length of stay is determined by progress towards goals identified upon admission and is reviewed on a regular basis by the Behavioral Health Partnership.

Residential Treatment Centers

A Residential Treatment Center (RTC) is a twenty four hour, seven day a week staffed treatment facility that offers integrated, structured therapeutic services, educational services and activities of daily living within the parameters of clinically informed milieu, and based on a well

defined, individually tailored treatment plan. This level of care is reserved for those children and youth who's psychiatric and behavioral status warrants the structure and supervision afforded by a self contained setting that has the ability to offer all necessary services including an on-site educational program, and provides line of sight supervision when necessary. Clinical and psychiatric consultation is available at all. RTC's can serve as a step down from a psychiatric hospitalization or may serve as the treatment of choice when a child's behavioral status places them or the community at risk should services be offered in a less restrictive setting.

There are currently 20 DCF Licensed Residential Treatment Centers (RTC) in Connecticut with a total of approximately 330 beds. Sixteen of the RTC's serve latency and adolescent children and youth with primary psychiatric and behavioral treatment issues. The licensed bed capacity for 16 of the Psychiatric Residential Treatment Centers ranges from 6 to 49 beds. The remaining four of the RTC's serve children and youth with primary substance abuse issues. The licensed bed capacity for these four programs ranges from 6 to 20 beds.

Outside of Connecticut, DCF currently has approved for utilization 65 Residential Treatment Centers. As of July 1st 2011 there were a total of 327 children and youth placed in out-of-state Residential Treatment Centers. These programs serve a much more diverse population of children and youth relative to the CT DCF licensed RTC's. In addition to serving children and youth with psychiatric and substance abuse issues, the out-of-state programs also serve children and youth with the following issues/needs: Moderate to severe/profound autism and mental retardation; traumatic brain injury; neurological impairments; blindness; hearing impairments; morbid obesity; pervasive developmental disorders; GLBTQ youth with psychiatric and other issues; complex medical issues; problem sexual behavior; fire setting; significant histories of conduct disorder/emerging anti-social behavior.

Maternity Group Homes

The DCF-funded maternity homes are group home settings with six to 12 beds. They are similar to PASS Group Homes in terms of their staffing and available services. Staff members support the youth's life skills development utilizing tools such as the Ansell-Casey Life Skills curriculum. The majority of youth served at maternity group homes have permanency plans of APPLA (Another Planned Permanency Living Arrangement).

Maternity group homes provide twenty-four hour congregate care for pregnant and parenting young women. Services include pre- and post-natal health services, an educational program, professional counseling, parenting education and child care. The program provides a safe, supportive, homelike environment where parenting options are explored, educational and vocational goals are pursued and parenting skills are enhanced.

Each resident and her infant receive their health care through a local health care provider. Program focus includes adolescent parenting and parent education by a certified parent educator and the facilitation of age-appropriate developmental activities. Ongoing assessment

of the adolescent mother's attachment to her infant and of her ability to parent is provided by trained residential staff to insure optimum care plans for the infant as well as the adolescent mother. Childbirth education is required of all prenatal residents. Day care is provided for all residents and is designed to model appropriate use of community-based day care. Residents are offered case management and counseling services. Each youth is encouraged to participate in an educational program that meets her interests and abilities.

There are currently two (2) maternity homes in operation in the state serving 23 pregnant females. A Comprehensive Assessment of Needs and Strength (CANS) form is submitted by regional offices to the Connecticut Behavioral Health Partnership for a level of care determination and match to an appropriate program.

Preparing Adolescents for Self-Sufficiency (PASS) Group Homes:

A PASS group home (Level 1.5 home) is a moderately-sized home, with six to ten beds. In contrast to therapeutic group homes, PASS homes are not intended to be utilized as clinical programs. These homes are located in neighborhood settings and are staffed with non-clinical paraprofessionals who provided services 24 hours a day, seven days a week.

The homes are designed to serve adolescents ages 14-21 years old with mild to moderate behavioral health needs who are either too young or lack the necessary skills to move into an independent living situation. These homes provide an environment that fosters individualized development in the areas of education, vocation, employability, independent living skills, health, mental health, community connections, and permanent connections. Youth attend school and obtain clinical services in the community. There are four PASS group homes for adolescent girls in Connecticut. The total bed capacity for adolescent girls is 34

Clinical services may include but are not limited to:

- Screening and referral
- Group treatment
- Consultation
- Linkage to individual, group and family therapy in the community, and
- Linkage to substance abuse screening or other services.

Group Home residents, and their families, are expected to receive all clinical individual, group and family treatment from community-based providers. Milieu therapy may include but is not limited to:

- The development of life skills
- Daily living skills
- Social skills
- Family living skills

- Interpersonal skills
- Personal advocacy skills, and
- Communication skills.

Residents also receive:

- Stress management and de-escalation training
- Crisis management skills
- Opportunities to participate in therapeutic recreation and enrichment (through the DCF Wilderness School) activities
- Opportunities to participate in community activities (e.g. memberships to local health facilities, routine public outings in the community)
- Tutoring and academic mentoring, support and advocacy, and
- Development of skills to increase employability, employment and vocational mentoring.

The Milieu is expected to involve each youth in a naturally occurring community support system that reinforces skill building, pro-social decision-making and personal growth and development. Individualized, intensive supervision will be provided in a structured setting in order to minimize behaviors related to functional deficits, ensure safety and maintain an optimal level of functioning.

Crisis Stabilization/Respite Treatment

This service provides short term, respite treatment (up to 15 days) for children with a rapidly deteriorating psychiatric condition, in order to reduce the risk of harm to self or others and divert children from admission into residential or inpatient care. Interventions offered focus on stabilization of the child's behavioral health condition including contributing environmental factors and enhancing existing outpatient services available to the child.

Several key components of the admission criteria help to keep the average length of stay within the 15 day target in most cases. These components include having a family or foster family willing and able to participate in family therapy, having a clear discharge plan with a place to live at 15 days, and a requirement that the child continue to attend the same school they had been attending prior to admission.

The target population for this service includes children and/or youth ages 7 – 18 years old who present with a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) Axis I diagnosis, or who exhibit complex behavioral health service needs and are at imminent risk of requiring longer term, out of home levels of care unless a short term intervention can be provided. The majority of referrals to Crisis Stabilization (2 programs serving the Hartford and New Haven areas) come from Emergency Mobile Psychiatric Services, DCF area offices, and the CARES program at CCMC/IOL.

All clients referred for Crisis Stabilization services receive a comprehensive evaluation, which result in the formulation of a multi-axial diagnosis and individualized treatment plan. The assessment should provide a clinical integration of medical, psychosocial, educational and treatment histories and be comprehensive enough to address the needs of the child within the context of the family and social community. The program is expected to provide a combination of flexible treatment and intervention approaches designed to meet the individual needs of children and their families, consonant with the goal of maintaining the child safely in the home and community.

Clinical services are expected to consist of individual, group and family treatment, consultation, linkage to family substance abuse screening or other services, family sessions, age appropriate therapy and after care planning. In addition, Crisis Stabilization services will have access to a psychiatrist to provide for timely consultation, assessment and evaluation of children warranting such clinical assistance.

Short Term Assessment and Respite Home (STAR)

STAR is a temporary congregate care program that provides short-term care, evaluation and a range of clinical and nursing services to children removed from their homes due to abuse, neglect or other high-risk circumstances. These homes serve children, ages 11 through 17, who may have recently experienced abuse and/or neglect and may be suffering trauma and loss due to their circumstances and the rapid removal from familiar surroundings. Staff provide empathic, professional child-care, and develop and maintain a routine of daily activities. The children and youth are expected to receive assessment services, significant levels of structure and support, and care coordination related to family reunification, or matching with a foster family or a congregate care setting, as appropriate.

Placements are made through an identified DCF Area Office liaison, or Hot Line manager who works closely with the Short Term Assessment and Respite Home Contractor. The contractor is expected to accept admissions twenty-four (24) hours a day, 365 days of the year. After hours and on weekends, the DCF Hot Line authorizes admissions. The Department will not refer children whose behavior or circumstances warrant placement in a hospital, acute psychiatric facility, or detention center.

All efforts are made to facilitate appropriate discharges for youth within 60 days of their placement in these homes. It is the responsibility of the DCF Area Office to effectuate discharge. Each contractor provides in-home aftercare services at the location of the subsequent placement for a minimum of 30 days. The contractor is expected to assure a minimum of 3 visits during the 30-day period following the month of discharge. The Contractor will be available as a resource for foster families or subsequent service providers regarding services delivered.

The STAR model of short term care was designed according to the following principles and components of care:

- Children and adolescents will be served in small group settings
- These settings will be geographically close to where the children live and/or the DCF office that supports them
- Program staffing will provide improved supervision especially during key times of day (i.e., after school, weekends, holidays, etc.)
- Services will be informed by an overarching clinically based philosophy of care that is trauma informed
- An array of on-site clinical services will be provided
- Aftercare services and supports will assist with the transition to community based settings

Supportive Work, Education, and Transition Program (SWETPs)

The Supportive Work, Education and Transition Program is a community-based, staffed apartment program serving adolescents, age 16 and older, who are committed to the Department of Children and Families. As with PASS homes, these programs are not designed as therapeutic clinical settings.

SWETPs focus on development of independent living skills, including but not limited to, community awareness, education, and pre-employment skill development. There are three SWETP programs in Connecticut. The program utilizes coaching, teaching, and adult leadership to promote the acquisition of independent living skills, including all aspects of self-care, education, vocational planning and community access with the goal that each youth will develop the skills necessary to function successfully as an independent adult. Successful completion for a resident will be determined by the resident's individual Treatment Plan and the acquisition of measurable skills.

This program is housed in one building, being the building's only occupant, and has space for staff offices, community living areas, educational area(s), and fully-functional individual apartments for residents to share during placement. The staff provides on site, awake supervision, 24 hours a day, and seven days a week. Staff has access to all areas of the building at all times.

The SWETPs have a statewide capacity of 24 beds (i.e., eight beds for males, 16 beds for females with four of those beds for females who have children). The majority of youth served at SWETPs have permanency plans of APPLA (Another Planned Permanency Living Arrangement). The average length of stay is 12 months.

Department of Developmental Services Group Homes

This group of homes is called a Community Living Arrangement (CLA) in the Department of Developmental Services' (DDS) system. CLA's, also known as group homes, are operated by private agencies that offer individuals opportunities to live in typical community housing.

Homes are small in size and generally serve six or fewer individuals. These homes are licensed by DDS, but they are not under contract with any agency.

Open beds are made available to DCF clients, typically clients who are eligible for DDS services and who will transition to DDS some time before or at age 21. Some exceptions are made for clients who are not DDS eligible, but who may function at a similar cognitive level. These homes may have residents who are only DDS clients as well as private community funded clients.

The DCF placements are funded via a fee-for-service rate established by DCF rate setting and are paid through LINK. The current daily rate schedule is available on the DCF Fiscal website Rate Setting link on the Rate Summary Spreadsheet.

The homes are accessed through the Behavioral Health Partnership (BHP) through the CANS process. These group homes operate under a behavioral model where an individual behavior plan is written and followed for each individual. A behaviorist, assigned to each home for a certain number of hours per week, works with individuals on their individual plans. A consulting mental health professional is available as needed.

These homes do not have a clinical component built into the program. Unlike DCF Therapeutic Group Homes (TGH), there are no clinicians assigned to the homes. Clinical services must be secured out of the home by individual community providers. These homes often accept very behaviorally involved clients who have been denied by DCF TGH's.

Supervised Apartment Program

The goal of the Supervised Apartment Program model is to assist teens in their transition to adulthood and independence by equipping them with the skills necessary for successful independent living. Youth reside in apartments and are expected to be independent while receiving the level of supervision necessary for success. Youth learn how to budget and save money, refine living and social skills and make a realistic, supported transition to independence.

This program offers a practice environment in which youth receive practical instruction and assistance vital in their role as consumer and tenant, geared to improving performance in a host of settings: at home, in school, at work, in the community, or in relationships. They are responsible for budgeting, food preparation and purchasing, an educational plan, setting vocational goals and positive recreation.

There is formal group instruction focusing in on mastering skills for successful independent living. There is a strong emphasis on improving interpersonal and communication skills. The curriculum is fine tuned to ensure meeting individual needs. The program works closely with the youth to establish a solid comfort level and maintain communication with the youth's caseworker. The teen is tested to ascertain abilities, strengths and deficits. The program assists the tenant by furnishing all of the belongings necessary to set up an apartment.

**Appendix B: Community Based Programs Funded or Supported
by DCF Serving Children 12 and Younger**

<i>Intervention</i>	<i>Problems Treated</i>	<i>Age Range</i>	<i>Ethnicity</i>	<i>Settings</i>
Outpatient Psychiatric Clinics for Children	Full Spectrum of Psychiatric Disorders but limited to those that can be treated with outpatient clinic based care	3-18 some serve early childhood but this is a minority of clinics	Not specified	Outpatient
Family Based Recovery (intensive in-home service to families where children have been exposed to substances in utero or in their early environment)	Parental Substance Abuse Developmental Delays Parent-Child Attachment	0-3	Not Specified	In-home
Extended Day Treatment	Range of Psychiatric and Behavioral Disorders amenable to community based intermediate level of care	5-18 (most programs serve a population between 5-13, although some only serve adolescents)	Not Specified	Clinic Based Milieu
Emergency Mobile Psychiatric Service	Behavioral Health Crises that occur in the community or a group home setting	0-18 but few referrals under 4 or 5	Not Specified	Home, School, or other Community Based Setting
IICAPS	Primary Psychiatric Disorders where child is at risk of hospital or other out of home treatment	3-17	Not Specified	In-Home

<i>Intervention</i>	<i>Problems Treated</i>	<i>Age Range</i>	<i>Ethnicity</i>	<i>Settings</i>
Care Coordination	Serious Emotional Disturbance that requires multiple treatment interventions and risk for out of home placement	0-17	Not Specified	Home and Community Based
Family Advocacy	Families of children with serious emotional disturbance that require advocacy and support to meet their child/family needs - most are receiving care coordination	0-17	Not Specified	Home and Community Based
FST/MDFT (conversion in process)	Primary Psychiatric Disorders and voluntary/child welfare system involvement where child is at risk of hospital or other out of home treatment or is in need of support in returning to the community	9-18	Hispanic African American	In-Home
Early Childhood Consultation Partnership	Children with Disruptive Behaviors, impaired social relatedness or other developmental delays that are receiving childcare services	0-5	Not Specified	Child Care Settings

Appendix C: Therapeutic Group Home Providers, Bed Capacity and Rates

Provider	Program Name	Licensed Bed Capacity	Per Diem Rate	Annual Bed Cost	Annual Agency Contract
CCARC	Black Rock House	5	\$576.83	\$210,542.95	\$1,052,714
Bridge Family Center	Eleanor House	6	\$455.74	\$166,345.10	\$998,070
Wellpath, Inc.,	Paladin House	5	\$520.23	\$189,883.95	\$949,413
Children's Center of Hamden	Gate House	5	\$521.36	\$190,296.40	\$951,486
Children's Home of Cromwell	Potter's House	5	\$520.23	\$189,883.95	\$949,417
Children's Home of Cromwell	Isaiah House	5	\$520.23	\$189,883.95	\$949,416
Children's Home of Cromwell	Esther House	5	\$520.22	\$189,880.30	\$949,406
Community Health Resources	Brook House	6	\$479.09	\$174,867.85	\$1,049,206
Community Health Resources	Mills House	5	\$534.40	\$195,056.00	\$975,278
Community Health Resources	Greenhaven House	6	\$455.74	\$166,345.10	\$998,070
Community Residences Inc	North Acre Place	5	\$576.83	\$210,542.95	\$1,052,714
Family and Children's Aid	For Harmony	6	\$455.74	\$166,345.10	\$998,070
Family and Children's Aid	Ten Harmony	6	\$479.73	\$175,101.45	\$1,050,600
Gilead	Baldwin House	5	\$520.23	\$189,883.95	\$949,415
Gilead	Iris Home	5	\$520.23	\$189,883.95	\$949,415
Key Services	Loveland Rd	5	\$576.83	\$210,542.95	\$1,052,714
Klingberg	Parkview Home for Boys	5	\$520.04	\$189,814.60	\$949,078
Klingberg	Phoenix House	5	\$520.23	\$189,883.95	\$949,415
Klingberg	Nia Sage House	5	\$520.23	\$189,883.95	\$949,415
MCCA	New Dawn House	5	\$520.23	\$189,883.95	\$949,415
NAFI	Bristol Group Home	4	\$633.03	\$231,055.95	\$924,225
NAFI	Dover Road	6	\$532.24	\$194,267.60	\$1,165,600
NAFI	Tress Road	4	\$628.67	\$229,464.55	\$917,858
NAFI	NAFI Thomaston	5	\$576.83	\$210,542.95	\$1,052,714
New Hope Manor	Hathorn House	5	\$520.23	\$189,883.95	\$949,415
New Hope Manor	McGuinness House	5	\$520.23	\$189,883.95	\$949,415
New Hope Manor	Rohde House	5	\$520.23	\$189,883.95	\$949,415
Noank	Gray Farm House	5	\$520.23	\$189,883.95	\$949,415
Northeast Center for Youth and Fam.	Hampton House	5	\$520.23	\$189,883.95	\$949,415
REM	Center Hill Road House	5	\$576.83	\$210,542.95	\$1,052,714
Village for Families and Children	Imani House (Now closed)	6	\$470.32	\$171,666.80	\$1,030,000
Wellspring	Pendana Home	5	\$520.23	\$189,883.95	\$949,415
Wheeler	Lighthouse	5	\$520.23	\$189,883.95	\$949,415

Wheeler	Farm Hill	5	\$520.23	\$189,883.95	\$949,415
Wheeler	Family Living Home	5	\$520.23	\$189,883.95	\$949,415
Youth Continuum	Bradley House	5	\$520.23	\$189,883.95	\$949,415
Youth Continuum	Harbor House	6	\$455.74	\$166,345.10	\$998,070
Shelter for Women	Allison Gill Group Home	6	\$455.74	\$166,345.10	\$998,070
Gilead	Anchorage	5	\$520.23	\$189,883.95	\$949,415
New Hope Manor	Donovan House	5	\$520.23	\$189,883.95	\$949,415
Waterford Country School	Fire Street Group Home (Now closed)	5	\$520.23	\$189,883.95	\$949,415
Youth Continuum	Helen's House	6	\$455.74	\$166,345.10	\$998,070
Northeast Center for Youth and Families	Horizon House	5	\$520.23	\$189,883.95	\$949,415
Noank	Main Street House	5	\$520.23	\$189,883.95	\$949,415
Community Mental Health Affiliates	Pando House	5	\$520.23	\$189,883.95	\$949,415
FOCUS	Shannon House	5	\$520.23	\$189,883.95	\$949,415
Wellpath, Inc.	Valiant House	5	\$520.23	\$189,883.95	\$949,415
KEY Service Systems, Inc.	Volpi Road Group Home	4	\$631.88	\$230,636.20	\$922,547
Connecticut Junior Republic	Winchester House	5	\$520.23	\$189,883.95	\$949,415
Community Health Resource	Grant House	6	\$455.74	\$166,345.10	\$998,070
The Wheeler Clinic	Sage House	5	\$520.23	\$189,883.95	\$949,415
Northeast Center for Youth and Families	Chaplin House	5	\$520.23	\$189,883.95	\$949,415
Youth Continuum	Laurel House	6	\$353.86	\$129,158.90	\$774,946
REM Connecticut Community Services	Mansfield Road House	5	\$336.48	\$122,815.20	\$614,083
Totals		279			\$52,057,409