Magellan Lehigh Valley Care Management Center

One-Year Outcomes Report
Short-Term Residential Treatment Facility (RTF) Pilot Program

June 28, 2010

These drawings of children and their families were created by children participating in the Short-Term RTF program at Warwick House.
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Magellan of the Lehigh Valley wishes to acknowledge the contributions of MCC Warwick, Shawnee Academy, Children’s Home of Reading and all of their staff for being pioneers and for venturing beyond the “traditional” to a place that promotes and instills resiliency in children and supports families while achieving positive outcomes.

We thank Lehigh and Northampton County HealthChoices Administrators for partnering with us in this pilot and for their ongoing leadership in promoting programs and services that positively affect the HealthChoices members and families in the Lehigh Valley.

We also wish to thank all of the children and families who were part of the Short-Term RTF pilot program. Our hope is to offer similar groundbreaking programs to more families and members in the Lehigh Valley as time goes on.
EXECUTIVE SUMMARY

Magellan is dedicated to ensuring that children and young people with behavioral health conditions and their families receive effective care with outcomes that enable them to participate successfully in all aspects of their lives. In 2008, leadership from Magellan’s Public Sector Solutions team took a comprehensive approach to developing a “white paper” exploring the effectiveness of various treatment options for children and young people. Magellan’s White Paper, “Perspectives on Residential and Community-Based Treatment for Youth and Families,” was developed in response to concerns about the reliance on residential treatment for children and adolescents with serious emotional disturbance and the underuse of evidence-based alternative treatments.

The Research

The content of the White Paper was shaped by literature reviews on the efficacy of residential and alternative treatment options and focus groups with parents, young adults who have received residential services, providers and representatives of various state and local child-serving agencies. A review of Magellan data supports our findings and guides our direction to ensuring that children and youth remain at home, live with their families and achieve success in their schools and communities.

The residential treatment research indicated the following:
• Youth in residential treatment often make gains between admission and discharge, but many do not maintain improvement post-discharge.
• Gains made during a stay in residential treatment may not transfer to the youth’s natural environment, creating a cycle where children are often readmitted.
• One large, longitudinal six-state study of adolescents discharged from residential treatment found at a seven-year follow-up that 75 percent had either been readmitted or incarcerated (Burns et al., 1999).
• The rate of returning to placement was 32 percent after one year, 53 percent after two and 59 percent by the end of the third year post-discharge (Asarnow, Aoki & Elson, 1996).
• Facilities with more successful outcomes have certain factors in common, including the following:
  Family involvement
   • The best programs partner with families to ensure meaningful family involvement during residential treatment.
   • Residential stays are shorter and outcomes are improved when families are involved.
   • It is preferred to have youth stay in residential programs that are family-centered in approach.
  Discharge planning
   • Successful residential treatment programs begin planning discharge at the time of admission.
   • Successful programs determine what the youth needs for successful discharge and focus on eliminating barriers and building necessary supports.
   • Gains are more likely to be maintained and readmissions decreased when attention is paid to what services and/or placement is needed post-discharge and the plan is executed.
  Community involvement and services
   • Effective residential treatment facilitates community involvement and services while the youth are in residential treatment.
   • Teaching youth the skills needed for reintegration into their community increases the chance of successful outcomes.
• Focus on outcomes
• Maintaining treatment gains post-discharge improves based on the following:
  • The amount of family involvement in the treatment process prior to discharge.
  • Placement stability post-discharge.
  • Availability of aftercare supports for youth and their families.
Although residential treatment is a necessary element in the spectrum of care for youth, community-based programs should be considered whenever possible. The best residential treatment programs focus on individualized treatment planning, intensive family involvement, discharge planning and reintegration in the community. Because youth admitted to residential treatment make most of their gains in the first six months and because of the adverse impact of extended length of stays (for example, loss of connection to natural supports, treatment gains frequently not sustained post-discharge and modeling of deviant peer behavior), long-term residential stays are often not in the best interest of the individual, family or society.

Research and recommendations specific to residential treatment were also a focus of Pennsylvania’s Department of Public Welfare, Office of Mental Health and Substance Abuse Services, which engaged Mercer Government Human Services Consulting to review current issues related to psychiatric residential treatment facilities. Mercer was tasked with developing recommendations that promote home and community-based alternatives to residential treatment, with particular emphasis on youth who are served through the juvenile justice system.

**Using What We Know to Make Change—Connecting Principles and Performance**

As a result of the Commonwealth of Pennsylvania’s attention to residential treatment and Magellan’s belief in the effectiveness of community-based alternatives to residential treatment, the Lehigh Valley Care Management Center (CMC), in partnership with Lehigh and Northampton counties, began to focus on residential treatment prior to the development of Magellan’s White Paper. Using the conclusions outlined in the Commonwealth’s White Paper, we began to propel change in our community. Ensuring that services and supports have positive outcomes for children, youth and their families goes beyond expressing our principle about opportunity—it is performing our obligation to create possibility.

Developing and promoting the Magellan White Paper was just the beginning. The document produced a shift in the culture of our work, generated changes in practice and inspired commitment to new possibilities for children, youth and their families. In other words, *practice has become our bridge from principle to performance.*

It is important to ensure that the White Paper is embraced locally—preventing it from becoming just another document in the files. Local acceptance has required diligent attention and careful consideration from leadership at our care management center. Local efforts have yielded rich dialogue with our customers and among the many stakeholders who are invested in children, youth and their families.

The Lehigh Valley clinical team facilitated four provider forums to present and discuss the key components of the White Paper and solicit feedback. More than 100 providers attended the forums. Representatives included psychiatrists, psychologists, directors, clinicians, nurses and direct care workers. Providers represented many levels of care, including Behavioral Health Rehabilitation Services (BHRS), Residential Treatment Facility (RTF), Acute Inpatient Program (AIP), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Family-Focused Solution-Based Services (FFSBS). Additionally, we presented the White Paper to Department of Public Welfare (DPW) state officials and Lehigh County and Northampton County stakeholder groups.

Reducing placement in “traditional” RTF programs and increasing in-home care calls for approaches that are as unique as the individuals who live in the communities we serve. We successfully approached challenges rooted in the dynamics of the community. Keeping the focus on outcomes and planning for the future are effective strategies for addressing these challenges. Presenting local data centered on outcomes helps balance discussions. Data provide a snapshot of what is happening for children and youth receiving various services delivered both in and out of home. That information is helping us work with our community to identify changes that can lead to better outcomes.
THE SHORT-TERM RTF MODEL

The Lehigh Valley CMC, in coordination with Lehigh and Northampton counties, identified a goal of further reducing traditional long-term RTF stays for children and adolescents and sought the expertise and partnership of three high-quality Joint Commission-accredited RTF providers in our network: MCC Warwick, specializing in younger children ages 6 to 13; Shawnee Academy, specializing in older adolescents ages 13 to 21; and the Children’s Home of Reading (CHOR), specializing in older adolescents ages 12 to 18.

Together, we developed a short-term RTF program design to meet the needs of youth and community safety while simultaneously working with families and providing empirically supported treatment on an intensive level. In this model, a child or youth has a brief placement (30 to 120 days) and returns to the community with intensive services in place.

Key Components

The Short-Term RTF model includes four key components: small caseloads, family involvement, comprehensive discharge planning and follow-up, and data collection.

Small Caseloads

A master’s-level clinician and a bachelor’s-level case manager work together as a team with a maximum caseload of four children or adolescents. The clinician provides individual group and family therapy, and the case manager focuses on aftercare planning. Small caseloads allow for frequent and individualized treatment for each child/adolescent, frequent therapy sessions and time for advocacy.

Family Involvement

Family involvement begins prior to admission and continues when the child returns home. Family therapy occurs at least once a week. As a result of the small caseloads, therapists can provide family therapy in the home environment. This allows the therapist to observe the child or adolescent in his or her natural setting and address situations that usually occur in the home. For example, the therapist can provide modeling and coaching to the parent during the morning when the child is getting ready for school if this is an identified stressor for the child or adolescent. Frequent home passes and overnight visits are also available while the child is in the Short-Term RTF program.

Comprehensive Discharge Planning and Follow-up

Discharge planning for children and adolescents in the Short-Term RTF pilot begins on the day of admission. While the clinician is working with the child and family through individual and family therapy, the case manager is setting up mental health or substance abuse treatment, coordinating with the school to ensure that the child or adolescent is placed in the appropriate classroom and exploring natural support in the home community based on his or her strengths and interests. The case manager also assists family members with developing community-based supports such as mental health or substance services and support groups.

Once the child or adolescent is discharged, the RTF clinical team continues contact with the family. This can include home visits and phone calls or attending IEP meetings or treatment team meetings with therapeutic foster home or family-based providers.

Data Collection

RTF providers submit monthly reports to the Lehigh Valley CMC tracking the following data: gender, age, custody status, diagnosis, presenting issues and number of therapy sessions per week at the facility and in the home. Post-discharge, providers track their ancillary contacts and admissions to twenty-four-hour levels of care.
MEMBER PROFILE

Demographics

Twenty-three members were admitted to the Short-Term RTF programs since May 2009. Sixteen members were from Lehigh County and seven were from Northampton County. Thirteen members were male, 10 were female, and they ranged in age from seven to 17. At all of the programs, most members were in the older range. At Children’s Home of Reading and Shawnee, seven older adolescents (ages 16 and 17) were the majority of members admitted to their programs, while seven of the children admitted to Warwick were at the older end of the spectrum (ages 12 and 13).

At this point in the data tracking, with 15 of the 23 members admitted being between the ages of 11 and 17, it appears that children ages 10 and younger are less likely to be referred for Short-Term RTF. Of the 15 members between ages 11 and 17, 10 members were between the ages of 11 and 14. Therefore, nearly half of the members admitted to Short-Term RTF were pre-adolescent.

Although the process of assessing the Short-Term RTF program and some information is preliminary, it does help us as we begin to determine the typical profile of a child who is appropriate for a Short-Term RTF program. We should not assume that younger children or older adolescents are not appropriate candidates for a Short-Term RTF program. Rather, this information shows us the most likely Short-Term RTF members as we move forward.

Custody status was another aspect of the member profile. An overwhelming majority of the members admitted (19) were in the custody of their parent(s), while two were in the custody of Children and Youth Services (CYS), and two were adjudicated delinquent and in the custody of Juvenile Probation. Family systems are a critical component of any treatment effort with a child or adolescent. The Magellan White Paper, along with our experiences managing care for children and their families, taught us that by promoting family engagement with the therapeutic process, we can better support the work that the member is doing and ensure that we maintain one of the most critical connections to the child’s natural environment.

Many of the families of members admitted to Short-Term RTF presented with significant dysfunction or other issues that historically would likely have caused barriers to the treatment efforts and ultimately hampered the ability to successfully transition the member home. However, within the short-term model, those challenges have been addressed more effectively. By actively engaging the family with both therapeutic and case management services early and often during the stay, we saw positive results in the outcomes for the member.

Therefore, as we continue to gather information to help us formulate the profile of a member likely to be referred to Short-Term RTF, we can postulate that the member is in the custody of his or her parent(s). Given the very high percentage of children in the custody of their parent(s), one might conclude that not being in the custody of his or her parents would result in a member being excluded from consideration from a Short-Term RTF program. However, that is not the case.

In cases where a child is in the custody of Children and Youth Services and/or Juvenile Probation and his or her plan is to be “reunified” with the parent(s), critical family work can occur within the Short-Term RTF, and the child can take major steps toward that longer-term goal. In these cases, the “pace” of treatment is no different than in cases where the plan is to go home immediately. In these cases, an interim plan is developed immediately while the therapeutic work is underway rather than later in the stay as often occurs in traditional RTF.
Most children and adolescents make progress in the earlier part of their stay in an RTF, so planning for transition from the moment the child enters the program is critical to ensuring that the child can be transitioned at the appropriate time. This approach allows even those children who are not in the custody of their parents and may not be going home as a first step in their transition to be discharged to another mental health placement or a child welfare placement when they are ready. Once the child is prepared to take that interim step, he or she can continue to work toward reunification as he or she returns to the community with the appropriate community-based services.

**Diagnosis and Presenting Issues**

Members admitted to Short-Term RTF presented with a variety of primary diagnoses. The most prevalent diagnosis among older adolescents admitted to Short-Term RTF was bipolar disorder. Major depression and mood disorder were the second most common diagnoses for adolescents. Younger children admitted to Short-Term RTF also presented a variety of diagnoses, with impulse control disorder the most common. Post-traumatic stress disorder (PTSD) was a diagnosis for both age groups.

All of the members admitted to Short-Term RTF had more than one diagnosis.

Following the first year of Short-Term RTF operation and subsequent data collection, one could draw the conclusion that a member admitted to Short-Term RTF would have more than one Axis I diagnosis. It seems more likely that an older adolescent would have bipolar as the primary diagnosis. If younger, the member would more likely have impulse control disorder as the primary diagnosis. This does not mean that only members with these diagnoses are appropriate for Short-Term RTF and that members with other Axis I diagnoses are excluded from Short-Term RTF consideration. Rather, it is another piece of the puzzle as we seek to create a profile for the “typical” Short-Term RTF member.

<table>
<thead>
<tr>
<th><strong>PRESENTING ISSUES</strong></th>
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<tbody>
<tr>
<td>Aggression</td>
<td>6</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>4</td>
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<tr>
<td>AWOL</td>
<td>4</td>
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<td>Anger Management</td>
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<td>Drug Use</td>
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<tr>
<td>Oppositional &amp; Defiant Behaviors</td>
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Another clinical feature of the member profile is “presenting issues.” This is defined as the manifested symptom or behavior that requires that the child receive treatment in an RTF setting rather than in the community. Typically, this would be a significant enough issue that community-based treatment would not be adequate to fully address it, thereby exposing the member or community to some form of risk. Also referred to as the “barrier behavior,” presenting issues may never be resolved fully; however, the goal is to address the issue so the member can be transitioned safely into the community to continue treatment.

Aggression was the most prevalent “presenting issue,” with six members having this behavior identified as their primary presenting issue. This occurred in all of the programs regardless of age or diagnosis. Aggressive behaviors include verbal aggression, property destruction and physical aggression or a combination of these. The aggression was either directed at oneself or at others and, in some cases, required physical intervention (restraints) to ensure the safety of the member or others.

Running away was the second most common presenting issue and crossed the lines of age and diagnosis. Running away creates a serious safety concern, particularly for younger children who often use running away as an escape behavior to avoid difficult situations.
Anger management was the third most commonly occurring presenting issue and is related to aggression. Children and adolescents who have difficulty tolerating the feelings associated with anger or frustration often act out aggressively. Drug and alcohol issues occurred in one case. As could be expected, this was an older adolescent who had “dual” needs/ issues with drugs and alcohol and mental health. When appropriate, the Short-Term RTF programs complete specialized assessments to determine how best to meet the needs of the child or adolescent. Drug and alcohol assessments in this case would be very important in helping to develop a comprehensive treatment plan, as well as a plan for transition to assist in the member’s eventual return to the community.

As we continue to refine the member profile for Short-Term RTF, presenting issues will play a large part in helping us to understand not only who these members are but also why these children and adolescents require residential treatment. In the relatively brief period of time that Short-Term RTF programs have existed, we have been able to observe some of the more common issues. Aggression and running away were present in more than half of the members who were treated and discharged from Short-Term RTF and, despite the significant challenge each poses in treatment, in the majority of these cases, the members were successfully discharged.

With adequate structure and support from the RTF provider for the member and his or her family, including clinical services that do not “define” the member by his or her issue and seek to understand the behavior better while working within the home setting at an aggressive pace, many key connections can be kept in place and issues can be addressed sufficiently to allow successful transition. Often families are reluctant to consider having a child return home until he or she is “fixed” or “cured.” However, within this model, much of the work seeks to help the family view the child positively and to set realistic goals, while reassuring them that support and help are available from the entire system as the member continues on the journey to recovery regardless of the diagnosis or presenting issues.
TREATMENT SUMMARY

Therapy Sessions

Admissions to Short-Term RTF began during the 2009-2010 contract year, and data were tracked for 12 months. Short-Term RTF is similar to traditional RTF in that many of the same program components are offered. Educational programming, therapeutic recreational activities, group therapy, vocational programs for older adolescents and many other services offered at a traditional RTF are also provided in Short-Term RTF programs.

Several key aspects differentiate Short-Term RTF programs from traditional RTF programs. These include a case manager who works alongside the master’s-level therapist within the home and natural environment to assist the member and his or her family in addressing any practical issues that might create barriers to progress or transition.

Another major difference in Short-Term RTF programs is the pace of treatment. The short-term providers act immediately to identify all of the needs, resources and possible pitfalls for a given member and his or her family so they can develop an individualized treatment plan. The Short-Term RTF providers do all of this while the member is still settling into the program and as early in the stay as possible. These providers attempt to capitalize on a window of opportunity when the member has made sufficient progress in treatment and could be transitioned, continuing treatment in the community. By having all of the other possible issues addressed or at least a plan to address them upon transition, the member is not forced to remain in RTF despite his or her progress and can transition much more quickly with the appropriate supports in all life domains.

A vital component of any mental health service is the treatment. Traditionally, RTF providers conduct therapy within the RTF setting. What sets the Short-Term RTF model apart is that a significant amount of the treatment and case management is done within the family’s home and community. The therapy also occurs at a greater frequency within the Short-Term RTF model than it does within a traditional RTF.

Twelve months of data collection from the Short-Term RTF model allow us to make a clear distinction between the treatment services that members in Short-Term RTF receive compared with their counterparts in traditional RTF. Members within the Short-Term RTF track received an average of six family therapy sessions within the home and six family sessions at the RTF for a total of 12 family therapy sessions on average per member. With an average length of stay of just over 12 weeks, that is an average of more than one family therapy session per week, far outpacing traditional RTF.

Each member also received an average of 13 individual therapy sessions during his or her stay. That equals just over one individual therapy session for each member every week. The treatment services provided for members within the Short-Term RTF are well in excess of the required minimums for traditional RTF programs.
Along with the quantity of services that provide a positive impact for the members and their families is the quality. Delivering family therapy and case management services within the home of the member and his or her family allows the treatment staff to see first-hand how the family operates in a natural environment. Staff can observe interactions and dynamics that would occur only in that setting. Observing the family helps determine how best to address those issues and to support the positive changes the family will need to make while building on their strengths.

This is a departure from the traditional model, where the treatment is provided exclusively within the artificial environment of the RTF setting and often focuses more heavily on the “problems” of the member and his or her family. To date, the Short-Term RTF approach supports shorter stays and more positive long-term outcomes for members and their families.
OUTCOMES

Discharge Disposition/Aftercare

Seventeen members were discharged from Short-Term RTF within the first 12 months of the pilot. The average length of stay for members in Short-Term RTF was 95 days. Although not all were successful within the model, the majority of discharged members successfully transitioned to a lower level of care, and most of them returned to their homes with community-based mental health services.

The most utilized mental health treatment upon discharge was Family-Based Services (FBS). Nine of the 11 children who returned home were referred for FBS. This is another critical level of community-based care that has proven successful in maintaining community tenure for children and adolescents discharged from residential treatment facilities. Family-Based Services, in the continuum of care in the Lehigh Valley since the beginning of HealthChoices in 2001, provides intensive in-home treatment focusing on the entire family.

The FBS team consists of two team members: a master's-level clinician and a bachelor's-level case manager. This team provides individual and family therapy, case management, linkage to resources and advocacy. Goals of the family-based programs include improving family communication, learning problem-solving skills, teaching parenting skills and accessing natural supports that the families need. Services are geared toward children and adolescents who are at risk of an out-of-home placement or who are returning from an out-of-home placement.

In 2006, the Lehigh Valley CMC completed a quality improvement activity (QIA) for Family-Based Services. State regulations permit the FBS team to begin services 30 days prior to discharge from the RTF. This 30-day overlap allows the team to develop a relationship with the child and family before the child returns home. The FBS team works with the RTF clinical team and continues working on the identified treatment plan goals. Pinebrook, New Story, MCC Warwick, PA Mentor and NHS Human Services are the family-based providers in the Lehigh Valley.

Family-Based Services provides a model that very closely replicates the Short-Term RTF model in the composition of the team and the services. A master's-level therapist works with the entire family system providing therapy, while a bachelor's-level case manager provides the member and his or her family with ancillary support on practical issues or barriers. This is critical for ensuring that the family can maximize the therapeutic services. FBS is also a service that can begin 30 days prior to discharge from an RTF.

Historically, one of the major challenges facing RTF providers has been discharge planning. Most other community mental health services must wait until the child is discharged to begin their work, leaving the RTF provider to make a referral and communicate previous efforts and expectations for the child and the family. A service overlap allows the Family-Based Services team to begin their work with the benefit of still having an actively engaged RTF treatment team. This also promotes continuity of care as the family-based team can begin to make connections and establish a rapport with the member and the family before taking on the case. This team can identify areas of need, what work has been done and what is needed upon discharge.

Based on the findings of the past 12 months, we have concluded that Family-Based Services will be a critical component in building a bridge to the community for Short-Term RTF members.
Family-Based Services alone is not enough, and other less restrictive placements and community-based services will allow a member’s plan for transition to be individualized. Other findings from the past 12 months show that two members stepped down to a less-restrictive mental health placement (therapeutic foster care and non-JCAHO RTF), and one member was detained by Juvenile Probation. Three members were deemed inappropriate for Short-Term RTF following their admission and were transferred to a “traditional” track within the RTF. In each of these cases, a combination of factors contributed to the outcome. These factors included severe and persistent symptoms and behaviors, as well as significant family dysfunction and chaos. Multiple daily episodes of aggression, self-injurious behavior and trying to run away from the RTF were present.

The clinical presentation alone did not result in the decision. Short-Term RTF providers also determined that transition plans such as stabilizing the family and preparing for a return home or a step-down plan to another mental health placement would take significantly longer in these cases because of the overall clinical picture. Decisions were made to transition the members into the “traditional” track and to continue treatment efforts. To date, two of these members are still in RTF programs with tentative discharge plans to be stepped down to less restrictive mental health placements. One member was detained by Juvenile Probation.

Discharge planning is a crucial component of these short-term programs. Short-Term RTF providers need effective assessments to determine the individual needs of the member and his or her family and to make referrals to the appropriate therapeutic services. Equally important is giving consideration to the aftercare service itself and weighing the pros and cons of a given service based on the needs of the child and the family. Short-Term RTF providers have committed to following members after they have been discharged from the program and to remaining an active resource as needed for the child and the family.

The model includes the expectation that, at minimum, the providers have two post-discharge follow-up sessions with the member and family. This is beneficial because the Short-Term RTF providers are committed to continuing the positive trajectory of the case. These providers can engage in any activities as needed to promote continued success and avert potential setbacks or crisis. The Short-Term RTF providers have worked diligently to establish positive relationships with community providers and other key systems within the Lehigh Valley. This has helped them gain credibility and defused potential “territorial” issues with community-based providers, keeping the focus on supporting the member through whatever means necessary.

**Community Resources**

Another overlooked aspect of discharge planning is identifying other community resources to support the overall transition of the member in traditional RTF programs. In the Short-Term RTF model, identifying community resources is just as important to the plan as any other resource or support. For members discharged from Short-Term RTF programs, school activities were used most frequently. Other resources included sports teams, extended family, church, YMCA and other systems such as Juvenile Probation or Mental Retardation.

<table>
<thead>
<tr>
<th>COMMUNITY RESOURCES</th>
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<tbody>
<tr>
<td>School</td>
<td>4</td>
</tr>
<tr>
<td>C &amp; Y</td>
<td>3</td>
</tr>
<tr>
<td>Family/Extended Family</td>
<td>2</td>
</tr>
<tr>
<td>Sports Team</td>
<td>2</td>
</tr>
<tr>
<td>Baum School of Art</td>
<td>1</td>
</tr>
<tr>
<td>YMCA</td>
<td>1</td>
</tr>
<tr>
<td>MR Supports</td>
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<td>JPO</td>
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<td>Church</td>
<td>1</td>
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<tr>
<td>Community Service Activities</td>
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By working with members and their families to tap into other supports and resources, these resources can help the member move beyond being overwhelmed by their “problems or issues” and re-establish balance and normalcy in their lives that will help them as they move forward in treatment.

Family involvement is a key component of the Short-Term RTF model and returning home is the ideal plan in most cases. However, it is not required. Alternative plans can be developed with an array of available services and other supports, along with highly active discharge planning, for members without an involved family or for members with families not fully prepared for their return.

**Comparing Short-Term RTF with Traditional RTF**

*Average Length of Stay*

Following the first 12 months of data collection for the Short-Term RTF pilot, the results for members are very promising. A comparison of the short-term program with “traditional” RTF shows a significant difference in average length of stay (ALOS). The ALOS for Short-Term RTF was 171 days shorter when compared with traditional RTF for the contract years of 2007-2010.

*Readmission Rates*

There were no readmissions to RTF following treatment in the Short-Term RTF program during the first 12 months compared to an average of six readmissions for traditional RTF programs for the 2007-2010 contract years.

Members placed in a Short-Term RTF program are discharged approximately five months sooner and are not likely to be readmitted to another RTF program within 90 days of their discharge. Before piloting Short-Term RTF, the Lehigh Valley CMC saw a downward trend in overall admissions to RTF, as well as fewer readmissions to RTF.

Several factors can be credited for this trend, including the clinical team’s focus on weekly RTF case rounds with the care managers, clinical supervisor and medical director; increased telephonic concurrent reviews; the development and utilization of an expansive continuum of community-based mental health services that allows children and adolescents to be treated within their natural environment; and a heightened awareness of the often negative outcomes related to long-term residential treatment.

With the promising early results of this pilot program, we are expanding admissions to Short-Term RTF. The Lehigh Valley CMC, through its partnership with our providers and Lehigh and Northampton counties, will continue to lead the way in shaping how mental health treatment for children and their families is both viewed and delivered.
**FAMILY STORIES**

**MCC Warwick: “A Knock on the Window”**

The Warwick House Short-Term Intensive Residential (STIR) program is designed to evaluate and treat youth and their family members in an effort to safely reunify them. By identifying important life experiences, both at the Warwick House and simultaneously in the home, it is possible to address these issues that get in the way of their ability to live safely together.

Barney was a 13-year-old who had not lived at home for five years and had out-of-home placements as a result of excessive aggression. Each time, he hoped to be sent home to his family. Incidents of neglect as a result of his mother’s substance abuse had required Children and Youth to intervene and remove Barney from the home. The STIR team set its sights on reunification.

Upon Barney’s admission to the STIR program, the staff received a hopeless history of a mother who was inconsistently involved in treatment and had frequent disappearing acts. The intensive program moved into action immediately to establish a relationship with Barney’s mother in order to determine her willingness for evaluation, treatment and reunification.

Moving against system-wide doubt, the team bonded with the mother, modeling the dedication necessary for reunification by relentlessly pursuing her, knocking on her windows to get her attention, and ultimately pulling in her own mother until she was able to push past her hopeless feelings of being a capable mother to Barney and her other two boys.

These actions triggered great anxiety for Barney at the Warwick House and during sessions in the home. He used fantasy and aggression. These behaviors would make most people think that he needed to stay longer in a residential treatment facility. However, the STIR team translated this acting out as Barney’s need to manage his insecurities in a more developed way. Mom became his greatest teacher and strongest support by developing safety plans and safe zones and by showing him how to incorporate sequencing techniques that he could apply in his everyday life.

Mom’s fear of failure had been heightened by the system’s disapproval. Now, she had strong support, a belief in herself and Children and Youth as a strong ally. Through STIR’s perseverance, Mom recognized the need for her own treatment along with the program’s family treatment.

It became clear that Barney would be safe in only one place, his mom’s home. The most triumphant day for Barney and his mother came when the judge said that after five long years, custody of Barney would be returned to his mother. Who would think that success would happen because of a knock on the window?

**Children’s Home of Reading: “For the Love of Art”**

Christopher is an adolescent who was involved with Juvenile Probation and over the years had been involved with multiple mental health services. In September 2009, he was admitted to Children’s Home of Reading’s Short-Term RTF program. In this intensive, family-focused program, the treatment team was able to engage Christopher’s father in family therapy. One barrier identified during the family therapy sessions and discharge planning was the father’s long work hours, which would leave Christopher home alone frequently throughout the week. The treatment team at Children’s Home of Reading collaborated to determine what natural supports could be built into the discharge plan.
At the initial Child and Adolescent Service System Program (CASSP) meeting, the CASSP team identified one of Christopher’s strengths. He was a very good artist. The RTF staff assisted him with applying to the Baum School of Art, and Christopher received a full scholarship, including art supplies. Upon discharge from the Short-Term RTF program, Christopher returned home with this father and has been attending the Baum School of Art after school. The art lessons have provided structure and supervision while his father is working. In addition, Christopher developed relationships with peers who have a common interest, and he is gaining skills that could lead to future employment.

Shawnee Academy: “Redefining Family”

Taylor was admitted to the Family-Integrated Residential Services and Treatment (FIRST) program on October 1, 2009, bringing with her an extensive history of acting-out behaviors. Her symptoms included dishonesty, manipulation, harm to the family pet, thoughts of harming others and dangerous behaviors that presented risk to herself and others. Family relationships were so damaged that, upon her admission to the FIRST program, Taylor refused to speak with her family for nearly a month. She often said that when she “messed up” she would prefer to “just not deal” with the family.

While working with Taylor, the FIRST team uncovered her anxiety issues, her fears of disappointing her parents and her avoidance of accountability. Her biological parents were separated, and Taylor often utilized her biological mother as an instrument to avoid accountability in her relationship with her biological father.

The treatment team devoted a tremendous amount of work to developing a unified message from all parents to present to Taylor. As the opportunities to create divisions between parenting units dissolved, Taylor took more risks in communicating with her family, and behavioral disruptions decreased. Through development of communication skills and improved unification among family members, Taylor tolerated confrontation and accountability for her behaviors with much more success.

Taylor was successfully discharged to the home from the FIRST program on December 23, 2009. She was hospitalized three weeks following her discharge, demonstrating a similar cycle of behaviors that precipitated admission to the FIRST program. The FIRST team reached out to Taylor and her family during that hospitalization, facilitated meetings and challenged Taylor to reflect on her history, progress and skills developed over the course of her stay.

These actions seemed successful, as Taylor was able to bounce back and refocus on the relationship in the home. The family showed strength in reinforcing limits and skills developed through family therapy. This was a reflection of the power of building collaborative, unified relationships and how that simple task can create a safe environment for a youth to have setbacks, still take accountability and move forward.
**LESSONS LEARNED**

**What Have We Learned in a Year?**

- The majority of the children or adolescents in the pilot were ages 11 to 17 and in the custody of their parents.
- More males than females were admitted during the first year of the pilot.
- A variety of primary diagnoses were provided; however, bipolar disorder was the most common diagnosis.
- Aggression was the most prevalent presenting issue across all ages.
- None of the children or adolescents was readmitted to a residential treatment program.
- Children or adolescents in the custody of Children and Youth or Juvenile Probation can be successful in a Short-Term RTF program. The intensive family therapy can assist in accomplishing the long-term goal of reunification with the family.
- The majority of the children or adolescents were discharged to their homes with Family-Based Services.
- An overlap of 30 days of Family-Based Services is necessary for a successful transition into the home environment.
- Discharge planning needs to include natural supports for the child or adolescent and the family.
- The pilot program was able to use non-JCAHO RTF and therapeutic foster homes as a step down from the Short-Term RTF programs.
- Increasing the number of evidence-based levels of care for children or adolescents in the community has led to a decrease in admissions and average length of stay for residential treatment.
- Children or adolescents can be treated successfully in a residential program within several months.
- A minimum number of RTF clinical team follow-up sessions with the member and family post-discharge further increases the maintenance of gains made during RTF and contributes to reducing readmissions.

**CONCLUSIONS AND NEXT STEPS FOR THE PILOT**

**Conclusions**

The development of this Short-Term RTF pilot and the outcomes to date confirm that a willingness to seek innovative solutions can produce positive treatment outcomes. The pilot has energized those involved to do more and to spread the word, and it has raised the bar with regard to our expectations for treatment. Our success will serve notice to others that it can be done. Naturally, we expect that the reduction in the use of traditional RTF will continue and, as Short-Term RTF continues to gain credibility as a positive alternative to the traditional approach, it likely will supplant the traditional RTF model. We look to expand the availability of Short-Term RTF services so that more members and their families can experience the same opportunity.

**Next Steps**

- Continue monthly data collection with Short-Term RTF providers.
- Expand the capacity and providers for Short-Term RTF: Silver Springs RTF has submitted a program description for discussion and is committed to implementing this innovative approach to treatment.
- Increase the number of admissions to Short-Term RTF and decrease the number of admissions to traditional RTF.
- Continue bi-monthly Short-Term RTF meetings with providers.
- Develop a profile of the child/adolescent who would benefit from a Short-Term RTF program.
- Examine the reasons certain members are not admitted to or not successful in the Short-Term RTF program. Use this information to further enhance the short-term model to serve these members.
- Share outcomes and provide ongoing education to stakeholders, families, state officials and mental health providers.
- Encourage the discussion of Short-Term RTF at CASSP meetings.
APPENDIX: Community-Based Care Available to Youth and Families

The Lehigh Valley CMC, in close collaboration with HealthChoices of Lehigh and Northampton counties, Children and Youth, and Juvenile Probation, implemented an optimal continuum of community-based services as an alternative to RTF placement for many children and youth. These services include interventions such as Multi-Systemic Therapy, Functional Family Therapy and Multidimensional Treatment Foster Care for youth and families at highest risk because of behavior, psychiatric functioning or complex multi-system involvement. These are evidence-based and empirically supported treatments where fidelity and outcomes are defined and monitored.

Multi-Systemic Therapy (MST)

MST has been identified as an evidence-based practice (EBP) for the treatment of youth criminal behavior, substance abuse and emotional disturbance, often preventing out-of-home placement. Treatment is offered in the home and community. Goals include separating youth from deviant peer units, improving school or vocational attendance and performance and developing natural supports for the family to preserve therapeutic gains.

Studies of MST programs show the following outcomes: reduced long-term rates of criminal offending in serious juvenile offenders, decreased recidivism, reduced rates of out-of-home placements for serious juvenile offenders, extensive improvements in family functioning, reduction of admissions to acute inpatient hospitals and decreased behavior and mental health problems for serious juvenile offenders. In the Lehigh Valley, Community Solutions is the MST provider.

Functional Family Therapy (FFT)

A research-based program for youth who are delinquent or at risk of delinquency and their families, FFT is a type of family therapy provided for three to five months in a clinic or at home. FFT focuses on family alliance, communication, parenting skills, problem-solving and reducing or eliminating problem behaviors. FFT is an outcomes-driven clinical intervention for youth who have demonstrated the entire range of maladaptive, acting-out behaviors and related symptoms.

The model is based on three phases: engagement and motivation, behavioral change and generalizations. The phases are sequentially linked to specific goals for each family interaction. Outcomes show decreased violence, drug use, conduct disorders and family conflict and reduced residential treatment placements and juvenile involvement with the corrections system. Valley Youth House and Pinebrook are the FFT providers in the Lehigh Valley.

Multidimensional Treatment Foster Care (MTFC)

MTFC is another evidence-based program that was researched and developed in the Lehigh and Northampton networks. Designed to divert youth from incarceration, MTFC is a cost-effective alternative to regular foster care and group or residential treatment. The evidence of positive outcomes from this unique multi-modal treatment approach is compelling. The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and pro-social behavior in children and adolescents who are in need of out-of-home placement. Children’s Home of Reading (CHOR), in the process of becoming a certified MTFC provider, was brought into the network to provide this service.