Magellan Behavioral Health of Pennsylvania
Lehigh Valley Care Management Center

Intensive Residential Treatment Facility (RTF) Program
Two-Year Outcomes Report
(Formerly the Short-Term RTF Program)
Drawings throughout this report were created by children participating in the Intensive RTF program.
Executive Summary

In 2008, leadership from Magellan’s Public Sector Solutions team developed a white paper, “Perspectives on Residential and Community-Based Treatment for Youth and Families,” that explored the effectiveness of various treatment options. The document 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.

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. Long-term residential stays often are not in the best interest of the individual, family or the community.

Residential treatment also was a focus of Pennsylvania’s Department of Public Welfare (DPW), Office of Mental Health and Substance Abuse Services (OMHSAS), which engaged Mercer Government Human Services Consulting 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.

As a result of DPW’s attention to residential treatment and Magellan’s belief in the effectiveness of community-based alternatives to residential treatment, the Magellan Lehigh Valley Care Management Center (CMC), in partnership with Lehigh and Northampton counties, focused on reducing the reliance on traditional residential treatment. Together, we began to propel change in our community with a Short-Term Residential Treatment Facility (RTF) program. (The name of the program recently was changed to the Intensive RTF program to better reflect the level of care.)

The Intensive RTF program outcomes clearly demonstrate that children can be successfully treated in a shorter period of time and reunited with their families with the support of community-based mental health services and natural supports. Conclusions appear on page 19 of this report.

Now with two years of outcomes on which to report, the results validate our combined vision and approach. We are pleased to share our learning to date and celebrate the successes of the children and adolescents who participated in the program.
Background

The Intensive RTF program was implemented in May 2009 with MCC Warwick House, which specializes in younger children ages 6 to 13 years old. Shawnee Academy and Children’s Home of Reading also implemented the Intensive model in the fall of 2009. The goal of this model was to reduce traditional long-term RTF stays for children and adolescents.

The Intensive Residential Treatment Facility 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 adolescents ages 13 to 21; and the Children’s Home of Reading (CHOR), specializing in adolescents ages 12 to 18. Together, we developed an Intensive RTF program designed 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.

“It was nice, quicker though... I know I’m not going back... It helped me realize I need to stay home.”

- PARTICIPANT
Key Components

The Intensive Residential Treatment Facility model includes four key components: small caseloads, family involvement, comprehensive discharge planning, and post-discharge follow-up.

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 or 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 or adolescent is getting ready for school if this is an identified stressor for him or her. Frequent home passes and overnight visits also are available while the child is in the Intensive RTF program.

Comprehensive Discharge Planning and Post-Discharge Follow-up
Discharge planning for children and adolescents in the Intensive RTF program 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 abuse 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 Individualized Education Program (IEP) meetings or treatment team meetings with therapeutic foster home or family-based providers.
Additional key components in the development of the Intensive RTF program include the following:

Data Collection
RTF providers submit monthly reports to the Lehigh Valley CMC tracking the following data: gender, age, custody status, diagnosis, presenting issues, use of evidence-based practices, admissions to acute inpatient facilities, and number of therapy sessions per week at the facility and in the home. Post-discharge, providers track their ancillary contacts and admissions to 24-hour levels of care.

Enhanced Rate
In the initial planning phase of this initiative, we discussed with our providers what resources would be needed to support this intensive model. An agreed upon consistent staffing model was integrated into the program descriptions and budgets. Included in each of our programs is an additional case manager position, as well as a master's level clinician. On average we are reimbursing our intensive enhanced programs 24.7 percent above existing contracted per diems.

“I think (the program) is a good thing because I can go back to my family sooner.”
- PARTICIPANT
Intensive RTF Year Two: What’s Changed?

The name of this program has changed from the Short-Term Residential Treatment Facility (Short-Term RTF) program to the Intensive Residential Treatment Facility (RTF) program. The change was made to place more emphasis on the intensive treatment children are receiving through this program.

Other program changes are shown in the chart below.

<table>
<thead>
<tr>
<th>Description</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participating Providers</td>
<td>MCC Warwick House</td>
<td>MCC Warwick House</td>
</tr>
<tr>
<td></td>
<td>Children’s Home of Reading</td>
<td>Children’s Home of Reading</td>
</tr>
<tr>
<td></td>
<td>Shawnee Academy</td>
<td>Shawnee Academy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(ended March 2011)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>KidsPeace (began March 2011)</td>
</tr>
<tr>
<td>Number of Designated Intensive RTF Beds</td>
<td>12</td>
<td>20</td>
</tr>
<tr>
<td>Number of Admissions</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td>Number of Discharges</td>
<td>17</td>
<td>24</td>
</tr>
<tr>
<td>Number of Providers with Sanctuary Certification</td>
<td>None</td>
<td>1 - Children’s Home of Reading</td>
</tr>
<tr>
<td>Family-based Providers</td>
<td>5</td>
<td>6 - MCC Warwick</td>
</tr>
<tr>
<td></td>
<td></td>
<td>implemented a family-based team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>specifically to serve children</td>
</tr>
<tr>
<td></td>
<td></td>
<td>who are discharged from the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Intensive RTF program</td>
</tr>
</tbody>
</table>

*Year One: 5/1/2009 to 5/31/2010, Year Two: 6/1/2010 to 6/30/2011*
Data Collection

Data is collected each month during Intensive RTF stays. RTF providers submit monthly reports to the Lehigh Valley CMC tracking the following data:

- Gender
- Age
- Custody status
- Diagnosis
- Presenting issues
- Number of therapy sessions
- Specific evidence-based practice
- Community supports
- Discharge level of care

Data collected 12 months post-discharge includes:

- Ancillary contacts
- Admissions to 24-hour levels of care

Post-discharge, Magellan tracks the following data:

- Level of care
- Readmission
- Length of stay in Intensive RTF upon discharge
- Community resources utilized
Primary Diagnosis of Children Admitted to Intensive RTF Program

In the second year of the program, bipolar disorder continues to be the most prevalent primary diagnosis. This is followed by intermittent explosive disorder and major depressive disorder. All of the children admitted had more than one diagnosis.

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Intermittent Explosive Disorder</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Impulse Control Disorder</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Oppositional Defiant Disorder</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Asperger’s Disorder</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Co-occurring Mental Health and Substance Abuse</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pervasive Developmental Disorder</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

*Year One: 5/1/2009 to 5/31/2010, Year Two: 6/1/2010 to 6/30/2011*

“I think the program will help a lot... I’m trying my hardest to do well.”

- PARTICIPANT
Age at Admission to Intensive RTF Program

The trends in the second year of outcomes are similar to the results of the first year.

- Children under the age of 10 are less likely to be admitted into an Intensive RTF program.
- 61.9 percent of the admissions were adolescents 13 to 17 years old.
- 38.8 percent of the admissions were children 7 to 12 years old.

Males are more likely to be admitted compared to females. 60 percent of the admissions were male and 40 percent were female.
Treatment Summary

A vital part of the Intensive RTF program continues to be the therapy sessions and case management, which are conducted in the home environment. The treatment team conducts family therapy sessions in the home with the child and his or her family. There also is a minimum of weekly individual therapy with the master’s level clinician.

Therapy Sessions by Provider (per month)

Shawnee Academy *(Program ended 3/31/11)*

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shawnee Academy</td>
<td>12</td>
<td>2.6</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Warwick House

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warwick House</td>
<td>5.4</td>
<td>2</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Children’s Home of Reading

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Home of Reading</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

KidsPeace *(Program began 3/26/11)*

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Family</th>
<th>Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>KidsPeace</td>
<td>6</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
Discharge Level of Care

• In the first year of the program there were 17 discharges, compared with 24 discharges in the second year of the program. Similar to the first year of the program, a family-based model was the most utilized mental health treatment. Throughout the first two years, 48 percent of the children were discharged to a family-based level of care.

• The family-based model closely replicates the Intensive model with a master’s-level therapist and bachelor’s-level case manager. A key component of the family-based model is the allowance of a 30-day overlap with RTF when the child is discharged from the RTF program.

• The family-based teams continue to overlap with the treatment team at the RTF program, which promotes continuity of care for the child or adolescent and his or her family. The family also participates in the quarterly Intensive RTF meetings.

• In the second year of the program, only one child was discharged to traditional RTF due to severe and persistent symptoms and behaviors that could not be addressed in the Intensive model.

• Six children were discharged to community-based non-Joint Commission RTF programs within the Lehigh Valley. These were older adolescents who required more skill building prior to moving on to independent living.

• There have been no children discharged to Behavioral Health Rehabilitation Services (BHRS) from this program.

A key component of the family-based model is the allowance of a 30-day overlap with RTF when the child is discharged from the RTF program.
<table>
<thead>
<tr>
<th>Discharge Level of Care</th>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family-Based Services</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Non-Joint Commission (NJ) RTF</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Community Rehabilitative Residential (CRR) Host Home</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Against Medical Advice (AMA)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Traditional RTF</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Family Focused Solution Based Services (FFSBS)</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>C&amp;Y Shape Program</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Multisystemic Therapy (MST)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Detention</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
<td><strong>24</strong></td>
</tr>
</tbody>
</table>

Throughout the first two years, 48 percent of the children were discharged to a family-based level of care.
Comparison of Intensive RTF with Traditional RTF

The tables below compare data for Intensive RTF with traditional RTF programs for admissions, average length of stay and re-admissions to RTF programs. The tables provide combined data for Lehigh and Northampton counties.

<table>
<thead>
<tr>
<th></th>
<th>Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional RTF</td>
<td>80</td>
</tr>
<tr>
<td>Intensive RTF</td>
<td>23</td>
</tr>
</tbody>
</table>

Children who were transferred from Shawnee Academy to alternative RTF programs were counted as a new admission to RTF. Seven children were transferred to an alternative RTF placement in March 2011.

Admissions to Intensive RTF programs increased from 22 to 33 percent in 2010 – 2011.
<table>
<thead>
<tr>
<th>Readmissions into RTF Programs from…</th>
<th>Traditional RTF Programs</th>
<th>Intensive RTF Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30 days 60 days</td>
<td>30 days 60 days</td>
</tr>
<tr>
<td>2009 – 2010 Contract Year</td>
<td>1 1</td>
<td>0 0</td>
</tr>
<tr>
<td>2010 – 2011 Contract Year</td>
<td>3 3</td>
<td>0 0</td>
</tr>
</tbody>
</table>

The Intensive RTF programs continue to have no re-admissions into RTF programs.

*Average Length of Stay in Days*

![Bar chart showing average length of stay in days for Traditional RTF and Intensive RTF programs from 2009-2010 and 2010-2011 contract years.]

The average length of stay for traditional RTF continues to decrease. The average length of stay for Intensive RTF is 165 days less than for traditional RTF during the same date span.
Presenting Issues and Barrier Behaviors

Presenting issues and barrier behaviors are a clinical feature of the child's profile.

- Aggression continues to be the most prevalent presenting issue for children who are admitted to the Intensive RTF program. The aggression is toward property, caretakers and siblings.

- Lack of compliance with community-based mental health treatment was the second most prevalent presenting issue; following the Child and Adolescent Service System Program (CASSP) principles, all the children admitted to the Intensive RTF program have been involved with community-based mental health services prior to admission.

- Several of the parents involved in the program also were coping with their own mental health issues. The case managers were able to connect the parents with treatment and support groups within the community.

Presenting issues and barrier behaviors are the most frequent reasons children are not able to receive treatment in the community.
Community Supports

Community supports are a vital key to discharge planning. Within the Intensive RTF program, the children and families also are connected with community supports. Below is the list of community-based supports that have been utilized in Lehigh and Northampton counties.

School
- After-School Programs
- Extended Family
- Boy Scouts
- Sports Teams
- YMCA
- Faith-based Organizations
- Dance Classes
- Art Classes

Big Brothers/Sisters
- Firemen Organization Youth Association
- Majorettes
- Family Answers
- Mental Retardation Supports (Respite)
- Support Groups
- ALATEEN
- Homework Clubs

Developing community-based natural supports continues to be critical for the children and their families as they transition back home from the RTF.

The case managers in the RTF program have done excellent work in identifying community-based services.
Family Story: “Moving Away from Anger”

Brian was admitted to the Intensive RTF program of the Children’s Home of Reading (CHOR) following a stay at the Lehigh County Juvenile Detention Center, where he had been detained for threatening a neighbor with a machete.

Brian had severe difficulty with anger management and impulse control. He had relationship issues with his father, who, in turn, had difficulty parenting his son. This had been going on for years. Anger was also an issue for Brian at CHOR, where he was disrespectful to staff and insulted his peers, calling them names.

During individual sessions with his clinician, Brian focused on interacting with others in socially acceptable ways. He needed to develop effective coping skills and strategies to control his aggressive impulses. His clinician’s efforts to build a trusting therapeutic relationship with him proved successful. He began taking his medications consistently. He steadily increased his level of cooperation and participation in the program.

Family therapy focused on his relationship with his father. His clinician assisted his father with improving parenting skills and linking Brian’s needs to his mental health issues.

Brian made steady improvement in all of his treatment areas. He opened up to staff, talking with them about his concerns. He became a positive role model for his peers. His interactions with them were supportive. He was well-liked and respected by peers and staff. Brian and his father continued to improve their relationship.

Prior to discharge, Brian experienced the anxiety that residents often have when discharge is near. He was irritable when upset. When his clinician explored his feelings, Brian revealed that most of his anxiety and sadness was the result of leaving CHOR.

Following some closure activities, including a lunch outing with staff of his choosing, he was ready to move on and was successfully discharged from the program. Brian’s social skills continue to improve, as does his ability to navigate normal adolescent stressors that he confronts daily.
Family Story: “The Family Circle”

Alf had spent months bouncing from host home to hospital before arriving at the Warwick House. He often expressed his frustrations violently, against himself or others, including his family. Alf frequently made allegations of abuse against his stepmother. She responded decisively, as did Alf’s father, an Iraq war veteran and member of the armed forces.

The Short-Term Intensive Residential (STIR) team at the Warwick House led treatment with Alf and his family. Alf’s parents consistently made themselves available to him, despite facing obstacles on other fronts. Alf’s father was frequently called to training services for impending deployment, and a crisis with a family member threatened to strain Alf’s treatment and progress. However, the family endured. Compassion and trust between the STIR team and the family grew.

Alf’s parents confronted their own pasts, and with the STIR team’s help, sought out and began to repair a fractured relationship with Alf’s grandparents to restore familial bonds and mutual support. One of the most painful and powerful obstacles was the specter of Alf’s mother, who had passed away years before.

Boldly confronted by the STIR team, Alf’s family learned how to navigate past these obstacles. Years of pain, hurt, distrust and miscommunication were replaced with a pledge to support and care for one another, and to best serve Alf.

Alf was typically polite and friendly, though not without his tantrums. However, he sometimes would refuse to follow a journal assignment, or “intentionally” lose his glasses. He would attempt to split the alliance between his grandparents and parents, and play on their differing methods.

Over time his stepmother’s improving relational abilities slowly repaired the hurt separating the two. Alf’s efforts to split and undermine the relationships between parent and grandparent were rebuffed.

Alf learned coping skills, and how to express his frustrations with words rather than outbursts. Stubborn though he sometimes was, he began to improve his compliance. Alf’s parents grew more optimistic, and Alf was ready to take the next step. He returned to his home, confident in his progress.
Next Steps and Enhancements

Next Steps

• Continue to collect monthly outcomes.
• Continue to increase the number of children admitted to Intensive RTF and decrease the number of admissions to traditional RTF.
• Expand the capacity and number of providers of Intensive RTF. NHS Human Services implemented their Intensive RTF program in August 2011.
• Magellan, Lehigh county and Northampton county will provide support and assistance to the providers who are seeking Sanctuary Certification.
• Share the second year outcomes with stakeholders.
• Continue quarterly meetings with the Intensive RTF and family-based providers.

Enhancements for Year Three

• *Electronic outcomes*: The Illume database will be utilized by providers to submit their monthly outcomes data.

• *More outcomes*: Providers are required to identify the evidence-based practice and/or clinical best practice guidelines that are being implemented on the treatment plan. Post-discharge, we will track admissions to acute inpatient facilities.

• *Required Certification*: Magellan and Lehigh and Northampton counties partnered with the Andrus Children’s Center and sponsored a five-day Sanctuary training as a first step toward implementing the Sanctuary model in the Intensive RTF program. Warwick House, KidsPeace and NHS Human Services all are pursuing Sanctuary Certification. The Sanctuary model facilitates the development of structures, processes and behaviors on the part of staff, clients and the community as a whole that can counteract the myriad negative effects suffered by the victims of trauma and prolonged exposure to adversity. Many of the youth and families who receive treatment in Intensive RTF programs have experienced trauma, adversity and chronic stress; therefore, the hope is that adopting the Sanctuary model will create a cultural shift that promotes an even greater opportunity for healing.

Continue to increase the number of children admitted to Intensive RTF and decrease the number of admissions to traditional RTF.
Conclusions

- Family-based services continue to be the preferred aftercare plan for children discharged from the Intensive RTF program.
- A key component of the family-based model is the allowance of the 30-day overlap with RTF when the child is discharged from the RTF program. This overlap creates the opportunity for successful transition of the child and family back into the community.
- The Intensive RTF program outcomes clearly demonstrate that children can be successfully treated in a shorter period of time and reunited with their families with the support of community-based mental health services and natural supports.
- On average, children in Intensive RTF were in placement outside of the home for 150 days less than children placed in traditional RTF.
- Delivering therapy in the home allows the therapist to work with the child and family in their natural environment, giving the therapist the ability to assist with real life issues that occur in the home.
- The 30- and 60-day readmission rates for Intensive RTF were zero, in comparison to traditional RTF readmission rates for the same measurement periods, which were double in year one and three times as many in year two. Additionally, the 30-day overlap of family-based services and the aftercare follow-up post-discharge contributed to the low readmission rates for Intensive RTF.
- Natural supports for the children and their families are key to a successful discharge plan.
- Intensive RTF appears to be a more efficacious and cost-effective care alternative, as emphasized by the level of intensive treatment provided within a brief time frame, the positive outcomes related to lack of readmission, and the reunification of the child with the family much sooner than in traditional RTF.
Executive Summary from 2010 Report

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.