CONNECTICUT DEPARTMENT OF CHILDREN AND FAMILIES

The Future of Riverview Hospital for Children and Youth: Ten Steps Forward

Report #1 in a Two-Part Series

This report has been prepared as authorized by
Connecticut General Assembly Section 32 of Public Act 10-3

April 13, 2011

This report outlines ten steps that will guide changes in the operation of Riverview Hospital for Children, including its consolidation with the Connecticut Children's Place and its expanding role in the system-wide transformation of the Connecticut Department of Children and Families. The report has been developed jointly with the Connecticut Office of the Child Advocate.

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The Future of Riverview Hospital for Children and Youth: Ten Steps Forward (Report #1)

Executive Summary

Pursuant to Section 32 of Public Act 10-3 and in consultation with the Office of the Child Advocate, the Connecticut Department of Children and Families (DCF) is submitting an initial report to the Connecticut General Assembly concerning the future of Riverview Children's Hospital (RVH). This report details a series of ten steps designed to assure the delivery of cost-efficient, high quality and highly effective services for children and youth with extraordinary mental health and behavioral needs.

First, the Department will create a management structure that consolidates the administration of Riverview Hospital with that of the Connecticut Children's Place, a second behavioral health facility operated by the department. This new entity will be administered by a single superintendent and will be renamed. A single Medical Director -- in cooperation with consolidated leadership over operations, nursing and residential services -- will assure continuity, quality and accountability for clinical services provided across the consolidated institution and will report directly to the superintendent of the newly consolidated entity. This action is being implemented now.

Second, pediatric services offered by the consolidated Riverview/Children's Place entity and the Connecticut Juvenile Training School will be fully integrated. This will begin in July 2011.

Third, as part of the new consolidated behavioral health institution, the Department will operate six inpatient hospital units at Riverview and six specialized treatment units, two at Riverview and four at the Children's Place in East Windsor. These six specialized units will operate at a lower level of treatment than provided at Riverview Hospital itself. Identification of the target population(s) is guided by an analysis of unmet needs of children and youth with complex mental health and behavioral needs. Across the consolidated institution, discharge planning will begin very early in the assessment and treatment process. A 12-month process of implementation will begin within the next 120 days.

Fourth, stronger linkages will be established and maintained between the new behavioral health institution and the department's regional service areas, which are also undergoing realignment and transformation. Areas of collaborative work include the agency-wide adoption of a framework based on strengthening families, making community connections, expanding access to multi-disciplinary teaming and trauma informed practice, and continued emergency access to facility services. There also will be renewed attention to gender and cultural responsiveness. This work has begun and will occur over a 24 month period.

Fifth, ongoing oversight of the consolidated institution has been assigned to the department's new Residential/Institutional Team in the DCF Central Office. Leadership of this new team will be responsible for strategic planning and program development across Connecticut's residential treatment sector and for assuring strong linkages between this sector, the consolidated institution and community settings to which children will return.

Sixth, Riverview Hospital will continue its current relationships with institutions of higher education, including Yale University and the University of Connecticut, with whom it shares joint residency and training programs. The Department will seek to more fully leverage the assets of Connecticut's public and private institutions of higher education. These discussions are currently underway.

Seventh, the Department will work more strategically with other state agencies that provide services for children and adults with complex behavioral/mental health needs and individuals with developmental disorders. This will assure a seamless and timely transition of youngsters from our system to the various state agencies who will serve them. This work, already in progress, will be formalized by October 1, 2011.

Eighth, staff from the Riverview/Children's Place consolidated institution will participate as teachers and learners in the new DCF Academy for Workforce Knowledge and Development. Opportunities will include adjunct faculty appointments and expanded grand rounds. Joint workforce development opportunities will also be available to DCF regional agency personnel and private providers who serve children pre- and post-inpatient treatment. This work has already begun.

Ninth, the Department will finalize policy and practice guidance related to its continued reduction in the use of restraints and seclusion for children and youth served at the consolidated institution. This will incorporate the department's expanded use of trauma-informed practices and will be finalized by October 1, 2011.

Tenth, the Department will apply the principles of "Implementation Science"[1] and a Results Based Accountability framework agency-wide. These management tools will be implemented over the coming 24-36 months, incorporating data on child and youth outcomes as well as service delivery to improve performance at the consolidated institution.

These proposed actions were developed through a collaborative team process involving Riverview and Children's Place leadership, leadership from the Office of the DCF Commissioner and the agency's Central Office, and representatives from the Connecticut Office of the Child Advocate. They represent the first phase in a two-part process of strategic planning and

[1] Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M. and 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).

accountability under the leadership of Justice Joette Katz, Commissioner of the Department of Children and Families.

The second step in this new process will involve further discussions with families, agency staff, labor and community leaders, and leadership from other key state agencies, the Governor's Office, the Connecticut General Assembly and the Connecticut Judicial Branch. The results of this second phase of work will be reported by October 1, 2011 as required in proposed legislation now under consideration by the General Assembly.

Message from the Commissioner

I want to formally acknowledge and thank the team led by Dr Janice Gruendel, Deputy Commissioner, for the thoughtful analysis and comprehensive treatment of the issues surrounding the future of Riverview Hospital for Children and Youth. I also wish to thank the DCF Transition Team for its earlier review of key action items included in this report.

This report, inter alia, details a series of ten steps designed to assure the delivery of cost-efficient, high quality and highly effective services for children and youth with extraordinary mental health and behavioral needs.

We endeavor to ensure that these children as well as all others in our care enjoy health, safety, well-being and successful learning experiences in and out of school, that they experience age-appropriate growth and development, advance their own special talents, and find opportunities to give back to their communities.

Justice Joette Katz
Commissioner
Department of Children and Families
April 12, 2011

Message from the Office of the Child Advocate

In response to growing concerns about the quality and extraordinary costs of care at the DCF operated Riverview Hospital for Children and Youth, the Connecticut General Assembly passed Section 32 of Public Act 10-3 requiring the Department of Children and Families (DCF) to submit a plan on the future of Riverview to the Select Committee on Children and the Human Services and Appropriations Committees by April 15, 2011. The bill requires DCF to develop the plan in consultation with the Office of the Child Advocate (OCA). The OCA was contacted for the first time to provide such consultation in February 2011, shortly after the appointment of Commissioner Katz.

This plan submitted by DCF proposes to maintain operations at Riverview Hospital (RVH) as well as Connecticut Children's Place (CCP) and, further, proposes to expand the capacity of both facilities. Since February, the OCA has participated in numerous discussions with DCF leadership regarding DCF's future plans for both of these facilities. For nearly a decade, the OCA has relentlessly provided independent oversight, investigation and recommendations for policy and practice reform related to the care and treatment of children at RVH, CCP and the other DCF operated facilities as well as DCF licensed private sector facilities. The OCA's concerns and recommendations have remained essentially unchanged during this time despite numerous changes in DCF's executive leadership.

The OCA has the statutory responsibility and obligation to make every effort to ensure that children who are currently served at RVH and CCP, and children who will be admitted in the future, receive the best possible protection and treatment. Commissioner Katz has been responsive to the concerns and recommendations made by the OCA, and I am fully confident that this will continue.

In addition to my general support of the DCF report, *The Future of Riverview Hospital for Children and Youth: Ten Steps Forward (Report #1)* and as Connecticut's Child Advocate, I urge serious consideration of the following recommendations.

1. A first priority must be ensuring the safety and best possible treatment for those children currently at RVH and CCP. Children and families served at RVH and CCP need these facilities to be safe, trauma-informed, clinically effective and restraint-free environments. DCF has already invested significant resources over the past several years to train and retrain staff with limited sustainable measurable progress. DCF is proposing new individualized units at both RVH and CCP. The OCA has expressed concerns that the vast majority of staff are the same individuals that have struggled over the past decade to implement specific programming options, and we continue to be concerned with their capacity to implement and sustain strengths-based, trauma informed, and family-centered care. DCF must ensure that staff at the facilities, and across the entire agency, are trained and accountable for the treatment, safety, and discharge and transition planning for these children before any program expansion occurs. To this day, DCF's data depicts a persistent reliance on restrictive measures,

including restraint, seclusion and frequent involvement of law enforcement in both facilities. It is critical that leadership issue a directive eliminating the use of restraint and seclusion applicable to both RVH and CCP including excessive use of hands-on staff interventions, high use of psychotropic and PRN medications, reliance on law enforcement to manage behaviors and establish quality assurance protocols to monitor fidelity to the directive and any exceptions to its implementation.

2. Concurrently, as the State's lead agency for children's mental health, DCF must reallocate significant staff and precious financial resources to further develop the capacity of the mental and behavioral health workforce and the current community-based continuum of care. The OCA's work as the only independent oversight entity for both RVH and CCP, and as a consultant in developing this report pursuant to Section 32 of Public Act 10-3, makes clear that Connecticut should be aggressively working toward divesting from its state-run facilities for children and investing in a community-based infrastructure that includes a full continuum of services to meet the needs of children and families.

   Connecticut's children would be best served if the abundant resources currently available within these facilities were more equitably distributed to further the growth of the community-based infrastructure, including acute care settings, which will eventually result in diminishing the need for state-run institutions and reliance on out-of-state providers for our children. Historically, private providers who serve the mental and behavioral health needs of children and families in Connecticut have lacked the funding levels allocated to state-run programs.

There is much work to be done and the Office of the Child Advocate looks forward to continued collaborative efforts on behalf of these children and the many others who will follow them. This work must be done in concert with the other sweeping child welfare reforms proposed by Commissioner Katz, which seek to improve the state's ability to identify the needs of children and families and promptly respond with timely and effective services at the earliest time possible. Reform efforts must address the well-documented pipeline from child welfare to a variety of very poor outcomes for children and youth.

It is also critically important to maintain strong external, independent oversight as reforms and changes are implemented because past experience demonstrates that progress and sustainability of gains has been fragile.

Jeanne Milstein
Connecticut Child Advocate
Office of the Child Advocate
April 12, 2011

Part I: What Is…

A Brief Chronology of the Department

The Connecticut Department of Children and Youth Services was established by the Connecticut General Assembly in 1969 "as the single state agency responsible for children's mental health, child welfare, juvenile justice, substance abuse and prevention services."[1] One year later, juvenile delinquency treatment and prevention programs were transferred to the department.[2]

In 1974, the General Assembly mandated transfer of children's mental health services to the department. Following two years of planning by a special commission, psychiatric and "other related services for children" were transferred to the department. These services included children's mental health programs and child welfare programs. Regions were established along with the State Advisory Council.[3]

In 1979, three facilities for children with mental health needs were transferred to the department: Riverview Hospital for Children; Fairfield Hills Hospital Adolescent Unit (renamed Housatonic Adolescent Hospital in 1979); and the Henry D. Altobello Children and Youth Center (formed by the merger of the Adolescent Units from Connecticut Valley Hospital and Norwich State Hospital).[4] Also in 1979, the Connecticut General Assembly "added responsibility for court-committed status offenders, called Families with Service Needs."[5]

Continuum of Care

- Community-based family support and prevention
- Community-based in-home, day treatment and outpatient
- Substitute care including foster family care, group homes and shelters
- Residential treatment and inpatient psychiatric hospital services

In 1980, the department adopted recommendations of a broad-based public-private working committee to develop children's mental health services according to a Continuum of Care model.[6] Four years later (1983-84) the department developed its first program budget modeled on the continuum of care.

In 1985-86, the General Assembly's Legislative Program Review Committee conducted a review of the Department's psychiatric hospital Services for children and adolescents. The Committee recommended that the department develop a comprehensive children's mental health plan based on a needs assessment of child and adolescent mental health needs. In addition, the

[1] *Carlos Rodriguez is Waiting… Connecticut's Plan for a Comprehensive, Community-Based Service System for Children and Adolescents who Experience Serious Emotional Disturbance and their Families."* CT Department of Children and Youth Services, (September 1989) p.7
[2] Ibid, p. 7
[3] Ibid, p. 7
[4] CT State Library, op cit
[5] Carlos Rodriguez is Waiting, op cit, p. 7
[6] Ibid, p. 8

department was directed to develop "the roles of the system components, conduct statewide planning, develop a service model based on needs, develop a scheme to insure that patients have better access to services, develop 24-hour emergency service programs which aid in screening referrals to inpatient programs [and] define and implement a referral process for mental health services."[7]

Appointment of a new Commissioner in 1987 followed by a review of agency operations revealed "a series of programs organized around categorical entry and service criteria and activated most frequently when service needs reached the point of crisis. The focus was on remediating the presenting problem of the child rather than prevention and intervention services which were child-centered and family-focused. Service availability also seemed to be unequal for minority children, with Black and Hispanic children over-represented on the child welfare and delinquency caseloads, but apparently under-represented in mental health services."[8]

To provide direction in addressing these concerns, in July 1987 the Commissioner published the department's first Mission Statement[9] and Operating Principles:

The Mission: To join with others to create conditions within which all children in Connecticut:

- Develop as healthy, productive and caring persons, free from harm and injury
- Experience enduring, nurturing relationships as members of permanent families
- Participate fully in community life
- Exercise age-appropriate opportunities for decision-making
- Are supported in their transition to adulthood, and
- Receive services that are respectful of child time, responsive to children's individual and developmental needs, and sensitive to their heritage."[10]

Operating Principles:

- Children have a fundamental right to grow up as members of a family. The Department therefore will work to support, enhance and empower individual families to care for their children.

- Some children live in economic and environmental conditions which do not promote their healthy development. These conditions include poverty, substandard housing, the presence of substance abuse, and the absence of adequate health care. The Department therefore will work with other Connecticut agencies and the private sector to address these public policy issues for Connecticut families.

[7] Ibid, p. 12
[8] Ibid, p. 9
[9] These mission statement and operating principles, crafted more than 20 years ago, are included here because they align well with the goal of the Department in 2011 as expressed by its new commissioner, Justice Joette Katz.
[10] Ibid, p. 10

- Decision-making on behalf of children works best when it involves the family as well as others serving the family. The Department therefore will develop an inter-disciplinary case planning process which includes and values the input of family members.

- Services work best when they are planned and delivered close to where people live. The Department therefore will provide for services through a system of regional planning, program administration and funding.

- The special needs of some children may require time-limited, out-of-home treatment. The Department therefore will plan for, operate or fund an integrated system to meet the particular needs of these children.

- Children and families are a vital source of information about the quality of services which they receive. The Department therefore will include children, families and citizen advocates in the assessment of services provided.

- The Department will invest in human and financial resources, to the greatest extent possible, in activities and programs most likely to advance this mission."[11]

In 1988, a Residential Work Group identified "gaps in the continuum of care which inhibit the movement of children through the service system. With regard to residential treatment programs, the group identified several underserved populations. (See the chart.) Also in 1988, a three-year plan was adopted to transfer "children's substance abuse services from the Alcohol and Drug Abuse Commission" to the Department of Children and Youth Services.[12]

Underserved Populations in 1988: Children and Youth who…

- Exhibit problematic sexual behaviors or sexual identify issues
- Set fires
- Are assaultive and/or acting-out in dangerous ways
- Are returning from psychiatric hospitalization
- Experience cognitive limitations, including mental retardation
- Are HIV-infected.

One year later (1989), the department issued its first ever children's mental health plan: *Carlos Rodriguez is Waiting: Connecticut's Plan for a Comprehensive Community-based Service System for Children and Adolescents who Experience Serious Emotional Disturbance and Their Families.*

This plan described the purpose of Connecticut's inpatient psychiatric hospitals as follows: "Inpatient intervention is required when the severity and/or complexity of the problems (of seriously emotionally disturbed children or adolescents) make outpatient services inadequate. Examples of severity include disturbances which are life threatening such as severe anorexia nervosa, suicide attempts, fire setting and self-mutilation. Children may also warrant psychiatric

[11] Ibid, pp. 10-11
[12] Ibid, p. 7

hospitalization because they exhibit a vicious cycle of deterioration which cannot be interrupted except by multi-disciplinary, 24 hour/day intervention. These disorders include severe attentional and anxiety disturbances and acute psychotic decompensation." Finally, "psychiatric hospitalization may be called for when a comprehensive and simultaneous set of psychological, neurological, interpersonal, familial and educational interventions is required."[13] In the same year, the department applied for but did not receive federal funding to implement this plan.

With completion of a new building on the grounds of Riverview Hospital for Children in 1993, the Altobello and Housatonic Adolescent Hospitals were closed and merged into Riverview. The facility, with a licensed bed capacity of 107, was then renamed the Riverview Hospital for Children and Youth.

Perhaps the single most significant structural event in the life of the Department (in addition to the consolidation of the agency's inpatient facilities in 1993) was the December 1989 filing and January 1991 settlement of the *Juan F.* federal lawsuit.[14] The lawsuit "charged that the Connecticut Department of Children and Families (DCF) was grossly underfunded and understaffed, high caseloads overwhelmed social workers, and the dwindling supply of foster parents were underpaid and inadequately trained."[15]

The state's attempts to achieve compliance with terms of the *Juan F* federal consent decree have resulted, over the past 20 years, in a dramatically expanded child protective services workforce, significant additional funding for services for children and youth covered by the decree, and regular compliance with 19 of the 22 required objective measures specified by the decree and subsequent modifications. Through the fall of 2010, it could be accurately said that a significant amount of agency resources and attention was directed at achieving performance improvement sufficient for the state to exit the decree.[16] With appointment of new leadership at the department by recently elected Governor Dannel Malloy, significant discussions are underway involving all parties with the goal of exiting the decree over the next 12 to 24 months.

[13] Ibid, p. 30

[14] More recently, the Connecticut General Assembly adopted sweeping legislation to "raise the age" of youth engaged in the juvenile as opposed to the adult justice system. This change will result in an increase juvenile justice caseload for the Department moving forward from 2011, and constitutes the 3rd significant area of modified policy focus for the agency.

[15] *Juan F. v. Rell* as cited and summarized by the National Center for Youth Law, online at -- www.youthlaw.org/publications/fc_docket/alpha/juanfvrell

[16] An exit plan was agreed to by all parties in February 2002. In 2008, still not in compliance, the department agreed to utilize national technical experts to develop a reform plan, focus effort on the over-reliance of residential placements, increase the number of foster families, clear its health services backlog, and address other unmet needs for children in custody.

Riverview Hospital Today

Located on 67 acres overlooking the Connecticut River in Middletown, Riverview Hospital for Children and Youth is the only publicly-operated psychiatric hospital for children in the state. The hospital is charged with providing psychiatric and other behavioral health services for children experiencing complex and persistent emotional and behavioral difficulties.

Riverview is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). It is eligible for federal Medicaid reimbursement as a Psychiatric Residential Treatment Facility. Each year, Riverview Hospital generates about $10 million in federal Medicaid reimbursement for the State of Connecticut.

The 88-bed[17] facility treats children ranging in age from five to 18 years. It includes eight living/treatment units,[18] two schools, indoor and outdoor facilities for therapeutic recreation, and space for maintenance and administrative functions. The facility employs 260 full- and 116 part-time staff and operates with projected expenditures of just under $51 million for the current fiscal year. This figure includes actual expenditures and the cost of state fringe benefits.

Over the period July 1, 2009 through June 30, 2010, 287 children and youth ages six through 17 years were served at the facility. Total admissions were 212 and total discharges were 218. This is largest number of children served in several years. Seventy-one percent (71%) of the children and youth served were involved with the Department of Children and Families; 29% were not.

Of the 212 admissions, 57% were males and 43% were females. Youngsters served were largely non-Caucasian: 63 were African Americans, 73 were Hispanic, and 9 were reported as "other." The youngest children served were seven years old (3 children in total). Just fourteen children were ages ten or younger. Thirty-one were 11 and 12 years of age, and 167 were ages 13 through 17 years.

Six of ten youngsters admitted (123) were committed to the department by the courts. Eleven percent were admitted under a 15-day physician's certificate (24); 2% were admitted for restoration to competency (5). An additional 27% were voluntary placements (57).[19]

Length of stay is a function of a child's legal status and the institution's commitment to complete a treatment program that will, to the greatest extent, enable the youngster to be successful in his or her next level of care. The current average length of stay is 112 days. Data for the past fiscal year (July 2009 through June 2010) are shown below:

- 127 youngsters stayed at Riverview for 90 days or less

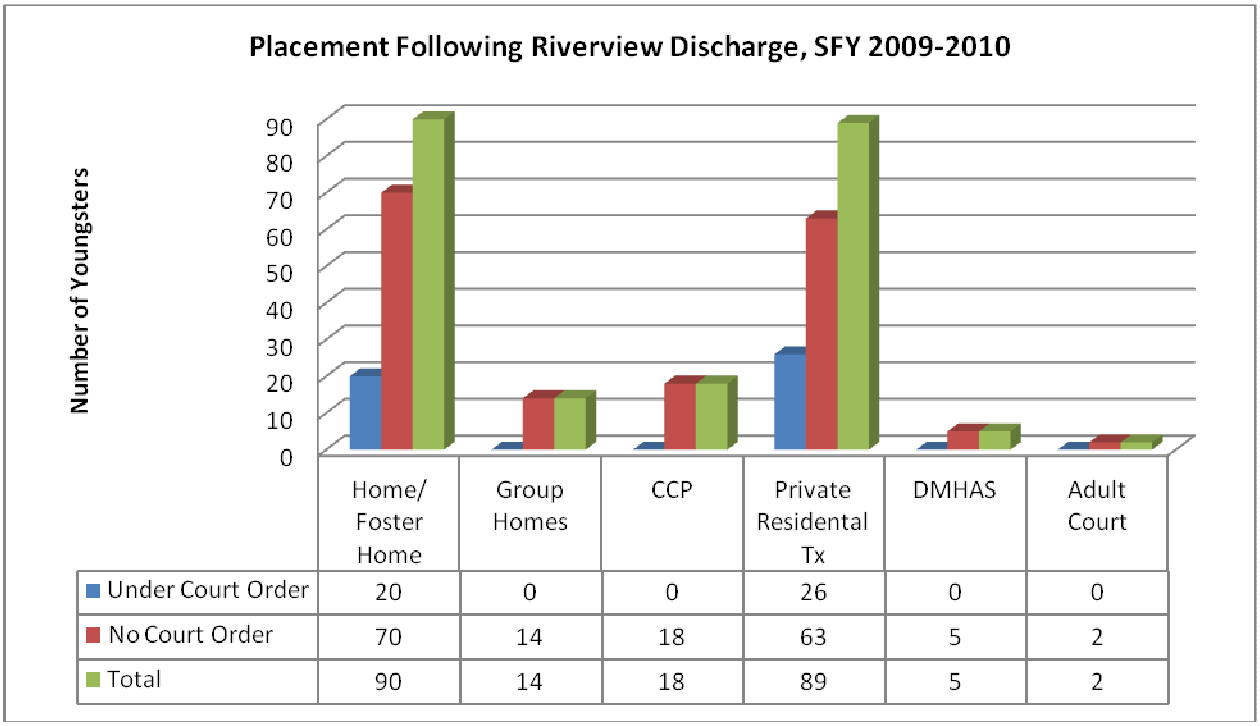
[17] Although opened as a 107 bed facility, its capacity has been reduced over time as the daily census has declined and as some rooms serving two children were converted into single rooms. Modifications over time have also resulted in reduced bed capacity.

[18] One of the eight units, Quinnipiac, was closed during the last state fiscal year, 2009-2010.

[19] Three youngsters admitted to Riverview in state fiscal year 2010 did not have an identified legal status.

- 35 remained for 91 to 150 days
- 42 remained for 151 to 270 days, and
- 14 remained at Riverview for over 270 days (that is, nine months or more).

Importantly, over the past fiscal year nearly as many youngsters went home to their biological or foster families (90) as went to private residential treatment facilities, including the Connecticut Children's Place (107). This is a remarkable finding given the complexity and crisis nature of children's needs upon admission to the hospital. A complete picture of discharges can be seen on the chart below.



	Home/ Foster Home	Group Homes	CCP	Private Residental Tx	DMHAS	Adult Court
Under Court Order	20	0	0	26	0	0
No Court Order	70	14	18	63	5	2
Total	90	14	18	89	5	2

To address the needs of children and youth admitted for evaluation and/or treatment, Riverview employs a holistic approach. This enables the hospital to be responsive to the needs of the child, the family and the community in which the child lived or to which the child will return. The schematic below presents the components of this holistic approach.

Recognizing the importance of family-centered treatment and care, family members are encouraged to participate in all aspects of their child's care, from admission to discharge. There are no limits on the hours families may visit or on the number of family members who participate. Quarterly family events are scheduled to celebrate special times of year. Family therapy can be scheduled on a flexible basis to accommodate evening participation by families.

Riverview incorporates evidence-based best practices and trauma-informed practice as part of its treatment program. [20] Reflective of its treatment philosophy and the complexity of the children it serves, Riverview has established enhanced direct care staffing ratios. The facility provides a complement of professional personnel including psychologists, psychiatrists, social workers, rehabilitation therapists, occupational therapists and nurses. The facility also employs a dietician, pediatrician, and a speech and language pathologist. Dental services are also provided.

Laboratory tests and specialized medical procedures (i.e., MRI, EKG, X Rays) are provided when necessary either on-site or through agreements with other medical providers. The costs for these procedures are included within the rate structure for Riverview. The department's Unified School District (USD#2) provides K-12 instruction and special education services for all youngsters at Riverview Hospital *at no cost* to the child's local public school district.

In addition to providing direct care and treatment, Riverview has served as a teaching hospital for more than 35 years. Through its collaboration with the Yale Child Study Center and

[20] Specific treatment programs now in use at Riverview include Life Space Crisis Intervention, Dialectical Behavior Therapy and Trauma-Focused Cognitive Behavior Therapy.

University of Connecticut, Riverview administers a nationally-known child psychiatry residency program that trains up to seven residents annually. In addition, Riverview also offers professional internships as well as training programs for psychologists, social workers, rehabilitation therapists and nurses.

Admission Criteria

Children and youth treated at Riverview represent some of the most behaviorally, psychiatrically and developmentally complex children and adolescents within the state. Connecticut Behavioral Health Partnership "Level of Care Guidelines"[21] include a description of the characteristics of children and youth who can be admitted to Riverview. Each child admitted must meet "medical necessity" criteria for inpatient care and exhibit at least one of the following:

- A recent history of multiple inpatient admissions with minimal improvement in status
- A co-occurring developmental disorder that requires intervention not available in other inpatient settings
- At-risk behaviors that require a higher staffing ratio than that found on other inpatient units to ensure safety.

Most children admitted to Riverview have lengthy treatment histories that reveal not only the complexity and persistency of their challenges, but also the struggles of the existing provider community to safely and effectively meet their needs. As one example, 19 of the 212 youngsters admitted last year came directly from hospital Emergency Departments because no other inpatient unit in the State would admit them. In addition, a number of Connecticut children who were in out-of-state hospitals came to Riverview for stabilization and treatment of their mental health needs.

A closer look at admissions over the period September through December, 2010 adds to the emerging picture of youngsters currently being served by Riverview Hospital. Over this 120-day period, 31 youngsters were admitted from various other *inpatient psychiatric hospital* settings. Among these 31 youth, more than half (18) had three or more prior psychiatric hospitalizations. Twenty eight (28) had at least three diagnoses at the time of admission, and three-quarters had experienced physical restraint, mechanical restraint and/or seclusion during the psychiatric hospitalization that preceded their admission to Riverview.

Riverview also admits youngsters under court orders from the Juvenile Justice System.[22] Following an initial clinical assessment indicating that the youngster has significant and complex mental health issues, a judge can order pre-adjudicated adolescents to Riverview for a 30-day

[21] Online at -- www.ctbhp.com/providers/prv_locguide.htm

[22] These admissions are specified in statute as well as in a Memorandum of Understanding between the Department of Children and Families and the Court Support Services Division of the Connecticut Judicial Branch.

evaluation. Youth may also be referred directly from Judicial Branch Detention Centers with a court order when clinical assessment indicates that the youngster requires inpatient care. By statute, Riverview is also the only facility in the state able to conduct juvenile inpatient restorations to competency. During SFY 2009-10, five of these youth were admitted to RVH for restoration to competency.

Some youngsters admitted to Riverview will likely require services and support from other public agencies as they transition to young adulthood. These are youngsters who experience ongoing mental illness requiring services from the Department of Mental Health and Addiction Services (DMHAS) and/or mental retardation and other developmental disorders requiring specialized support from the Department of Developmental Services (DDS). Also engaged with other state agencies are youngsters with mental health problems who are involved with the juvenile justice system and require coordination with Court Support Services Division (CSSD), the Department of Corrections and DCF Juvenile Justice Services. As of March 31, 2011, 13 of the youngsters currently in residence at Riverview require transition to DMHAS or DDS.

Meet Nathaniel, Maria, Shane and Justine[23]

While data are essential, the faces of the children treated at Riverview Hospital tell another part of this story. In this report, we present four representative case summaries treated at the hospital over the past several years. Each is very briefly summarized below. Although a more detailed summary is presented as an appendix to this report, the following précis shows the dire circumstances that bring children to Riverview and the challenges the staff face in helping to reintegrate them into family and community settings.

Meet Nathaniel. Nathaniel is a 15-year old boy with severe intellectual impairments and autism. He is also hypoglycemic. He is six feet two and weighs 300 pounds. His behavior is mercurial, one minute happy and laughing but the next physically intimidating. Prior to admission at Riverview in February, Nathaniel had been cared for by his family -- his mother, father and three sisters. His behavior had, however, become assaultive, and with the aid of the local police, he was transported by ambulance to the Emergency Department of the local hospital where he was restrained and sedated. From there he was transferred to Riverview.

Nathaniel's mother visits at Riverview almost every night. She brings food from home, reads to him, and prepares him for bed. The discharge plan for Nathaniel is to go back home where many supports will be needed. As of April 6th, 2011 Nathaniel remains in residence at Riverview with a plan for return to his home with specialized supports for him and his family coordinated jointly with the Department of Developmental Services.

Meet Maria. Maria has been at Riverview five times, first when she was eleven years of age. She had a history of emotional abuse by her mother, who also voluntarily terminated her parental rights. Following placement at two separate instate residential treatment facilities, she

[23] All of these names are fictional. The youngsters are real.

arrived at Riverview inconsolable and actively suicidal. After a period of treatment, she was discharged to another residential treatment center. She became suicidal again, was admitted to a community-based psychiatric hospital, and then re-entered Riverview for the second time. Maria again improved and the Department found a family interested in adopting her. The process of visitation began but Maria became acutely suicidal. After some weeks, she was stabilized and placed in residential treatment.

This process repeated itself two more times. Maria returned to Riverview for the 5th time. Working with a psychiatrist she knows and trusts, she is doing well. She is in good academic standing as a 10th grader in the Riverview School. Maria has been referred to a specialized group home, from which – it has been recently reported – she has run away.

Meet Shane. Shane was admitted to Riverview in March of 2005 as a 12 year old. He came from a residential facility in Massachusetts where he had lived for 18 months. Since the age of seven years, Shane had experienced lengthy stays in four other psychiatric facilities.

When first removed from his mother in 2003, the Department learned that Shane had been sexually abused by an uncle and exposed to domestic violence. Family members on both sides of his family had a history of severe and prolonged mental illness, including schizophrenia and major depression. Shane has four siblings, one of whom also experienced serious mental health issues.

Shane had received inpatient hospital treatment at Riverview from March 2005 until September 2007, when he improved enough to go to a sub-acute unit on campus. Five months later, in February 2008, he was matched with a residential facility in South Carolina where he had family. In South Carolina, he was successfully transitioned from residential treatment to a foster family. He mother has moved close by and visits him regularly. Shane now attends school in the community.

Meet Justine. Justine was admitted to Riverview as a young teenager for the first time in 2005 for assaulting a staff member and a peer at a residential treatment facility. He is an older youth whose troubles began even before birth, when his father assaulted his mother during the pregnancy. Domestic violence continued in his early years, by both his father and then his mother's boyfriend. At the age of five, his ten-year old sister was killed in a car driven by his mother's boyfriend, who then assaulted her. When his mother attempted suicide, the Department of Children and Families removed Justine along with an older brother and sister. Removed to foster care, he was physically and sexually abused. A second set of foster parents treated him well but could not manage his aggressive behaviors. By the time he was 12, Justine had been in and out of psychiatric hospitals 20 times for aggressive and self-injurious behaviors.

After 90 days at Riverview, in 2005, he had recovered enough for discharge to a residential treatment facility. Recovery continued and he was reunited with his mother, but over the next 18 months, Justine was frequently suspended from school, did not take his medications and was then placed in four different residential facilities. In September of 2009, after being

arrested 22 times for assault, he was sentenced to the Department of Correction's Manson Youth Institute.

After 90 days at Manson, Justine bounced between residential and private psychiatric hospitalization due to aggression, paranoia, suicidal ideation and frequent flashbacks from his earlier trauma. He re-entered Riverview for the second time in April 2009. After months of treatment, he wanted to return home to his mother who had also undergone several years of recovery and treatment. He was able to return home where he remains today, with continued ongoing treatment for both himself and his mother.

Connecticut Children's Place

The Connecticut Children's Place is an unlocked congregate care facility located within a residential and commercial area of East Windsor. The mission of the Children's Place is to provide "short-term intensive therapeutic services to children/adolescents whose psychiatric and behavioral status places them or the community at risk."[24]

The facility has a total bed capacity of 36 to 42 depending how many youth share a bedroom. On average, 38 youngsters can be served on a daily basis. On campus there are four residential cottages, a clinical building, dining hall and an education building. Although established in 1883, the facility has been upgraded and modernized over time. In November of 2010, two cottages were closed to admission at the Children's Place in order for the facility to re-assess its program focus. One unit remains closed but staffed at the present time, and the youth population as of April 2010 is 17.

The current projected cost to operate the Children's Place in 2011 is just over $22 million. The facility currently employs 148 full-time and 32 part-time staff. The facility is not licensed by the department or an outside agency, nor is it accredited at the present time.

Children served by the facility range in age from 13 to 18. All are in the care and/or custody of the Department of Children and Families or have been accepted into the department's Voluntary Placement Program. Over the 2010 calendar year, the Children's Place served 77 youngsters, including 39 new admissions and 32 discharges. The average age at time of admission was 16 years, and all youngsters except two were 14 years of age or older. Thirty five (35) girls and 42 boys were served by the facility. Two-thirds of all youngsters served (52) were children of color.

Over calendar year 2010, all but four youngsters experienced an out-of-home placement immediately prior to admission to the Children's Place. Twenty-two (22) were referred from Riverview or other psychiatric hospital; 22 came from in- and out-of-state residential treatment

[24] *Connecticut Children's Place Advisory Council Report to the Commissioner of the Department of Children and Families.* February 2011, p. 2.

facilities[25]. The remaining youngsters were referred from foster or group homes (4), their own homes (4), detention and/or the Department of Correction (3), maternity homes or shelters (3) or other specialized settings.

On February 15, 2011 the Children's Place opened one cottage as an emergency unit for boys. This came as a result of extensive planning to define admission criteria and DCF area office need. The Emergency Cottage for boys provides short term (not to exceed 30 days) placement for up to 12 boys between the ages of 13-18. Access to these beds is restricted to DCF area offices and to the department's 24-hour Hotline program.

The Emergency Cottage provides temporary placement for DCF involved youth who require immediate placement in a safe, secure setting until a more permanent treatment/placement setting can be obtained. Youth served in this cottage may have just come into DCF custody through a 96-hour hold, or have disrupted from a foster home setting or are waiting for the next vacancy in another residential or group home setting that can better meet their needs. Over the past several months, no more than five of these beds have been occupied at any point in time.

Challenges and Progress

Both Riverview and Connecticut Children's Place have experienced periods within the past five years during which treatment and care have not been at acceptable levels,[26] and questions about the cost-effectiveness of each have been raised.

An extensive review of Riverview Hospital in 2006 conducted by the Office of the Child Advocate, the *Juan F.* Consent Decree Court Monitor, the department's own Bureau of Continuous Quality Improvement and the DCF Office of the Ombudsman revealed both strengths and weaknesses at the facility.[27]

Strengths included its attractive physical plant and the "dedication and creative potential of the majority of its staff."[28] This staff includes a high level of child care workers complemented by in-house professionals in the fields of psychiatry, psychology, social work, rehabilitation therapy and nursing.[29] "However," the report concludes, "…at this time these strengths have not adequately transferred into effective team work for staff and effective care for children across

[25] This number includes 8 youngsters who transferred from High Meadows, a Department of Children and Families congregate care facility closed in 2010.

[26] See the 2006 program review of Riverview Hospital and a recent report on the Children's Place by the Department of Children and Families licensure unit.

[27] See *Riverview Hospital for Children and Youth Program Review,* December 1, 2006. See also *Supplemental Recommendations to the Program Review* submitted by the Office of the Child Advocate on December 11, 2006.

[28] Ibid, p. 3

[29] Other strengths included individual staff members who support their peers and foster a team environment while working with children, the existence of a plan for on-unit trainers to assist staff in specialized behavior management training, and the creation of "traditions and rituals which most children and staff can attend and participate in…" (p. 7).

all of the eight units in the hospital. While currently unfulfilled these strengths do represent potential for effective teamwork and care for children in the future."[30]

Its challenges, as called out in the report, were significant. Some units were markedly more effective than others in meeting the needs of children and youth at the facility, resulting in the uneven and often siloed delivery of treatment from one unit to another. Some units were more effective in minimizing the use of "rigid, behavioral control focused approaches."[31] Beyond problems across units, a fractured system of relationships was described, between staff and the administration as well as between staff across the various disciplines.

The highly complex needs of the youngsters that they serve, complicated by significant trauma in the lives of these children, result in high levels of trauma among staff themselves. In part due to the highly variable roles of clinical staff across units, unit staff members were often found to be "'flying blind' in trying to work with very complex children without any real understanding of these children."[32]

Finally, the report found a "significant degree of paralysis in the ability to implement change."[33] "For the majority of the hospital's units there are persistent patterns where problematic incidents and issues involving both children and staff are repeated with a limited ability for the units to independently self correct, or for the hospital systems to address."[34]

The Program Review made in excess of 100 recommendations (105) for improvement. In addition, the Office of the Child Advocate issued 15 additional recommendations related to agency leadership (8 recommendations) and specific to Riverview itself (7 recommendations). In March 2007, the current Superintendent of the Riverview Hospital for Children and Youth – Joyce Welch -- was appointed on an interim basis. Her appointment was made permanent in October of 2007.

Superintendent Welch has effectively overseen a series of improvements over the past four years, anchored in the 2006 Program Review recommendations. These include development and implementation of a strategic improvement plan with annual progress updates[35] and a dramatic increase in the use of trauma-informed training for staff and its infusion into therapeutic practices for the children and youth served by the facility.

[30] Ibid, p. 3
[31] Ibid, p. 3
[32] Ibid, p 4
[33] Ibid, p. 3
[34] Ibid, p. 3
[35] The strategic plan includes the following sections: Mission Statement; Riverview's Goal for the Future; Statement of Values; Areas of Focus; Staff Competencies and Organizational Development; Building Partnerships; Improving Treatment. In addition, each year Riverview Hospital staff members prepare an annual report. The latest, for 2010, is available from the superintendent upon request. It is not posted online.

During this period, there has been much stronger cross-unit cohesion and continuity of practice along with vastly improved staff satisfaction and a sense of competence. Finally, Riverview Hospital has dramatically reduced the use of restraint and seclusions, eliminated mechanical restraints for all children aged 10 and younger, and is on the verge of total elimination of mechanical restraint for all youngsters served by the facility. (See Part III for data.)

With regard to issues of cost-effectiveness, the department is currently conducting a comparative analysis of the cost of services included in the daily rate of Riverview Hospital and private inpatient hospital services. A first step has been to identify the amount of annual revenue returned to the Connecticut General Fund as the result of Medicaid billing and billing to a patient's or family's private insurance. That annual amount is approximately 10 million dollars.

The second step has been to create a rubric for disaggregating component elements in the Riverview daily rate and comparing these component parts (not billable to Medicaid or Private Insurance) across services. Comparison institutions are the inpatient psychiatric services provided by the Connecticut Children's Medical Center/Institute of Living in Hartford, St. Francis in Hartford, and St. Raphael Hospital in New Haven. Data of this type have been of interest in the past and, yet, difficult to develop as access to the information requires collaboration between public and private inpatient psychiatric facilities and hospitals.

It is anticipated that the active interest in developing a long-term program of services for Connecticut's children and youth with extraordinary mental health and behavioral needs will motivate both the public and private sectors to collaborate in the collection and analysis of this important data. The Department of Children and Families is enthusiastic about partnering with the Connecticut Hospital Association to secure this information.

By the October 1st report, fiscal analyses will be complete. They will include:

- Results of any additional analyses required under proposed legislation being deliberated on now by the Connecticut General Assembly
- Analyses of state cost savings resulting from this proposal to consolidate facilities and restructure half of the units for specialized services at lower staffing levels.

Finally by October 1st, the department will determine – with the Department of Social Services and the Governor's Office of Policy and Management – what federal Medicaid reimbursement strategy makes most sense for use with the consolidated behavioral health institution.[36]

[36] The State of Connecticut currently receives federal Medicaid reimbursement for Medicaid-enrolled clients who receive services at Riverview Hospital. DCF will engage formally with the Department of Social Services to examine the cost vs. fiscal return of pursuing obtaining Medicaid reimbursement for youth in the six step-down units where staffing required for reimbursement may be dramatically higher than needed to serve the target population.

Part II: Transforming the Department of Children and Families: Core Changes

Mission Clarity

In a posting on February 24, 2011 to all agency staff and interested citizens – just 45 days into her term as the department's new commissioner -- Justice Joette Katz presented a reframed mission for the entire agency. "Our goal is for all children in the care of the Department to be healthy, safe, and learning. We want them to experience age-appropriate growth and development, to advance their own special talents, and find opportunities to give back to their communities. We also want them to be successful in and out of school."[37]

This statement more completely matches the department's 1987 mission as presented earlier in this report and reflects the intent to move away from a singular focus on safety to a more complete view of the whole child and a more comprehensive and developmental emphasis on health, safety and learning.

In addition, the department will focus agency-wide efforts to strengthen the vital roles that families play in the lives of all children. Central to this is implementation by December of 2011 of a new Practice Model, developed with national technical assistance. This model is focused on true family engagement, the identification of family strengths in addition to risks, and a more respectful agency posture towards families. This includes, for example, replacing unannounced visits with a phone call to families to announce a visit from a departmental staff member. The department will also adopt and implement a new Differential Response System over the next 24 to 36 months. For low risk cases, the Differential Response System will move the department *from* a focus on investigative, child protection services *to* a focus on voluntary services and new partnerships with natural family supports at the community level.[38]

Service Delivery Teams, Not Silos

Early in February, 2011 Commissioner Katz directed agency leadership to take down silos that have existed between bureaus and begin to build a collaborative leadership team model for the DCF Central Office. This constitutes a significant driver for the internal Central Office realignment now underway. To replace siloed bureaus, three new teams have been established and the existing Training Academy, originally focused quite exclusively on child protection issues, has been re-established and broadened as the agency-wide DCF Academy for Workforce Knowledge and Development.

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[37] *An Update to All Staff: Commissioners' Corner*. February 24, 2011. Online at -- www.ct.gov/dcf/lib/dcf/homepage/pdf/chronology_of_change_commissioner_katz.pdf

[38] For more information, go to -- www.childwelfare.gov/pubs/issue_briefs/differential_response/differential_responsea.cfm

One team – Clinical and Community Consultation and Support -- will focus on expanding the use of evidence-based clinical and community support programs, including community congregate care programs. In addition, this team will:

- Host "communities of practice" for clinical professionals assigned to the agency's regional offices and its institutions
- Guide the expansion of attention to children's health[39], the development of a strategic plan for children with complex medical and health needs, and
- Initiate an expanding engagement with the Behavioral Health Partnership. [40]

The second team – Child and Systems Development, and Prevention -- will expand the application of the latest science on child and adolescent development to all agency operations. This will include close attention to early childhood brain development as reported by the Harvard Center on the Developing Child.[41] In addition, this team will:

- Guide improvements in agency-wide foster and adoptive outreach and support implementation of the Strengthening Families Practice Model in the regions
- Promote cross-agency systems development in such areas as homelessness
- Develop new relationships with local school systems
- Advance attention to disproportionate minority representation and gender-specific program development
- Support the expansion of youth work and learn programming as well early childhood investment.

The third team – Residential Treatment and Institutional Services – has been organized to focus on the nearly 1,000 Connecticut youngsters being served by residential and institutional programs in and beyond Connecticut. This group of programs shares two core characteristics: (a) they are intended for short, time intensive treatment, and (b) they are *not* community-based residence programs. Over the coming 12-24 months, this team will lead a comprehensive review of all placements and programs in order to advance the process of performance contracting. The team will also provide oversight for the department's institutions and guide the application of data-driven accountability, program improvement and new program development related to both residential and institutions services. The superintendent of the consolidated behavioral health institution (Riverview and the Children's Place) and of the Connecticut Juvenile Training School are members of this team.

[39] Cite from Academy and children's services Malloy report
[40] Additional information is available at the CT Behavioral Health Partnership, online at -- www.cga.ct.gov/ph/BHPOC
[41] Online at -- //developingchild.harvard.edu

Building Regional Systems for Children's Health, Safety and Learning

The department operates with five regions and 14 area offices. In order to implement the broader goal of the department – that is, advancing health, safety and learning of all children in the care or custody of the agency, or receiving services as the result of agency funding – the agency will move to an expanded regional structure capable of supporting and coordinating a comprehensive "systems of care" model.[42]

The expanded structure will provide many doors to service entry and will include increased use of interdisciplinary teaming in both assessment and intervention. It will focus specific attention on the early years of childhood and on development of new collaborative relationships with natural family support organizations and with agencies that receive DCF funding. The regions will more completely use data on child and family outcomes to determine service needs and usage, will increasingly focus on protective as well as risk factors, and will be linked more effectively to both the central office and the department's facilities.

Each of the department's regions will be led by an individual hired into a new unclassified position called Regional Director.[43] In addition, a number of staff from the department's central office and its institutions will be reassigned to the regions. These reassignments will include parole workers now managed centrally along with additional nursing/health and educational staff.

Realigning Agency Institutions

Results of our first review of agency institutions are reflected in this report and its proposal to consolidate the agency's two behavioral health facilities. Upon completion of the October 1, 2011 implementation report, attention will be directed at a review of the current operations of the Connecticut Juvenile Training School.

Building the DCF Academy for Workforce Knowledge and Development

The new DCF Academy will build upon and expand the agency's original Training Academy to include the separate DCF provider academy directed at outside agencies serving children and youth as well as the Grand Round process now in place at Riverview Hospital for Children and Youth. New partnerships with the public and private higher education sector in Connecticut will be established. The new Academy will be co-led by two highly respected department

[42] There is a rich literature on systems of care, including increased attention to financing strategies. See in particular, Effective Financing Strategies for Systems of Care: Examples from the Field, 2nd Edition. This report, by the Research and Training Center for Children's Mental Health, is available online at -- //rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/Study03-exp-fr-field.pdf

[43] The job classification for Regional Director is currently being authorized by the Connecticut General Assembly. The position of Service Area Director will be eliminated upon selection of the departments' new Regional Directors.

professionals who will model collaborative team leadership as part of the department's transformation.

The new framework for knowledge development and learning will integrate cross-disciplinary expertise (including child welfare, children's mental health, restorative juvenile justice, domestic violence and family substance abuse) through a public-private partnership framework. It will utilize a higher education "faculty" model that includes a core of full time DCF faculty along with an expanding corps of adjunct faculty members invited from both the public and private, state and community service and management sectors.

Several core areas for increased attention have already been identified. These include:

- The expanding neuroscience of child and adolescent development
- Expansion of family-centered engagement, the Strengthening Families Practice Model, trauma-informed practice, and agency-wide change management
- A focus on regional implementation of the Differential Response System
- Attention to improved supervision competencies, the expanded use of data to improve client outcomes and agency strategic planning
- Knowledge development and support for the agency-wide implementation of a Results Based Accountability process

Part III: Ten Steps Forward

Step #1: Administrative Consolidation of Riverview and the Connecticut Children's Place

The Department will create a management structure that consolidates the administration of Riverview Hospital with that of the Connecticut Children's Place, a second behavioral health facility operated by the department. This new entity will be administered by a single superintendent and will be renamed. A single Medical Director -- in cooperation with consolidated leadership over operations, nursing and residential services -- will assure continuity, quality and accountability for clinical services provided across the consolidated institution and will report directly to the superintendent of the newly consolidated entity. This action is being implemented now.

Rationale: Several challenges and opportunities make this the appropriate time for the department to consolidate individual institutions that share a common therapeutic purpose, to:

- Assess, stabilize, and treat youngsters using evidence-based interventions for children and youth , and
- Improve the process of transition and discharge planning, whether back to a family or community setting, or to a residential treatment facility.

Several challenges and related opportunities exist. First, the current statewide fiscal climate requires delivery of the most cost-effective taxpayer-supported services possible. We believe that cost-savings can accrue through the consolidation and/or improved coordination of common leadership, management and core facility functions (e.g., human resources, data services, maintenance and the purchase of materials and supplies).

Second, both facilities will experience the loss of current senior management by June 1st, due to retirements and the conclusion of durational assignments, and prior leadership vacancies have been difficult to fill. Through the consolidation of key leadership positions across the two facilities, including that of Superintendent and Facility Medical Director, we will require fewer positions and, at the same time, strengthen these critical leadership, management and accountability roles. Recruitment for superintendent of the consolidated institution is underway.

Third, reviews previously referenced in this report have revealed fragmentation and a lack of therapeutic focus in each facility at different times over the past five years. Riverview has addressed this issue substantively while the Children's Place has not. Appointment of a single clinical leader will strengthen the coherence of clinical practice.

Step #2: Coordinated Pediatric Services, including the Connecticut Juvenile Training School

Step #2: Pediatric services offered by the consolidated institution and the Connecticut Juvenile Training School will be fully integrated. This will begin in July 2011.

Rationale: At the present time, two full-time pediatricians and one part-time pediatrician staff the three facilities serving a total of some 250 children and youth. One of these physicians will retire in June, 2011. By coordinating the delivery of these services at the newly consolidated institution with the Connecticut Juvenile Training School, an appropriate level of service can be provided without refilling this position. Of note, dental services are already shared between Riverview Hospital for Children and Youth and the Connecticut Juvenile Training School.

Step #3: Inpatient and Specialized Units Matched to Unmet Needs

The new consolidated behavioral health institution will operate with six inpatient hospital units at the Riverview campus and six specialized treatment units, two at Riverview and four at the Children's Place campus. The six specialized units will operate at a lower level of treatment than provided at the inpatient hospital units. Across the consolidated institution, discharge planning will begin early in the assessment and treatment process. Planning for this realignment has been guided by an analysis of unmet needs of children and youth with complex medical and behavioral needs. A 12-month process of implementation will begin within the next 120 days.

Background: Several data analyses recently completed or currently underway have led to the proposal for establishing two levels of care and treatment at the newly consolidated institution. Information is organized and presented below related to each of the three changes proposed.

Reducing Riverview Hospital inpatient bed capacity

Riverview Hospital includes eight inpatient units,[44] which have an average census of 66 youngsters. Under this proposal, the number of inpatient hospital units will decrease to six, and the total capacity of the six units will range between 62 and 68 beds. Better utilization of existing units will allow the facility to serve the same (or slightly more) youngsters for inpatient treatment while reconfiguring two units for lower level treatment as described below.

Several specific actions will be required as this planed unit reduction is implemented. First, the department will collaborate with the Court Support Services Division and detention centers operated by the Judicial Branch as well as private inpatient hospitals and emergency departments to assure that a backlog in placement capacity does not occur in any of these settings. Second, because more efficient assessment, discharge planning and timely transition to the next level of care will be necessary, the Department will also engage more fully with the Behavioral Health Partnership to ensure timely access to community services/settings. This will

[44] As noted earlier, the Quinnipiac unit has been closed for admissions for the past year.

help to prevent an increase in discharge delay from the institution. Third, initial priority for admission to Riverview's two step-down/ lower level treatment units (see below) will be accorded current patients to prevent out-of-state placement.

Establishing two lower-level units on the campus of Riverview

One target population being considered for treatment at one or both of the less intensively staffed units would be adolescent girls with complex psychiatric and behavioral needs. The program could provide an in-state placement option that is centrally located, trauma informed, gender responsive, culturally sensitive and family centered. By better utilizing existing staff and physical plant resources, more cost effective care can be delivered.

Justification for developing this option stems from the fact that there are 29 adolescent girls currently in out-of-state placement, 16 of whom are placed out of state due to their complex psychiatric needs. At the present time, Connecticut does not have the in-state residential capacity to effectively treat this population.

Girls targeted for this program will need to be of average intelligence in order to benefit from the cognitive behavior therapy approach that will be utilized. Length of stay will be from 120 to 180 days, with priority placed on return of the girls to their communities or to a lower level of treatment. To prepare further should this redesign proposal advance over the coming 120 days, staff from Riverview will seek guidance and consultation from two of the facilities in Massachusetts effectively caring for this group of girls now, capitalizing on their expertise and replicating it here in Connecticut.

Establishing four lower-level treatment units on the campus of the Children's Place

To begin this analysis, the department created a master listing of all DCF children and youth placed in residential treatment facilities, both in- and out-of state as of early March 2011.[45] That data coupled with other residential treatment reports[46] and subsequent analyses reveal information about the capacity of programs and the characteristics of children receiving services in residential treatment facilities.

Of note, the number of youngsters in residential treatment funded by the department has dropped significantly from 2004 through 2011 – from 965 to 625.[47] Of these, 352 were in out-of-state residential treatment facilities in March 2011. Also, over the past seven years the number of in-state residential treatment beds has been reduced by some 450. This is due

[45] These data were collected and analyzed by Dr. Peter Mendelson, Department of Children and Families, in early March 2011.

[46] *Department of Children and Families (Out of State) Residential Treatment Analysis*, March 2009; the Connecticut Behavioral Health Partnership's *Riverview Data Report* (including data from 2008 through the 3rd quarter of 2010);

[47] Mendelson, March 2011, op cit.

largely to issues of quality, the acuteness of needs of youngsters being referred and/or fiscal concerns.[48]

Analysis by age: Among these youngsters in out-of-state residential treatment facilities, 37 are twelve years of age or younger. Twenty-seven are males; ten are females.

Most are child welfare cases (26), but eleven have been placed in out-of-state residential facilities through the department's Voluntary Placement program. For nearly two-thirds of these children (23), reunification with their families is the current plan.

These 37 youngsters fall into three diagnostic clusters:

- Children with problematic sexual or fire setting behaviors (n=6)
- Children with severe cognitive limitations or pervasive developmental disabilities (n=17)
- Children with severe psychiatric disorders (n=14).

Because planning for younger children should focus on family-based alternatives, the department will re-focus on the development of therapeutic foster care for these and other children with complex mental health, behavioral or developmental needs who cannot be returned to their biological families. This proposal for development of four treatment units on the Children's Place campus, therefore, does not address the needs of this group of children.

Older youth (young adults) constitute 36% of the 352 out-of-state placements, 125 youngsters. Among these, 96 are young men and 29 are young women. Nearly two-thirds are child welfare cases (82), 22 are voluntary placements, and 14 were placed because of juvenile justice involvement.

These 125 older youth fall into five diagnostic clusters, shown below along with the numbers of youth in each category by gender.

Diagnostic Cluster	Males	Females	Totals
Youth with problem sexual behaviors or who start fires	34	1	35
Youth with severe cognitive limitations or pervasive developmental disorders (autism)	21	10	31
Youth with conduct disorders and juvenile justice involvement	16	2	18
Youth who are substance abusers	3	0	3
Youth with severe psychiatric disorders	22	16	38
Totals	96	29	125

[48] Mendelson, March 2011, op cit.

Because many of these young adults will require treatment, support and/or supervision by adult agencies, their needs are discussed in Step #7 later this report. This group is not being considered as a target population for the four lower-level treatment units in the consolidated institution.

Analysis by diagnostic category: Not unlike the needs of youngsters reported in the 1989 children's mental health plan cited earlier in this report,[49] the clinical needs of youth placed in out-of-state residential treatment facilities fall into five clusters.[50] These are youth with:

- Problem sexual behaviors
- Aggressive behaviors and conduct disorders
- Aggressive behaviors and co-occurring major psychiatric disorders
- Cognitive limitations and/or autistic spectrum disorders
- Substance abuse problems.

"Youth who are placed out of state have generally had at least one, in many cases several, and in some cases more than a dozen failed placements since entering care."[51] For 15% of all youngsters currently in out-of-state residential placement, current length of stay is in excess of 700 days.

Eliminating both younger children and young adults from consideration, the target population for the four treatment units is likely to be drawn from youngsters ages 13 through 16 who have complicated mental health, behavioral or developmental needs.

Step #4: Linkages with the DCF Regional Services Offices, Families and Community Services

Stronger linkages will be established and maintained between the consolidated institution and the department's regional service areas, which are also undergoing realignment and transformation. Areas of collaborative work include the agency-wide adoption of a framework based on strengthening families, making community connections, expanding access to multi-disciplinary teaming and trauma informed practice, and continued emergency access to facility services. There also will be renewed attention to gender and cultural responsiveness. This work has begun and will occur over a 24-month period.

Rationale: In the past, there has been a systemic disconnect between the department's institutions and its regional and area offices. Yet, because families are at the center of children's growth, development and recovery from illness, the development of creative approaches to identifying, educating and supporting caregivers is essential to the work of all agency facilities. In addition, department facilities must be much more directly connected to the community

[49] See Part I, which identifies these populations as underserved in the 1989 children's mental health plan, *Carlos Rodriguez is Waiting*

[50] Note: Most of the agency's data systems continue to use the category "mental retardation". In this report, the terminology of "severe cognitive limitations" is used. This terminology better reflects the current ways in which persons with mental retardation are described.

[51] Mendelson, March 2011. Op cit

sector, which can, with help, better prevent out-of-home placements and promote the return of youngsters following residential treatment.

From a facility perspective, teaming with DCF area office staff must occur at the time youngsters are admitted to Riverview/Children's Place. Regional staffers help identify resources within the immediate family and, as needed, identify or recruit therapeutic foster care and other resources necessary for discharge. Once families are identified, DCF institutional staff can help to educate caregivers and regional staff about the child's condition and provide the tools and techniques necessary to manage behaviors and promote health outside of the inpatient therapeutic environment. These tools and techniques could include home-based interventions or on-site consultation with staff who will be assuming post-discharge care to assist with the transition from inpatient to home care or to the next level of care. Discharge planning, begun at the time of admission to the consolidated institution, will greatly assist in this collaborative, team-based process.

In addition to improvements in the discharge planning and team processes noted above, staff from the consolidated institution will promote linkages with DCF offices and community providers through:

- The provision of and participation in joint training opportunities hosted by the DCF Academy for Workforce Knowledge and Development, with a focus on trauma-informed practices (See also Step #8 below)
- Examination of the tools, assessments and practices included within the Strengthening Families Practice Model for adoption within the institution
- Consultation on difficult or multi-disciplinary assessments directed at individual children and youth
- Consultation with community providers (including community congregate settings) to inform delivery of an effective therapeutic practice and policy.

Step 5: Residential and Institutional Services within a Continuum of Placement Alternatives

Administrative oversight of the consolidated institution is assigned to the department's new Residential/Institutional Team in Central Office. Leadership of this team will be responsible for strategic planning and program development across Connecticut's residential/institutional treatment sector and for assuring strong linkages between this sector, the department's new behavioral health entity and community settings to which children will return.

Rationale: Much work has been done across the nation in the development of systems of care for children, youth and families with mental health or behavioral challenges, especially from a community-based perspective.[52] Here, we focus on strategies that will be utilized over the next 12 to 24 months to create a continuum of residential and institutional treatment alternatives

[52] The federal Substance Abuse and Mental Health Services Administration has organized and chronicled many of these online at -- //store.samhsa.gov/list/series?name=Systems+of+Care+and+Sistemas+de+Cuidado

designed to best meeting the needs of Connecticut youngsters with complex mental health, behavioral and developmental needs.

Data for this strategic planning and accountability work will be derived from a new level of partnership and transparency between the consolidated institution, the Connecticut Juvenile Training School, Connecticut Behavioral Health Partnership and Value Options, representatives from in-state residential treatment facilities and Central Office teams and individuals.[53] While focused first on residential and institutional treatment services, the larger goal will be articulation of a "system of care" that includes community family and congregate settings, outpatient services, educational and developmental programs at the community levels.

The first phase of this work will be designed and managed by the new Residential and Institutional Services Team described in Part II of this report, and will begin upon selection of the Team Leader and the new superintendent at the consolidated institution. A proposed work plan will be in place by the end of August 2011 for inclusion in the October 1 implementation report.

Step 6: Continued Residency Training Opportunities

As a teaching hospital for the past 35 years, Riverview will continue its current relationships with institutions of higher education, including Yale University and the University of Connecticut, with whom it shares joint residency and training programs. The Department will seek to more fully leverage the assets of Connecticut's public and private institutions of higher education. These discussions are currently underway.

Background: Riverview collaborates with Yale Child Study Center and University of Connecticut to train Child Psychiatry Residents. These child psychiatrists then serve the most complex children and adolescents not only in the State of Connecticut but around the country. All of the child and adolescent psychiatrists at Riverview Hospital play an integral part in teaching and training, as well as providing critical psychiatric services. Riverview also trains Post Doctorate Child and Adolescent Psychology Fellows each year in collaboration with Yale. This represents another specialty area of which there is a shortage in Connecticut.

Riverview collaborates with the University of Hartford by offering an internship opportunity to four of their masters' level students in the PhD Psychology Program. These students, under close supervision, are provided opportunities to strengthen their clinical work and psychological testing skills to prepare them as they continue on towards their PhD.

Riverview has historically been a teaching hospital for graduate level social work students. Masters' level students from the University of Connecticut, Southern Connecticut State

[53] Staff across the department will be engaged in this work, including representatives from the Planning and Quality Assurance units, from administrative, fiscal and information systems units, from the DCF Academy for Workforce Knowledge and Development, and from the other two teams on the operational side of the agency, described earlier.

University, Fordham University, Springfield College and Smith College School for Social Work and St. Joseph College have graduated from Riverview.
Most recently, Riverview has served as a placement for Naugatuck Valley Community College nursing students' clinical rotations. Occupational Therapy students from Quinnipiac University have also been placed at the hospital. In addition, Riverview has also supervised students in the Rehabilitation Therapy field with specialties in music therapy and art therapy.

Step 7: Strategic Interagency Planning and Coordination

The Department will work more strategically with other state agencies that provide children's and adult services for persons with continued complex behavioral and medical needs. This will assure a seamless and timely transition of children and youth from our system to the various state agencies who will serve them. This work, already in progress, will be formalized by October 1, 2011.

Rationale: Many youngsters served at Riverview now require coordination of care and transition planning across several agencies. At present, 13 youngsters currently at Riverview Hospital (and many more over the past year) have been identified by DCF as likely to require continued mental health services or developmental supports as they transition to adulthood. A great deal of coordination activity is focused in the following four areas:

- Youngsters with serious and persistent mental illness who may require services from the Department of Mental Health and Addiction Services (DMHAS)
- Youngsters, like Nathaniel, with mental retardation or other cognitive deficits and developmental disorders who will be best served by the Department of Developmental Services (DDS)
- Children and youth with complex special education needs who require policy level coordination with the State Department of Education (SDE) and ongoing services from local school districts
- Youngsters in the juvenile justice system with ongoing mental health problems that require coordination with the Court Support Services Division (CSSD) of the Judicial Branch, the Department of Corrections (DOC) and the DCF Connecticut Juvenile Training School.

In these cases, DCF area office, central office, and Riverview Hospital staff work closely with DMHAS, DDS, local educational authorities, and CSSD to improve the screening, identification, referral, and transition of youngsters from one agency to another. There is a particularly important need to develop interagency care plans and then troubleshoot barriers to timely discharge from the hospital. If discharge agreements are not timely or essential services are not available from partner agencies, hospital discharges are delayed.

This resulting "gridlock" has several effects. First, young people are held at Riverview longer than their treatment needs require. Second, other children who need admission to the institution are delayed because beds remain filled with youngsters who should be moving on. Beyond better coordination related to individual youngsters and their current and future needs across agencies, there is a significant need for improved joint strategic planning across agencies to develop long-range projections of population needs over time. For example, by jointly tracking the emergence of increased numbers of younger children along the autism spectrum, it will be possible for the State of Connecticut to project its residential and family support needs over time. Steps in this process should include:

- *Earlier* identification and screening of children and youth potentially eligible for DMHAS or DDS services through streamlined processes and interagency agreements regarding assessment instruments and acceptance criteria.

- Formal early determination of which agency is responsible for immediate and future service planning.

- Assessment of strengths and needs that includes the identification of key people in the child's life who can participate in child-centered planning and the active inclusion of these people in the process.

- Maintenance of a complete placement history along with cross-agency access. This history should include documented child, family and community success upon which to build.

- Identification of permanency goals with specific services and supports designed to increase the likelihood of continued community, rather than eventual institutional, placement.

- Development of common quality assurance and case management processes to increase cost-effective service delivery and care coordination across agencies.

Achieving these client-specific and interagency system goals will require enhanced Memoranda of Understanding, more complete data sharing across agencies, better alignment of service systems, structures to support troubleshooting where processes have bogged down, and improved monitoring and accountability. This type of work is ongoing but needs to be accelerated for both individual clients and for systems improvement. It has been accorded a level of urgency and importance by the new leadership now in place across state agencies. Responsibility for leading this work on behalf of DCF clients rests with the Clinical and Community Consultation and Support Team in the department's Central Office.

Step 8: Partnership with the DCF Academy for Workforce Knowledge and Development

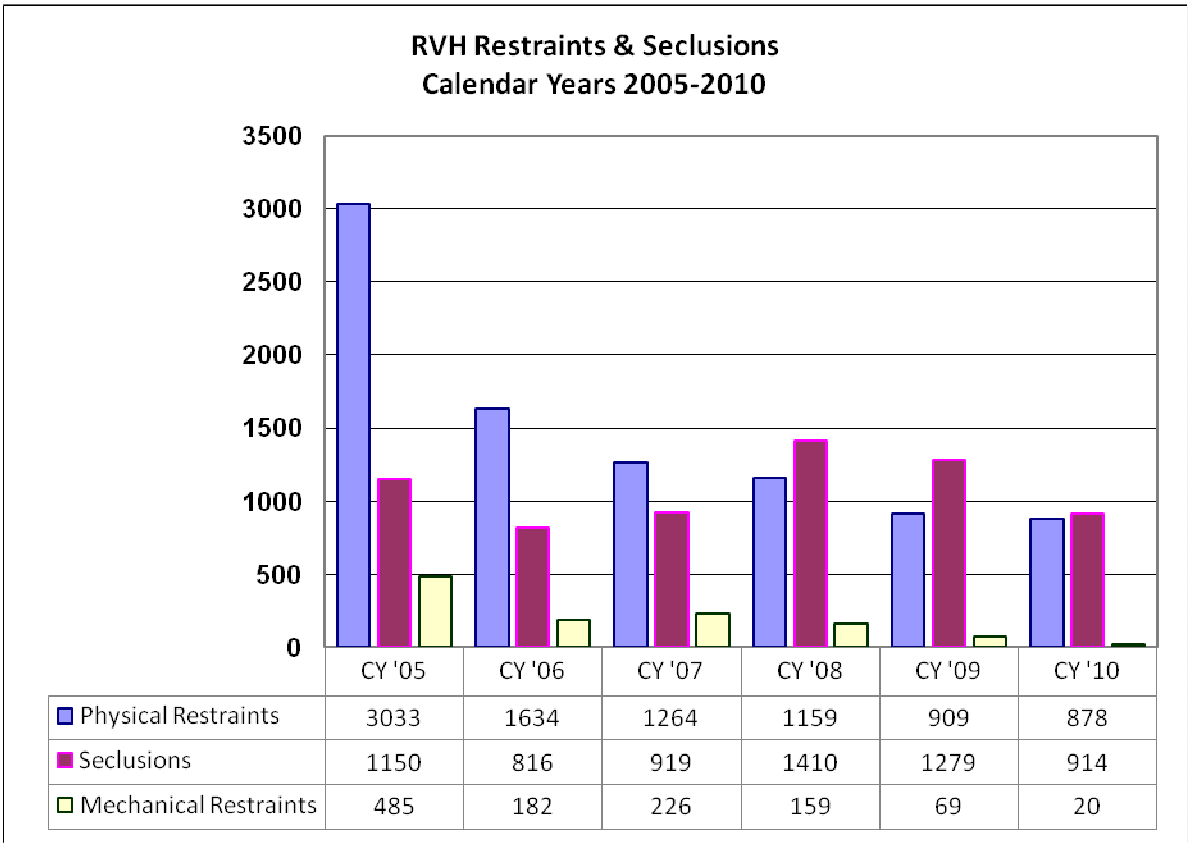
Staff from the consolidated institution will participate in the new DCF Academy for Workforce Knowledge and Development as both teachers and learners. Opportunities will include adjunct

faculty appointments and expanded grand rounds. Joint workforce development opportunities will also be available to DCF regional agency personnel and private providers who serve children pre- and post-inpatient treatment. This work – described earlier in this report -- has already begun and involves the new leadership of the Workforce Academy in partnership with training leaders at both Riverview and the Children's Place.

Step 9: Policy and Practice: Reducing Restraints and Seclusion through Trauma-Informed Practice

The department will finalize policy and practice guidance related to its continued reduction in the use of restraints and seclusion for children and youth served at the consolidated institution. This will incorporate the department's expanded use of trauma-informed practices and will be finalized by October 1, 2011.

Background: As referenced earlier in this report, Riverview Hospital has embraced trauma-informed practice which, among other benefits, has led to a marked overall reduction in restraints and seclusions across the hospital over time. These data do reveal, however, that more remains to be done.



	CY '05	CY '06	CY '07	CY '08	CY '09	CY '10
Physical Restraints	3033	1634	1264	1159	909	878
Seclusions	1150	816	919	1410	1279	914
Mechanical Restraints	485	182	226	159	69	20

Step 10: Implementing Results Based Accountability

The Department will apply the principles of *Implementation Science*[54] along with a Results Based Accountability framework agency-wide. These management tools will be implemented over the coming 24-36 months, incorporating data on child and youth outcomes as well as service delivery to improve performance at the consolidated institution.

Rationale: Agencies statewide are moving to adopt the Connecticut General Assembly's Results Based Accountability (RBA) framework to design and present budget information. The Department of Children and Families has begun this work in selected areas of service and the Legislative Program and Investigations Office has utilized an RBA framework to study several agency programs and functions. The department estimates that it will take no less than 24 months to train for, coach on and employ the RBA-framework throughout the agency.

To guide this process, agency leadership will convene a RBA working group and lodge responsibility to guide development jointly under the Deputy Commissioner for Administration and the new DCF Academy for Workforce Knowledge and Development. A first position within the department has already been reallocated to support the working group. This person is now assigned to the Academy. In addition, staff members are self-selecting to attend ongoing sessions of the statewide RBA Practitioners Network, led and supported by the Charter Oak Group.

A Results Based Accountability approach will be incorporated into work related to the consolidation of the Riverview Hospital for Children and Youth with the Connecticut Children's Place as proposed within this report.

[54] Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M. and Wallace, F. 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. 2005 (FMHI Publication #231)

Part IV: The Work from April 15 through October 1, 2011

Implementation Steering Committee

Following the receipt of comments on this report (requested by April 30, 2011), the Department of Children and Families will establish an Implementation Steering Committee to assist the department and the Riverview/Children's Place Administrative Team. Membership will be diverse and will include individuals from both inside as well as outside of the Department. The Connecticut Child Advocate will be included as a member, and the Connecticut Department of Social Services will be consulted to assure that all issues related to Medicaid reimbursement are addressed.

Tasks of the Implementation Steering Committee will include:

- Reviewing additional data that may be required by key stakeholders or by statute
- Identification of changes in policy, program and practice changes that will arise from the consolidation of Riverview and Children's Place
- Assistance in the decision-process related to target populations for the six new lower-level units, and
- Recommending client and performance benchmarks and data necessary to implement an automated, data-rich, facility-wide quality assurance process, track progress, identify challenges, and improve accountability for outcomes.

Key Benchmarks for the Period from April 15 to October 1

1. Create and begin to implement a Consolidation Plan (On or before June 15, 2011) that will:

    - Outline administrative reporting structures and processes for the consolidated Riverview/Children's Place entity
    - Specify the functions that are to be consolidated and those that remain specific to the six inpatient hospital units and the six lower-level treatment units
    - Propose an implementation schedule to guide admission of youngsters to the six lower-level units
    - Include an assessment of current staffing and identify process to address any labor concerns that may arise
    - Complete an assessment of data collection resources, develop a database and specify data points assist the facilities in measuring child and youth outcomes
    - Describe ongoing infusion of trauma-informed policy and practice at the consolidated institution
    - Establish an admission process for all new admissions to the consolidated institution, beginning May 1, 2011. Each youngster's treatment plan will be immediately reviewed upon admissions and throughout the period of treatment to assure its alignment with

the intent and elements of this report (eg., family-centered, trauma-informed practice, discharge planning early in the case process).

As part of the planning process, the Department and the administrative team of the consolidated behavioral health institution will collaborate with key members of referring agencies and departments to identify potential obstacles with reducing inpatient bed capacity at the facility. This will involve discussions and planning with CSSD, juvenile judges, the Behavioral Health Partnership and private inpatient hospitals and emergency departments.

2. Coordinate pediatric services across DCF Institutions (Beginning July 1, 2011)

3. Report on policy and practice Issues related to the Regional Offices (On or before September 15, 2011)

   The Implementation Steering Committee will conduct an assessment of the facility's strengths and weaknesses in relation to family engagement, improving relationships with community agencies, and supporting multi-disciplinary treatment teaming at the regional level. This will include outreach to family members, community and other referral agencies and/or departments, area offices and youth. Recommendations will be included in the October 1st report.

4. Formal clarification of agency policy related to the use of restraint, seclusion and the involvement of police in treatment situations (On or before October 1, 2011)

   The department will adopt policy and practice prohibiting mechanical restraints for children ages ten years and younger, and will support and assist in other statewide initiatives to reduce restraints, seclusions and other restrictive interventions with children and adolescents. The new consolidated institution will develop a plan to decrease and eventually eliminate floor restraints. In addition, the department will review the role of police in the milieu therapy in all units of the combined institution.

5. Interagency planning, data analysis and transfer agreements in place (e.g. with DMHAS and DDS) for youngsters with complex mental health, behavioral and/or developmental needs (Due on or before October 1, 2011)

   A multi-agency committee will review deficiencies in planning and coordination of services between state agencies. This committee will be called upon to develop a strategic plan that focuses on steps to correct areas of concern and to strengthen interagency collaboration.

Appendix A: Meet Nathaniel, Maria, Shane and Justine

Meet Nathaniel

Fifteen year old Nathaniel arrived at Riverview in late February from a hospital where he was in the emergency room for a week. His family -- mother, father and three sisters -- had cared for him at home without any disruptions until he became too much to handle.[55] One day recently, Nathaniel exploded. He knocked over the refrigerator. He came up behind his mother and assaulted her. He tore down blinds and pictures in the home. The police were called and he was taken by ambulance to the emergency room. He was kept in his bed through the use of sedating medication, and he was restrained.

When no suitable place could be found for Nathaniel after a week, Riverview Hospital admitted him -- although neither he nor his family ever had involvement with the Department of Children and Families. While at Riverview, Nathaniel receives services from a multi-disciplinary team. He gets occupational therapy to develop fine and gross motor skills as well as medical care and assessment to determine if hypoglycemia is contributing toward his weight gain and behaviors. In addition, he receives psychiatric, clinical and nursing care, speech and language therapy, all coordinated with the Department of Developmental Services and his former school.

Nathaniel's mother visits at Riverview almost every night. She brings food from home, reads to him, and prepares him for bed. On many nights, one of his sisters comes as well. The discharge plan for Nathaniel is to go back home where many supports will be needed. It is, therefore, essential that what works at the hospital is transferrable to home, including the predictable structure afforded by a strictly-followed schedule. As of April 6th, 2011 Nathaniel remains in residence at Riverview with a plan for return to his home with specialized supports for him and his family coordinated jointly with the Department of Developmental Services.

Meet Maria

Articulate and bright, Maria looks and talks like a typical college-bound teenager. She is pretty, engaging and has a sharp sense of humor. Maria wants what most teenage girls want: a home, friends, an education and, one day, a husband and family. So, many are shocked to learn that Maria, at age 17, has been psychiatrically hospitalized 17 times. Five of those were at Riverview.

Maria first came to Riverview when she was 11 -- a year after her mother ejected her from her family of origin after years of severely emotionally abusing Maria. For six months after Maria learned that her mother voluntarily terminated rights to be her parent, she remained inconsolable and actively suicidal. Months of treatment at two separate Connecticut residential treatment facilities were not enough to help Maria want to live. During her first stay at Riverview, she raged and refused to eat. At times, she required IV fluids at the emergency

[55] Children with autistic spectrum disorders can successfully live at home, but it is not uncommon that as they enter adolescence, puberty and sustained growth spurts, they exceed the family capacity.

department. After weeks of treatment at Riverview, Maria gradually forgot about wanting to kill herself all the time. She received intensive minute-to-minute care from nurses and children's services workers. Her clinician and psychiatrist met with her daily. Rehabilitation therapists coaxed her into taking an interest in her surroundings and to be creative. The school setting tolerated her mood swings and encouraged her to develop her academic skills. Eventually she was doing so well that she was discharged to a lower level of care, a residential treatment center.

It didn't work. Maria become suicidal again and went to a community-based psychiatric hospital where she continued to try to kill herself. The hospital referred Maria to Riverview again because it did not have the resources or expertise to deal with such an acutely and chronically suicidal child. Maria again improved at Riverview and the department set out to find a family who would adopt her. The Department found a family and visits commenced. It looked like there might be an adoption in the works. But Maria, like so many severely abused and neglected children, could not trust this family enough to allow the adoption to happen. She became acutely suicidal and needed several more weeks of treatment before being ready to consider residential treatment again.

The cycle repeated itself twice more. Following Maria's fourth Riverview hospitalization, she was placed out of state in a residential treatment center in Vermont. She was in good spirits and full of hope. She did well at first, taking some community college classes and almost getting her CNA certificate. Then Maria became suicidal again, was psychiatrically hospitalized at the Brattleboro Retreat, a renowned teaching hospital. After several months, they too said that they could not treat Maria anymore. She attempted to hang herself.

Maria is back at Riverview, doing well in treatment again and working with a psychiatrist and clinician who know her well and whom she trusts. Despite these hospitalizations, Maria is in good academic standing as a 10^{th} grader thanks to the small classes and individual attention given at Riverview's school. Maria's creative talents have been nurtured. She is a poet and a good singer and dancer.

In January, 2011 following five months of treatment at Riverview, Maria was discharged to a specialized in-state group home. At the present time, she is on runaway status from that setting.

Meet Shane

When Shane was admitted to the Riverview in March of 2005, he was 12 years old. He exhibited confusion, disruptive behaviors, aggression, bizarre and sexually reactive behavior, developmental delays, and psychosis. He had had been at a residential treatment facility in Springfield, Massachusetts for 18 months before coming to Riverview. Since the age of seven years, Shane also had lengthy stays in four other inpatient psychiatric facilities.

In 2003, when Shane was removed from the care of his mother, the Department of Children and Families (DCF) knew that Shane had been sexually abused by an uncle and that he had been exposed to severe domestic violence. DCF also knew that family members on both sides of Shane's family had been diagnosed with severe and prolonged mental illnesses, including schizophrenia and major depression. Over the period from 2003 to 2005, Shane exhibited dangerous behaviors and psychiatric symptoms. At the same time, his mother became overwhelmed with the care of Shane's four siblings, one of whom also has very serious mental health issues. Shane keenly felt his mother's diminished presence in his life.

Initially, the treatment team targeted Shane's disorganized thinking and began to assess whether Shane was schizophrenic. Several medication trials followed. Conventional medication treatments were tried to treat his mood swings and psychosis, but his symptoms and disorganized behavior persisted. Then less common medications were used, with some improvement but side effects appeared which had to be treated with other medications. More tests were conducted.

Over the next year Shane's medicines were adjusted and staff observed bizarre, dream-like episodes that could last up to two hours. Shane's ability to function independently, while all these medication changes were going on, was minimal. He was routinely incontinent and often completely unaware of his surroundings. By the summer of 2007, Shane's ability to function markedly improved. He was more lucid than he had ever been, and it was clear he wanted to be able to live in a less-restrictive setting near his mother in the Carolinas.

In September of 2007, Shane was transferred to a sub-acute unit at Riverview. Initially, Shane required almost one-to-one supervision from staff to complete his activities of daily living and organize his day. As staff continued to work with him, he gradually progressed to a more independent level of functioning. Eventually, he was able to complete most tasks on his own with just the help of an activity checklist and verbal prompting from staff. Shane became more comfortable with himself and others and was able to participate in activities off the unit and in public.

In February 2008, Shane was matched with a residential facility in South Carolina. Riverview staff continued to support Shane as he packed and said goodbye to the patients and staff who had served to support, nurture and care for him for the past three years. To ensure a comfortable, successful transition, Riverview staff accompanied Shane and his DCF Area Office worker on his first plane trip to the facility in South Carolina and his awaiting family in February 2008. Later, Shane was successfully transitioned from this facility to a foster home in the area. His mother moved close by, visits him regularly and Shane now goes to school in the community.

Meet Justine

Justine is a young man who has seen the inside of dozens of hospitals, residential treatment centers, and juvenile justice facilities. He has been exposed to extreme violence, even before he

was born. Justine's father assaulted his mother numerous times while she was pregnant with him. Soon after birth, Justine began to vomit so severely that he was hospitalized for three months on a general pediatric floor.

His mother escaped this relationship. But her next boyfriend was equally violent. When Justine was five, his ten year-old sister was killed in a car accident. His mother's boyfriend was driving and intoxicated. When Justine's mother confronted her boyfriend, he beat her severely. Afterwards, his mother made a serious suicide attempt. All the children -- Justine, an older brother and an older sister -- were removed and went into foster care for several months. Justine was physically and sexually abused in his first foster home and moved to another. The next family treated him well, but could not handle his aggressive and explosive behavior. By the time Justine was 12, he had been psychiatrically hospitalized 20 times for aggressive and self injurious behaviors, and he had been in numerous foster homes that could not handle his behavior.

Justine was admitted to Riverview for the first time in 2005 when, after two weeks at a residential treatment center, he seriously injured a staff member and assaulted a peer. After three months at Riverview, Justine was doing extremely well. He was discharged to another residential facility, where he also did well. Meanwhile, Justine's mother's recovery was progressing, and after almost a year of successful residential treatment, he was reunited with his mother.

The next 18 months at home were very difficult. Justine was frequently suspended from school for aggression. He did not take his medication. Mother, too, was struggling and not compliant with her treatment. Justine was removed and placed in four different residential facilities without success. Justine repeatedly assaulted peers and staff. By September 2009, he was sentenced to the Department of Corrections' Manson Youth Institute. He found himself in adult prison after having been arrested 22 times for assault.

After three months at Manson, Justine was placed at another residential facility. For six months he went back and forth from this facility to psychiatric hospitals because of ongoing agitation, paranoia, aggression, and being suicidal. Justine had frequent flashbacks to earlier trauma: beatings, the death of his sister, his mother's difficulties. After three hospital inpatient stays, Justine came to Riverview for the 2nd time, in April 2009.

At first, Justine had difficulty trusting staff. He misinterpreted attempts to reach out to him. He replied to questions only when required. He was angry, depressed and hyper-vigilant. He thought his peers were out to get him. Riverview staff coaxed him into interacting by engaging him in basketball and poetry groups. Physical activity helped Justine to release tension. Poetry gave him an outlet to express feelings to peers and staff in a way he could not before. Justine formed tight bonds with two male staff attuned to his tendency to misinterpret the behavior of people around him, and they taught him to think about other people's feelings before acting on his own.

Dealing with his peers was Justine's biggest challenge. On one occasion, he grossly misinterpreted what a peer was telling him, and he assaulted the boy. This was the single and last episode of violence during Justine's Riverview stay. He spent several days realizing he had to earn back the trust of the people whom he had come to like and respect. Justine felt guilty for hurting his peer and sorry that he let everyone down: "I don't like it when y'all don't trust me any more," Justine said.

After a few more weeks of stability, it became clear the best discharge option for Justine was to live with his mother. Justine's mother had a few years of successful recovery and treatment, and both she and Justine badly wanted to repair their relationship and recapture lost time. It took several months and intense planning, but Justine got his Christmas wish this year. He is again living with his family successfully, and he and his mother are motivated to remain in treatment.

Justine felt strongly enough about his Riverview experience that before he left he shared some advice with other children at the hospital. One day, several kids were playing dominoes in the dayroom when a new patient complained he wanted to go back to detention. Justine stopped playing, walked over to the boy and said, "Make the most of it here. These people actually care about you."