

Bring the Kids Home Focus Area

Decrease Recidivism to Residential Psychiatric Treatment Centers

Program Performance Accountability

1. Who are our customers?

Customers of the Bring the Kids Home (BTKH) Focus Area include all children in Alaska with, and at risk for, severe emotional disturbances. The goal of the Bring the Kids Home Focus Area is to develop and improve an integrated mental health service system in Alaska, so that children and youth are served in the most culturally competent, least restrictive setting, as close to home as determined to be safe and appropriate.

2. How can we measure if our customers are better off?

One important measure for youth who experience a severe emotional disturbance and receive treatment in a Residential Psychiatric Treatment Center (RPTC) is their recidivism rate, or the percentage of youth returning within one year to RPTC. Recidivism can indicate problems with treatment quality or discharge planning or result from gaps in community-based resources. High quality residential treatment should prepare the youth and the family for the youth's return home, and should include extensive discharge planning and a strong transition plan. However, if system gaps prevent delivery of appropriate services, then recidivism is more likely to occur. For these reasons, recidivism is a key measure for tracking system performance and monitoring resource availability.

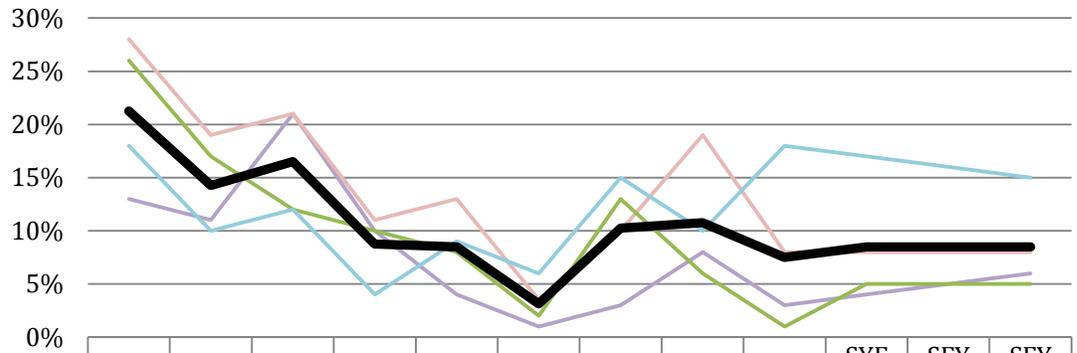
3. How are we doing?

Between FY11 and FY12 the overall recidivism rate dropped from 8% to 5%.

- Between FY11 and FY12, recidivism rates decreased except for non-custody children in out-of-state RPTC, which increased from 10% to 18%.
- Cross year comparison: In FY04 the overall recidivism rate was 20% this decreased to 5% for FY12.

As fewer children are served in RPTC, their acuity is increasing. This makes it difficult to maintain a low recidivism rate and creates greater fluctuation due to the small numbers of youth. We anticipate on-going challenges to reduce recidivism rates over the next several years.

Recidivism Rate* Comparison



	SFY 04	SFY 05	SFY 06	SFY 07	SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13 Projec tion	SFY 14 Projec tion	SFY 15 Projec tion
— Custody In-State	13%	11%	21%	10%	4%	1%	3%	8%	3%	4%	5%	6%
— Custody Out-of-State	28%	19%	21%	11%	13%	3.5%	10%	19%	8%	8.0%	8%	8%
— Non-Custody In-State	26%	17%	12%	10%	8%	2%	13%	6%	1%	5%	5%	5%
— Non-Custody Out-of-State	18%	10%	12%	4%	9%	6%	15%	10%	18%	17%	16%	15%
— OVERALL RATE	21.3%	14.3%	16.5%	8.8%	8.5%	3.1%	10.3%	10.8%	7.5%	8.5%	8.5%	8.5%

Data Source: MMIS, SFY12 *Recidivism* means a return to an RPTC level of care within one year.

4. What is the story behind the curve?

Between FY 1998 and FY 2004, placement in out-of-state residential psychiatric treatment centers (RPTC) for youth experiencing severe emotional disorders grew by 800 percent (from 83 to 749 children). The RPTC recidivism rate in FY 2004 was 20%. "Recidivism" means a return to an RPTC within one year. BTKH efforts to reduce reliance on RPTC should not result in failed transitions and repeated RPTC placements.

A number of factors contributed to the reliance on out-of-state RPTC services between FY 1998 and 2004, including:

- Lack of gate-keeping and resource coordination
- Limited in-state RPTC bed capacity
- Lack of clearly articulated guiding principles and poor integration of desirable principles into regulations, policies, procedures, and practices.
- Workforce issues and employee turnover in beneficiary-related service positions,
- Service gaps including insufficient in-home services and family therapy, and inadequate access to services
- Lack of support for performance improvement and implementation of best practices
- Resource issues including lack of adjustment for market changes for Medicaid rates, limitations on access to existing beds and lack of funding for individualized needs
- Little incentive for coordination across systems

These factors led to placement into out-of-state RPTC and often resulted in ineffective discharge planning and recidivism to RPTC.

In FY2004, the BTKH focus area was initiated by the Trust, in partnership with the Department of Health and Social Services and stakeholders. One focus area goal was to decrease recidivism to RPTC by expanding in-state capacity, ensuring placement in appropriate levels of care, and improving transitions. These efforts had an impact: out-of-state RPTC recidivism declined from 19.3 percent in FY2004 to 5.4 percent in FY2007.

Strategies that assisted in reducing the RPTC recidivism rate included:

- Alaska statute 47.07.032 clarified that prior to out-of-state RPTC placement a determination that the services are unavailable in the state was required.
- Peer navigation to help families and youth find in-state resources and access support.
- Individualized funding to prevent residential placement or facilitate a child's return home.
- Expansion of behavioral health service capacity to allow access to services closer to home, including in rural areas of the State
- Sub-acute crisis stabilization to prevent unnecessary acute care placements and to provide a discharge option while in-state services are being developed.
- Increased requirements for discharge planning from RPTC.
- Increased requirements for family therapy while a child was in RPTC.
- Enhanced care management services to meet the needs of the child and the family prior to and after the child's return home.
- Educational transition support services to ensure communication, discharge planning and community service development between parents, RPTC and schools.

Between FY2007 and FY2012, the out-of-state RPTC recidivism rate began to fluctuate: as fewer children are placed in RPTC, small increases in numbers of youth returning to RPTC result in greater fluctuation. Also, as the number of youth out-of-state decreased, their acuity increased. The majority of children in out-of-state RPTC have co-occurring disorders, complex trauma histories and family substance abuse or mental health problems. Children with co-occurring developmental challenges often have trouble generalizing skills from RPTC to home. Children with histories of trauma and family issues often need intensive in-home supports. However, many in-state providers are not prepared to treat youth with co-occurring disorders, complex trauma, or to provide intensive in-home and family-based services. As a result, these youth may experience a higher rate of RPTC recidivism until in-state community service competence is developed.

Fluctuation in resources also impacts recidivism. Individualized Service Agreement (ISA) funds were over budget for FY10 resulting in changes to increase accountability. This decreased ISA utilization during FY11 and FY12. Many providers found the changes to be unwieldy and no longer use ISA to stabilize a child in a community setting, referring the child to residential care instead.

There also continue to be service gaps for intensive outpatient and brief stabilization services. It is difficult for Alaska Native youth to receive services in their homes and communities. Two rural crisis respite facilities closed in 2010 and 2011, resulting in fewer short-term stabilization beds.

For these reasons, we project that the recidivism rate may only decrease slightly from its current level, despite on-going efforts to improve services and transitions. In order to better understand recidivism trends, DBH data development will explore the utility of gathering recidivism data for other levels of residential care. However, 'recidivism' is not a meaningful term in some cases, as sporadic use of residential stabilization can be an anticipated part of a successful treatment plan.

5. Who are key partners that have a role in turning the curve?

- Alaska Mental Health Trust Authority
- Trust Statutory Partner Advisory Boards
- Family & Youth Advocate Agencies
- Behavioral Health Providers
- Other Community Providers
- Denali Commission
- Tribal Entities
- Department of Health and Social Services
- Department of Education
- School Districts

6. What works to turn the curve?

The Surgeon General's Report on Mental Illness (USDHHS, 1999) was a children's mental health landmark report on the future direction for service delivery. Eight recommendations were set forth in the Surgeon General's report:

- Continue to build a science base;
- Overcome stigma;
- Improve public awareness of effective treatment;
- Ensure the supply of mental health service providers;
- Ensure delivery of state-of-the-art treatments;
- Tailor treatment to age, gender, race, and culture;
- Facilitate entry into treatment; and
- Reduce financial barriers to treatment

These recommendations guide BTKH planning, and in addition, a variety of evidence-based strategies have informed BTKH. For youth with serious emotional disturbance and complex needs, research has consistently supported better outcomes from a wraparound process than from alternative services¹. One required component of wraparound is access to flexible funding. Family and youth advocates support access to flexible funding, and child welfare research has demonstrated greater rates of reunification with access to flexible funding². BTKH *Individualized Service Agreements* were developed as an avenue to provide these individualized services.

Reducing system barriers and enhancing collaboration is also essential. A 2004 paper outlined strategies to improve services for individuals with co-occurring developmental and behavioral health challenges including cross system communication, data development and tracking, use of best practices, and use of a universal assessment tool³. DHSS is working internally and with providers to improve collaboration and services for youth who span these systems.

Most children in out-of-state RPTC have families who have experienced serious challenges such as substance abuse, mental health problems, domestic violence, abuse or neglect. To keep children at home, families must have access to effective parenting strategies, a support network and to resource navigation. Alaska has adopted a *Family Peer Support* model with services through the Alaska Youth and Family Network (AYFN). The family movement has developed of two roles for families in systems of care: *Families as Service Coordinators* and the *Family as Faculty*⁴. This is currently being practiced by AYFN through *Parenting with*

1 Summary of the Wraparound Evidence Base: April 2010 Update; Bruns, Eric and Suter, Jesse C.
[http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-\(evidence-base\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-(evidence-base).pdf)

² Children's Bureau, 2010b; Wulczyn & Martin, 2001; Wulczyn, Zeidman, & Svirsky, 1997

³ National Association of Mental Health Program Directors "Serving Individuals with Co-Occurring Developmental Disabilities and Mental Illnesses: System Barriers and Strategies for Reform, 2004".

http://www.nasmhpd.org/general_files/publications/MIDD%20report102704FINAL.pdf

⁴ Osher, deFur, Nava, Spencer, & Toth-Dennis, 1999

Love and Logic® classes which provide practical training to raise responsible children, enjoy parenting and make changes in children's behavior⁵. In addition to peer services; families require intensive clinical and in-home services. *Parenting with Love and Limits*® (PLL) is an evidence-based treatment for children with severe disturbances and their families that is being implemented in Alaska. PLL outcome studies have found lower recidivism and better improvement for PLL as compared to control group youth and families⁶. DHSS is also developing a 'home grown' strategy to support performance improvement for family therapy and in-home services in order to achieve statewide system improvement.

The lack of school-based services also undermines youth success in community settings. When children cannot remain in school and require parental supervision during work hours, family stress increases and this can ultimately result in an out-of-home placement. The Center for Mental Health Services (CMS) identified three key school-based behavioral health practices:⁷ using clinicians and student support providers, focusing on wraparound and case management services, and providing school wide prevention and early intervention programs. *Positive Behavioral Intervention and Supports* is a model that includes these CMS key practices and that is being supported through BTKH and through the education and school districts.

Most youth in RPTC have a history of complex trauma. The *Attachment, Self-Regulation and Competency Clinical Services* (ARC) framework is recognized as a promising practice. ARC is being practiced in Anchorage to address interventions and improve outcomes for youth exposed to complex trauma⁸. In addition, trauma informed treatment strategies are being implemented in residential and community-based settings and in Juvenile Justice facilities.

Young people with behavioral health challenges often experience homelessness, unemployment, poverty and reliance on emergency health and mental health services as they move into adulthood. The *Transition to Independence Process* (TIP) is an evidence-supported practice to assist young people with severe disturbances to transition to adulthood with better outcomes. Six outcome studies have demonstrated improved postsecondary progress through TIP⁹ and early implementation data in Alaska is showing strong outcomes.

A history of adverse events results in risk taking behaviors in adolescence and adulthood including alcoholism and drug abuse, suicide attempts, and multiple sexual partners¹⁰. As adults, children exposed to adverse events have higher risks for heart disease, stroke, diabetes, mental illness and other chronic health problems. Early Childhood Mental Health Consultation (ECMHC) is a best practice to intervene with young children in their family, day care and early learning settings. ECHC is being piloted in several sites using BTKH funding. DHSS is using a "tribal team" approach that provides staff support, training tools and contractors to assist tribal behavioral health agencies to implement strategies to expand access to Medicaid and increase local service delivery. This is an expansion of on-going technical assistance through Health Care Services. Outcomes are still being monitored for this practice.

⁵ See Love and Logic website: <http://www.loveandlogic.com/>

⁶Professional Issues in Criminal Justice, Vol 6, Reducing Adolescent Oppositional and Conduct Disorders: An Experimental Design Using the Parenting with Love and Limits® Model, Scott P. Sells, Kristin Winokur Early, Thomas E. Smith, 2011

⁷ Burns & Goldman, 1999

⁸.Kinniburgh, Blaustein, Spinazzola & van der Kolk 2005, Psychiatric Annals

⁹ Theory and Research Underpinnings Supporting the Transition to Independence Process (TIP) Model; <http://www.tipstars.org/TIPModelEvidence.aspx>

¹⁰ See Adverse Childhood Experiences Study website: <http://www.acestudy.org/>

7. What do we propose to do to turn the curve?

In order to continue to reduce recidivism to higher levels of care, Alaska must have behavioral health services that are collaborative, individualized and able to work with youth with co-occurring conditions, complex trauma, and with aggressive and challenging presentations. Services must also engage families effectively and develop the resources and resilience needed for children to return to or remain in their homes. In addition, services must reach children and families before needs become complex and out-of-home placement are indicated. The following activities will help achieve these goals:

- RPTC admitting and continued stay criteria have been rewritten. Phase II will include tightening up of this criteria.
- Continue work to align service delivery with BTKH guiding principles.
- Continue implementation of the Complex Behaviors Collaborative.
- Continue best practice improvement work around trauma informed care.
- Expand access to peer navigation and support services.
- Expand access to family therapy and intensive in-home treatment.
- Expand best practices for youth of transition age.
- Streamline administration of individualized funding while maintaining accountability for funding use and outcomes.
- Continue to increase Medicaid-funded culturally competent behavioral health services in rural communities.
- Continue collaboration to expand best practices in the schools.
- Expand best practices for young children with behavioral health problems.
- Intervene with young children with behavioral health and their families in early learning and day care settings through the TACSEI project.
- Identify systemic strategies ensure that families, schools and communities are prepared for youth to return home from residential treatment with the resources they need.
- Clearly define expectations around discharge planning for RPTC providers.
- Expand availability of short-term crisis stabilization placements in rural areas.