Using TCOM in residential treatment

THE STORY OF THE CANS

The Problem

55,000 children in care in child welfare in 1995

$1.5 billion annual budget with $400 million spent on residential care

Either children got nothing in the community or the failed enough usually with multiple hospitalizations until they were placed in residential care

Director wanted to fix and proposed community re-investment strategy—reduce residential placements to save money to be re-invested in the community.

First attempted solution

Asked residential providers to nominate youth to be returned to community

Instead of saying ‘Take Mary, she is doing great’. They said ‘Take Johnny. We are not helping Johnny, maybe you can’

So precisely the wrong youth were identified.

DISASTER

The first TCOM solution

Held focus groups with every perspective willing to meet to ask about what characteristics should be used to guide decisions about placement in residential treatment---psychiatrists, psychologists, social workers, teachers, parents, probation officers and youth.

Once conversations could be shifted from services (and money), a three dimensional model was identified across perspectives

- Symptoms
- Risk Behaviors
- Caregiver Characteristics

First version—Childhood Severity of Psychiatric Illness

Behavioral emotional needs, Risk Behavior, Caregiver Capacity and Functioning items identified.

Structure was developed to allow both prospective and retrospective application of the measure

Stratified random sample of 330 youth currently in residential treatment

- 13% had never had any risk behavior
- 20% had historical but not present risk
- 67% had active risk at time of placement only half of these youth still had active risk at time of review.

Strategy

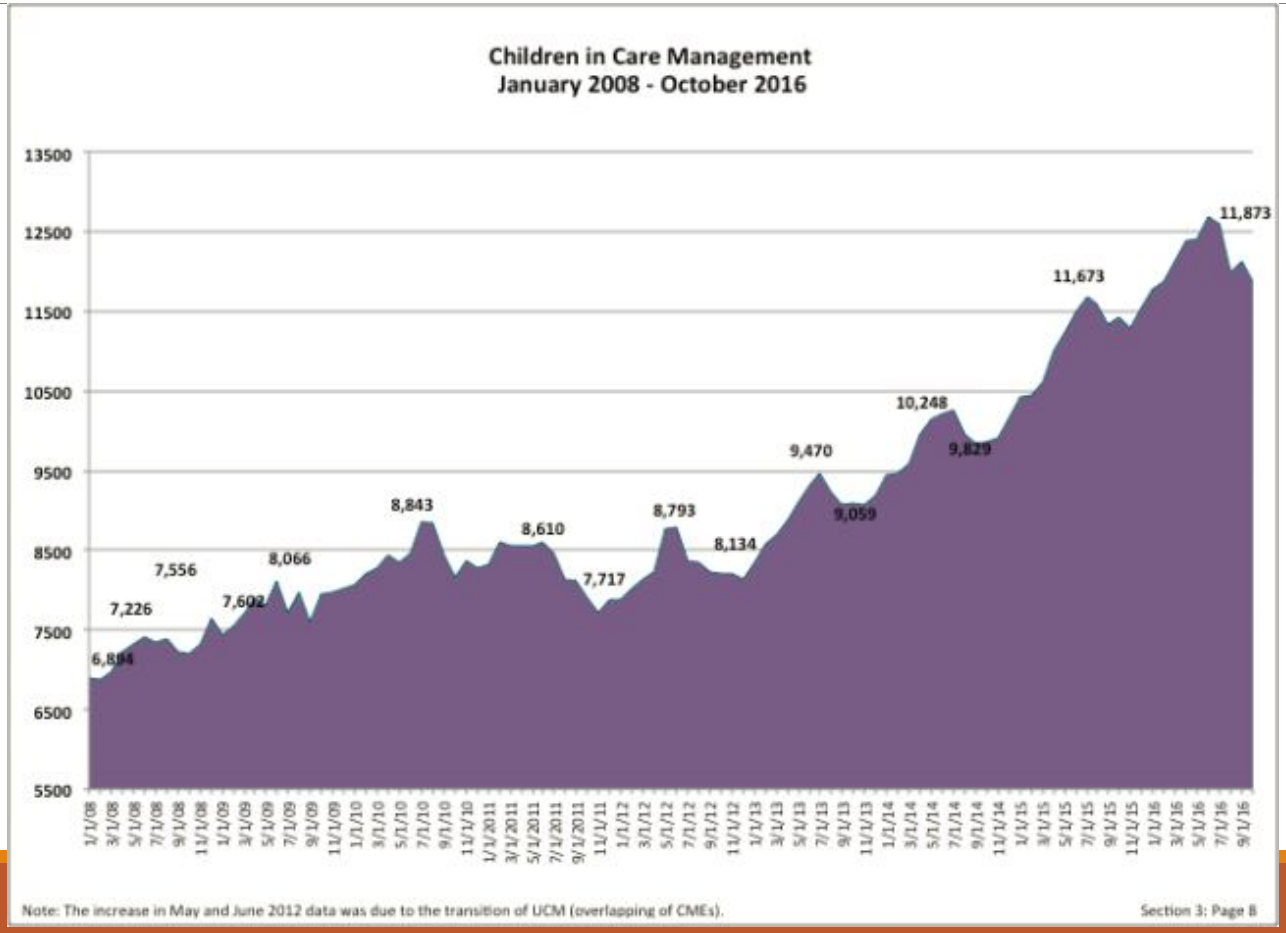
First algorithm. To be in residential treatment a youth should have at last one ‘2’ or ‘3’ on a Behavioral/Emotional need AND at least one ‘2’ or ‘3’ on at least one Risk Behavior

Created a placement review process

Reallocated Targeted Case Management Case Workers for step-down team

Within 18 months they had reduced the number of children in residential treatment from 6000 to 4000 (now it is about 1800).

New Jersey's expansion of their Children's System of Care from 2008 to 2016



New Jersey Children's System of Care number of youth placed in residential care from 2010 to 2016

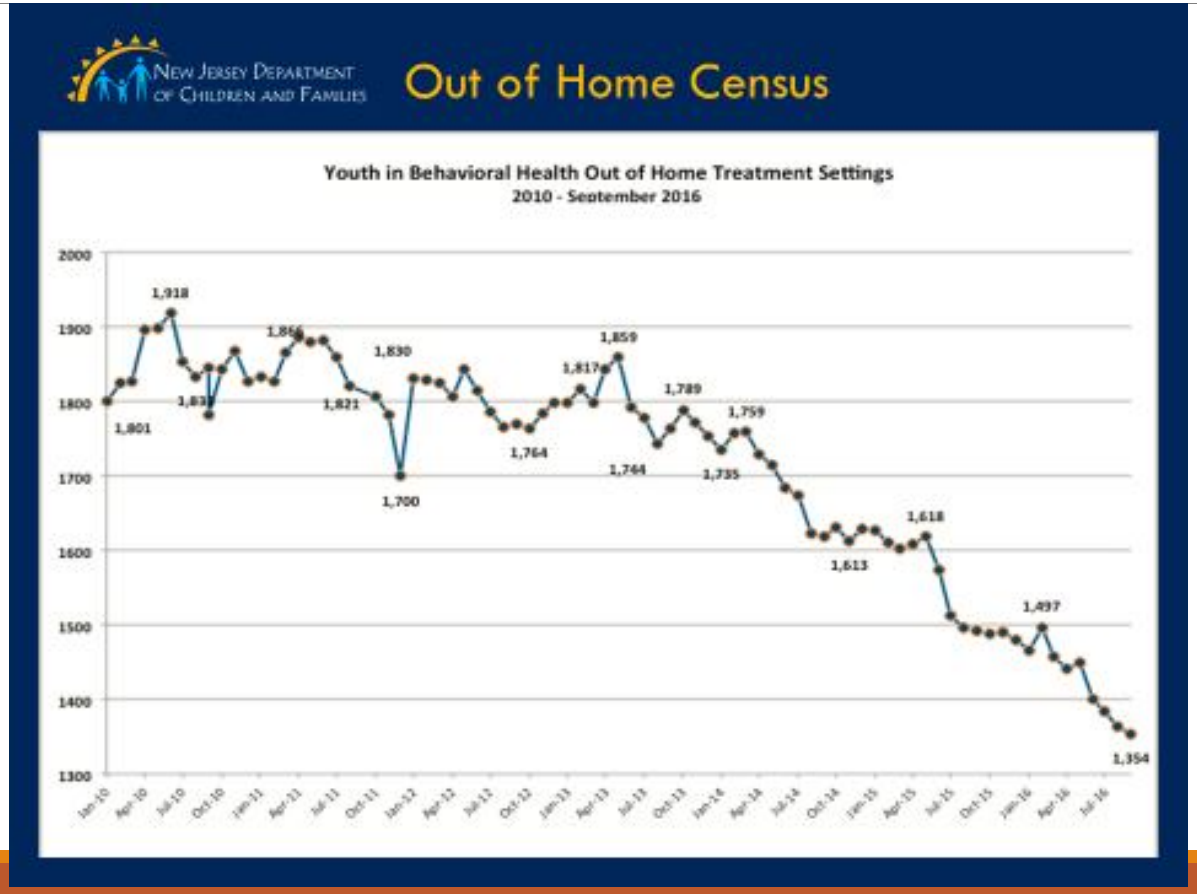


Table 2. Outcomes on Behavioral and Emotional Needs of 5248 youth over a residential treatment episode of care using items of the Child and Adolescent Needs and Strengths

Mental Health	%Presenting	%Resolved	%Improved	%Identified	%Worsened	%Transitioning	%NetGain
Anger Control	60.2%	47.1%	56.1%	25.6%	14.0%	42.0%	30.2%
Psychosis	10.9%	70.5%	74.7%	5.0%	10.8%	7.6%	30.2%
Adj to Trauma	48.5%	50.1%	60.1%	22.2%	15.2%	35.0%	27.8%
Depression	48.0%	52.0%	55.9%	24.5%	5.3%	35.8%	25.4%
Opposition	49.5%	42.7%	50.5%	22.9%	12.5%	37.9%	23.4%
Conduct	29.6%	59.3%	66.1%	16.7%	14.6%	23.8%	19.6%
Attention-Impulse	49.7%	46.7%	55.1%	20.0%	9.1%	40.1%	19.3%
Anxiety	29.5%	50.9%	54.1%	19.0%	6.0%	25.1%	14.9%
Substance Use	16.0%	55.8%	61.1%	11.6%	17.3%	15.5%	3.1%

Outcomes on Behavioral and Emotional Needs of 5248 youth over a residential treatment episode of care using items of the Child and Adolescent Needs and Strengths

Dangerous Behavior	%Presenting	%Resolved	%Improved	%Identified	%Worsened	%Transitioning	%NetGain
Suicide	11.0%	82.0%	83.9%	3.9%	10.3%	5.4%	50.9%
Sexual Aggression	11.6%	76.7%	82.9%	5.0%	14.0%	6.5%	43.9%
Self Injury	9.2%	80.2%	83.0%	3.7%	20.3%	5.2%	43.4%
Danger to Others	37.6%	66.1%	69.8%	27.2%	8.6%	23.3%	38.0%
Other Self Harm	17.1%	78.4%	80.7%	9.0%	5.2%	11.2%	34.5%
Runaway	37.2%	49.2%	58.1%	22.5%	35.7%	33.0%	11.3%

Illinois Trajectories of Recovery before and after entering different types of Child Welfare Placements