CHILDREN'S LEAGUE OF MASSACHUSETTS

PROMOTING THE WELFARE OF CHILDREN AND THEIR FAMILIES THROUGH PUBLIC POLICY

Returning to our North "STARR"

Current Challenges Faced by STARR Programs and Recommended Solutions

We are 18 months into the ongoing global pandemic and the Short-term Assessment and Rapid Reintegration (STARR) programs, like so many providers in the human services sector, are at crisis level. In September 2021 the Children's League of Massachusetts surveyed our members who run STARR programs under contract with the Department of Children and Families (DCF). The responses–from 11 providers operating 27 STARR sites with 291 contracted beds—illustrate the immense strain that STARR staff and youth are under, and reflect both shared and unique experiences of the individual sites. They offer recommendations for DCF to better work in partnership with STARR programs to alleviate these pressures and return to the intended use of STARR programs as they shift to the new Emergency Residence model.

Key takeaways from the data

Children are staying in STARR far longer than the program is designed to serve them, without an exit plan.

- Across all sites, the average length of stay for current residents is 83 days.
    - 83% of sites have an average over 45 days – the intended maximum for a STARR placement
    - 33% of sites have an average over 90 days – twice the intended maximum for a STARR placement
- We asked programs: *Of the youth currently in your program, think of the child who has been there the longest continuous period of time. How long have they been in your program?* The average for these "stuck kids" is 138 days; the shortest stay is at 54 days, the longest at over one year.

Most programs are operating at their original contracted capacity.

- One-third of programs reduced the number of beds in the past few months by an average of 30%, and all were reduced as a result of staffing shortages.[1]
- Across the 27 sites, 84% of the reduced beds are filled, and more than half of programs are at 90%+ capacity, leaving very few available slots at any given time.

On average, programs are staffed to about two-thirds of full capacity.

- On average, sites report that 32% of their staff positions are open due to vacancies or staff out on leave.

Challenges faced by STARR programs, staff, and youth[2]

It is clear from survey responses that STARR programs are being used in a way that was never intended. Youth are referred to the program because there is no place else to put them that will suit their behavioral and clinical needs. These placements in turn are taking a toll on staff. Direct care staff were not hired or trained with the clinical expertise needed to meet the needs of these higher acuity youth, and programs cannot in the current climate maintain the ratios needed to meet basic STARR needs, much less the lower ratios needed to serve higher acuity youth.

> *"Over the past several months we have seen a dramatic and unsettling trend in the STARR programs including significant increased length of stay, lack of DCF contact and involvement, severe aggressive behaviors, lack of available clinical services, inability to make connections with the youth and an overall sense of hopelessness. These trends are exacerbated by the workforce crisis that has made it impossible for the programs to hire quality staff whom we are able to retain."*

[1] According to previous data collected by CLM, the number of contracted STARR beds has been reduced approximately 25% in the past five years.

[2] Challenges are presented largely in the original language reported by programs. **Not all challenges apply to all programs/sites.**

STARR programs also deal with the challenges experienced by the youth themselves, who feel "frustrated," "not invested in the program," and "hopeless." These feelings translate to increased aggressive behavior and a downward spiral for youth whose initial purpose for entering STARR was only a short stabilization.

Youth are being diverted to STARR simply because there is no other place to put them, regardless of their level-of-care needs.

"There has been an increased number of youth placed in our program due to limited appropriate options in the state."

- There is a statewide shortage of psychiatric hospital beds, so youth who need acute psychiatric care are sent back to STARR because no beds are available in hospitals.
- Clients who need a Res-Ed (Campus) Placement, or a 1:2, or a 1:1 ratio, are sent to STARR, which is a 1:3 environment, and the staff are worn down trying to keep them safe.
- Due to the statewide lack of placements many of the youth have had multiple placements, which increases their frustration and anger.
- Youth are waiting months for clinical services, medication evaluations and home-based services. Youth can't start a plan to return home because they are not in services and the wait list for services can be months.

"The children in care are coming to the program with more complex needs (medical, educational, emotional) than in the past."

- In recent months, the level of acuity of the youth's behavioral health needs have become significantly more challenging, resulting in burn out and stress of staff.
    - The clients are much more acute and there is a constant mixture of clients with self-harming behaviors as well as those with delinquent and assaultive behaviors.
    - There has been an increase in youth being discharge to the program from psychiatric hospital with many psychotropic medications.
    - Client acuity has increased dramatically especially around serious assaults and self-harming behaviors.
    - Youth are presenting with increased and intense mental health needs.
    - In the past it might be that a program is working with one hard youth at a time, now it's three hard youth at a time and the behavior can be non-stop and extreme.
- We often do not get accurate information regarding clients' histories, needs, and presenting issues. This makes it difficult to provide needed services timely and effectively.
- The youth's behavioral health challenges become even more acute as they experience these placement disruptions.

Staff training, ratios, and retention are at a breaking point.

"The largest issue at this program is the staffing crisis. Several staff have left, some are on medical leave and new hires are not yet fully trained to manage the needs of the children." "Current staff, who look at this as a career, [are] hanging on by their fingernails." "It's increasingly difficult to hire people to do jobs they were not trained to do."

- It difficult to operate at full capacity without using relief or temp services or mandating overtime, which leads to staff feeling overwhelmed and overworked.
- We have multiple youth who need one-to-one care and we don't have the ability to provide that due to staffing.
- We currently are only able to consistently run each shift with two people. This is often one seasoned staff and one staff that has not completed all trainings and cannot be left alone with residents. This impacts our ability to complete after hours intakes (can't leave trainee alone on the floor with kids, can't have the training staff member do an intake without observing someone else do one first). It also impacts ability to conduct client appointments or transports.

On average, sites reported **633 hours of overtime just in the past quarter**, at an average cost of $10,724 per site. This does not include overtime hours put in by exempt program and management staff who provided extra coverage but do not receive overtime compensation.

- DCF has proposed to us on multiple occasions … that we combine our two STARR programs to cover staff ratios and increase the amount of youth we can serve. However, we have staff who use public transportation [or rely on family] to get to work…Many of our staff are also coming to the program for one or two shifts a week from their primary job. These staff are not willing to add a 45-60 minute commute to their work day, extending their work day, and impacting child care.
- While we have developed additional training, new and less experienced staff are not able to handle being threatened by youth and do not return, leaving the senior staff to provide additional and unreasonable hours of coverage.
- Going into a weekend, the staff schedule will have multiple openings because there are not enough physical bodies to fill the positions and staff don't want to work overtime as they have already had to work extra hours. More Clinicians/administrative staff than ever have had to come in and work ratio in their off-time more in the last 1.5 years than ever. Direct Care Staff are being mandated and/or asked to work doubles, 16 hours a day, multiple days in a row, and manage these high-end youth during that time.
- The challenges in hiring staff also impact the ability [of staff] to connect with youth.

STARR programs are being asked to provide support they are not designed, staffed, or equipped to provide. Behavioral challenges are exacerbated by the lack of plans for the youth.

"Staff are frustrated and angry that youth are left in the STARR for extended periods of time and have no plan." "Serving children who need a secure setting or one-to-one care in a community-based 1:3 model is very difficult on staff and the other children in the program."

- The youth presenting to the STARR over the past several months have little to no investment in the program, generally because there is no plan. Therefore, they are abusive and aggressive towards staff, they don't want to be at STARR, but at the same time have no plan or place to go.
- As a result of [the greater level of acuity among youth] there has been an increase in property damage and assaultive behaviors towards clients and staff.
    - Staff are not trained for restraint intervention in the case of assaultive behavior. Staffing shortages are inhibiting the ability to run the training.
    - The police are no longer able to help because they are unable to make an arrest for assaults unless they witness it, and it is an assault with a dangerous weapon. For example, punching a staff person in the face multiple times will not result in an arrest.
    - Another program has been hesitant to press charges due to the youth likely staying in placement once this is done which could result in an increase in behaviors despite charges having been pursued.
    - We've had multiple complaints about us calling various police departments excessively, however this is the course of action staff feel they need to take in the moment, as CPI/de-escalation is not enough to de-escalate a youth or maintain staff or other client safety. Additionally, accountability by law enforcement/courts has significantly decreased and many youths have the attitude that nothing is going to happen to them, they don't care, so they are going to do what they want to do.

In the current quarter (July-Sept.), sites reported **105 assaults** on staff.

- Mixing populations (co-ed) and mixing clients who have vastly different needs and require specialized staff (autistic clients) in one program makes it challenging for us to provide consistently high-quality services to all.
- There is no longer a geographical consideration so youth are placed in communities that are far from their home restricting and sometimes eliminating any family, school, or peer connections.

Any positive community connections that a STARR program would typically build upon are no longer available in part due to the distance as well as COVID concerns. Placing clients in STARR in another region also presents numerous obstacles to providing family work.

In the past year, **79% of programs reported damage to site property caused by clients**. Not all programs track the value of this damage, but those that do collectively reported over $65,000, not including staff time devoted to repairs.

DCF is not always seen as a helpful partner under the current conditions.

"The lack of response from SOME—not all—DCF workers leaves staff feeling hopeless resulting in good staff resigning their positions."

- Youth have stated that they have not seen their DCF worker in "forever" and have no plan. With many youth being placed out of areas or far from the DCF office there is no regular contact or a "drop in/check in" that reassures that youth that they have not been forgotten.

> *"Children are being stuck in the program. One child (6 years old) was there for 213 days."*

- It is very concerning that DCF workers are still not coming into the programs. Many staff have commented that it is ok for them to be exposed to COVID but the state workers, who make considerably more than the direct care staff, will not come into the STARR.
    - Not having DCF staff and supervisors in the office also creates a double standard leaving the STARR staff feeling devalued and disrespected.
    - We have had several incidents in which a youth has become volatile due to leaving numerous messages and not receiving any calls back from the DCF worker.
- Staffing shortages have led to increased need for intensive one-to-one interventions that will pull one staff away from second staff, creating additional safety issues. This is workable during first shift when administrative team is present and can support floor as needed but not on shifts where there aren't extra bodies. DCF frequently indicates that they will pay the program for a one-to-one for these youth, but we simply do not have the staffing to pull in another person to staff a one-to-one.

Recommendations

1. Expedite funding and contract renewal decisions.
    - Award contracts early and/or on a rolling basis if DCF already knows they will be keeping a particular program, rather than waiting for all contracts to be ready. At minimum announce/confirm the number of beds that will be awarded.
    - Fund the programs at the new rate that they committed to for October 1 or allocate bridge funding to allow for staffing up or other changes that need to be in place by January 1.
    - Increase the rate of pay for staff who work in emergency resident programs.
    - DYS contracts have a 1:5 clinician to staff ratio yet the new contract with DCF is 1:9. Having more than one clinician in each program would allow for more intensive treatment especially when the population we are serving is so acute.

2. Use STARR programs as intended.
    - Develop and stick to clear criteria for admission to each of the programs so that programs can adequately meet the youth's needs. Ensure placement profiles are aligned with the intentions of STARR and with contracts.
    - Limit the length of stay as intended.
    - Ensure an exit plan is under development from the day a child enters STARR.
    - Obtain placements for children at the correct level of care for their treatment needs; do not treat STARR as a catch-all option when no other option is available.

3. Improve planning and collaboration between DCF and STARR programs.
    - Improve communication and the amount and quality of information that programs receive prior to the client's arrival at the program.
    - Require weekly in-person visits from DCF social workers for all STARR youth. Do not allow weekly meetings with youth to be cancelled. Supervisors/APM should attend meetings if the DCF worker is not available.
    - Engage in concurrent discharge planning to reduce the number of youth who remain in the program past 45 days.

- Collaborate with programs to find the right placement; programs have to be able to say no to kids with needs they can't meet, but are willing to work with DCF to find the right spot for a child. This requires conversation and flexibility on all parts.
- Maintain local regional focus on use of STARR programs so that they can preserve connections that youth and families have in their communities and reintegrate clients into their communities effectively.

The OCA report on the death of David Almond illustrates the need for better collaboration between DCF and its partners in child and family services to ensure **timely** action that puts youth needs front and center.

The report also references the need to use available information to make the best **clinical** decision for a child; putting a child in a STARR program because there is no other option does not meet this standard.

4. Provide concrete and useful staffing support to STARR programs.
   - Provide real in-person DCF staff support so that we don't have to pay staff overtime. Examples of how DCF staff could help support staffing:
     - DCF worker transports youth to appointments and to/from school/activities
     - DCF worker stays at the hospital when a kid is waiting for bed
     - DCF workers take youth to get COVID tested/vaccinated
   - Consider adding a supervisor to the STARR's to help train and support new staff and stabilize the programs. The high level of clinical needs of the kids is overwhelming the new/green staff. Additional Supervisors can help us to train the new staff properly, model interventions and reduce the 51A's. Supervisor rates need to be competitive.
   - Provide more in-depth training from external experts.

5. Expedite internal processes that are roadblocks for STARR staff and youth.
   - Expedite 51A investigations against program staff, to reduce the number of staff days lost to required administrative leave.
   - Move youth at STARR to the top of waitlists for therapeutic services (therapeutic mentor or outpatient therapy).

In the current quarter there were 45 51A's filed on staff.
- 51% of these were screened out or unsupported
- 22% were supported
- 16% are still pending

6. Focus on solving the most immediate systemic interagency issues.
   - Until the Intensive Emergency Residence program is established, contract with an inpatient program who has dedicated beds where youth can be stabilized.
   - Include DYS, DCF, and the courts in joint sessions to discuss the severity of the cases that are resulting in staff assaults with no legal ramifications.
     - Work more closely with DYS and the courts to address staff assaults and property damage.
     - Continue to work with the courts and probation around issues such as timely hearing of cases, decisions about when to place a youth in DYS custody, and ensuring regular visits from probation officers.
   - Assist in providing EEC required trainings.
   - Work with providers to develop a CQI process that maintains the integrity of the Intensive program versus the "regular" Emergency Residence programs.

7. Ensure youth have the support and conditions they need to be successful.
   - Prioritize immediately identifying a school placement for a child entering STARR.
   - Require the DCF case worker visit the STARR program when there is a crisis with their assigned youth.
   - Keep youth in a program close to their home and community supports.
   - Assign every youth a mentor, therapeutic mentor, or community support worker who can provide clinical support, advocacy, access to enrichment activities outside of the program, and more.