



State of Delaware

*The Department of Services for
Children, Youth and Their Families*

RFI# CYF13-03

Request for Information

SERVICE COMPONENTS

Youth & Family Centered Residential Services Initiative

Responses due: Friday October 25, 2013 by 4 pm ET

NO contract awards will result from this action.

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Section 1 Overview

The Delaware Department of Services for Children, Youth & their Families (DSCYF), Division of Prevention & Behavioral Health Services (DPBHS) is committed to the development of a fully integrated behavioral health system for children and families and striving to fulfill its vision: *“Resilient Children and Families Living in Supportive Communities.”*

This Request for Information (RFI) is intended as one of several strategies DPBHS is employing to obtain stakeholder input and invite commentary on discrete elements of this Youth & Family Centered Residential Services Initiative in order to help shape a planned Request for Proposal (RFP) for these services. The intent of this RFI is for DPBHS to obtain feedback on: a) the operational challenges of implementing new conceptual framework / program models, b) innovative strategies that may have already been implemented in the provider community, and c) how a re-engineered out-of-home system should be designed. **It is important to note that responding to this RFI will neither increase nor decrease a future bidder’s chances of being awarded a contract resulting from any future procurement action.**

DPBHS has systematically procured services over the past decade with a System of Care lens and has embraced family voice in all aspects of their work, from the individual case level to the highest levels of administration and governance. All of this is consistent with an emerging national consensus on the delivery of residential services that is articulated in the Building Bridges Initiative. We now have an opportunity to procure respite, crisis bed, and residential treatment services to support the further evolution of the system.

Our goal in releasing this RFI and the planned RFP is to achieve better and more sustainable positive outcomes for children and families. This requires full family / caregiver engagement during all aspects of a child’s care and treatment including residential treatment services. The objective is to be able to provide effective residential treatment services for most youth in Delaware, that prepare families to successfully manage their children at home, and that prevent ‘treatment failure’ and a return back into care. Likewise, school transitions will be facilitated to maximize the likelihood of academic success, and social supports will be identified and in place to provide developmentally appropriate resources.

Specifically, DPBHS is interested in:

- 1) Procuring program models that provide trauma-informed care environments and are focused on strengthening connections to the family and community,
- 2) Embedding evidence-based clinical practices in those programs that are responsive to the complex social, emotional, educational and psychological needs of children and families,
- 3) Supporting stronger integration and continuity of out-of-home behavioral health services with those that are delivered in the home and community settings,

- 4) Identifying and coordinating resources to support youth and families who present with different, divergent treatment needs (sole entity, coordinating with other specialists, formal agreements among a defined group of agencies, etc.)
- 5) ‘Right-sizing’ the range and scope of services to meet prevailing and future demographic and treatment trends,
- 6) Strengthening in-state service capacity in order to provide Delaware alternative(s) for many youth that currently require out-of-state residential service settings,
- 7) Providing a fair rate of reimbursement for these services, and
- 8) Rewarding providers that consistently deliver positive outcomes.

You may respond to as many of the questions in this RFI as you wish, and you do not have to answer all of them. If you have additional information that you feel we should consider that we have not asked about, or you have information that you recommend DPBHS take into consideration in the development of the planned RFP, please submit them as well.

Section 2 Background Information

DSCYF is the primary provider of child services, including child welfare, juvenile justice, and child mental health and substance abuse (behavioral health) services provided through DPBHS. As the State Child Mental Health Authority, DPBHS's responsibilities include planning, coordinating services, contracting, managing, and monitoring Delaware's system of public mental health services for children with moderate to severe emotional disturbance and behavioral health disorders. Additionally, DPBHS oversees new service and program development and provides expert clinical training and technical assistance to the community providers of children's behavioral health treatment, disseminating and promoting the use of evidence-based treatment to obtain the best outcomes for children with behavioral health issues and their families.

Overview of DPBHS:

- DPBHS was established pursuant to TITLE 29, State Government, Departments of Government, CHAPTER 90 DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH AND THEIR FAMILIES; § 9006. Major organizational units created; (2) Division of Prevention and Behavioral Health Services which shall be responsible for the provision of prevention, outpatient and residential mental health, and drug and alcohol treatment services for children and youth;
- DPBHS operates as a statewide, national accredited public managed care entity for the delivery of behavioral health services for children who have Medicaid/CHIP, are uninsured, or have exhausted the behavioral health benefits in their private insurance. Through the State's 1115 waiver, children who are enrolled in Medicaid/CHIP receive up to 30 units of outpatient services through the Medicaid contracted Managed Care Organizations. DPBHS covers all services once these benefits have been exhausted, or if a child requires more intensive services.
- DPBHS was the first child and public behavioral health system in the nation to be accredited by The Joint Commission, from 1997 to 2006, when they ended accreditation in that category. DPBHS is currently accredited under CARF (2007 through 2016)
- DPBHS operates a statewide, comprehensive child behavioral health system of care. Services are provided through a provider network with a wide array of levels of care including: crisis intervention, outpatient, intensive home-based outpatient treatment, part day treatment, day treatment, individual residential treatment, facility-based residential treatment and psychiatric day and inpatient hospital treatment. A description of DPBHS's current residential services is included in Appendix IV;
- DPBHS is funded through a line item budget allocated as part of the State of Delaware Annual Budget. In FY 2013, DPBHS's State budget was over \$49M. In addition to its state-funded budget, DPBHS manages both the SAMHSA Mental Health and Substance Use Block Grant funds for children's services. DPBHS has successfully competed for \$24.5M in external funds (including several SAMHSA grants) over the

past 11 years to expand access to Delaware children and their families and to institute and disseminate the use of evidence-based treatments, such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent Child Interaction Therapy (PCIT), Trauma and Grief Component Therapy for Adolescents, Early Childhood Mental Health Consultation, and Lifelines Suicide Prevention Training:

- Direct client care management includes Clinical Services Management Teams, each led by a licensed behavioral health professional, which support shared decision making with clients and their families (or client representatives), determine medical necessity, authorize treatment, facilitate children/families selection of service provider(s), monitor clinical progress in treatment, conduct comprehensive discharge planning, and arrange and manage transitions across providers, levels of care or discharge from the system;
- Provides clinical training in evidence-based treatment to community clinicians annually;
- Provides community education forums, conferences and trainings for behavioral health promotion and prevention, to promote and increase public awareness of children's behavioral health, how to identify behavioral health issues in children and how to make informed referrals to services;
- In SFY12 (7/1/11-6/30/12), DPBHS provided behavioral health treatment services to 4,675 children and their families (unduplicated count of treatment services and specialized services) and provided early intervention and prevention services to another 2,940 children and their families across the state.
- DPBHS has been providing behavioral health services to children and their families using a system of care approach (including families in decision-making and in system development and design) since 1988; and
- DPBHS partners with families, schools, providers, early care and education programs, law enforcement and advocates to address community child behavioral health issues and promote the mental health of children and their families across Delaware.
- DPBHS has demonstrated its ability to effectively provide children's behavioral health services statewide while containing costs, particularly in psychiatric hospital treatment. Savings in the reduction of the use of inpatient psychiatric hospital were achieved by DPBHS's children's behavioral health care system primarily through DPBHS's highly effective use of clinical care management and the design, development and use of alternative, community-based treatments.

Section 3 RFI Information

3.1 Program Requirements

DPBHS has assessed the performance of the current system and conducted research into new and promising practices in residential care. We are considering including the following requirements in contracts for all residential programs in order to best serve children and families in these settings.

- All programs embrace the concept of family-driven and youth-guided care. DPBHS wants to strengthen efforts that support youth and families as integral partners and ensure that they have a primary decision-making role in service delivery decisions and provider agency functioning, including having roles of significance on agency boards and committees.
- All programs have a strategic plan to reduce and prevent the use of restraint and seclusion that is informed by the Six Core Strategies© (Appendix II) and is reviewed and updated annually.
- All programs have a strategic plan to improve their family engagement practices that includes at minimum:
 - Assessment of current family engagement practices, utilizing the Building Bridges standardized tool, updated annually (www.buildingbridges4youth.org/sites/default/files/BB-SAT.pdf);
 - A plan for identifying a caring adult who can support youth who have an alternative permanent plan of living independently in the community;
 - Whenever appropriate, a plan for pro-actively engaging both parents, including the non-resident parent, in the lives of their children in care.
- All programs serving adolescents and young adults age 14 and above incorporate education and training in skills needed to be self-sufficient adults, including assistance with job placement, living arrangements, and support, based on a positive youth development model.
- All programs will align their clinical, managerial and systemic practices with the System of Care philosophy, principles and values. See Building System of Care: A Primer, Sheila A. Pires, 2002. Available from Georgetown University Child Development Center at: https://gushare.georgetown.edu/ChildHumanDevelopment/CENTER%20PROJECTS/WebSite/PRIMER_ChildWelfare.pdf
- All programs will have credible mechanisms for self-assessment, measuring and reporting on provider-agency and Division outcome measures, and demonstrating their adherence to the principles articulated in the RFI.

Questions:

1. These new potential requirements reflect, in part, a new conceptual framework (Building Bridges Initiative). What recommendations do you have to facilitate the implementation of these requirements? What support would an agency like yours require from DPBHS to implement these new requirements?

2. What are the challenges, if any, to implementing the proposed requirements for residential services?
3. Please define other requirements you believe should be added that would drive toward improvements in the existing system.

3.2 Community and Family Engagement

DPBHS has processes in place that engage formal and informal community-based services to facilitate successful integration of youth within community life. Residential providers also will help to connect families and youth to these resources in their own community. These resources will offer additional supports to families and youth during residential services as well as after discharge.

Questions:

1. The national Building Bridges Initiative recommends the incorporation of family partners/parent support specialists and youth graduate/young adult peer mentors as part of the residential services workforce. What recommendations do you have regarding how to translate this recommendation into requirements in the proposed procurement in order to ensure the programs can successfully adopt these roles?
2. What are the training needs associated with the envisioned residential services approach? Identify what training, if any, should be offered by DSCYF and what would be best conducted by the provider?
3. List effective solutions you have employed to support a family's and youth's connection to formal and informal resources in their community of origin. What barriers have you found particularly challenging and how have you overcome them?
4. Identify key areas and/or issues that must be addressed in the proposed procurement to ensure that the resulting services will meet the unique needs of youth aging out of child services.
5. What solutions should be employed to partner successfully with support services to ensure they are in place before a youth's transition from residential to community-based care? What barriers have you found particularly challenging and how have you overcome them?
6. What community-based services are most readily integrated into residential services, and how would this integration be best achieved?
7. What recommendations do you have to support, or improve, collaborative practice between providers and schools? Are there specific actions DPBHS or others should take to support these recommendations?
8. What suggestions do you have to ensure the voices of youth and family are fully and meaningfully incorporated into the Youth & Family Centered Residential Services Initiative?
9. What are the challenges of providing services to children with a parent who has mental illness? What solutions could be employed for successful family reunification when a parent has a mental illness?

3.3 Service Trends & Capacity to Treat Delaware Youth

Utilization and clients served over the past three years have been:

	←-----Units (Days)----->			←-----Clients----->		
	2011	2012	2013	2011	2012	2013
State Run Services						
Crisis Bed MH	1496	1762	1482	189	186	172
Residential Treatment, MH	8843	8767	6615	82	75	59
Contracted						
In Delaware						
Crisis Bed MH	364	357	259	69	105	76
ICT - Residential	602	1393	1370	2	5	5
Individualized Residential Treatment	2601	1120	898	12	7	6
Residential Treatment, MH	8132	6876	6129	57	64	58
Therapeutic Respite	69	11	13	10	4	3
Out of State						
ICT - Residential	22	868	1707	1	3	7
Residential Treatment, MH	3796	6305	7548	27	38	51
Residential Treatment, SA	2147	2349	2391	59	59	57
Treatment Foster Home	365	366	274	1	1	1
Treatment Group Home	0	68	138	0	1	1

- The number of youth referred out of state has increased 34%.
- Approximately 30% of children in residential services are also active with the Division of Family Services, 33% with the Division of Youth Rehabilitative Services and 12% are active with all three DSCYF service divisions.
- Children and youth in residential mental health treatment services in FY2013 had the following Axis I diagnoses:

Oppositional Defiant Disorder	68
Mood Disorder NOS	68
Attention-Deficit/Hyperactivity Disorder, Combined Type	66
Posttraumatic Stress Disorder	50
Parent-Child Relational Problem	27
Conduct Disorder	23
Bipolar Disorder NOS	22
Attention-Deficit/Hyperactivity Disorder NOS	21
Cannabis Abuse	14
Depressive Disorder NOS	13

- Residential mental health services procured out of state were generally in Psych-Under 21 / Accredited Residential Treatment facilities.

- All youth requiring residential substance abuse treatment are sent out of state. Youth placed in out of state substance abuse treatment in FY2013 had the following Axis I diagnoses:

Cannabis Dependence	24
Alcohol Abuse	22
Attention-Deficit/Hyperactivity Disorder, Combined Type	13
Opioid Dependence	12
Oppositional Defiant Disorder	11
Cannabis Abuse	11
Depressive Disorder NOS	10
Poly-substance Dependence	10
Mood Disorder NOS	9
Conduct Disorder - Adolescent-Onset Type	9

- Treatment foster care and treatment group home placements were typically co-authorized with the Division of Family Services.
- Interagency Collaborative Team (ICT) are co-funded services among the Department of Education, the Division of Developmental Disabilities, and DSCYF.

Questions:

Capacity/Utilization

1. Based on the referral and utilization data described above, identify approaches to meet the level of capacity that you believe DPBHS should establish across respite, crisis, and residential services, and what methodology you used to arrive at that recommendation.
2. Please describe any ‘right-sizing’ challenges you believe DPBHS would encounter if fewer services were procured and how you would address the challenges.
3. Please identify the challenges that providers would face in providing care to youth with substance abuse needs who currently are sent out of state for treatment. Offer recommendations to address these challenges.
4. If you were tasked with maintaining youth with substance abuse treatment needs in Delaware, what would you put in place to accommodate their treatment service needs and success in the community?
5. If you were tasked with maintaining all youth with mental health treatment needs in Delaware, what would you put in place to accommodate their service needs and success in the community?
6. Should DPBHS consider procuring a different array of residential service (Please see Appendix IV for our current array of residential services)? If so, please identify what new service you would recommend and why.

7. Are there missing elements in the current residential services? What enhancements would you recommend? What changes would you not recommend?

Innovations

8. Please describe your organizations innovations, creative strategies, emerging/promising or best practices that you believe DPBHS should consider as we redesign our residential services.
9. Do you believe that every treatment provider should adopt a formal model of care? Is there an approach you strongly recommend be adopted by all providers?
10. Are there current residential treatment practices that DPBHS should ‘sunset’ or limit?
11. Should families be taught the same skills, techniques and methods that direct-service staff in residential service facilities are taught?
12. Should youth/families have formal and informal roles in residential provider agencies and treatment programs?

3.4 Purchasing and Pricing Methodologies

DPBHS believes that compensation rates should be adequate to meet the costs of an efficient and economically operated provider, take into account the costs to providers of any existing or new governmental mandates, be regularly reviewed for adequacy, and reflect any meaningful geographical differences in the costs of service delivery.

DPBHS will research payment systems employed by other states to identify features and methods that could be applicable for replication in Delaware. Pricing options to be explored may include a single case rate, a tiered rate that is adjusted based on client status and functioning (i.e., no longer meets criteria for placement, meets transitional criteria, meets aftercare criteria) or pricing of service components according to type, frequency and intensity. It is likely that any changes to DPBHS rate setting would be phased in over time.

Questions:

1. Staffing intensity is likely to be the greatest determinant of variability in rates. What other major programmatic inputs should be evaluated for their effect on cost?
2. How does type of physical facility affect the pricing structure? Should rates reflect variation in how the provider acquired the physical structure (Rent? Purchase? Donated?)
3. Historically bed/day has been the unit of service utilized for residential services. Should DPBHS consider other types of unit rates such as a per-case over a pre-determined period of time, such as an episode, bed/day plus a follow-up rate of some type for post residential services? Other types?

4. Should rates be case-mix adjusted? In your experience have you encountered valid tools that would support efforts to adjust rates by case-mix?
5. There has been discussion of a performance-based payment system. What additional data would need to be collected to develop and evaluate such a system?
6. Would additional data collection for pricing be perceived as burdensome? Would your agency be willing to assist with the development of a tool to collect this data?
7. Do you have recommendations on how to involve providers in the development of rate options?

3.5 Performance-Based Contracts

DPBHS is considering moving toward a Performance-Based Contracting system for a portion of these services. In this type of system, it is possible that implemented contracts will include what outcomes are desired and expected relative to contractor service specifications and will include incentives for providers to achieve the desired youth and family outcomes. Such a system would require identification of desired outcomes, core components of the services, the populations that are most likely to benefit, a way to reliably and validly measure when those desired outcomes have been achieved, and reasonable rewards for high performing programs.

DPBHS is considering the following outcomes for programs entering into a performance contract:

- Improved rates of successful discharge to a home or stable community placement;
- Improved stability in the home and in community-based services;
- Improved safety through prevention and reduction of restraint and seclusion;
- Improved child/youth functioning (as measured by CANS or similar outcomes measurement tool).

Questions:

1. Identify the key service components of a Residential Program that offer the greatest likelihood that children and families will succeed in achieving these outcomes.
2. Define possible performance rewards DPBHS should consider. Are there rewards other than financial ones that would incentivize performance to desired outcomes?
3. What process would you recommend for obtaining consensus on outcomes, measures, service components, eligible populations and performance rewards for a performance contract?
4. Are there other outcome measures that should be included in a performance contract?
5. Please identify the key indicators of program quality that should be tracked.
6. What process would you recommend that the Agencies use in establishing level-of-service criteria for each level of care?

7. What are the criteria that are most important to consider when determining the need for continuing care?
8. What standards would you recommend the Agencies establish related to discharge planning and decision-making?

Section 4 RFI Response Instructions

4.1 RFI Response Instructions

RFI responses must be received by **October 25, 2013, by 4:00 p.m.** Eastern Time. Questions or requests for clarifications of this document should be submitted by email to Howard Giddens at Howard.Giddens@state.de.us

Parties interested in responding to this RFI should prepare a typed response that includes a cover sheet that states the respondent's name, organization, address, telephone number, email address, and affiliation or interest (e.g., family member, community member, provider, advocacy organization). Responses may be submitted either electronically or in hard-copy format.

- Response by e-mail to: Howard.Giddens@state.de.us
- Respond with hard copy to:
Howard R. Giddens
Prevention and Behavioral Health Program Administrator
1825 Faulkland Road
Wilmington, DE 19805

Questions should be answered in order of appearance and numbered according to the RFI question number. Respondents are invited to respond to any or all of the RFI questions; please respond to as many as you feel are appropriate. Responses, including any attachments thereto, should be clearly labeled and referenced by name in the RFI response. No part of the response can be returned. Receipt of RFI responses will not be acknowledged.

4.2 Use of RFI Information

Information is being solicited in the RFI to assist DSCYF/DPBHS in the development of a Request for Proposal for residential services. The RFI is not binding on DSCYF/DPBHS and shall not obligate DSCYF/DPBHS to issue a procurement that incorporates any RFI provisions or responses. Responding to this RFI is entirely voluntary, will in no way affect DSCYF/DPBHS's consideration of any proposal submitted in response to any subsequent procurement, and will not serve as an advantage or disadvantage to the respondent in the course of any future procurement that may be issued. Responses to this RFI become the property of the state of Delaware and are public records under Delaware law. However, information provided in response to this RFI identified by the respondent as trade secrets or commercial or financial information shall be deemed confidential and shall be exempt from disclosure as a public record. This exemption does not apply to information submitted in response to any subsequent procurement unless stated at that time.

It is important to note that responding to this RFI will neither increase nor decrease a future bidder's chances of being awarded a contract resulting from any future procurement action.

APPENDIX I

Definitions

Building Bridges Initiative: Building Bridges is a national initiative working to identify and promote practice and policy that will create strong and closely coordinated partnerships. These collaborations occur between families, youth, community- and residentially based treatment and service providers, advocates and policy makers to ensure that comprehensive mental health services and supports are available to improve the lives of young people and their families. (www.buildingbridges4youth.org)

Community-Based Residential Services (Residential Services): Current programs include:

- Respite service
- Crisis Bed service
- Residential Mental Health treatment
- Residential Substance Abuse treatment
- Individual Residential treatment

Family: broadly defined as biological, kin, guardian, foster, pre-adoptive or adoptive person(s).

Performance-Based Contracting: A Performance-Based Contract is one that focuses on the outputs, quality and outcomes of service provision and may tie at least a portion of a contractor's payment as well as any contract extensions to their accomplishment (Martin, 1997:1 & 8).

Positive Youth Development: Children who are connected to caring adults are more likely to be emotionally healthy and engaged in school, and less likely to participate in delinquent or destructive behavior.

Six Core Strategies©: The Six Core Strategies© were developed by national experts working through the Office of Technical Assistance at the National Association of State Mental Health Program Directors (NASMHPD, the organization that represents public mental health systems throughout the United States). The Core Strategies are a public-domain curriculum and model designed to create organizational culture change. They have been successfully applied to reduce and prevent the use of restraint, seclusion and violence in care settings. The Six Core Strategies© have been used in child/adolescent and adult settings including schools, residential, inpatient, juvenile justice and correctional facilities. See Appendix I.

System of Care: “A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families”. (Stroul, B., & Friedman, R. 1986) “A System of Care incorporates a broad array of services and supports that is organized into a coordinated network, integrates care

planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels". (Pires, S. 2002)

Utilization Management: The process of managing service use and costs through effective planning and decision-making to ensure that services provided are appropriate, meet the intended goals and are cost-effective.

Wraparound: A definable planning process involving the youth and family that results in a unique set of community services and natural supports individualized for that youth and family to achieve a positive set of outcomes. See also National Wraparound Initiative (<http://www.nwi.pdx.edu>) for further description of Wraparound.

APPENDIX II

Available at: <http://www.buildingbridges4youth.org/>



Promoting Youth Engagement:

What Providers Should Know About Best Practices and Promising Strategies

September 2012

Acknowledgments

The Building Bridges Initiative (BBI) gratefully acknowledges the support and commitment of the Substance Abuse and Mental Health Services Administration (SAMHSA). BBI was initiated and has been sustained through SAMHSA's leadership.



The Building Bridges Initiative would like to acknowledge the support of Magellan Health Services, Inc. Their commitment to BBI principles and practices ensures that the voices of families and youth are foremost in providing guidance to the field to promote successful engagement.



The generosity of SAMHSA and Magellan made the development of *Promoting Youth Engagement* possible. We are deeply appreciative.

The content of this publication does not necessarily reflect the views, opinions or policies of the Substance Abuse and Mental Health Services Administration or the Department of Health and Human Services.

Promoting Youth Engagement: What Providers Should Know About Best Practices and Promising Strategies

Youth with lived experience¹, providers², and policy makers³ have articulated the crucial need for residential services to embrace youth-guided principles and practices. This paper provides a summary of best and promising practices for promoting youth engagement in residential settings. The document was developed as a companion piece to the Building Bridges Initiative paper, *Promoting Youth Engagement in Residential Settings: Suggestions from Youth with Lived Experience*, which describes insights and suggestions from youth currently in residential settings about ways providers can engage them. Below is a synopsis of key research findings, articles, and documents regarding youth engagement in residential. These best and promising practices complement and contextualize the perspectives offered by the youth in the previous paper.

Why Engage Youth?

- *Youth engagement is associated with positive relationships and increased motivation.* Youth who actively engage in treatment tend to develop strong relationships with service providers, express a willingness to change, and participate and collaborate with others in the context of treatment (Smith, Duffee, Steinke, Huange, & Larkin, 2008).
- *Youth engagement is important for positive outcomes post-discharge.* Studies suggest that youth engagement is correlated with better treatment outcomes, and that youth engagement predicts treatment retention and success (Burns et al., 1999, Courtney et al., 2004, as cited in Lebel, Hucksort, & Caldwell, 2010; Hawke, Hennen, & Gallione, 2005; & Hoagwood, 2005).

¹ The Youth Movement is composed of youth and young adults with lived experience in residential. It has grown substantially over the last twenty years, from small, grassroots efforts to statewide and national networks. These youth activists promote youth choice and voice in services (Redefining Residential, 2010; Tenney, Dech, Orlando, & Sanchez, 2006).

² A growing number of residential providers have endorsed the Building Bridges Initiative's Joint Resolution, which articulates the need for youth-guided services. To read the Joint Resolution and to view a list of providers who signed it, visit: <http://www.buildingbridges4youth.org/products/joint-resolution>.

³ The *President's New Freedom Commission on Mental Health*, a document that reviewed and made recommendations regarding the state of mental health delivery services in the United States, articulated the importance of involving youth and adult consumers in treatment planning and mental health reform efforts (2003).

How Can Providers Improve Residential Services and Increase Youth Engagement?

- **Defining clear goals and shortening lengths of stay.** Residential-specific research shows improved outcomes with shorter lengths of stay (Hair, 2005; Walters & Petr, 2008).
- **Providing Stimulating and Effective Academic Environments.** Academic success is correlated with sustained positive outcomes, as youth are discharged from residential (Hair, 2005).
- **Emphasizing family involvement and participation.** Emerging research suggests that youth are more likely to sustain positive outcomes upon discharge from residential when their families are involved and engaged (Hoagwood, 2005; McNeal, Handwerk, Field, Roberts, Soper, Huefner, & Ringle, 2006; Pottick et al., 2005). To promote family and youth participation, it is essential to involve youth and families in meaningful roles and to value their input (see Lebel et al., 2010; Polvere, 2011; *Redefining Residential*, 2010). Further, increased family involvement, stability, and support in the post-residential environment are crucial to success (Walters & Petr, 2008).
- **Promoting a youth's "choice and voice" in services.** To engage youth, it is essential to implement services in a manner that privileges youth choices and preferences (Joyce & Shuttleworth, 2001; Polvere, 2011; Tenney, 2000; Tenney, Orlando, Dech, & Sanchez, 2006). From a developmental perspective, adolescence and emerging adulthood is typically defined as a time of independent exploration (Arnett, 2000). However, residential settings that limit opportunities for choice and exploration do not promote this normative developmental process (Mohr & Pumariega, 2004), leaving youth ill prepared to re-enter the community (Pottick, Warner, & Yoder, 2005; Pumariega, 2007). Therefore, it is essential to provide concrete opportunities for youth to express their choices and opinions regarding helpful services (Joyce & Shuttleworth, 2001).
- **Providing trauma-informed services.** Many youth in residential settings have acute histories of abuse and neglect (Connor et al., 2004; James et al., 2006). Youth in residential settings are more likely to have experienced traumatic events, such as parental incarceration, familial substance abuse, and poverty (Connor et al., 2004; James et al., 2006). To address experiences of trauma, emerging research supports the implementation of trauma-informed care. Trauma-informed care emphasizes practitioner awareness of trauma and safety for youth. It emphasizes the importance of providing opportunities for youth to rebuild a sense of control,



particularly by emphasizing choice and agency. Trauma informed care is rooted in a strength-based approach (Hopper, Bassuk, & Olivet, 2010). Consistent with the principles of trauma-informed care, "residential should be first and foremost a "sanctuary" with an abundance of relational safeguards to prevent further re-traumatization" (Latham, et al., 2010, p. 81).

- ***Eliminating Restraint and Seclusion.*** Restraint and seclusion has been found to re-traumatize youth in residential, many of whom have experienced significant traumatic events in their lives prior to placement (Miller et al., 2006; Lebel et al., 2010; Latham et al., 2010; Polvere, 2011). A proactive strategy that can assist residential providers in eliminating restraint and seclusion is the development of individualized safety or soothing/calming plans for youth, which include supporting youth in "learning how to recognize what triggers their distress, how they experience the upset, and what interventions help them calm down" (Lebel et al., 2010, p. 174).
- ***Changing the Organizational Culture.*** As providers seek to promote youth engagement, it is essential to provide leadership that leads to significant organizational change (Lebel et al., 2010; *Redefining Residential*, 2010). Strategies include inviting youth to participate in staff hiring decisions, training and hiring peer advocates, developing Youth Advisory Councils and a Youth Bill of Rights, and including residential alumni on the Board of Directors (*Redefining Residential*, 2010). Youth Advisory Councils and other youth involvement initiatives can be an important way to move toward youth-guided care by fully incorporating youth voice and input at all levels of practice. Further, to achieve the goal of youth-guided care, it is important to embed youth empowerment into the mission of the agency, to incorporate youth advocates into agencies, to facilitate youth understanding of their rights, and to build in measures of accountability for youth empowerment outcomes (Romanelli et al., 2007).
- ***Implementing Culturally and Linguistically Competent Services.*** For residential services for children and youth to be effective and engaging, it is essential for staff and organizations to become culturally and linguistically competent, as cultural awareness plays a key role in influencing mental health outcomes (Osher, Cartledge, Oswald, Sutherland, Artilles, & Coutinho, 2004; Clark & Unruh, 2009). Cultural competence is having the capacity to "step outside of our own framework" and to treat youth as individuals by "respecting and acknowledging their cultural beliefs and values" (Osher et al., p. 63). Further, staff should be knowledgeable about the impact of systemic injustices faced by ethnic minority youth, such as racism and discrimination. When residential settings display cultural biases or insufficient knowledge of a youth's culture, this is a significant barrier to effective services (Osher et al., 2004). Linguistic competence refers to the ability of an organization to convey information at a level that is easily understood by diverse groups, including



individuals with limited English proficiency, low literacy skills, or disabilities (Goode, Dunne & Bronheim, 2004). Cultural and linguistic competence, particularly in regard to youth culture, is a key strategy for promoting youth engagement⁴. Culture and linguistic competence facilitates informed and trusting relationships between youth and staff.

- **Understanding Youth Culture.** It is important for residential providers to recognize that youth also have their own culture (Clark & Unruh, 2009). Youth culture consists of “linguistic characteristics, fashion trends, high-tech communication, social hierarchy, values, and norms” specific to adolescent and young adult development (Clark & Unruh, 2009, p. 230).

The Building Bridges Initiative (BBI)

Building Bridges is a national initiative focused on supporting positive outcomes for youth and families served in residential programs and their community counterparts. Founded on core principles, an emerging evidence base, and acknowledged best practices, the BBI emphasizes strong collaboration and coordination between providers, families, youth, advocates, and policymakers to achieve its goals. More than 130 organizations have endorsed the Joint Resolution, which articulates the values and principles of BBI. To find out more about the national Building Bridges Initiative (BBI), please visit: <http://www.buildingbridges4youth.org>

Additional Resources

A companion document to this paper, *Promoting Youth Engagement in Residential Settings: Suggestions from Youth with Lived Experience*, can be found on the Building Bridges website: www.BuildingBridges4youth.org.

The Building Bridges Initiative has compiled a list of articles, websites and other resources to support the practice of youth-guided care. This can be found at: <http://www.buildingbridges4youth.org/resources/presentations>.

⁴ See the Building Bridges Guide, *Cultural and linguistic competence: Guidelines for residential programs*, for strategies and emerging promising practices. <http://www.buildingbridges4youth.org/workgroups/cultural-linguistic-competence/products>.

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APPENDIX III

Guiding Principles for Successful Restraint and Seclusion Reduction Reform

The National Technical Assistance Center and NASMHPD have identified six "core strategies", based on literature reviews and on "lessons learned" from successful restraint/seclusion reduction efforts, which can serve as guiding principles for similar initiatives. In brief, those are:

1) Leadership toward Organizational Change:

Leadership must define and articulate the vision for reduction and elimination of seclusion and restraint; clarify the values and philosophy on which new practice strategies will be based; and establish accountability for implementing those practices. Development of multi-disciplinary teams to lead the change effort has proven helpful in many successful restraint/seclusion reduction and elimination efforts.

2) Use of Data to Inform Practice:

Collection of restraint/seclusion data at the unit, facility, and agency levels is needed in order to establish pre-change-effort baselines of restraint and seclusion events; to identify patterns in restraint/seclusion use; to establish accountability through setting and tracking progress toward reduction and elimination goals; and for tracking injuries related to restraint/seclusion use.

3) Workforce Development:

Building the skill and knowledge of program staff is at the heart of efforts to supplant the use of restraints/seclusions with a trauma-informed, recovery-oriented treatment milieu. Ability to utilize alternatives to restraint and seclusion; to safely implement least restrictive interventions when necessary; and to accurately record required data elements are among the fundamental skills needed by staff of a quality residential treatment program. Both intensive and ongoing trainings which engage and challenge staff are necessary in order to develop needed skills and knowledge, to update staff with new information, and to prevent "drift" and regression to undesired practices.

4) Use of Seclusion/Restraint Prevention Tools:

These include an understanding of and attunement to the emotional impact and behavioral sequelae of traumatic events, including experiences of restraint and seclusion; the use of individualized assessments to document histories of trauma, violence or self-harmful behavior, the situations or events which may trigger behavioral crises, and strategies for calming and de-escalation; linking that information to individualized treatment and recovery plans which staff actively utilize; and the teaching of self-soothing and self-management skills.

5) Consumer Roles in Care Settings:

Consumers, families, and other advocates have contributed significantly to successful restraint/seclusion reduction and elimination efforts by providing compelling first-hand testimony to the impact of coercive interventions; through participation in the planning and monitoring of change initiatives; and by serving on debriefing teams and as peer support advocates. Full and formal involvement of consumers, families and other advocates at all stages of restraint/seclusion reduction efforts has proven fundamental to the success of these initiatives.

6) Debriefing Techniques:

Two types of debriefings are recommended after a seclusion/restraint event has occurred. The first involves an immediate review of antecedents, behaviors, non-coercive interventions that were attempted, and possible missed opportunities to implement safe alternatives. The second is a more formal review involving staff, supervisor(s), the resident, advocate(s), and the treatment team. Purposes of debriefing are both to learn from negative events and reduce the likelihood of future restraints/seclusions, and to ameliorate to the extent possible the emotional impact of coercive interventions on the resident, staff, and any witnesses involved.

Huckshorn, K.A. (2006). "A Snapshot of Six Core Strategies for the Reduction of S/R". National Technical Assistance Center and National Association of State Mental Health Program Directors.

APPENDIX IV: DPBHS Services

Psych Under 21:

Psych Under 21 services include inpatient hospitalization, and accredited Residential Treatment Centers.

1. Inpatient Hospital: Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored and treatment interventions can be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services.

A therapeutic milieu with strong psychiatric medical support is central to effective inpatient treatment. Therapeutic interventions, activities, milieu and educational components must be carefully integrated to create a total ecological treatment regime.

Components of the service include:

- Independent psychiatric assessment within 24 hours of admission.
- A thorough assessment of the medical, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptoms.
- Focused brief treatment and stabilization as medically necessary, including individual and group approaches and problem-specific approaches.
- Therapeutic stabilization of youth in crisis, including physically aggressive minors and minors who are a danger to self or others.
- Safe and secure environment for all minors who are involuntarily admitted, including those who are violent and dangerous to themselves and/or others.
 - Involuntary inpatient treatment should be used only in extraordinary circumstances where a minor meets the legal definition for involuntary admission and a parent or legal guardian's signature for voluntary inpatient treatment is unavailable. Treatment is used primarily for acute crisis resolution to address behavior and symptoms which cannot be addressed at other less restrictive levels of care. When the acute crisis is resolved, the client should continue treatment in a less restrictive context.
- Careful monitoring of psychotropic medications and their effects on the client's behavior.
- High degree of structure, order and predictability with regard to the routines of daily living, the management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
- Programmed activities for the amelioration of presenting problems, including skill building with an emphasis upon interpersonal and problem solving skills; self-care/life skills; activity and recreational programming.

- Brief family therapy with focus upon reintegration into the community within the shortest clinically appropriate time frame.

This service may include the following elements:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health, with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

2 Facility Based Residential Treatment Services: Services at this level are characterized by the provision of a 24-hour residential living environment which is deliberately designed to create a structured therapeutic milieu and which forms the basic foundation around which clinical treatment services are organized and integrated. Within the residential treatment level of the DPBHS continuum, programs and services are differentiated along several key dimensions:

- Restrictiveness of the milieu, in terms of both the physical characteristics of the environment and its proximity to the community.
- Nature and extent of clinical resources deployed in support of the milieu.
- Ratios of child care staff-to-clients and the nature and extent of client supervision and care provided.

The residential living environments are thoroughly integrated with the clinical and educational services provided in the day treatment component, together constituting a 24-hour therapeutic milieu. A key feature of the program's design allows transition of youth from residential treatment status to day-treatment-only status with no loss of treatment continuity or momentum.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health , with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

Rehabilitation Services:

These services include Crisis Intervention/Crisis Bed, Facility Based Residential Treatment Centers, Individualized Residential Treatment, Day Hospital, Part Day and Day Treatment, Intensive Home-Based Outpatient, Behavioral Intervention, Therapeutic Respite, Outpatient, Functional Behavior Assessment and assessment. Each of these services is described below.

1.Crisis Intervention/ Crisis Bed – Child Priority Response services are provided to a person who is experiencing a psychiatric crisis, designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation, and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goals of Crisis Interventions are symptom reduction, stabilization, and restoration to a previous level of functioning. All activities must occur within the context of a potential or actual psychiatric crisis. Crisis Intervention is a face-to-face intervention and can occur in a variety of locations, including an emergency room or clinic setting, in addition to other community locations where the person lives, works, attends school, and/or socializes.

Services are available 7-days per week, 24 hours per day with in-person crisis assessment and intensive intervention and case management for youth in behavioral health crisis. A supervised crisis bed is also available for youth who present minimal risk but whose safety cannot be assured with supervision available in his/her usual residence. The purpose of the crisis program is to enhance the client's/families coping skills and to identify and strengthen its natural helping network as support during the period of crisis.

Program components include:

- Crisis Response- first contact response with a youth experiencing a mental health emergency.
- Crisis Bed-temporary (1-3 night target) supervised setting which provides for safety and respite for a youth in a crisis situation.
- Crisis Intervention-intensive short term therapeutic intervention to assist the youth and his/her caretaker(s) to improve coping mechanisms, identify and address the issues that precipitated the crisis and plan, in conjunction with DPBHS, for further treatment if necessary.

This service may include the following elements:

- A. A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment and/or referral to other alternative mental health services at an appropriate level.
- B. Short-term crisis interventions including crisis resolution and de-briefing with the identified Medicaid eligible individual.
- C. Follow-up with the individual, and as necessary, with the individuals' caretaker and/or family members.
- D. Consultation with a physician, if appropriate, or with other qualified providers to assist with the individuals' specific crisis.

2. Facility Based Residential Treatment Services: Services at this level are characterized by the provision of a 24-hour residential living environment which is deliberately designed to create a structured therapeutic milieu and which forms the basic foundation around which clinical treatment services are organized and integrated. Within the residential treatment level of the DPBHS continuum, programs and services are differentiated along several key dimensions:

- Restrictiveness of the milieu, in terms of both the physical characteristics of the environment and its proximity to the community.
- Nature and extent of clinical resources deployed in support of the milieu.
- Ratios of child care staff-to-clients and the nature and extent of client supervision and care provided.

The residential living environments are thoroughly integrated with the clinical and educational services provided in the day treatment component, together constituting a 24-hour therapeutic milieu. A Key feature of the program's design allows transition of youth from residential treatment status to day-treatment-only status with no loss of treatment continuity or momentum.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health , with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or

- employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
 - C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health.
 - D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

3. Individualized Residential Treatment: The Individualized Residential Treatment services are characterized by the use of highly trained professional treatment parents, who implement individualized treatment in their own homes on a continuous basis (24 hours per day, seven days per week) under the clinical supervision of licensed mental health professionals. One of the trained parents must commit as a full-time treatment parent, available to provide consistent, ongoing interventions and support to the youth in home, school and community. Professional treatment parents are recruited and trained to serve as the primary therapeutic interventionist, responsible for providing services to an assigned youth under the direction of a licensed mental health therapist.

The professional treatment parents:

- Participate in the development of and implement their roles in treatment/educational/vocational plans.
- Act as agents of behavioral change by implementing specific behavior modification programs based upon principals of positive reinforcement.
- Provide positive role modeling, guidance and counseling to assist the youth in managing the demands of everyday living and in ameliorating specific behavioral deficits and problems.
- Teach and otherwise foster the development of adaptive living skills by the youth.
- Provide general care and supervision of the youth, consistent with their roles as surrogate parents.
- Manage emotional and behavioral crisis, with clinical supervision and support in accord with the youth's treatment plan and with Divisional protocols for crisis management and intervention.
- In conjunction with biological or adoptive parents, advocate for the youth making contact with schools and collateral service providers as necessary to support the youth.

- Maintain a therapeutic living environment that is well structured and designed to nurture and support the youth.
- Arrange for appropriate ancillary services (e.g. transportation, etc.) needed to implement the youth's treatment plan.
- Work directly under clinical supervision with biological or adoptive families, as indicated in the treatment plan, to teach and model appropriate social, interpersonal and parenting skills.
- Participate in meetings with the DPBHS Clinical Services Management Teams for the purpose of planning the treatment and monitoring client progress in treatment.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health , with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health .
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

4. Day Hospital Services: Day Hospital Treatment is a milieu-based, medically managed, full-day intensive treatment program that provides intensive clinical services under psychiatric supervision, integrated with an educational component that permits the program to be used as an alternative to school attendance for emotionally disturbed and mentally ill children and adolescents who are unable to function safely in a normal school environment. The program functions on a five hour per day, five day per week basis and is specifically designed to accommodate the ongoing treatment and development needs of severely disturbed clients. Direct psychiatric supervision of treatment is required due to the acuity of the behavioral health presented by these clients.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health , with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

5.Part-Day and Day Treatment: Part-Day Treatment (Substance Abuse Only) is a 5 day per week intensive program of three (3) hours per day that provides a developmentally approach after-school intervention for substance abusing children and adolescents who are unable to fulfill the functional requirements of this developmental stage without this level of intensive service. The program is available to clients for whom it is clinically necessary. Clients receive the same clinical services as are provided in full day treatment except for the academic component. Substance abuse programs also focus on client and family education regarding a variety of topics related to substance abuse, e.g., AIDS prevention, 12-Step activities and relapse prevention.

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for seriously disturbed children or adolescents who are unable to fulfill the functional requirements without this level of intensive service. The program is available as clinically appropriate and is open approximately 225 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the client's natural environment. They include but are not limited to:

- Professional diagnostic and therapeutic services, e.g., psychological and psychiatric services, individual and family; family assessment; individual, group and family treatment; medication evaluation/monitoring and case management.
- Activities are provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation with the DPBHS crisis unit.

- Transportation to and from program activities.
- Educational program, appropriate to the level and individual educational needs of the client, with instruction provided by certified teachers (The DSCYF Division of Management Support Services provides educational staff, for cost-reimbursable contracts).
- Substance abuse programs also focus on client and family education regarding a variety of topics related to substance abuse, e.g., AIDS prevention, 12-Step activities and relapse prevention.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health, with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health.
- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

6. Intensive Home-Based Outpatient Treatment (IOP) is goal directed supports and solution-focused interventions intended to achieve identified goal or objectives as set forth in the individual's individualized treatment plan. IOP is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. IOP contacts may occur in community or residential locations where the person lives, works, attends school, and/or socializes. IOP is an alternative to psychiatric hospitalization, residential treatment or day treatment. It provides intensive community-based intervention designed to assist the client and the family (especially those who are unable to benefit from insight oriented treatment), the school and other members of the natural helping network to learn skills to deal with existing problems.

Objectives are:

- To reduce the frequency of inpatient psychiatric hospitalization episodes.

- To reduce the length of stay of clients admitted to psychiatric hospital or residential treatment.
- To reduce the frequency and duration of behaviors that may lead to out-of-community residential treatment and/or psychiatric hospitalization, (symptom reduction)
- To increase the number of days between hospital, residential and crisis episodes.
- To increase the frequency of appropriate social contacts made by the client in his/her community and/or within the psycho-social group. (increase in functioning)
- To increase the number of consecutive days the client is able to engage in academic, vocational or other training program.

7. Behavioral Intervention Program: Behavioral Intervention Services are designed to augment mental health/substance abuse (MH/SA) treatment provided directly by MH/SA providers through the use of an interventionist working directly with the client and family to carry out elements of the MH/SA treatment plan developed by the therapist. The aide is available to help generalize treatment to other settings. The service is time-limited, focused on specific goals and used to aid in transition between levels of care or to facilitate acquisition of specific developmental tasks.

Objectives are:

- To provide home/community based services adjunct to mental health/substance abuse treatment to children and families who require more than routine outpatient services.
- To provide additional therapeutic services as an alternative to a higher level of service provision or to aid in the transition between levels of care.
- To transition the client to natural, community based support systems.

This service may include the following components:

- A. Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual's behavioral health , with the goal of minimizing the negative effects of behavioral health symptoms or emotional disturbances or associated environmental stressors which interfere with the individual's daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.
- B. Individual and family supportive counseling, solution focused interventions, emotional and behavioral management, and problem behavior analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living and independent living skills to restore stability, to support functional gains, and to adapt to community living.
- C. Participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their behavioral health.

- D. Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan and/or as appropriate, seeking other supports to restore stability and functioning.

8. Therapeutic Respite Service: Occasional periods of respite care can significantly reduce stress in the family and enhance the family's ability to keep their child/youth at home in the community. Caring for a family member with serious emotional disturbance, behavioral health or substance abuse problems can be highly stressful and time consuming. Therapeutic Respite Service is a planned temporary opportunity to provide families time they need to renew their energies so that they can continue caring for their children at home.

Therapeutic Respite Service is defined as supervised, supported care, including overnight, for a child with behavioral health issues, serious emotional disturbance, behavioral health or substance abuse disorders and is provided in units of 12 or 24 hours. A full day of respite service is 24 hours of care. It is a temporary opportunity to provide relief to the family or primary caregiver of a child in order to facilitate the family's ability to maintain the child or youth in their home and community. Therapeutic Respite Service is a planned event to provide families with occasional relief in order to support them in continuing to care for their child at home. The purpose of therapeutic respite is to significantly reduce stress in the care-giving family, enhance the family's ability to keep the child at home in the community and prevent or delay the use of more restrictive and expensive behavioral health services for the child.

Provider Qualifications: Therapeutic Respite Service is provided by specially trained professional therapeutic respite parents/families in their own homes on a continuous basis for the defined respite period. Services are provided under the supervision of a respite treatment coordinator, a master's level behavioral health professional. Professional therapeutic respite parents will be recruited and trained by the Contractor to serve as primary therapeutic interventionists, responsible for providing services to an assigned youth under the direction of a the respite coordinator. The therapeutic respite parents will:

- Participate in the development of treatment planning, and implement their roles in the Respite Plan.
- Provide positive role modeling, guidance and counseling to assist the youth in managing the demands of everyday living.
- Teach and otherwise foster the development of adaptive living skills by the youth.
- Provide general care and supervision of the youth, consistent with their role as surrogate parents.
- Manage emotional and behavioral crises, with clinical supervision and support, in accord with the youth's respite plan, and with Divisional protocols for crisis management and intervention.
- Maintain a therapeutic living environment that is well structured and designed to nurture and support the youth.
- Work directly, under clinical supervision, with biological or primary caregivers, as indicated in the respite plan, to teach and model appropriate social, interpersonal, and parenting skills.

- Participate in meetings with the DPBHS Clinical Services Management Teams for the purpose of planning, and monitoring progress.
- The Contractor is responsible for recruitment, training, supervision and support of the professional therapeutic respite parents. Specifically, the Contractor will provide:
 - A minimum of 40 hours of pre-service training for each person in a therapeutic respite role, to include a unifying theoretical model to guide and inform all activities. Additionally, training is to include those topical areas required by the Delacare Requirements for Child Placing Agencies.
 - Direct providers of this service need to know the characteristics of serious emotional disturbance (from depression to manic behaviors) including co-occurring issues related to developmental disabilities and mental retardation; behavior management principles and strategies; how to prevent escalation not just how to de-escalate; strategies to help prevent as well as manage a crisis situation from aggressive acting out behaviors to harming self or others to suicide attempts. Direct providers of the Therapeutic Respite Service (provider staff and parents in a therapeutic respite home) must be trained and supported by the Contractor in a manner that enables them to provide adequate supervision and care for a child with serious emotional and behavioral health issues, some of whom may be dually diagnosed with developmental disabilities including mild to moderate mental retardation
 - Continuing education for each person in a therapeutic respite role, for a minimum of 30 hours per year.
- In coordination with DPBHS, the Contractor will establish referral and intake and respite placement processes.
- An individualized Respite Service Plan, including crisis planning, will be developed for the authorized respite period. Respite planning will be coordinated with the biological family or primary caregiver and the DPBHS Clinical Services Management Teams.
- The Contractor will provide twenty-four hour consultation, support and crisis direction and intervention during the entire term of each therapeutic respite event.
- Matching of the direct therapeutic respite provider with the youth and their family is critical and is the responsibility of the Contractor. Basic information about the child who needs respite care will be provided by DPBHS.
- Generally, one client per home setting is preferred. In special circumstances (e.g. siblings), the admission of two clients to a Therapeutic Respite home may be given consideration. The appropriateness and number of biological children of the professional therapeutic respite provider who reside in the home during the client's admission for therapeutic respite will also be taken into consideration on a case-by-case basis. Preference is for only one, possibly two, biological children in the home during course of therapeutic respite.
- Generally, the maximum benefit for therapeutic respite services that may be received in support of any one child or adolescent is not more than 24 full days of care per year. The year is calculated from the point therapeutic respite is first provided.

- Community supports (memberships in youth organizations, community athletic clubs, library memberships, etc.) are encouraged to support and enhance the therapeutic respite service for children.

9. **Outpatient Services:** Outpatient Services are goal directed support and solution focused interventions intended to assist an individual with their identified mental health or substance abuse challenge. Outpatient services include psycho-education, individual therapy, family therapy, and/or group therapy. Outpatient services are a face-to-face intervention with the individual present; however, family or other collaterals may also be involved.

Objectives are:

- To reduce the frequency of inpatient psychiatric hospitalization episodes.
- To reduce the length of stay of clients admitted to psychiatric hospital or residential treatment.
- To reduce the frequency and duration of behaviors that may lead to out-of-community residential treatment and/or psychiatric hospitalization, (symptom reduction).
- To increase the number of days between hospital, residential and crisis episodes.
- To increase the frequency of appropriate social contacts made by the client in his/her community and/or within the psycho-social group. (Increase in functioning).
- To increase the number of consecutive days the client is able to engage in academic, vocational or other training program.

10. **Functional Behavioral Assessment:** A functional behavioral assessment looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant, person-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non-occurrence) of specific behaviors. This broader perspective offers a better understanding of the function or purpose behind the child's behavior. Behavioral intervention plans based on an understanding of "why" a child misbehaves are extremely useful in addressing a wide range of problem behaviors.

Key elements include:

- Assessment
- Treatment planning
- Provision of training to persons who are part of treatment (parent/caregiver, etc.)
- Monitoring of progress
- Revision of treatment plan as necessary

11. **Assessment Services:** Assessment Services include psychological consultations and evaluations of children and youth by a licensed psychologist or staff under the supervision of a licensed psychologist. Referrals are made for assessment of child/youth who are presenting with behavioral problems, emotional problems or possible substance use problems. The purpose of the consultation or evaluation is to determine if the child/youth has a mental health and or substance abuse disorder and if so diagnosis it and provide treatment recommendations. While

in most cases the assessment is done face-to-face with the child/youth, in some instances consultation can consist of a record review followed by a report.