

Interagency Performance Standards and Practice Guidelines

State of Hawaii
Department of Education
Comprehensive Student Support System
And
Department of Health
Child & Adolescent Mental Health Division

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INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

TABLE OF CONTENTS

Introduction	v
SECTION I: GENERAL PERFORMANCE STANDARDS.....	1
OVERVIEW	2
A. ACCESS & AVAILABILITY	2
B. COORDINATION.....	3
C. ASSESSMENTS.....	3
D. SERVICE PLANNING	4
E. REFERRAL PROCESS FOR CAMHD CONTRACTED SERVICES	5
F. STAFFING.....	6
G. CREDENTIALING REQUIREMENTS	9
H. MAINTENANCE OF SERVICE RECORDS	11
I. SERVICE QUALITY	13
J. MINIMUM REPORTING REQUIREMENTS.....	14
K. RISK MANAGEMENT	16
L. CONSUMER RIGHTS AND CONFIDENTIALITY	18
M. COMMUNITY FORCUS	19
N. TEAM-BASED DECISIONS.....	20
O. COMPLAINTS/APPEALS.....	20
P. ACCOUNTABILITY/SERVICE STANDARDS	20
Q. CHILD ABUSE AND NEGLECT REPORTING MANDATES.....	20
SECTION II: SERVICE SPECIFIC PERFORMANCE STANDARDS.....	21
SECTION II - PART A: EMERGENCY MENTAL HEALTH PERFORMANCE STANDARDS	22
I. EMERGENCY MENTAL HEALTH SERVICES	23
A. 24-HOUR CRISIS HEALTH SERVICES.....	23
B. MOBILE CRISIS OUTREACH	26
C. CRISIS STABILIZATION	31
SECTION II - PART B: SCHOOL - BASED BEHAVIORAL HEALTH SERVICES PERFORMANCE STANDARDS.....	36
II. SCHOOL-BASED BEHAVIORAL HEALTH SERVICES.....	37
A. FUNCTIONAL BEHAVIORAL ASSESSMENTS AND BEHAVIORAL SUPPORT PLANS	38
B. MENTAL HEALTH ASSESSMENTS	41
C. PSYCHIATRIC MEDICATION EVALUATION.....	45
D. INDIVIDUAL THERAPY.....	48
E. GROUP THERAPY	54
F. FAMILY THERAPY.....	60
G. MEDICATION MANAGEMENT.....	66
H. FAMILY COURT TESTIMONY	69
I. EDUCATION PLANNING (IEP/MP) PARTICIPATION.....	71
J. SCHOOL CONSULTATION	73
K. COMMUNITY-BASED INSTRUCTION	76
SECTION II - PART C: INTENSIVE MENTAL HEALTH SERVICES PERFORMANCE STANDARDS	81
III. INTENSIVE MENTAL HEALTH SERVICES	82

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

A.	PSYCHOSEXUAL ASSESSMENTS.....	82
B.	INTENSIVE DAY STABILIZATION	86
C.	INTENSIVE HOME AND COMMUNITY-BASED INTERVENTION	91
D.	MULTISYSTEMIC THERAPY.....	97
E.	FOSTER HOMES WITH THERAPEUTIC SERVICES.....	101
F.	RESPIRE HOMES.....	106
G.	THERAPEUTIC GROUP HOMES	109
H.	INDIVIDUALIZED HIGH RISK THERAPEUTIC GROUP HOMES	114
I.	COMMUNITY-BASED RESIDENTIAL PROGRAMS	119
J.	COMMUNITY-BASED RESIDENTIAL PROGRAMS- HIGH RISK	125
K.	HOSPITAL-BASED RESIDENTIAL	131
SECTION II - PART D: SERVICES FOR CHILDREN and YOUTH WITH PERVASIVE DEVELOPMENTAL DISORDERS and/or SIGNIFICANT MENTAL RETARDATION		136
IV.	SERVICES FOR CHILDREN AND YOUTH WITH PDD and/or SIGNIFICANT MR.....	137
A.	ASSESSMENT.....	137
B.	INTENSIVE SUPPORT BY TRAINED PERSONNEL	139
C.	AUTISM AND/OR SIGNIFICANT MENTAL RETARDATION CONSULANT	141
D.	SKILLS TRAINER.....	145
E.	EXTENDED SCHOOL YEAR SERVICES	148
F.	THERAPEUTIC RECREATION	151
G.	SPECIAL SCHOOLS.....	153
SECTION III: INTERAGENCY PRACTICE GUIDELINES		155
I.	INTRODUCTION.....	156
	PLANNING STRATEGIES AND FORMATS	157
II.	ACCESSING SUPPORTS.....	157
A.	IDENTIFICATION AND REFERRAL.....	157
B.	FORMAL ASSESSMENTS: FUNCTIONAL BEHAVIOR ASSESSMENT AND MENTAL HEALTH ASSESSMENT	158
C.	SUPPORT AND SERVICE PLANNING	158
D.	ASSESSMENT TECHNIQUES AND PROTOCOLS	158
E.	CARE COORDINATION.....	161
F.	OUTCOME-BASED PLAN EVALUATION	161
G.	SUPERVISION.....	161
H.	INTERVENTIONS AND SUPPORTS.....	161
III.	ATTENTION PROBLEMS AND HYPERACTIVITY (e.g., ADHD).....	162
A.	ASSESSMENT PROTOCOLS SPECIFIC TO ATTENTION PROBLEMS AND HYPERACTIVITY	162
B.	OTHER CONSIDERATIONS.....	163
C.	COEXISTING /CO-OCCURRING CONDITIONS.....	163
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS	163
E.	ADDITIONAL CONSIDERATIONS	164
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	164
IV.	ANXIETY PROBLEMS AND DISORDERS (INCLUDING PTSD AND OCD).....	164
A.	ASSESSMENT PROTOCOLS SPECIFIC TO ANXIETY PROBLEMS AND DISORDERS	164
B.	OTHER CONSIDERATIONS.....	166
C.	COEXISTING/CO-OCCURRING CONDITIONS	166
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS	167
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	167

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	168
V.	PERVASIVE DEVELOPMENTAL DISORDERS (INCLUDING AUTISM)	168
A.	ASSESSMENT PROTOCOLS SPECIFIC TO PERVASIVE DEVELOPMENTAL DISORDERS	168
B.	OTHER CONSIDERATIONS	170
C.	COEXISTING/CO-OCCURRING CONDITIONS	171
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS	171
E.	ADDITIONAL INTERVENTION CONSIDERATIONS	171
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	172
VI.	CHILDHOOD SCHIZOPHRENIA.....	172
A.	ASSESSMENT PROTOCOLS SPECIFIC TO SCHIZOPHRENIA.....	172
B.	OTHER CONSIDERATIONS	172
C.	COEXISTING/CO-OCCURRING CONDITIONS	173
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS	173
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	173
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	173
VII.	CONDUCT AND OPPOSITIONAL PROBLEMS (INCLUDING JUVENILESEX OFFENDERS).	174
A.	ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL PROBLEMS AND DISORDERS	174
B.	OTHER CONSIDERATIONS	175
C.	COEXISTING/CO-OCCURRING CONDITIONS.....	175
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTIONS	176
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	176
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	176
VIII.	DEPRESSION.....	176
A.	ASSESSMENT PROTOCOLS SPECIFIC TO DEPRESSION.....	176
B.	OTHER CONSIDERATIONS	177
C.	COEXISTING/CO-OCCURRING CONDITIONS	178
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTION.....	178
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	178
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS	179
IX.	EATING DISORDERS.....	179
A.	ASSESSMENT PROTOCOLS SPECIFIC TO EATING DISORDERS.....	179
B.	OTHER CONSIDERATIONS	180
C.	COEXISTING/CO-OCCURRING CONDITIONS	180
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTION.....	181
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	181
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	181
X.	SUBSTANCE USE	181
A.	ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL DISORDERS	181
B.	OTHER CONSIDERATIONS	182
C.	COEXISTING/CO-OCCURRING CONDITONS	182
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTION.....	182
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	182
XI.	BIPOLAR DISORDER	183

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

A.	ASSESSMENT PROTOCOLS SPECIFIC TO BIPOLAR DISORDER.....	183
B.	OTHER CONSIDERATIONS.....	184
C.	COEXISTING/CO-OCCURRING CONDITIONS.....	184
D.	MOST PROMISING PSYCHOSOCIAL INTERVENTION.....	184
E.	ADDITIONAL INTERVENTION CONSIDERATIONS.....	184
F.	MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS.....	185
XII.	MANAGEMENT OF PSYCHIATRIC MEDICATIONS.....	185
A.	PSYCHOSTIMULANTS.....	186
B.	TRICYCLIC ANTIDEPRESSANTS.....	187
C.	NONTRICYCLIC ANTIDEPRESSANTS.....	188
D.	MOOD STABILIZERS.....	189
E.	ANTIPSYCHOTICS.....	190
F.	ANXIOLYTICS AND OTHERS.....	192
XIII.	SUMMARY.....	193
XIV.	REFERENCES.....	195
	SECTION IV: INTERAGENCY SERVICE INTENSITY GUIDELINES.....	197
I.	INTRODUCTION.....	198
A.	PROCEDURES.....	198
B.	SCHEDULING.....	199
C.	WHO SHOULD ATTEND.....	199
D.	REVIEW PROCESS.....	199
E.	RELATIONSHIP TO CARE COORDINATION RESPONSIBILITIES.....	199
F.	RELATIONSHIP TO OTHER SUPPORT SERVICES.....	199
II.	SCHOOL-BASED BEHAVIOR SUPPORT SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH.....	201
III.	INTENSIVE COMMUNITY-BASED MENTAL HEALTH SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH.....	202
IV.	OUT OF HOME MENTALHEALTH TREATMENT SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH.....	203
V.	SCHOOL-BASED BEHAVIOR SUPPORT SERVICES FOR YOUTH WITH AUTISM/PDD ...	204
VI.	INTENSIVE HOME AND COMMUNITY SUPPORTS FOR YOTH WITH AUTISM/PERVASIVE DEVELOPMENTAL DISORDERS.....	205
VII.	OUT OF HOME EDUCATIONS/THERAPEUTIC SUPPORTS FOR CHILDREN WITH AUTISM/PERVASIVE DEVELOPMENTAL DISORDERS.....	206
	SECTION V: GLOSSARY.....	207
	SECTION VI: APPENDIX.....	A1
A.	CASSP PRINCIPLES.....	A3
B.	COMPRHENSIVE STUDENT SUPPORT SYSTEM.....	A5
C.	COMMUNITY-BASED RESIDENTIAL LEVEL II (ADDENDUM APRIL 2, 2002).....	A7

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

INTRODUCTION

The Department of Education (DOE) and the Department of Health (DOH) collaboratively strive to provide an integrated system of care for children and youth with educational disabilities and related mental health challenges. Since the inception of the Felix Consent Decree (FCD) in 1994 (pursuant to the settlement of the *Felix vs. Waihee class action suite No. 93-00367-DAE*), the Departments have prioritized efforts to design and implement an integrated education and behavioral health system in accordance with all requirements of the individuals with Disabilities Education Act (IDEA), Section 504 - Subpart D of the Rehabilitation Act of 1973, and as amended in 1974 (504), and the Child & Adolescent Service System Program (CASSP) principles [see Appendix A].

The Department of Education, through its Comprehensive Student Support System (CSSS) Model [see Appendix B] and School-Based Behavioral Health (SBBH) services, provides a supportive educational environment for all children. CSSS and SBBH provide for varying levels of support including prevention, risk reduction, early intervention, and specially designed strategies and treatment. SBBH staff are located within schools to assist teams in understanding student problem behaviors and developing strategies and supports to help students benefit from their education. For those children requiring specifically designed services, SBBH workers and professionals collaboratively plan with the child's Individualized Education Program (IEP) or Modification Plan (MP) team to develop measurable objectives and intervention strategies. SBBH services include assessment and diagnostic services, as well as specifically designed classroom strategies and individualized behavioral supports and treatment interventions.

The Child and Adolescent Mental Health Division (CAMHD), a division of the DOH, provides intensive mental health services for the youth with emotional and/or behavioral challenges beyond those which can be effectively managed at the school level. CAMHD provides intensive case management services (also referred to as care coordination services) through its Family Guidance Centers (FGC) throughout services designed to reduce and/or alleviate the severity of emotional and/or behavioral challenges experienced by the eligible children and youth. Often, other child serving agencies, including child welfare and judiciary, are also involved in the lives of these children and youth. The Mental Health Care Coordinator (MHCC) uses a coordinated service planning (CSP) process to bring all team members together in developing an integrated comprehensive plan addressing all areas of need.

DOE and DOH have jointly developed this manual for use by DOE and DOH personnel, and DOE and DOH contracted providers when developing individualized plans for youth. These standards and guidelines are designed to define service content standards, and improve the efficiency and effectiveness of the school based behavioral health and intensive mental health services.

If any of these Performance Standards or Practice Guidelines present a conflict with requirements of IDEA or Section 504-Subpart D, then all federal regulations supercede this manual.

In **Section 1** of this manual, there is a description of general standards governing behavioral health services provided by DOE and CAMHD. **Section 2** provides a more detailed description of the Specific Performance Standards for varying levels of care. **Section 3** reviews Practice

Guidelines for various diagnostic groupings. **Section 4** reviews the criteria that DOE and CAMHD teams use when evaluating the intensity of service delivery.

Unless otherwise granted a written waiver from the Departments, all CAMHD and DOE contracted provider agencies and their employees or subcontractors, are required to comply with all elements of this manual when providing services.

Performance monitoring of contracted professionals and agencies will include review of adherence to the performance standards and practice guidelines as outlined in this manual.

SECTION I:
GENERAL PERFORMANCE STANDARDS

SECTION I: GENERAL PERFORMANCE STANDARDS

OVERVIEW

The General Performance Standards are requirements for all contracted SBBH and CAMHD services, and apply to each of the specific services. They are set forth as a basis to guide effective practices in the delivery of behavioral health supports and services for eligible youth in the State of Hawaii. In Hawaii's integrated system, supports and services are provided in accordance with all regulations as required by IDEA/Section 504, and with active involvement of families and communities in alignment with the Hawaii CASSP principles. Services are based on team determinations of what each student needs in order to benefit from his or her education.

In order that youth receive the greatest benefit from services, the DOE and CAMHD intend to utilize evidence-based treatment interventions and supports. The commitment to use evidence-based interventions is an important basic principle in a system that strives to produce positive outcomes in an accountable way, and which strives to continually update and improve itself based on empirical evidence. In the ***Report on the Most Promising Treatments for Child and Adolescent Disorders (The CAMHD Task Force for Empirical Basis August 2000)***, the CAMHD, the DOE, the University of Hawaii, and community experts have committed to a process of continual literature review and regular updating of practice guidelines based on that review. The practice guidelines are based on the most current information available on evidence-based interventions/treatments and will be periodically updated as empirical support for evidence-based interventions evolves over time.

In order to assure quality services for youth, all services are expected to comply with applicable State of Hawaii Laws and Administrative Rules. Contractors are expected to adhere to all official DOE and CAMHD policies and procedures.

A. ACCESS & AVAILABILITY

SBBH services delineated in this document are delivered in accordance with an IEP/MP. Services are accessed based upon team decision. Requests for services may be made to the student's teacher, Student Services Coordinator (SSC) or school administrator.

Intensive Mental Health Services are implemented for youth whose complex needs extend beyond their school based educational program (and whose community and home environments require additional specific supports). These services are implemented so that these youth may achieve a moderate degree of emotional and behavioral stability, and benefit from their educational program more fully. Youth who have been identified by an IEP/MP team to require intensive mental health services (using guidelines in Section IV) are enrolled with the FGC located in the school district of their home school. They are assigned an FGC MHCC at that time. The youth may, and often will, continue to receive SBBH services and supports in conjunction with the intensive services.

DOE/CAMHD services and supports are delivered based upon decisions of the IEP/MP/CSP team and FGC clinical review (as appropriate). The exceptions to this are the Emergency Services and Psychosexual Assessment Services that are provided to youth experiencing a mental health emergency, or in need of psychosexual assessment at the request of the Family Court.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

SBBH and CAMHD services, whether they are delivered by employees or contract providers, are expected to be initiated and provided in a timely and consistent manner, as guided by the standards defined in this manual.

B. COORDINATION

Each youth is assigned a Care Coordinator (CC) to facilitate access to services. This CC arranges for timely implementation of all levels of service (with the sole exception of emergency interventions) as guided by this manual.

The role of the CC is to serve as the central point of coordination and communication for eligible youth and their families within the context of the team model. Services provided through DOE will have a single CC. This CC will be identified after the completion of either the IEP or 504 MP meeting. They will be a member of the student's educational team.

For youth served by CAMHD, the MHCC is responsible for coordinating routine home visits, school visits, and community contacts. When appropriate, responsibilities also include coordination of care with Juvenile Justice, and Department of Human Services. Coordination functions also include ongoing family engagement, ensuring the efficient delivery of quality services, and continuous monitoring of the effectiveness of interventions. The youth's MHCC is responsible for convening an initial CSP meeting within thirty (30) days of registration at the FGC, or immediately if the youth has immediate needs. Contractors are expected to participate in CSPs when their involvement will help to inform effective planning for individual youth. The MHCC is responsible for facilitating the integration, coordination, and monitoring of behavior health services across programs and domains.

Coordination of services that are provided within a CAMHD contracted agency is the responsibility of that contractor. Coordination and communications are particularly important in settings where there are multiple staff providing services for a youth. CAMHD contracted agencies are also expected to coordinate efforts with school and community settings that the youth may be involved in. Of equal importance is ongoing communication and coordination with families.

C. ASSESSMENTS

Functional Behavioral Assessments (FBA) – FBAs are necessary components to serving youth with challenging behaviors. A timely and comprehensive FBA is completed prior to planning and implementation of supports and services. An FBA allows for an assessment of the reasons for behaviors as well as suggestions for ways to adequately and effectively address these behaviors. Ongoing behavioral assessments to address significant changes, current status, and consequent recommendations are regularly conducted.

The FBA culminates in a Behavior Support Plan (BSP) that assists the team with strategies and supports. All youth served by DOE and CAMHD can expect to have a BSP from his/her home school.

Mental Health Assessments (MHA) – MHAs are specifically necessary to diagnostically understand a child's presenting symptoms so that the most effective treatment interventions can be applied. MHAs are part of the set of information that informs

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

planning and strategies for treatment interventions, and are necessary prior to initiation of an individualized treatment intervention. MHAs are informed by the youth's developmental course, family history, school functioning, social roles, substance use, psychiatric and medical history, degree of success or failure of previous interventions, current Diagnostic Statistical Manual (DSM) version diagnoses on all 5 axes, prognosis, and recommendations for treatment within the context of a long-range view of the youth. Measures of the child's behavior and functioning (e.g. Child and Adolescent Functional Assessment Scale, Child Behavior Checklist) are to be included along with other relevant measures so as to inform treatment recommendations. Ongoing measurement and review will be conducted during the course of treatment by contracted providers and shall be used for adjusting treatment.

If an FBA has been conducted, it should be reviewed. If one has not previously been conducted, it is necessary to conduct one prior to a move to a more restrictive placement. Assessments are reviewed and/or conducted annually. All recommendations incorporate youth/family strengths, are evidence-based, and based on the identified needs of the youth as they relate to educational benefit. Recommendations will describe and address the needs of the youth/family and not specify a particular service, program, or eligibility status.

D. SERVICE PLANNING

Behavioral Support Plan (BSP): An IEP team, including the youth (as appropriate), family/legal guardian, FGC MHCC (if required), and providers identify needs based on an assessment. The IEP team develops a BSP to address the youth/family needs. The BSP includes specific goals, measurable objectives, target dates to reach objectives, and appropriate interventions to achieve these objectives. The BSP includes a crisis plan identifying specific actions to take in case of an emergency, and a transition plan to prepare for a smooth transition to eventual termination of services. IEP teams meet regularly to review services and progress, and modify plans and interventions, as needed, to appropriately meet the needs of the youth/family.

Mental Health Treatment Plan (MHTP): MHTPs must be directly linked to achieving goals in a youth's IEP/MP and CSP. They are to identify evidence-based treatment interventions that are the most promising options for delivering positive treatment outcomes for a youth's individual goals and objectives. Team members shall reference the practice guidelines (in Section III of this manual) when identifying specific treatment strategies. Progress on plans shall be tracked continuously and treatment revised as necessary.

Services delivered by CAMHD contracted providers are clearly presented in a MHTP. It is the role of the contractor to regularly monitor and adjust treatment plans, with input from the youth, family, and MHCC. Services shall be reviewed monthly and plans shall be reviewed on a quarterly basis at a minimum. The goal of all treatment is to improve the youth's emotional and behavioral functioning such that the youth may experience a moderate degree of emotional and behavioral stability allowing him or her to benefit from a free and appropriate public education. In CAMHD contracted residential programs, observations and assessments following admission shall culminate in a comprehensive MHTP inclusive of crisis and transition plans. Initial plans should be developed at admission based on all available information, with the comprehensive plan developed within seven (7) days of admission (except where otherwise specified in the Service-specific Standards).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Coordinated Service Plan (CSP): Upon assignment to an MHCC, a CSP meeting will be convened. The CSP is built upon the strengths of the child, family, DOE, and community, and is developed with full engagement and involvement of youth, families, and key individuals involved in the youth's life. By definition it includes full participation of schools and other public agencies. CSP planning is guided by a long-term holistic view of the youth's life. The purpose of the CSP is to identify the specific strategies that will achieve broadly defined goals for the youth and family, and to integrate strategies across any personnel involved. The MHCC shall convene CSP meetings minimally on a quarterly basis, and as clinically indicated, in order to assure that youth's needs are continually monitored and modified as necessary.

All plans (BSP/MHTP/CSP) must be developed with youth (when appropriate) and parent/guardian involvement. The plan encompasses:

- Specific goals, measurable objectives, target dates to reach the objectives, and appropriate interventions to achieve these objectives;
- Strengths, needs and evidence-based strategies and interventions;
- A proactive crisis plan reflective of strategies to avert potential crises, and specific and appropriate strategies already known to staff for implementation to manage situations without placement disruptions. In the event a youth's behavior is deemed to be a risk to self or others, the school or contracted agency's clinical professional staff must be involved in assessment and determination of appropriate courses of actions. Requests for police assistance are limited to situations where the youth's behavior is deemed to be critically out of control and can no longer be safely contained by staff. Schools and agencies must have written protocols in place for managing crises; and
- A transition/termination/discharge plan.

E. REFERRAL PROCESS FOR CAMHD CONTRACTED SERVICES

Children will routinely access mental health/behavioral health services through their SBBH program. When the capacity of those resources is exceeded (see Section IV Guidelines), additional services and treatment interventions are accessed through CAMHD and the array of contracted providers.

Upon determination of needs through the youth's IEP/MP and CSP, the MHCC initiates appropriate referrals as indicated by the admission criteria in the Individual Standards. The MHCC shall initiate prompt authorization of services. With the exception of Emergency Services, all contracted CAMHD services require prior written authorization.

It is expected that all youth will have full access to any needed service. The role of the MHCC is to make referrals to agencies based on a full review of the youth's current needs.

All referrals will include explanation of the purpose of treatment, the goals to be achieved via treatment, anticipated duration of treatment, and the discharge/transition criteria.

Within three (3) working days of placing a telephone call referral, the MHCC will submit a complete referral packet to include:

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- Application;
- Summary report of relevant background information;
- Current IEP/MP/MHTP/CSP;
- Review of the Admission Criteria to ensure appropriate referrals (as written in the Individual Standards);
- Current mental health assessment and FBA (within twelve (12) months);
- DOE diagnostic packet or reevaluation information, and a written update on any significant change since the IEP/MP; and
- Any recent Admission/Discharge Summaries psychiatric/psychological evaluations from previous out-of-home placements, as relevant.

Within twenty-four (24) hours of the receipt of the packet, the contractor shall contact the FGC to schedule any necessary youth or family interviews. Within forty-eight (48) hours from the completion of interviews, the contractor shall forward a letter to the FGC to confirm a date for initiation of services. If for any reason the agency decides not to accept a youth for treatment, a complete written explanation by the contractor's Clinical Director should be forwarded to the MHCC.

F. STAFFING

1. Professional Standards

To ensure safety of children and youth, and ensure quality of services provided, all contracted providers must adhere to their respective professional standards as set forth in professional practice guidelines and standards, ethical principles, and codes of conduct.

2. Orientation and Training

- a. Over a period of at least 18 months, CAMHD (and DOE) will provide to contracted agency staff centralized training in evidence-based practices, with an emphasis on incorporating elements of empirically-supported interventions into the proposed array of behavioral/mental health services.
- b. Greater responsibility for this training, mentoring, and supervision will rest with the contracted agencies over time. Contracted agencies are expected to provide a plan detailing how information from CAMHD/DOE training will be supported internally through mentorship, supervision, or other professional guidance during this initial period and beyond.
- c. All contracted agencies are responsible for the provision and acquisition of all other training needed for their own staff and all sub-contracted staff.
- d. Contracted agency must designate a staff person responsible for training of staff and/or sub-contracted providers in all other aspects

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

of the delivery of services. The contractor's trainer(s) is/are responsible for providing and/or arranging for the provision of training and documentation of all staff training, to include an outline of the discussion points; the topic, name and credentials of trainer; trainees that attended the training; the date, time, duration of the training; and an analysis of its impact on improving services delivered.

- e. The contracted agency must have a specific training plan detailing how and when staff will be trained. As part of the orientation and training for staff and contracted personnel the agency will include: legal and ethical issues and the Hawaii system of care for Felix eligible youth, inclusive of the Felix Consent Decree, Individuals with Disabilities Education Act (IDEA), CASSP principles, and general state organizational structure and team-based decisions. The orientation process must be completed prior to serving youth.
- f. At a minimum, each contracted agency shall provide all new employees, or sub-contracted personnel, twenty-four (24) hours of orientation to the organization within their first thirty (30) days of employment and/or contract. These twenty-four (24) hours can be applied towards the forty (40) hours of ongoing professional development required for the year. [Forty (40) hours for full time professional work; those working fifteen (15) hours or less may reduce to twenty (20) hours annually]. The orientation must include:
- An understanding of the agency's mission and goals;
 - A review of agency policies and procedures;
 - An understanding of all laws and regulations regarding confidentiality;
 - A review of agency structure, lines of accountability, and authority;
 - An understanding of the employee's job description;
 - A review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide;
 - Acceptable behavior support techniques;
 - Crisis intervention procedures, including suicide precautions;
 - An Overview of Felix Consent Decree, IDEA, 504; and
 - A review of Hawaii CASSP principles.
- g. All staff providing direct services to youth must annually attend, successfully complete, and document in their personnel file at least forty (40) hours of training, in service, and/or approved continuing education professional development seminars and/or conferences that are directly related to their work that year (for full time-work). The documentation must include the name, date, place, and time of the training; an outline of discussion points, and the name/credentials of the instructor and of the organization sponsoring the training. Treatment team meetings and supervision,

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

although expected, are not considered as part of these required forty (40) hours.

- h. Qualified Mental Health Professionals (QMHP) that require continuing education for license renewal may submit evidence of license renewal for documentation of ongoing professional development.

3. SUPERVISION

The DOE, CAMHD, each FGC, each school complex and each contracted provider agency shall have clear lines of accountability for all employees and independent contractors.

Contracted agencies must have policies and procedures and the mechanism to ensure supervision of all direct service professional and paraprofessional staff by a QMHP or Mental Health Professional (MHP) supervised by a QMHP as appropriate.

All personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed by their respective supervisor. Documentation must include dates and duration of the supervision sessions, name and credentials of supervisor, goals and interventions, and summary of the sessions. Documentation must be included in the individual's credentialing file and must be consistent with the most recent supervision sessions and supervision status.

Regular case reviews must be a part of supervision to ensure effective and efficient treatment for youth and families served. The frequency of the case reviews is dependent on the level of care as set forth in the service standards.

A QMHP shall participate in peer reviews minimally two hours per month as evidenced by documentation in their supervision file. (Two (2) hours for each one hundred sixty (160) hours of work may be adjusted for part-time professionals). An MHP shall receive at a minimum, one hour of individual and one hour of client-specific group supervision each month from a QMHP, that is documented in their personnel file.

A QMHP shall supervise the equivalent of no more than six (6) full-time MHPs. ***Paraprofessionals must receive a minimum of two (2) hours of client-specific group supervision each month, with a QMHP. Case reviews must be a part of each supervision hour. Treatment plan goals and objectives must be reviewed and outcomes from interventions utilized must be assessed for information to process for continued or revised course of treatment, depending on the outcomes. In addition, paraprofessionals are expected to work under the guidance of the MHP assigned to their team.***

For paraprofessional employees who work 15 hours or less a week at an agency, they are required to receive one hour of group supervision a month.

The CAMHD and DOE are developing an online supervision and clinical contact monitoring tool designed to replace monthly progress summaries. When this program is operational, it will be required instead of monthly reports. The tool will

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

consist of an online checklist of clinical activity documenting each child contact and reviewed by their agency supervisor(s). Information and training about the online tool will be provided by the CAMHD/DOE upon implementation. Prior written notification will be given to Providers before implementation of the tool. Once implemented all contracted agencies are required to report supervision electronically.

4. Evaluation of Staff Performance

All CAMHD, DOE, FGC, school complexes and contracted agencies shall have a process for evaluation of staff performance that includes a review of qualifications (i.e., an assessment of the employee's capabilities, experience, and satisfactory performance), reports of complaints received and resolutions, corrective actions taken, and supports provided to improve practice and to continue the monitoring process.

G. CREDENTIALING REQUIREMENTS

All CAMHD and DOE Contractors shall have written policies and procedures that address their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, and clinical supervisory staff on a timely basis. Contractors may use CAMHD's or DOE's policy and procedures as guidelines in developing their policies and procedures.

1. All professionals contracted or employed by DOE or CAMHD Contractors to provide direct services to youth and families shall have minimally met initial credentialing requirements for provisional appointments through submittal of required documents and satisfactory verbal verification of primary sources prior to date of hire. Full credentialing requirements that include documented evidence of required primary sources shall be met within six (6) months of hire.
2. Credentialing shall occur at least every two years to update information obtained in initial credentialing, including consideration due for re-certification. Refer to the CAMHD Recredentialing Policy and Procedures for items that need verification.
3. Manual or electronic tracking systems shall be established and maintained by Contractors to ensure that required documents and procedures for initial credentialing, recredentialing, and primary source verification processes are timely and current.
4. Individual credentialing files for each direct care employee and subcontractors shall be established separately from general personnel files and maintained in the following format to ensure consistency in filing:
 - All primary source verifications must be kept in one section, tabbed to match the tracking log column numbers for each requirement;
 - Letters requesting primary source verification; and
 - Notes.

Individual Practitioner Credentialing Information

1. **Qualified Mental Health Professional:**

Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified in Child/Adolescent Psychiatry

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

OR

Must possess a current Hawaii license in Psychology, Social Work Certification (QCSW), Diplomate in Clinical Social Work (DCSW) or Board Certified Diplomate (BCD) only, or Marriage and Family Therapy (LMFT) with experience in behavioral health

OR

Must possess a current Hawaii license and certification to practice as an Advanced Practice Registered Nurse (APRN) in behavioral health

OR

Must be a Hawaii licensed social worker (LSW) holding a master's degree from a nationally accredited university and having at least one year of full-time, clinically supervised progressive experience inclusive of residency, internship, or practicum in the care or treatment of youth in a mental health or educational setting.

2. **Mental Health Professional:**

Must be a physician in training in an ACGME (Accreditation Council on Graduate Medical Education) accredited residency program in child and adolescent psychiatry under program faculty supervision

OR

Must have a Ph.D. in Clinical, Counseling or School Psychology from a nationally accredited university

OR

Must have a Master's degree from a nationally accredited university as a national board certified behavior analyst, marriage and family therapist, Nationally Certified Counselor, psychologist, social worker, school psychologist, or psychiatric nurse

OR

Must be a Ph.D. student in clinical psychology studying in an accredited program under program faculty supervision

AND

Must have at least one year of full-time, clinically supervised progressive work experience inclusive of residency, internship, or practicum in the care or treatment of youth in a mental health or educational setting (experience may be substituted with certificates in a specialty such as Certified Substance Abuse Counselors (CSAC) or Registered Professional Nurses certified in psychiatric nursing).

AND

Must be supervised by a QMHP.

3. **Mental Health Professional Waivers**

If a professional does not meet the **experience** requirement a waiver request shall be submitted to, and reviewed by, the DOE or CAMHD (dependent upon state agency contracting for services) Credentialing Committee before the individual can provide services. The waiver request must justify why and under what conditions the agency feels the applicant is capable of performing the duties of the position. School psychologists and clinical psychologists employed by the DOE may be credentialed to provide behavior support and supervision services as allowed under exemption in applicable state laws and regulations.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

4. Paraprofessional

Must be personnel with a Bachelor's degree from a nationally accredited university in either Psychology, Social Work, Nursing, Counseling, Education, or Special Education, must possess at least (one) 1 year of full-time, and clinically supervised progressive work experience in the care or treatment of children or adolescents in a mental health or educational setting

OR

Must be personnel with a degree less than a Bachelor's level from a nationally accredited university in either Psychology, Social Work, Nursing, Counseling, Education, and Special Education, shall possess at least two (2) years of full-time, clinically supervised work experience in the care or treatment of children or adolescents in a mental health or educational setting

OR

Must be personnel with a high school diploma, with at least three (3) years supervised experience in direct care of children in formal, organized children's therapeutic programs

OR

If the individual does not meet any of the above listed requirements a waiver request must be submitted to, and reviewed by, the CAMHD or DOE Credentialing Committee before the individual can provide services. The waiver request must justify why and under what conditions the agency feels the applicant is capable of performing the duties of the position.

H. MAINTENANCE OF SERVICE RECORDS

School complexes (those elementary and secondary schools serving students in a specific geographic area), CAMHD personnel, contracted agencies, and contracted individual professionals shall have and implement written policies and procedures to guide the content and protocol of youths' records for adherence to Federal law, State statutes, accreditation and Medicaid standards. Service records must be current, well organized, legible, comprehensive and consisting of all relevant documentation for the optimum treatment of youth served.

Contracted agencies and professionals are required to maintain master client files, including those on youth served by subcontracted providers, in a central, secure location in locked storage to which access is limited to designated persons. Files given to the custody of other personnel or external auditors or reviewers for information retrieval or data entry are also maintained securely while in their custody.

1. Progress Notes

- a. Progress notes are written for each activity/event by the staff/professional providing the service. The youth's full name and either the date of birth, student identification number, record number or social security number must be identified on each progress note page. Progress notes shall be entered in the youth's file within twenty-four (24) hours of the service.
- b. Agencies and individuals are responsible for oversight of client documentation and must have policies and procedures in place for

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

providers' accountability for appropriate maintenance of records in accordance with these standards and guidelines.

- c. The focus in the content of notes clearly evidences the relationship of the intervention to the youth's IEP/MP/BSP/MHTP plan. Progress notes need to reference the goals and objectives stated in the youth's treatment plan and include data summaries, the interventions provided and the measurable outcomes resulting from them. Additionally, progress notes need to address what may not be working and what will be done differently for better results. Progress notes indicate duration of service, date of service, and place of service. Each note is signed off by the person who performed the service, indicating that person's title, and countersigned (if applicable) by a supervisor with full signature and title.
- d. Progress notes also include collateral communications pertinent to the treatment of the youth.
- e. Contracted providers shall also submit monthly progress summary reports to the DOE or CAMHD (depending upon state agency issuing contract) specifying youth served, dates and types of services provided, and total charges billed.

The CAMHD/DOE are developing an online supervision and clinical contact monitoring tool designed to replace monthly progress summaries. When this program is operational, it will be required instead of monthly reports. The tool will consist of an online checklist of clinical activity documenting each child contact and reviewed by agency supervisor(s). Information and training about the online tool will be provided by the CAMHD upon implementation. Prior written notification will be given to Providers before implementation of this tool. Once implemented all contracted agencies are required to report supervision electronically.

2. Service/Treatment Plan

- a. DOE and CAMHD are committed to providing families (and youth as appropriate) opportunities for involvement in the development and implementation of the BSP, IEP, MP, CSP, and MHTP. Thus, whenever possible, families and youth will be provided with reasonable involvement in determining the nature of service or support consistent with the youth's needs and within established procedural guidelines. Services may be provided in the school, home or community.
- b. Service/Treatment plans are discussed, written and implemented by the youth's treatment team members inclusive of parent(s)/caregiver(s), providers, FGCs, involved school personnel, and other persons/agencies involved with the youth's treatment.
- c. Service/Treatment plans are goal-oriented with specific timelines in which to reach the youth's identified treatment objectives. These

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

goals and objectives are linked to the youth's IEP/MP, and are guided by practice guidelines.

- d. Participant's signatures, obtained as appropriate, on the treatment plan indicate their presence and participation in the treatment planning process. MHTPs must be reviewed quarterly and more often as needed.
- e. CAMHD residential Providers are required to send MHTPs and reviews to the FGCs within one (1) week of the treatment planning meeting or, as applicable, as stipulated in the Individual Performance Standards (see Section II) pertaining to the specific level of care in which services are being provided.

3. Discharge Summary

A written discharge summary is completed within *one (1) week* of service termination. The discharge summary shall include the duration of service, level(s) of care, youth's adjustment, significant problems or concerns that arose, significant youth and family accomplishments, the transition process and status of the youth in relation to the prescribed mental health treatment plan.

I. SERVICE QUALITY

CAMHD and DOE are committed to assuring appropriate and effective services for eligible youth and their families. Services are designed to support youth in their educational program, promote healthy functioning, increase independence, and to build upon the natural strengths of the youth, family and community. Families are encouraged to be active participants in the behavioral support process, given the overwhelming evidence that constructive family participation enhances their youth's progress. Interventions are to be evidence-based and tailored to address the identified needs of the youth/family. Interventions/plans are to be regularly reviewed and modified, as needed, to effectively achieve goals. Providers are to participate with the integration of services across domains (home, school, and community) as needed. Providers are to assist with transition planning (as it relates to greater and lesser levels of support and services) in collaboration with the youth, family and other team members. DOE and CAMHD encourage individuals with specific concerns regarding service quality to bring them to the attention of the school, provider agency, FGC, CAMHD, and/or DOE District Office, as appropriate.

CAMHD contract providers assume all responsibility for the quality of services provided by employees or subcontracted providers. All contractors shall implement a Quality Assurance Improvement Plan (QAIP) and demonstrate commitment to ongoing quality improvement activities. The QAIP must meet Medicaid requirements. Contractors must submit quarterly reports of quality monitoring.

CAMHD Personnel, including MHCCs, Clinical Directors, Specialists, and Quality Assurance (QA) Reviewers and DOE care coordinators shall have full access to youth and youth records while in a CAMHD contracted program. CAMHD operates a co-planning and co-management model (active involvement and co-management by FGC Clinical Team) for any child that is receiving intensive services, and also conducts regular reviews of child status and a Contractor's performance as part of its accountability and oversight functions.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

J. MINIMUM REPORTING REQUIREMENTS

DOE and CAMHD require submittal of the following reports:

- 1. Credentialing Tracking Form of Licensed Providers (manual or electronic):** Contractors are expected to track licensed individual staff and subcontracted professionals and their specific status toward being fully credentialed. This spreadsheet includes individuals' active status during the month by name, professional discipline title, appointment date, and termination date. Report is submitted to DOE or CAMHD's Credentialing Specialist (depending upon contracting state agency) within two (2) weeks following the end of each month.
- 2. Monthly progress report:** Contractors must submit monthly progress reports regarding the treatment and progress of the youth/family that are due at the FGC by the fifth day of the following month and to the DOE upon billing. The report must include, but is not limited to, the client name; CR number; DOB; IDEA/504 status; school/program attending; and the type, date and time of mental health services. A statement regarding the mental health goals and objectives that were addressed, service activities related to the goals, assessment of progress, ongoing client needs, plans to address needs, and projected discharge dates must be included. The report must be signed and dated by the provider.

The CAMHD and DOE are developing an online supervision and clinical contact monitoring tool designed to replace monthly progress summaries. When this program is operational, it will be required instead of monthly reports. The tool will consist of an online checklist of clinical activity documenting each child contact and reviewed by agency supervisor(s). Information and training about the online tool will be provided by the CAMHD upon implementation. Prior written notification will be given to Providers prior to its implementation.

- 3. Quarterly Assurance Summary Report:** Contractors must submit quarterly assurance reports that are based upon the agency's Quality Assurance and Improvement Plan (QAIP) that define indicators for identified clinical and non-clinical process and outcome objectives. These reports state the findings and analyses conducted as well as actions that have been or will be taken by the agency following its internal review. The following components are reportable every quarter, no later than thirty (30) days following the end of each quarter to the CAMHD Performance Management Section:
 - Sentinel events
 - Complaints
 - Personnel activities
 - Training – Type of training, basis for determining, and effect of youth treatment
 - Staffing – Patterns, youth/worker ratios, adequacy, turnover, overtime, double back shifts

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- Clinical Supervision – Degree to which standards are met and effect on staff and youth
- Credentialing – Extent to which timelines are met
- Clinical documentation – Accuracy, completeness and timeliness
- Length of stay and Client outcome
- Facility – Status of cleanliness, orderliness and safety
- A summary of corrective actions and any required deliverables resulting from CAMHD review of Contractor's performance. Reports should be sent to CAMHD Performance Management Section within the timelines specified in the Corrective Action Letter.

Comparisons will then be made to previous quarters as well as the extent to which objectives have been achieved.

4. **State Facility License:** Contractors shall send a copy of all applicable State facility licenses to CAMHD's Facility Licensing Specialist each time facilities are granted licensure and upon renewal of licenses.
5. **Start-up list:** All applicable Contractors of all Foster Homes with Therapeutic Services shall submit two (2) weeks after the award of contract, to the CAMHD's Utilization Management Section, a start-up list with all of the following information:
 - Name of parents
 - Address of home
 - Gender of youth
 - Age of youth
 - Number of CAMHD youth
 - Number of other agency youth

Thereafter on a weekly basis, the Contractors shall update this report and submit any changes to the Utilization Review Coordinator who shall maintain the information in accordance with all confidentiality requirements.

6. **Policies, schedules, training curriculum, and other documents:** Applicable Contractors of Therapeutic Group Homes and Community-Based Residential treatment services shall submit copies, on request, of policies, schedules, training curriculum, and other documents as requested by CAMHD's Facilities Licensing Specialist as part of any start-up process to meet licensing requirements.
7. **Summary of licensing corrective actions and any required deliverables:** Applicable Contractors must provide a summary of corrective actions and required deliverables that result from desk or site reviews conducted by CAMHD's Facilities Licensing Specialist.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

8. **Sentinel events:** All sentinel events, as defined in the CAMHD Sentinel Event/Incidents Policy and Procedures, must be called in on the day of occurrence within twenty-four (24) hours and a written CAMHD hard copy report submitted within seventy-two (72) hours.
9. **Accreditation:** Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Council on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) is required. All Contractors shall submit evidence of accreditation to CAMHD Performance Management Section.
10. **CAMHD Weekly Census Report on Client Status:** Foster Homes with Therapeutic Services, Therapeutic Group Homes, Community-Based Residential and Hospital-Based Residential treatment service contractors are required to submit a CAMHD Weekly Census Report on Client Status in standard format to CAMHD's Utilization Review Coordinator no later than Tuesday noon of each week.
11. **Attendance and encounter records:** Attendance and encounter records must be maintained at each facility for prescribed program activities. Residential facilities must maintain a log of whole day and/or night absences from both program and residence whether authorized or not. Such records are filed in the youth's file and made available to CAMHD upon request.
12. **Title IV-E administrative reports:** In accordance with CAMHD's efforts to maximize federal reimbursement, quarterly submission of Title IV-E Training Activity and Cost Reports by applicable Contractors to the CAMHD Fiscal Section is required, using standard training reporting forms.
13. **Admissions and discharge summary** sent to the FGC MHCC.
14. Other specified reports/documents periodically requested by the CAMHD and/or DOE (depending upon contracting state agency).

K. RISK MANAGEMENT

All CAMHD/DOE Contractors must have policies and procedures that address critical risk management activities that include the following:

1. Criminal, Child Abuse, and Background Screening

DOE and CAMHD require a background check on each employee that has direct contact with children and youth receiving contracted services. This includes a criminal history record check through the Hawaii Criminal Justice Data Center and Hawaii Child Protective Services System, a State Child Abuse and Neglect screening, a driver's license screening, and references from all employers for the previous three (3) years of employment. Annually a Child Abuse and Neglect screening is conducted. Every three (3) years a local criminal records check is conducted. This is documented in the employee's personnel file. The contracting agency is responsible for reviewing the documentation and taking actions as needed.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

2. Safety

The Contractor has policies and procedures to insure the safety and well being of youth at all times. Safety is relative to known risks, and is not an absolute protection from all possible risks.

Contractors shall manage, control, or alter potentially harmful conditions, situations, or operations including those leading to abuse, neglect and sexual exploitation, or induced by youth's high risk behaviors to prevent or reduce the probability of physical or psychological injuries to youth.

Safety from harm extends to freedom from unreasonable intimidation and fears that may be induced by other children, line staff, treatment professionals, or others.

Safety applies to settings in the natural community as well as to any special care or treatment setting.

3. Restraints and Seclusion

The DOE, CAMHD and all Contractors shall have internal policies and procedures regarding Restraints and Seclusion.

Any use of seclusion and restraint must be documented and tracked following the use of the most recent and current Centers for Medicare and Medicaid Services accreditation requirements.

Seclusion involves maintaining a child in a locked and/or secure room to ensure the safety of the child or others. Any such isolation in a secure environment from which the child is not potentially free to leave is considered seclusion (e.g., having a staff member block the exit from an unlocked seclusion room). Seclusion shall be used only for the safety of the child or others and must include a written order by a physician or licensed psychologist designated by the contracted agency, followed by a face-to-face assessment by that licensed individual within one hour. The licensed individual is required to monitor the continued need and duration for seclusion. PRN orders for seclusion are prohibited.

Mechanical restraint involves restricting a child's movement through the use of a restraining device (e.g., four point bed restraints) to ensure the safety of the child or others. Mechanical restraint shall be used for this purpose only and must include a written order by a physician or licensed psychologist designated by the contracted agency, followed by a face-to-face assessment by that licensed individual within one hour. The licensed individual is required to monitor the continued need and duration for mechanical restraint. PRN orders for mechanical restraint are prohibited.

Physical restraint involves any use of physical force to restrict a child's freedom of movement. Physical escorts in which the child is willfully cooperating with the guide is not considered restraint until such time as the child no longer intends to follow or be escorted (e.g., child struggles with staff). Physical restraint shall be used only to ensure the safety of the child or others, and must include a written order by a physician or licensed psychologist designated by the contracted agency, followed by a face-to-face assessment by that licensed individual within one hour. PRN orders for physical restraint are prohibited.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Chemical restraint involves the incidental use of medications and drugs to control unsafe behavior through temporary sedation or other related pharmacological action. Chemical restraint shall be used only to ensure the safety of the child or others, and must be preceded by a written order by a physician designated by the contracted agency, followed by a face-to-face assessment by that physician within one hour. PRN orders for chemical restraint are prohibited.

Appropriate use of Time Out does not involve restraint of any kind. Time Out does require the removal of the child from peers or rewarding situations, but its primary purpose is not confinement of the child. It therefore does not involve seclusion, only separation.

Only individuals trained and certified in the physiological and psychological impact of their use may impose seclusion and restraints.

Non-aversive interventions and positive behavioral supports should be the absolute first course of action to ensure the safety of the child and others. These strategies should be part of a programmatic plan to anticipate and manage a child's unsafe behavior. Evidence of the use of non-aversive interventions and positive behavior supports is the expectation at all levels of care. In the event of seclusion or restraint, there must be clear documentation that such strategies were the first recourse.

Seclusion and restraint must be followed by a complete documentation of the episode in the CAMHD seventy-two (72) hour Sentinel Event Report, including (1) a review of the non-aversive alternatives that were considered and (2) a reference to the debriefing with all staff involved in the event.

4. Sentinel Events and Incidents

All Contractors must have internal policies and procedures regarding sentinel events and incidents. At a minimum these policies must address:

- How the Contractor shall notify CAMHD and DOE within twenty-four (24) hours by fax or telephone and in writing within seventy-two (72) hours of any sentinel event that compromises the safety (physical or emotional) of any youth;
- How each agency shall track the occurrence of all incidents and sentinel events to identify trends and patterns in order to implement improvements; and
- A complete analysis of the event as well as actions taken to address the event must be submitted. Both the initial notification and the subsequent written report must be forwarded to the CAMHD Quality Operations Section and the FGC MHCC, or DOE school (depending upon contracting state agency involved).

L. CONSUMER RIGHTS AND CONFIDENTIALITY

CAMHD and DOE recognize the rights of all individuals and families accessing behavioral health services. All contracted agencies and their employees or subcontracted

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

professionals are required to also recognize client's rights and responsibilities. These include:

- The right to a safe and humane environment;
- The right to be free from unlawful discrimination;
- The right to be free from harm;
- The right to a written individualized plan, and the right to on-going participation in the planning process;
- The right to review their record and access to that record;
- The right to confidentiality of information discussed and communicated in the context of the intervention and planning, with information to be shared with appropriate individuals only with the consent or authorization of the youth or if the youth is at significant risk of harm to self or others and sharing of information is necessary to prevent that harm;
- The right to agree to service delivery except in emergency situations where the client presents a danger to himself or to others;
- The right to refuse participation in services, which includes experimental service plans or procedures;
- The right to confidentiality of records;
- The right to procedural safeguards when disagreements arise;
- The right to request changes in the service plan at any time;
- The right to be informed of and fully understand one's rights;
- The right to file a complaint and to be able to do so without fear of retaliation; and
- The right to services in a manner sensitive to the cultural and spiritual differences of the recipients.

All employed and contracted providers must adhere to these rights in the provision of behavioral health services to eligible youth. Each Contracted agency is to identify a Behavioral Health Rights Advisor within their organization who will ensure that all youth and families are made aware of their rights, and that the provider respects and upholds these rights.

Each Contracted agency shall have in place, its own administrative process through which youth and their families can have their concerns and/or complaints addressed in a thorough and efficient manner. Parents (and youth as appropriate) will sign a form acknowledging receipt of this information, provided in booklet form.

M. COMMUNITY FOCUS

DOE and CAMHD shall participate in the local community organizations, including Community Children's Council (CCC). DOE and CAMHD shall work collaboratively with the community organizations to address issues and concerns about the services and the continuum of care provided to Hawaii's eligible youth. Contract providers are required to participate in local CCCs to ensure healthy, ongoing communication between the providers and the CCCs, and to provide opportunities for collaboration in the development

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

of behavior health services/resources to complement existing services and to meet local needs.

N. TEAM-BASED DECISIONS

All behavior health services with some exclusion of other services, such as emergency services are the result of team-based decisions. The IEP/MP/CSP team utilizes assessment information and behavior guidelines and standards of this manual to make decisions. Services emanate from an IEP, MP, or CSP with a BSP or MHTP to define the specifics.

O. COMPLAINTS/APPEALS

DOE and CAMHD respect the right of any youth or family to disagree with aspects of planning or service delivery and will make every effort to resolve these disagreements directly with the family. If resolution is not possible in direct exchange, families and providers have additional recourse through the DOE Due Process Administrative Hearing avenue, or CAMHD's Complaints, Grievances and Appeals Process. Youth and/or families are informed of these processes at their school-based team meetings, and upon registration at a FGC.

P. ACCOUNTABILITY/SERVICE STANDARDS

All contract providers will remain obligated to the aspects of the contract as agreed upon by DOE, CAMHD, and the provider, to general professional practice and ethical standards as dictated by the various licensing boards within the State of Hawai'i, to general standards of most promising practice as evidenced by available evidence-based literature, and to service standards as delineated in this manual.

DOE and CAMHD shall be responsible for monitoring each contract at least annually and more frequently as needed.

Q. CHILD ABUSE AND NEGLECT REPORTING MANDATES

Providers shall adhere to state law regarding the mandated reporting of suspected child abuse. Youth's clinical records will reflect assessment of suspected abuse and any contacts with Child Protective Services or other related agencies.

SECTION II:

**SERVICE SPECIFIC
PERFORMANCE STANDARDS**

SECTION II – PART A:

**EMERGENCY MENTAL HEALTH
PERFORMANCE STANDARDS**

**SECTION II – PART A: EMERGENCY MENTAL HEALTH
PERFORMANCE STANDARDS**

I. EMERGENCY MENTAL HEALTH SERVICES

A. 24-HOUR CRISIS TELEPHONE STABILIZATION

Definition	Hot line serving all youth whose immediate health and safety may be in jeopardy due to a mental health issue. After receiving support, consultation and referral that dissipate the crisis situation, the youth's natural environment has the capacity to allow the youth to remain safely in the community. The absence of this capacity would indicate need for mobile outreach services to assess situation and arrange appropriate course of actions.
Services Offered	Hotline Services available twenty-four (24) hours/seven (7) days a week. Initial assessment is made regarding the nature of the mental health crisis. Support, consultation and referral services are provided. The program provides the caller with sufficient information or guidance to dissipate crisis.
Initial Authorizations	Not applicable
Re-Authorization	Not applicable
Admission Criteria	Not applicable
Continuing Stay Criteria	Not applicable
Discharge Criteria	Not applicable
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. A Hawaii licensed psychiatrist is on call twenty-four (24) hours a day, seven (7) days a week, in the event of medical or complex psychiatric related situations in need of consultation. A Hawaii-licensed psychiatrist, American Board of Psychiatry and Neurology (ABPN) certified in child and adolescent psychiatry or Hawaii-licensed clinical psychologist is available for on-call service, consultation, direction, and case debriefings.
3. The program staff must be under the supervision of a QMHP. A MHP with crisis experience other than the psychiatrist must be on hot-line premises at a minimum of eight (8) hours/day and must be on call at all other times.
4. The hotline agency must have adequate numbers of workers available, particularly during peak call hours to minimize call-waiting and call hold instances.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

5. Prior to performing hotline services, hotline workers receive at least twenty-four (24) hours of orientation training including, but not limited to topics such as crisis assessment and intervention, suicidal assessment, homicidal assessment, clinical protocol, proper documentation, and knowledge of community resources.
6. Hotline workers shall receive individual guidance by MHPs with experience in crisis work, at a ratio of one (1) hour for every forty- (40) on-duty work hours minimally. The supervision may utilize a combination of methods such as direct observation, coaching, and mentoring that assess the workers' levels of skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.
7. Hotline workers must be familiar with community resources and services to provide guidance and referrals to callers.
8. Minimally on a monthly basis, hotline workers shall participate in two (2) hours of group case debriefings led by a QMHP. It is expected that agencies with a high volume of critical calls hold more frequent debriefings.
9. At a minimum, crisis hotline workers must have: a high school diploma and two (2) years experience working informally or formally as a human services worker, with a desire, attitude and aptitude for working with people. College education may substitute for work experience on a year for year basis.
10. The program must have specific protocols in place that address all aspects of service provision.
11. The program must have documented training on a quarterly basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by hotline workers.

Clinical Operations

1. Trained hotline workers must be available at all times to assess the nature and severity of the mental health crisis, provide needed support and consultation, and refer for appropriate treatment or other needed service.
2. The crisis hotline must be a toll free number for all callers in the covered geographic area.
3. All hotlines must have TTY or TTD capacity.
4. All calls must be answered by trained hotline workers within three (3) rings or ten (10) seconds.
5. All calls must not be on hold for more than fifteen (15) seconds.
6. The agency must have a process for dispatching hotline calls for on-site visits by the mobile outreach team when situations warrant face-to-face lethality assessments and consultation.
7. The agency must have protocols for hotline workers to ensure the caller receives sufficient information or guidance until the crisis dissipates or diminishes, or until the mobile outreach team arrives.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Documentation

1. An emergency service note must be completed and entered in the service log immediately, that includes, to the extent provided by the caller:
 - a. Identifying demographic information.
 - b. The date and actual time and duration of the services rendered.
 - c. The worker who took the call.
 - d. The nature of the crisis.
 - e. Description of the nature of interventions made, including natural community resources utilized in diminishing the crisis and ensuring the safety of the youth.
 - f. The involvement of additional staff in the provision of service, particularly the on-call QMHP.
 - g. The youth's status, referrals for continued services and disposition at the end of the call.
 - h. If the youth's name is not given, a note describing any relevant general information (e.g. male teenager) is obtained. Anonymous caller notes are placed in a separate file.
2. If the youth is registered with a FGC, this documentation must be forwarded to the MHCC by closure of the next business day.
3. The crisis hotline agency must have the necessary systems in place to monitor calls, length of calls, call wait times and aborted calls. These reports must be provided to CAMHD every quarter.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

B. MOBILE CRISIS OUTREACH

Definition	This service provides mobile assessment and stabilization services for youth in an active state of psychiatric crisis. Services are provided twenty-four (24) hours per day, seven (7) days per week and can occur in a variety of settings including the youth's home, local emergency facilities, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation if necessary.
Services Offered	<ol style="list-style-type: none"> 1. Twenty-four (24) hour-seven (7) day a week response; 2. Response to service request is within forty-five (45) minutes of notification; 3. Pre-hospitalization screening and assessment; 4. Crisis intervention and counseling; 5. Family counseling; 6. Medication management; 7. The program shall arrange or assist with transportation to a community residential shelter or hospital-based emergency units (when needed); 8. Care coordination, including arranging appropriate referrals to community resources; and 9. For non-Felix youth, the program will make referrals to DOE for eligibility determination within the next school day.
Initial Authorizations	Prior procurement is not required for this level of care. Usual time frame is one (1) to four (4) hours. (one (1) unit = fifteen (15) minutes)
Re-Authorization	Not applicable
Admission Criteria	<ol style="list-style-type: none"> 1. The youth may be a danger to self or others; OR 2. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable in their current living situation; OR 3. The youth's behavior has significantly strained the family's or current caregiver's ability to safely and adequately respond to the youth's needs; OR 4. The youth evidences lack of judgment and/or impulse control and/or cognitive/perceptual abilities.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The youth continues to be a danger to self or others; OR 2. The youth continues to display acute psychotic symptoms (such as delusions, hallucinations, and thought disorganization) that are unmanageable in their current living situation;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	OR
	3. The youth continues to engage in behavior that significantly strains the family's or current caregiver's ability to safely and adequately respond to the youth's needs;
	OR
	4. The youth continues to lack judgment and/or impulse control and/or cognitive/perceptual abilities.
Discharge Criteria	1. The youth's symptoms and/or behaviors abate to a level no longer requiring outreach services;
	OR
	2. Appropriate community or natural resources are planned and/or engaged to reduce stress factors and to stabilize the current living environment;
	OR
	3. The youth has the ability in the current living environment to cope with the immediate situation;
	OR
	4. A safe living environment is re-established in the youth's natural environment or temporarily established elsewhere if the ability of the environment to safely respond to the youth's behavior is questionable;
	OR
	5. The youth is escorted to a hospital-based emergency unit to be evaluated for possible admission to an acute facility and/or provided immediate treatment and released.
Service Exclusions	None
Clinical Exclusions	None

Staffing Requirements:

1. The program must be under the supervision of a QMHP. This QMHP must be available for service and treatment consultation, direction, facilitation or field visits as necessary.
2. Psychiatric services must be available twenty-four (24) hours/seven (7) days a week, for youth who need immediate assistance with medication. The program must have an ABPN child and adolescent certified psychiatrist, licensed in Hawaii, for medically related or potential hospitalization service and treatment consultation, direction, and facilitation, or field visits as necessary.
3. At a minimum, mobile outreach staff must have:
 - a. A Bachelor's degree either in Social Work, Psychology, Counseling, or Nursing working under the guidance of a MHP, with two years supervised clinical experience in providing direct crisis response for youth.

OR

 - b. A MHP with one (1) year supervised clinical experience in providing direct crisis response for youth.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

4. There are no specific face-to-face ratios, however pairs of staff may be needed where the safety of workers is of concern or where more than one staff is needed to successfully defuse the situation.
5. Staff must have at least twenty-four (24) hours of orientation training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
6. Staff receive, at a minimum, two (2) hours per month of individual guidance by a MHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.
7. Minimally on a monthly basis, staff shall participate in two (2) hours of group case debriefings led by a QMHP. More frequent debriefings are expected of agencies with a high volume of critical calls.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Staff respond and are on site within forty-five (45) minutes of the initial phone call.
3. For more remote or small geographic locations such as Hana or Ka'u, face-to-face assessments by the staff shall occur within the usual transport time to reach that destination if staff is not stationed at the remote site. However, the program must make, with the approval of their QMHP, alternative interim arrangements sufficient to ensure the safety of the youth until the mobile outreach worker arrives.
4. Assessment and therapeutic resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Families/caregiver(s), CSP/treatment team member (per crisis plan), if not already involved, are immediately sought and informed when located.
5. If the youth is registered with a FGC, the crisis worker contacts the FGC MHCC at the time of the crisis or leaves a telephone message for the MHCC with a full report of the occurrences, including any requirements for MHCC follow-up. Information exchange guides the collaboration process toward resolution and disposition and follow through of services.
6. The youth and family are provided information about and as necessary, linked to appropriate medical, social, mental health, or other community resources.
7. Prior to arranging for emergency room assessments for possible inpatient admission, the staff shall seek consultation of the crisis program's on-call psychiatrist. The psychiatrist may either make a field visit for a face-to-face evaluation and possible emergency treatment, or contact the emergency unit with significant information in anticipation of the youth's arrival, or conduct a face-to-face evaluation at the emergency unit where the psychiatrist has staff privileges.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- The program's Medical Director will direct the staff regarding additional actions to make or preparations to take.
8. Staff are expected to remain with the youth at any overnight holding center if necessary or at any emergency unit until the youth is either admitted, transported, or released.
 9. If indicated, referrals of non-Felix youth are initiated for DOE identification and eligibility procedures within two (2) days.
 10. If follow-up services for non-Felix youth are necessary, the agency must arrange follow up services through families' medical insurance or community resources within one (1) day.
 11. The agency must make a follow-up call to the family within twenty-four (24) hours of the mobile crisis intervention to ensure that the crisis has stabilized and referral sources (if needed) were contacted.
 12. The program must have documented ongoing training on a quarterly scheduled basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by emergency workers.

Documentation

1. Clinical documentation must be recorded and include all significant written information available, including, but not limited to: the nature and status of the crisis; demographic information; signed parental consents to transport youth; or ex-parte applications and authorizations. All such documentation must be prepared and arranged in advance of the youth's arrival at any emergency unit.
2. The crisis plan in the MHTP is developed or updated.
3. An outreach service note must be documented for each youth. The note must include all of the following:
 - a. Identifying information: youth name, DOB, address, phone number, legal guardian, school/home-school, and grade.
 - b. The place, date and actual time (start and end time) and duration of services rendered.
 - c. The outreach service worker rendering the service.
 - d. Details of the mental status and psychosocial assessments of the youth and the immediate situation including a risk assessment.
 - e. Description of the nature of the crisis and interventions made, including natural community resources utilized.
 - f. The status of the youth at closure of the outreach services, including temporary shelter arrangements as applicable and significant information regarding the parent(s)/caregiver(s).
 - g. Specific follow-through recommendations, including the need for additional services.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

4. A copy of this note is sent to the MHCC by closure of the next business day if the youth is registered with an FGC or to the referring agency if the youth is not a Felix youth with appropriate consent with release of information.
5. A brief written summary accompanies the youth to the emergency unit or shelter placement and consists of information that facilitates assessment, communication, and disposition of the youth.
6. A written referral will be made to DOE as applicable for a comprehensive evaluation to determine IDEA/504 eligibility.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

C. CRISIS STABILIZATION

Definition	This service offers short-term, acute residential interventions to youth experiencing mental health crises. This is a structured residential alternative to, or diversion from, Hospital-Based Residential Services. Crisis stabilization services are for youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the youth.
Services Offered	<ol style="list-style-type: none"> 1. Services are available twenty-four (24) hours, seven (7) days a week; 2. Services are provided in a twenty-four (24) hour supervised residential setting; 3. The program provides crisis intervention and counseling; 4. The program provides family counseling; 5. Medication assessment and management services are provided; 6. The program provides skills development directed at improving the youth's ability to cope with daily stressors; manage emotions and behaviors; improve communication and strengthen interpersonal relationships; and 7. Services are provided to assist youth and families to find and secure necessary community supports and to communicate and collaborate with relevant community members, or with the IEP/CSP team.
Initial Authorizations	Day 1-3 = no prior authorization needed. Day 4-7 [maximum of four (4) additional days] = prior authorization required. [Unit = one (1) day]
Re-Authorization	Not applicable
Admission Criteria	<ol style="list-style-type: none"> 1. The youth may be a danger to self or others, expressing suicidal ideation or is engaging in self-destructive or self-mutilating behaviors; <b style="text-align: center;">OR 2. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable in their current living situation; <b style="text-align: center;">OR 3. The ability of the youth's family or current caregivers to safely and adequately respond to the youth's needs is significantly strained; <b style="text-align: center;">AND 4. The youth evidences lack of judgment and/or impulse control and/or cognitive/perceptual abilities; <b style="text-align: center;">AND 5. Without this out-of-home intervention the youth would be at high risk of an out-of-home placement for a longer period of

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	time in a more restrictive setting.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The youth continues to be a danger to self or others; OR 2. The youth continues to display acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable in their current living situation; OR 3. The youth's family continues to be unable to safely and adequately respond to the youth's needs without significant strain; AND 4. The youth continues to lack judgment and/or impulse control and/or cognitive/perceptual abilities; AND 5. The youth continues to be at high risk of out-of-home placement for a longer period of time in a more restrictive setting.
Discharge Criteria	<ol style="list-style-type: none"> 1. The youth's targeted symptoms and/or behaviors have abated; AND 2. The youth's psychological, social and/or physiological levels of functioning have returned to a level that allows the youth's safe return to his/her natural environment with the necessary support services; AND/OR 3. Appropriate natural community resources are planned or engaged to reduce stress factors and to stabilize the current living environment; AND/OR 4. Considering the youth's health and safety, the severity of the youth's symptoms or behavior is such that the youth requires continued therapeutic interventions, structure, and supervision, longer than is appropriate in a short-term crisis shelter.
Service Exclusions	Not offered at the same time as Hospital-Based.
Clinical Exclusions	Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition

Staffing Requirements:

1. Staff supervision is provided on a twenty-four (24) hours, seven (7) days a week basis.
2. The program staff must be under the supervision of a QMHP.
3. If indicated as needed by the program's QMHP, suicidal watches require a staff ratio of one to one (1:1).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

4. A licensed psychiatrist must be available twenty-four (24) hours, seven (7) days a week. The psychiatrist must have staff privileges at the nearest community hospital. The psychiatrist arranges for coverage in his or her absence. The person who is covering must be Hawaii licensed and ABPN board certified in child and adolescent psychiatry and able to conduct face-to-face assessments as necessary.
 5. A QMHP must oversee the treatment planning.
 6. The crisis stabilization agency ensures the provision of necessary additional personnel, inclusive of therapeutic family homes to meet the special needs of crisis-sheltered youth or for emergencies including escorting and remaining with the youth at an emergency unit, or maintaining one to one (1:1) supervision of a youth at a hospital-based or other holding unit.
 7. At a minimum crisis stabilization staff must have:
 - a. A Bachelor's degree either in Social Work, Counseling, Psychology, or Nursing working under the guidance of a MHP (who is in turn supervised by a QMHP), with two (2) years supervised clinical experience in providing direct crisis response for youth and adolescents.
- OR**
- b. A MHP with one (1) year supervised clinical experience in providing direct crisis response for youth and adolescents. MHP must be supervised by a QMHP.
 8. Staff receive at minimum, two (2) hours per month of individual guidance by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve staffs' levels of skill. The amount and frequency of guidance may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.
 9. Minimally on a monthly basis, staff shall participate in two (2) hours of group case debriefings led by a QMHP.
 10. Staff must have at least twenty-four (24) hours of orientation training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, proper documentation, knowledge of community resources as well as knowledge of the court processes and legal documents relative to emergency procedures and specific legal issues governing informed consents that must be completed prior to performing crisis stabilization services.
 11. The program must also have documented training on a quarterly scheduled basis, to expand knowledge base and skills relative to crisis intervention and treatment protocols as guided by the agency's training curriculum, and youth-specific situations experienced by emergency workers.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Youth must be in the presence of staff at all times.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. In conjunction with the anticipated short duration of stay, youths' education is not considered to be a primary focus. However, transition planning shall consider youths' educational needs such that loss of academic credits is minimized.
4. Crisis stabilization programs ensure the youth's presence and safety through minimally quarter-hour visual checks during the youth's first four (4) hours following admission. Quarter-hour visual checks for placements in therapeutic family shelters may be waived if crisis outreach assessments clinically justify the absence of lethal or elopement factors and this is duly documented and signed by the qualified professional making the assessment.
5. There is daily communication between the crisis agency, the shelter facility, and the treatment team, through the MHCC if a Felix youth, to keep apprised of the youth's status and progress.
6. The physical structure of group living premises shall, to the extent possible, prevent the youth's elopement during sleep hours between visual bed check intervals.
7. The crisis stabilization program has medical emergency information, plans, and mechanisms to ensure appropriate and timely medical emergency interventions.
8. Severe crisis occurrences at shelters may call for consultation with either the crisis agency's psychiatrist or the shelter agency's psychiatrist (as arranged through sub-contract or memorandum of agreement). The existence of medical indications, including the possibility of hospitalization requires the psychiatrist to conduct a face-to-face assessment and provide necessary guidance and treatment either at the shelter facility or at a hospital emergency unit. The psychiatrist will contact a hospital to which he or she has staff privileges to facilitate arrangements for an evaluation at the hospital emergency unit if it seems indicated that the youth might need inpatient care.
9. Assessment and therapeutic resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Family (ies)/caregiver(s), CSP/treatment team member (per crisis plan), if not already involved, are immediately sought and informed when located.
10. The crisis worker contacts the FGC MHCC at the time of admission to the crisis stabilization program and maintains daily contact with the MHCC.
11. If indicated, referrals of non-Felix youth are initiated for DOE identification and eligibility procedures.
12. Follow-up services for non-Felix youth are arranged through families' medical insurance or community resources.

Documentation

1. If a crisis plan does not exist, the agency's MHP shall formulate the crisis plan and transition plan for the crisis residential program (See definitions in Glossary).
2. The crisis agency actively participates in crisis treatment planning processes and communicates daily with the shelter agency, the youth and family, and the MHCC for Felix youth.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. Crisis plans shall be detailed, specific to each youth's needs, including to whom, when and how information is conveyed, and actions to be implemented.
4. Clinical documentation must be recorded and include all significant information available, including, but not limited to: the nature and status of the crisis; demographic information; signed parental consents to transport, evaluate and treat at emergency units, and to hospitalize as applicable; and ex-parte applications as applicable, all of which must be prepared and arranged in advance of any youth's arrival at any emergency unit.
5. The crisis plan in the CSP/MHTP is developed or updated in coordination with the youth's Mental Health Treatment Team.
6. A brief written summary accompanies the youth to another level of care and/or school consisting of information that facilitates assessment, communication, ongoing intervention and disposition of the youth with appropriate consent for release of information.
7. A written referral to DOE as applicable for a comprehensive evaluation to determine IDEA/504 eligibility.
8. Individual staff's shift notes and crisis foster parent's brief daily notes reflect youth's status in adjusting to the new environment through observations and interventions.
9. The MHP's daily progress notes shall reflect clinical observations and progress and therapeutic interventions with a specific focus on both the youth as well as the parent(s)/caregiver(s).

SECTION II – PART B:

**SCHOOL - BASED
BEHAVIORAL HEALTH SERVICES
PERFORMANCE STANDARDS**

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

SECTION II – PART B: SCHOOL - BASED BEHAVIORAL HEALTH SERVICES PERFORMANCE STANDARDS

II. SCHOOL - BASED BEHAVIORAL HEALTH SERVICES

A. FUNCTIONAL BEHAVIORAL ASSESSMENTS AND BEHAVIORAL SUPPORT PLANS

Definition	<p>Functional Behavior Assessment (FBA) is a process that provides a framework for developing effective programs for students. It examines the events that reliably predict and maintain problem behavior while using a strength-based approach that considers the “whole child” and the context in which the behavior occurs. It addresses problem behavior by developing behavior support plans that move away from being reactive and punitive in nature, to plans that are proactive with research-validated practices. The approach is geared at utilizing a student’s strengths to provide a basis for plan development, instructional programming, and behavior management that are geared to each individual’s needs, preferences, and long- term goals.</p>
Services Offered	<ol style="list-style-type: none"> 1. Gathering broad information: <ol style="list-style-type: none"> a. Student’s strengths and skill limitations b. Daily routines and activities c. Student and family preferences and goals d. Health concerns e. Quality of life indicators (relationships, choice and control, access to preferred activities) <p>* This type of information can be gathered from various places including team discussions, interviews, review of records, rating scales, specific skill assessments.</p> 2. Gathering specific information: <ol style="list-style-type: none"> a. Student’s strengths and skill limitations b. Daily routines and activities c. Student and family preferences and goals d. Health concerns e. Quality of life indicators (relationships, choice and control, access to preferred activities) f. What specific events or factors contribute to the student’s problem behavior? g. When is the student most likely to engage in the problem behavior? h. What appears to be maintaining the student’s behavior? i. What function(s) does the problem behavior serve for the student? j. When is the student less likely to engage in problem behavior? (Identify characteristics of these situations.) k. What other factors might be contributing to the student’s

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p style="text-align: center;">problem behavior?</p> <p>* This type of information can be gathered from various forms of informant and observation techniques including team discussions, scatter plots, ABC analyses</p> <ol style="list-style-type: none"> 3. Once the assessment process is completed and predictable patterns emerge that explain when and why the student is engaging in problem behavior, a hypothesis statement needs to be developed. The hypothesis will serve as a foundation on which to design a behavior support plan and should include the following: <ol style="list-style-type: none"> a. When this happens (a description of specific antecedents associated with the problem behavior), b. The student does this (a description of the problem behavior) c. In order to (a description of the possible function of the behavior) 4. Clear hypothesis statements should lead to interventions that are based on understanding the functions of the student's behavior. Behavior Support Plans should be detailed and contain the following elements: <ol style="list-style-type: none"> a. Antecedent and setting event modifications b. Teaching of alternative skills using research based practices c. Consequence strategies to strengthen alternative skills, reduce the pay-off for the problem behavior, and crisis prevention/intervention d. Lifestyle Interventions that include long-term maintenance of skills e. Implementation date f. Delineation of who is responsible for each intervention g. Criteria to evaluate progress h. Crisis management plan (if necessary).
<p>Initial Authorizations</p>	<p>Up to four (4) units (to include assessment, behavior support plan, and feedback session)</p> <p>One (1) Unit = One (1) Hour [may be in increments with .25 units = fifteen (15) minutes]</p> <p><i>Note: Procured units reflect the time required for completing the data gathering, assessment process, behavior support plan, and feedback session. There is not payment for travel time, wait time, no-shows, or cancellations.</i></p>
<p>Re-Authorization</p>	<p>For some youth with more challenging behaviors, up to twenty (20) units may be warranted. Specific authorization for these hours must be agreed upon by the IEP/MP team.</p>
<p>Admission Criteria</p>	<p>Student is in need of assessment services for one of the following reasons:</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ol style="list-style-type: none"> 1. Requires an assessment to determine behavior health needs and recommendations as part of an early intervention process. 2. Requires an assessment to determine behavior health needs and recommendations as part of the Chapter 56 or Chapter 53 process.
Continuing Stay Criteria	FBA is an ongoing process. Initially personnel may procure up to four (4) hours. If additional units are requested, the provider must submit justification, to CC.
Discharge Criteria	<ol style="list-style-type: none"> 1. If the student is not a Chapter 56 or Chapter 53 eligible student and the assessment team has convened and determined services are no longer warranted. 2. If the student is Chapter 53 or Chapter 56 eligible and the IEP or Modification Team has convened and removed services from the plan.
Service Exclusions	None
Clinical Exclusions	None

Staffing Requirements:

Classified, certified, or licensed behavior support and educational staff who are trained in FBA and plan development can effectively facilitate functional assessments and plan development actions.

*The level of expertise required for more complex data gathering will depend on the nature of referral questions. For example, if a team believes a child's diagnosed mental health condition is a setting event for problem behavior, a masters or doctoral level behavioral health professional should provide the clinical assessment data necessary to clarify.

Clinical Operations

1. Parent(s), student, and staff associated with the behavior support plan were actively involved in the process.
2. Plan contains all required service content components.
3. Plan is typed.
4. Plan is submitted and meets timelines.
5. Plan is proactive and is strength based.
6. Plan addresses a student's needs and does not specify a particular program or eligibility status.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

7. Assessment of student progress in plan objectives yields a clear picture of plan effectiveness.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision.
3. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

B. MENTAL HEALTH ASSESSMENTS

Definition	Diagnostic and evaluation services involving a strengths-based approach to identify youth's needs in the context of school, family and community. These services include completion of initial assessments, tri-annual assessments, and initial supplementary mental health assessments as part of the DOE identification and eligibility process. Service components include written assessments, a feedback session, and MHTP suggestions.
Services Offered	<ol style="list-style-type: none"> 1. Contact family and arrange for appointment with the youth and family within one week of procurement; 2. Conduct assessment within three weeks of procurement. <ul style="list-style-type: none"> • Obtain consents for assessment. • Review and incorporate DOE diagnostic team reports, including psychometric test results, if available. • Review and incorporate any other relevant data including developmental, psycho-social, medical, educational, and legal histories as provided by the CC/intensive case manager. • Conduct face-to-face or phone interviews with school personnel: teachers, counselors, and/or administrators, or other persons that have first-hand knowledge of the functioning of the youth. • Interview family/significant others. • Interview youth face-to-face. • Administer assessment instruments as indicated to include at a minimum the CAFAS* and Achenbach checklists from home (CBCL) and school (TRF) and youth (YSR), if 11 years or older; <ol style="list-style-type: none"> f. Complete written report within one week from date of assessment. A written report includes <u>all</u> of the following: <ul style="list-style-type: none"> • Date(s) of Assessment and Date of Report; • Identifying Information: youth name, DOB, legal guardian, home-school, grade, IDEA/504 status; • Reason(s) for Referral; • Sources of Information: including review of records, interviews, and assessment tools; • Brief developmental, medical, family, social, educational, and psychiatric history-include post and current use of and reasons for psychotropic medications; • Substance Use History; • Description and history of presenting problem(s); • Behavioral Observations and Mental Status Exam; must include <u>all</u> of the following: <ol style="list-style-type: none"> a. Appearance, attitude and behavior;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> b. Orientation; c. Affect and mood; d. Thought Content/Processes: <ul style="list-style-type: none"> i. Fund of knowledge; ii. Intelligence; iii. Cognitive Processes; iv. Memory; e. Insight; f. Judgment; and g. Homicidal/suicidal risk. <ul style="list-style-type: none"> • Assessment Results and Interpretation; must include specific scores, plotted profiles, and analytical interpretations of the CAFAS* and Achenbach Checklists; • Youth and Family Strengths; • Clinical Formulation/Justification of Diagnoses (include severity and duration of diagnoses; for Rule/Out or Provisional diagnoses, explain what needs to occur to obtain a more definite diagnosis); • Diagnostic Impression: DSM IV - 5 Axes; • Statement addressing how diagnosis impacts youth's ability to benefit from their educational program; • Summary of strengths, concerns, and description of needs that must be met for student to benefit from his/her education; • Strengths-based recommendations with suggested goals and measurable objectives must be included. Recommendations will conform to the following: <ul style="list-style-type: none"> a. Supported by empirical research; b. Describe and address the needs of the youth and family; c. Avoid specifying a particular service, program or eligibility status. For example, it should not be specified that youth needs therapeutic aide services, day treatment, or that the youth should be certified Emotionally Impaired under IDEA. Instead, recommendations should focus on youth's particular needs, e.g., "the youth is in need of close supervision due to..." or "the youth is in need of a structured school environment and intensive therapy services" or "the youth's symptoms include..." d. Include possible least restrictive classroom modifications and/or school-based intervention recommendations that may address youth's needs.
Initial Authorizations	<p>Up to four (4) units (to include assessment and feedback session).</p> <p>One (1) Unit = One (1) Hour (may be increments, with .25 units = fifteen (15) minutes).</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	Note: Procured units reflect the time required for completing the review of data, assessment process, feedback session, and MHTP formulation. These units do not include report-writing time, as it is incorporated in the unit cost. There is no payment for travel time, wait time, no-shows or cancellations.
Re-Authorization	Not applicable
Admission Criteria	Youth is in need of assessment services for one of the following reasons: a. Requires an Initial assessment to determine mental health needs and recommendations, as part of the DOE identification and eligibility process, <p style="text-align: center;">OR</p> b. Requires an annual assessment to determine current mental health needs and recommendations
Continuing Stay Criteria	May initially procure up to four (4) units for Assessments. If additional units are needed, the provider must submit justification for review by the school level CC.
Discharge Criteria	<ol style="list-style-type: none"> 1. The assessment and feedback session have been completed. 2. The written reports are submitted to DOE and meet standards, as described. Assessments not meeting these criteria will be returned to assessor without payment. 3. Scores and plotted profiles of the CAFAS and Achenbach forms are attached.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

Initial and Tri-annual assessors shall meet one of the following requirements:

- a. Be a Hawaii licensed psychologist or psychiatrist **AND** have a minimum of one (1) year of supervised training in child and adolescent assessment.

OR

- b. Have a Master's degree, doctoral degree, or be a doctoral candidate in a graduate program in psychology or psychiatry from a regionally or nationally accredited program, **AND** a minimum of one (1) year of documented training and supervised experience in child and adolescent assessment, **AND** work under the supervision of a licensed psychologist or psychiatrist meeting standards above.

At a minimum, the supervisor must review all prior reports/data; review all current assessment data; and participate in the interpretation of data, and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

the development of diagnoses and recommendations. The supervisor is to sign the report acknowledging responsibility for the assessment.

OR

- c. Be a school psychologist or clinical psychologist employed by the DOE specifically credentialed to mental health assessment services as allowed under exemption in applicable state laws and regulations.

Clinical Operations

The mental health assessment shall include all required service content components.

1. Report is typed.
2. Report is submitted within one week of assessment completion.
3. Recommendations describe and address a youth's needs and do not specify a particular service, program or eligibility status.
4. Report includes original signature(s) of the assessor (and supervisor, as needed) acknowledging responsibility for the assessment.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within 24 hours of service provision.
3. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

C. PSYCHIATRIC MEDICATION EVALUATION

Definition	<p>The assessment of a youth’s presenting symptoms for the purpose of possible prescription and administration of medication by a physician. This service includes informing the youth and family of possible side-effects and obtaining consent for medication. Psychiatric medication evaluation includes examination of the patient or exchange of information with the primary physician, and other informants such as the family, CC or other relevant people. This service is limited to an initial evaluation. These evaluation services do not involve psychiatric treatment or medication management.</p>
Services Offered	<ol style="list-style-type: none"> 1. Once the service is procured the provider is responsible for contacting the family to set up an appointment with the youth and family within one (1) week of procurement. The evaluation interview(s) and data gathering shall be completed within three (3) weeks of procurement. The written report shall be submitted to the CC within one (1) week of the last evaluation appointment. 2. Psychiatric medication evaluation of a patient includes examination of a patient or exchange of information with the primary physician, other informants such as nurses or family members, and the preparation of a report. 3. A written report is generated to document the nature, chronicity, and severity of the disorder, and recommendations regarding medication. A report must be submitted to the FGC MHCC within one (1) week of completion of the evaluation. The report will include the following: <ul style="list-style-type: none"> • Behavioral observations and general presentation; • Description and history of presenting problem; • Description of current medical issues; • Any on-going substance use; • Current medications; • Discussion of findings and recommendations with youth and family. When medication is prescribed the psychiatrist obtains written, formal consent from the parent/legal guardian and the youth (if appropriate), after fully explaining the benefits, risks, and alternatives; <p style="text-align: center;">AND</p> <ul style="list-style-type: none"> • Assure that services are provided to youth in a safe, efficient manner in accordance with accepted standards and clinical practice.
Initial Authorizations	<p>There is a maximum of one (1) unit authorized initially. The psychiatrist is expected to review all previously collected data prior to interviewing youth and/or family. If additional time is sought the psychiatrist must notify the CC, and identify need for additional time. Procurement must be approved by the DOE Clinical Review</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>Team.</p> <p>One (1) Unit = One (1) Hour (may be in increments with .25 Units = fifteen (15) Minutes)</p>
Re-Authorization	Not applicable
Admission Criteria	The youth's symptoms and/or maladaptive behaviors require complete psychiatric evaluation
Continuing Stay Criteria	<p>Further procurement of units may be approved by the DOE Clinical Review Team if:</p> <ol style="list-style-type: none"> 1. The youth's symptoms and/or maladaptive behaviors during the assessment interviews persist at a level of severity such that a complete evaluation has not been achieved, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. New symptoms, maladaptive behaviors, or medical complications have appeared during the interview process which require an additional session to evaluate.
Discharge Criteria	<p>At least one of the following must be met:</p> <ol style="list-style-type: none"> 1. Psychiatric medication evaluation was successfully completed and written report, provided to the CC, is reviewed and accepted by the IEP team, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. Youth exhibits new symptoms or maladaptive behavior which precludes the ability to safely or effectively complete the evaluation, and youth was referred to a more intensive level of care.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

Psychiatric medication evaluation services shall be provided by personnel that meet the following requirements:

1. Hawaii licensed physician;
- AND**
2. Privileged through the provider's credentialing and privileging process to render diagnostic services, or
 3. Board certified in child and adolescent psychiatry.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Quality Indicators

1. The service contains all required service components.
2. The psychiatrist meets credentialing requirements.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision.
3. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

D. INDIVIDUAL THERAPY

Definition	<p>Regularly scheduled, individual face-to-face therapeutic services to the youth in his/her most appropriate natural environment for the purpose of addressing symptoms/problems that prevent the youth from benefiting from his/her educational program. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited with interventions reduced and discontinued as youth and family are able to function more effectively.</p>
Services Offered	<p>Individual therapy services include regularly scheduled face-to-face interventions with youth designed to improve functioning that allows the youth to reasonably benefit from his/her educational program. These services may be provided in the school, community, home or, if appropriate, in the contractor's office.</p> <p>Individual therapy includes evidence based therapeutic interventions involving cognitive-behavioral strategies, behavioral plans, skills training, systemic interventions, crisis planning and facilitating access to other community services and supports as needed to improve overall functioning and increase independence.</p> <p>Individual Therapy sessions can include a brief conference with the parent, if appropriate. Specific goals may include: reduce symptoms; increase behavioral control; and improve attention, communication, social, recreational, coping, anger management, problem-solving, and other daily living skills. Interventions are evidenced based and tailored to address identified youth needs.</p> <p>Services are designed to promote healthy functioning and to build upon the natural strengths of the youth/family and community. Service should follow a BSP in pursuit of measurable goals and objectives.</p> <p>The provider must begin contacting the youth/family within one week of procurement or IEP development and be able to initiate service within two (2) weeks of procurement unless otherwise indicated by the CC.</p> <p>Specific services include <u>all</u> of the following:</p> <ol style="list-style-type: none"> 1. Access and review all historical and assessment data available in the youth's clinical record. 2. Identify relevant issues, needs, and related goals to aid in behavior support planning. 3. Develop a written crisis plan in collaboration with the youth, family, teachers, and other relevant parties. 4. Develop a written BSP - with measurable goals and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>objectives, specific interventions, and target dates for reaching objectives - in collaboration with the youth, family, CC, and other relevant parties.</p> <ol style="list-style-type: none"> 5. Review a written transition/discharge plan to include discharge goals, specific target dates for reaching each goal, and criteria to determine when therapy can appropriately conclude. (The transition/discharge plan should be included in the students IEP). 6. Implement, monitor, and adjust interventions as needed to address needs and accomplish objectives and goals. 7. Review interventions, needs, goals and progress at least every 30 days and update crisis, treatment, and discharge plans within BSP based on such reviews. 8. Schedule regular sessions to work with youth to facilitate his/her ability to cope and function in a healthy manner through encouragement, support, therapy, education, skills training, and linkage to appropriate community services and resources. 9. Participate with integration of services across domains (home, school, and community) as needed. 10. Assist with discharge planning in collaboration with IEP. 11. Participate in the implementation of FBA and the development of a BSP and IEP. <p>Specific required documentation include <u>all</u> of the following:</p> <ol style="list-style-type: none"> 1. Completion of progress notes reflecting all contacts and placement of notes in the clinical record within twenty-four (24) hours. 2. Development review of a written crisis plan with the youth/family within one (1) week of initiating service, to be signed by all parties, and updates as needed. 3. Review of a written BSP plan with the youth/family prior to initiating service and written reviews of BSP with the youth/family as specified in the IEP. 4. Review of a written transition/discharge plan with the youth/family within four weeks of initiating service and updates as needed. 5. Regular completion of Treatment and Progress Summary completed and submitted to the Behavioral Health Supervisor within one week following each contact. 6. Record adjustments to crisis, treatment, and discharge plans as needed to effectively meet youth/family needs and are documented in the BSP.
<p>Initial Authorizations</p>	<ol style="list-style-type: none"> 1. Individual therapy services can be of varying degrees of intensity and complexity depending upon the youth/family situation and needs. Regular sessions are scheduled per BSP and typically will decrease in frequency as needs are met and goals are reached. These services are intended to be focused

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>and time-limited with services reduced and discontinued as youth/family are able to function more effectively. The usual course of treatment is six (6) to twenty-four (24) sessions or six months, whichever occurs first.</p> <ol style="list-style-type: none"> 2. The IEP team recommends these services. The scope and nature of services are collaboratively determined by the IEP. 3. Unit = one (1)-fifty (50) minute face-to-face therapy session and ten 10 minutes of documentation of the session, treatment planning and other case related activities. [allows for increments with .25 unit = fifteen (15) minutes]. <p>Note: Telephone contacts and logistical planning/preparation is assumed in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.</p>
Re-Authorization	Need for continuation of services is reviewed as designated in the BSP.
Admission Criteria	<p>An IEP/MP Team determines the following:</p> <ol style="list-style-type: none"> 1. The youth is experiencing mild to moderate behavioral and/or emotional problems due to a behavior disorder, manifested by a mild to moderate risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill developmentally appropriate responsibilities, presence of stress-related symptoms, decompensation, or relapse. AND 2. The identified behavioral and/or emotional problems interfere with youth's ability to gainfully benefit from his/her educational program. AND 3. There is reasonable expectation that the youth will benefit from this service, i.e., that therapy will remediate symptoms and/or improve functioning that relate to improved ability to benefit from his/her educational program. AND 4. Less restrictive services are not adequate to meet the youth needs based on documented response to prior treatment OR based on the judgment of the IEP team. 5. Continuation of services will be based on the student's progress on IEP goals and objectives.
Continuing Stay Criteria	<p><u>All</u> of the following criteria must be met as determined by IEP Team review of service documentation, plans and progress as specified in the BSP and IEP:</p> <ol style="list-style-type: none"> 1. All admission criteria continue to be met; AND 2. Services are being provided per BSP as documented in progress reports and plan reviews;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p style="text-align: center;">AND</p> <p>3. There are regular and timely assessments and documentation of youth/family response to interventions. Timely and appropriate modifications to the BSP are made that are consistent with the youth/family's status;</p> <p style="text-align: center;">AND</p> <p>4. A transition/discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, identifies specific transition/discharge goals to be met, and includes specific target dates for reaching each goal;</p> <p style="text-align: center;">AND</p> <p>5. At least <u>one</u> of the following criteria must be met;</p> <p>a. Symptoms or behaviors persist at a level of severity that was documented upon admission, the projected time frame for attainment of BSP goals as documented in the BSP has not been reached, and a less restrictive level of care would not adequately meet youth's needs. In this situation the BSP may need to be adjusted to better meet the youth/family's needs. If ongoing treatment and adjustments are not effective, alternative services and levels of care will need to be explored;</p> <p style="text-align: center;">OR</p> <p>b. Youth is demonstrating progress, behavioral goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services, and a less intensive level of care would not adequately meet youth needs;</p> <p style="text-align: center;">OR</p> <p>c. Minimal progress toward behavioral goals has been demonstrated, the BSP has been modified to more effectively address needs, there is reason to believe that goals can be met with ongoing therapy services, and a less intensive level of care would not adequately meet youth/family needs;</p> <p style="text-align: center;">OR</p> <p>d. New symptoms or maladaptive behaviors have developed, plans have been modified to address these additional behaviors, the behaviors can be safely and effectively addressed through therapy services, and a less intensive level of care would not adequately meet youth/family needs;</p>
<p>Discharge Criteria</p>	<p>Youth is no longer in need of or eligible for services due to at least <u>one</u> of the following:</p> <p>1. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the BSP;</p> <p style="text-align: center;">OR</p> <p>2. Youth has demonstrated minimal or no progress toward BSP goals for a three month period and appropriate modifications</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>of plans have been made and implemented with no significant success, suggesting the youth is not benefiting from individual therapy services at this time; OR</p> <p>3. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through individual therapy services; OR</p> <p>4. Youth no longer meets admission criteria for this service; OR</p> <p>5. Youth does not meet eligibility criteria.</p>
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

Individual therapy services shall be provided by personnel that meet one of the following requirements:

1. Hawaii licensed, graduate level social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist, National Certified Counselor, Option C only, **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services,

OR
2. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, counseling or behavioral science from a regionally or nationally accredited program **AND** a minimum of two years of supervised training and experience in the provision of child and adolescent mental health services,

OR
3. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, counseling or behavioral science, from a regionally or nationally accredited program **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, **AND** currently working under the supervision of personnel meeting criteria A or B above.

OR
4. Be a school psychologist or clinical psychologist employed by the DOE specifically credentialed to mental health assessment services as allowed under exemption in applicable state laws and regulations.
5. Staff must have at least thirty (30) hours of CAMHD/DOE approved basic training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.

6. Full time Staff shall receive at a minimum, two (2) hours per month of individual supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Initial appointment with youth/family is scheduled within two weeks of plan development or procurement or per instructions of CC as evidenced by progress reports.
2. Progress reports completed according to standards and placed in the confidential record within twenty-four (24) hours.
3. Crisis plans completed, regularly reviewed, and updated per standards.
4. BSP completed, regularly reviewed, and updated per standards.
5. Transition/Discharge plans completed, regularly reviewed, and submitted per standards.
6. Contract Reports completed and submitted per standards.
7. Evidence of credentialing.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision.
3. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

E. GROUP THERAPY

Definition	Regularly scheduled, face-to-face therapeutic services for groups of three (3) to twelve (12) youth in the most natural, appropriate environment for the purpose of addressing symptoms/problems that prevent the youth from benefiting from their educational program. These therapy services are designed to promote healthy independent functioning and are intended to be focused and time-limited .
Services Offered	<ol style="list-style-type: none"> 1. Group therapy services include regularly scheduled face-to-face interventions with groups of three (3) to twelve (12) youth designed to improve functioning that allows the youth to reasonably benefit from his/her educational program. A co-therapist is required for groups of eight (8) or more youth; this ratio may be greater for more disruptive youth. Groups are both focused and time-limited or youth are discharged from the group as BSP goals are reached. Group therapies may involve verbal instruction, modeling, coaching, role-playing, behavioral practice and other group-oriented experiential modalities. Specific goals may include: reduce symptoms; increase behavioral control; and improve attention, communication, social, recreational, coping, anger management, problem-solving, and other daily educational skills living skills. Interventions are evidenced based and tailored to address identified youth needs. Services are designed to promote healthy independent functioning and to build upon the natural strengths of the youth and community. 2. The provider must begin contacting the youth/family within one week of procurement and be able to initiate service within three weeks of procurement, unless IEP development or otherwise indicated by the CC. 3. Specific services include <u>all</u> of the following: <ol style="list-style-type: none"> a. Accessing and reviewing all historical and assessment data available in the youth's record. b. Identify relevant issues, needs, and related goals to aid in behavior support planning. c. Develop a written crisis plan in collaboration with the youth, family, teachers, CC and other relevant parties. d. Develop a written BSP Plan, with measurable goals and objectives, specific interventions, and target dates for reaching objectives - in collaboration with the youth, family, teachers, CC and other relevant parties. e. Develop a written transition/discharge plan to include discharge goals, specific target dates for reaching each

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>goal, IEP, and criteria to determine when therapy services can appropriately conclude.</p> <ul style="list-style-type: none"> f. Implement, monitor, and adjust interventions as needed to address needs and accomplish objectives and goals. g. Review interventions, needs, goals and progress at least every thirty (30) days and update crisis, treatment, and discharge plans based on such reviews. h. Schedule regular group sessions to work with youth to address identified needs and goals per BSP plan. i. Participate with integration of services across domains (home, school, and community) as needed. j. Assist with discharge planning in collaboration with IEP team. <p>4. Specific required documentation includes:</p> <ul style="list-style-type: none"> a. Completion of progress notes reflecting all contacts placed in the clinical record within twenty-four (24) hours. b. Review of a written crisis plan with the youth/family and school within one (1) week of initiating service, to be signed by all parties and updated as needed. c. Review of a written BSP with the youth/family and CC within two (2) weeks of initiating service and written reviews of BSP with the youth/family at least every twelve (12) units or three (3) months, whichever comes first. d. Update written discharge plan with the youth/family within four (4) weeks of initiating service as needed. e. Submission of crisis plans, BSP updates, discharge plans, and reviews to the CC/and supervisor within one (1) week of completion. f. Regular Contact Summary completed and submitted to the CC/and supervisor within one (1) week following the end of the reported month. g. Record adjustments to BSP crisis, treatment, and discharge plans as needed to effectively meet youth/family needs.
<p>Initial Authorizations</p>	<ul style="list-style-type: none"> 1. Group therapy services can be of varying degrees of intensity and complexity depending upon the youth's situation and needs. Regular sessions are scheduled per BSP plan and typically will be time-limited. 2. These services are recommended by the IEP. The scope and nature of services are collaboratively determined by the IEP. 3. Unit = one (1) Hour (allows for increments with .25 unit = fifteen (15) minutes). <p>Note: Billable time is limited to time spent in face-to-face therapy with youth. Telephone contacts and logistical planning/preparation is assumed in the unit cost. There is no payment for travel time, wait time, no-shows, or cancellations.</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Re-Authorization	Need for continuation of services is reviewed at least every twelve 12 units or three (3) months, whichever occurs first.
Admission Criteria	<p>An IEP/MPTeam determines the following:</p> <ol style="list-style-type: none"> 1. The youth is experiencing mild to moderate behavioral and/or emotional problems due to a behavior disorder, manifested by a mild to moderate risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill developmentally appropriate responsibilities, presence of stress-related symptoms, decompensation, or relapse. AND 2. The identified behavioral and/or emotional problems interfere with youth's ability to gainfully benefit from his/her educational program. AND 3. There is reasonable expectation that the youth will benefit from this service, i.e., that therapy will remediate symptoms and/or improve functioning that relate to improved ability to benefit from his/her educational program. AND 4. Less restrictive services are not adequate to meet the youth needs based on documented response to prior treatment OR based on the judgment of the mental health treatment team.
Continuing Stay Criteria	<p><u>All</u> of the following criteria must be met as determined by IEP Team review of service documentation, plans and progress every twelve (12) units or three (3) months, whichever occurs first following admission:</p> <ol style="list-style-type: none"> 1. All admission criteria continue to be met. AND 2. Services are being provided per BSP as documented in progress reports and plan reviews. AND 3. There are regular and timely assessments and documentation of youth/family response to interventions. Timely and appropriate modifications to the BSP are made that are consistent with the youth/family's status. AND 4. A transition/discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, identifies specific discharge goals to be met, and includes specific target dates for reaching each goal. Transition/discharge plans are to be integrated within the IEP. AND 5. At least <u>one</u> (1) of the following criteria must be met: <ol style="list-style-type: none"> a. Symptoms or behaviors persist at a level of severity that was documented upon admission, the projected time frame for attainment of BSP goals as documented in the

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>BSP has not been reached, and a less restrictive level of care would not adequately meet youth's needs. In this situation the BSP may need to be adjusted to better meet the youth/family's needs. If ongoing treatment and adjustments are not effective, alternative services and levels of care will need to be explored,</p> <p style="text-align: center;">OR</p> <p>b. Youth is demonstrating progress, behavioral goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services, and a less intensive level of care would not adequately meet youth needs,</p> <p style="text-align: center;">OR</p> <p>c. Minimal progress toward behavioral goals has been demonstrated, the BSP has been modified to more effectively address needs, there is reason to believe that goals can be met with ongoing therapy services, and a less intensive level of care would not adequately meet youth/family needs,</p> <p style="text-align: center;">OR</p> <p>d. New symptoms or maladaptive behaviors have developed, plans have been modified to address these additional behaviors, the behaviors can be safely and effectively addressed through therapy services, and a less intensive level of care would not adequately meet youth/family needs.</p>
Discharge Criteria	<p>An IEP/MPTeam determines youth is no longer in need of or eligible for services due to at least <u>one</u> (1) of the following:</p> <ol style="list-style-type: none"> 1. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the BSP plan, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 2. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modification of plans have been made and implemented with no significant success, suggesting the youth is not benefiting from group therapy services at this time, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 3. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through group therapy services, <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 4. Youth no longer meets admission criteria for this service.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Staffing Requirements:

Group therapy services shall be provided by personnel that meet one (1) of the following requirements:

1. A Hawaii licensed, graduate level social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist, or a National Certified Counselor, Option C only **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services,

OR

2. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, counseling or behavioral science from a regionally or nationally accredited program **AND** a minimum of two (2) years of supervised training and experience in the provision of child and adolescent mental health services,

OR

3. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, counseling or behavioral science, from a regionally or nationally accredited program **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, **AND** currently working under the supervision of personnel meeting criteria A or B above.

4. Staff must have at least thirty (30) hours of CAMHD/DOE approved basic training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.

5. Full time Staff receive at a minimum, two (2) hours per month of individual supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

OR

6. Be a School psychologist or clinical psychologist employed by the DOE specifically credentialed to group therapy services as allowed under exemption in applicable state laws and regulations.

Clinical Operations

1. Initial appointment with the youth/family is scheduled within three (3) weeks of plan development procurement or per instructions of the CC plan.
2. Progress reports completed according to standards and placed in the confidential record within twenty-four (24) hours.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. Crisis plans completed, regularly reviewed, and updated per standards.
4. BSP completed, regularly reviewed, and updated per standards.
5. Discharge plans completed, regularly reviewed, and submitted per standards.
6. Treatment and Progress Summary completed and submitted per standards.

Documentation

Specific required documentation includes:

1. Completion of progress notes reflecting all contacts placed in the clinical record within 24 hours.
2. Review of a written crisis plan with the youth/family and school within one (1) week of initiating service, to be signed by all parties and updated as needed.
3. Review of a written BSP with the youth/family and CC within two (2) weeks of initiating service and written reviews of BSP with the youth/family at least every twelve (12) units or three (3) months, whichever comes first.
4. Update written discharge plan with the youth/family within four (4) weeks of initiating service as needed.
5. Submission of crisis plans, BSP updates, discharge plans, and reviews to the CC/and supervisor within one (1) week of completion.
6. Monthly Progress Summary completed and submitted to the CC/and supervisor within one (1) week following the end of the reported month.
7. Record adjustments to BSP crisis, treatment, and discharge plans as needed to effectively meet youth/family needs.
8. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
9. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision.
10. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

F. FAMILY THERAPY

Definition	Regularly scheduled face-to-face therapy sessions of a qualified behavioral health professional with a youth together with his/her family delivered in the most natural environment appropriate for their individual needs. Family therapy services are designed to be time-limited with interventions reduced and then discontinued as youth/family are able to function more effectively in area related to the youth's progress on educational goals and objectives. Family therapy is to be child-centered and family-focused as well as culturally sensitive. The primary goal of family therapy is to help the youth and the family improve their overall functioning in home, school, and community settings. The family therapist attempts to accomplish this goal by helping the youth and family increase effective coping mechanisms, healthy communication strategies, constructive problem-solving skills, and increased insight into the nature of the youth's difficulties. In addition, by facilitating the development of positive parenting skills and child management techniques, the family becomes empowered to better help their child.
Services Offered	Family therapy services include regularly scheduled face-to-face interventions with youth and their families designed to improve youth/family functioning that allows the youth to reasonably benefit from his/her educational program. The youth usually is present for family therapy sessions. There may be occasions where it is therapeutically indicated that the youth not be present. Reasons for this are documented in progress notes and monthly progress summaries. These services may be provided in the school, community, home or, if it is appropriate and agreeable to the family, in the contractor's office. This goal can be accomplished through encouragement, support, modeling, therapy, education, skills training, and linkage to appropriate community supports and resources. Specific interventions may include: <ol style="list-style-type: none">1. Assist family with developing and maintaining appropriate structure within the home.2. Assist family with development of effective parenting skills and child management techniques.3. Assist family with developing increased understanding of their child's symptoms and problematic behaviors, developing effective strategies to address these issues, and encouraging emphasis on building upon their child's strengths.4. Facilitate effective communication and problem-solving between family members.5. Facilitate effective communication between family members and school and/or other community agencies.6. Facilitate linkage to community supports and resources as needed.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>Interventions are evidenced based and tailored to address identified youth and family needs. Services are designed to promote healthy functioning and build upon the natural strengths of the youth, family and community. These services are intended to be time-limited with services reduced and then discontinued, as youth/family are able to function more effectively in achieving educational goals and objectives.</p> <p>The provider must begin contacting the youth/family within one week of plan development or procurement and be able to initiate service within two (2) weeks of plan development or procurement unless otherwise indicated by the CC. Specific services include:</p> <ol style="list-style-type: none"> 1. Access and review of all historical and assessment data available in the youth's clinical record. 2. Identify relevant issues, needs, and related goals to aid in treatment planning. 3. Develop a written crisis plan in collaboration with the youth, family, and other relevant parties. 4. Develop a written mental health treatment plan - with measurable goals and objectives, specific interventions, and target dates for reaching objectives - in collaboration with the youth, family, and other relevant parties. 5. Develop a written discharge plan to include discharge goals, specific target dates for reaching each goal, and criteria for when therapy services can appropriately conclude. 6. Implement, monitor, and adjust interventions as needed to address needs and accomplish objectives and goals. 7. Review interventions, needs, goals and progress at least every 30 days and update crisis, treatment, and discharge plans based on such reviews. 8. Schedule regular sessions to work with youth and family members together to: <ol style="list-style-type: none"> a. Facilitate youth's ability to cope and function in a healthy manner. b. Facilitate parent/caretaker's ability to effectively manage, teach, and positively reinforce their child. c. Promote positive communication, interaction, negotiation, and problem-solving skills for all family members. 9. Participate with integration of services across domains (home, school, and community) as needed. 10. Assist with discharge planning in collaboration with the mental health treatment team.
<p>Initial Authorizations</p>	<p>Family therapy services can be of varying degrees of intensity and complexity depending upon the youth/family situation and needs. Regular sessions are scheduled per BSP and typically will decrease in frequency as needs are met and goals are reached. These services are intended to be time-limited with services reduced and then discontinued as youth/family are able to function</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>more effectively and the youth demonstrates progress on educational goals and objectives.</p> <p>These services are recommended by the IEP team and procured by the school. The scope and nature of services are collaboratively determined by the IEP team.</p> <p>Unit = 1 50 minute face-to-face therapy session and 10 minutes of documentation of the session, treatment planning and other case related activities. (allows for increments with .25 unit = 15 minutes).</p> <p>Note: Telephone contacts and logistical planning/preparation is assumed in the unit cost. There is no payment for phone calls, travel time, wait time, no-shows, or cancellations.</p>
Re-Authorization	<p>Need for continuation of services is reviewed every 12 units or three months, whichever occurs first.</p>
Admission Criteria	<p>An IEP/MP Team determines the following:</p> <ol style="list-style-type: none"> 1. The identified youth meets at least one of the Service Eligibility criteria for CAMHD. AND 2. The youth is experiencing mild to moderate behavioral and/or emotional problems due to a behavior disorder, manifested by a mild to moderate risk for self-injury, injury to others, delay in appropriate developmental progress, deterioration in ability to fulfill developmentally appropriate responsibilities, presence of stress-related symptoms, decompensation, or relapse. AND 3. The identified behavioral and/or emotional problems interfere with youth's ability to gainfully benefit from his/her educational program. AND 4. Direct family involvement in interventions is essential to the youth's progress, i.e., lack of direct family involvement would result in lack of progress or deterioration. AND 5. Less restrictive services are not adequate to meet the youth needs based on documented response to prior treatment OR based on the clinical judgment of the IEP team.
Continuing Stay Criteria	<p>An IEP team determines the following:</p> <ol style="list-style-type: none"> 1. All admission criteria continue to be met. AND 2. Services are being provided per BSP as documented in progress reports and plan reviews. AND 3. There are regular and timely assessments and documentation of youth/family response to interventions.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>Timely and appropriate modifications to the BSP are made that are consistent with the youth/family's status.</p> <p style="text-align: center;">AND</p> <p>4. A transition/discharge plan is formulated and regularly reviewed, revised, and appropriately implemented in a timely manner, identifies specific transition/discharge goals to be met, and includes specific target dates for reaching each goal.</p> <p style="text-align: center;">AND</p> <p>5. At least <u>one</u> of the following criteria must be met:</p> <p>a. Symptoms or behaviors persist at a level of severity that was documented upon admission, the projected time frame for attainment of BSP goals as documented in the BSP has not been reached, and a less restrictive level of care would not adequately meet youth's needs. In this situation the BSP may need to be adjusted to better meet the youth/family's needs. If ongoing treatment and adjustments are not effective, alternative services and levels of care will need to be explored,</p> <p style="text-align: center;">OR</p> <p>b. Youth is demonstrating progress, behavioral goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services, and a less intensive level of care would not adequately meet youth needs,</p> <p style="text-align: center;">OR</p> <p>c. Minimal progress toward behavioral goals has been demonstrated, the BSP has been modified to more effectively address needs, there is reason to believe that goals can be met with ongoing therapy services, and a less intensive level of care would not adequately meet youth/family needs,</p> <p style="text-align: center;">OR</p> <p>d. New symptoms or maladaptive behaviors have developed, plans have been modified to address these additional behaviors, the behaviors can be safely and effectively addressed through therapy services, and a less intensive level of care would not adequately meet youth/family needs.</p>
Discharge Criteria	<p>An IEP/MP determines the following:</p> <p>1. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by attainment of goals in the BSP,</p> <p style="text-align: center;">OR</p> <p>2. Youth/family have demonstrated minimal or no progress toward behavioral goals for a six month period and</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>appropriate modification of plans have been made and implemented with no significant success, suggesting the youth/family is not benefiting from family therapy services at this time,</p> <p style="text-align: center;">OR</p> <p>3. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through family therapy services,</p> <p style="text-align: center;">OR</p> <p>4. Youth no longer meets admission criteria for this service,</p> <p style="text-align: center;">OR</p> <p>5. Youth does not meet eligibility criteria.</p>
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

Family therapy services shall be provided by personnel that meet one of the following requirements:

1. Hawaii licensed, graduate level social worker, marriage/family therapist, psychiatric nurse specialist, psychologist, or psychiatrist, National Certified Counselor **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services,

OR
2. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, counseling or behavioral science from a regionally or nationally accredited program **AND** a minimum of two years of supervised training and experience in the provision of child and adolescent mental health services,

OR
3. An advanced (graduate level) professional degree in social work, marriage/family therapy, psychiatric nursing, psychology, psychiatry, counseling or behavioral science, from a regionally or nationally accredited program **AND** a minimum of one year of supervised training and experience in the provision of child and adolescent mental health services, **AND** currently working under the supervision of personnel meeting criteria A or B above.

OR
4. Be a School psychologist or clinical psychologist employed by the DOE specifically credentialed to mental health assessment services as allowed under exemption in applicable state laws and regulations.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

5. Staff must have at least thirty (30) hours of CAMHD/DOE approved basic training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
6. Staff receive at a minimum, one (1) to two (2) hours per month of individual supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Initial appointment with youth/family is scheduled within two weeks of plan development or procurement or per instructions of CC as evidenced by progress reports.
2. Progress reports completed according to standards and placed in the confidential record within 24 hours.
3. Crisis plans completed, regularly reviewed, and updated per standards.
4. BSP completed, regularly reviewed, and updated per standards.
5. Transition/Discharge plans completed, regularly reviewed, and submitted per standards.
6. Contract Reports completed and submitted per standards.
7. Evidence of credentialing.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within 24 hours of service provision
3. Data entry into ISPED must be submitted before invoice submission and payment

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

G. MEDICATION MANAGEMENT

Definition	The ongoing assessment of the youth's response to medication, symptom management, side effects, and adjustment in medication dosage. Routine medication management may be provided by a registered nurse or public health nurse under the supervision of the physician.
Services Offered	<ol style="list-style-type: none">1. Medication Monitoring may include the following tasks:<ol style="list-style-type: none">a. Assessing the youth's ongoing need for medication, orb. Determining overt physiological effects related to the medications used in the treatment of the youth's psychiatric condition, including side effects, orc. Determining psychological effects of medications used in the treatment of the youth's psychiatric condition, ord. Monitoring compliance to prescription medication, ore. Renewing prescription(s).2. The confidential record includes:<ol style="list-style-type: none">a. Full documentation of Informed Consent, including a signed description of potential benefits and possible side effects of the prescribed medication, must be placed in the clinical record prior to initiation of medication. The Consent must be signed and dated by the youth's parent(s) or legal guardian.b. A progress note must be placed within the patient's record with a copy sent to the CC within 24 hours of the date of service. Medication Management shall be identified as the service on the progress note. The progress note must include all of the following information:<ol style="list-style-type: none">i. Name of patient;ii. The date and actual time the services were rendered;iii. The signature of the Mental Health Professional who rendered the service;iv. The place of service;v. Current medications the youth is taking including dosage and intervals when medication is to be administered;vi. Side effects or adverse reactions the youth is experiencing;vii. Conditions in which the youth is refusing or unable to take medications as ordered or if the youth is compliant in taking medications as prescribed;viii. Whether the medication(s) is effectively controlling symptoms; and,ix. Any results from laboratory testing.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Initial Authorizations	This level of care may be procured by all schools after seeking consultation from the school nurse or consulting physician. 1 Unit = 1 Hour (may be in increments, with 15 min = .25 unit).
Re-Authorization	Not applicable
Admission Criteria	An IEP/MP Team determines the following: <ol style="list-style-type: none"> 1. The youth has been evaluated by a psychiatrist, and is deemed in need of medication to prevent admission to a more restrictive or intensive service level. AND 2. Once prescribed medication, the youth requires ongoing monitoring for effectiveness and adverse reactions and renewing prescriptions at frequencies consistent with accepted practice.
Continuing Stay Criteria	Ongoing medication monitoring requires discussion between school personnel and the contract provider regarding the patient's adjustment. The requirements for the review process with school personnel are the following: <ol style="list-style-type: none"> 1. At least monthly, during the first three months of initiation of any medication (may occur more frequently if so requested by CC/school nurse, or consulting physician). AND 2. At least quarterly, once the contract provider and the school nurse or consulting physician documents that the medications are effectively regulating the affective, behavioral, thought disorder.
Discharge Criteria	At least <u>one</u> of the following must be met: <ol style="list-style-type: none"> 1. The youth's symptoms have stabilized and all medications have been discontinued, OR 2. The youth and family no longer desire psychopharmacological interventions and have withdrawn consent; therefore, the medications have been discontinued, OR 3. Youth no longer meets all appropriate eligibility criteria. As part of discharge, psychiatrist will coordinate the transfer of the youth to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Medication Monitoring may be provided by a licensed physician or Hawaii State licensed registered nurse under the supervision of a licensed physician.

Clinical Operations

Documentation meets standards as described in Service Content B 1 and B 2.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within 24 hours of service provision.
3. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

H. FAMILY COURT TESTIMONY

Definition	<p>Participation in a Family Court hearing at the request of DOE. This participation is in addition to a State representative's (i.e., Assistant Attorney General) presence in court and is intended to ensure that the court has access to all relevant information needed.</p> <p>Note: If a specific report must be submitted, the CC may request that the contract provider complete specific documentation to assist in the writing of the report. The unit of service for the generation of the specific documentation is limited to a maximum of one hour.</p>
Services Offered	<ol style="list-style-type: none"> 1. Attend court hearing as requested by the CC to present relevant clinical data needed. 2. Specific report writing by provider needed for court hearing (Monthly Progress and Summary report, provider's progress notes, clinical evaluations, other existing reports do not suffice). 3. Recommendations are based on the presenting needs of the youth and family. Note: Recommendations will not be accepted regarding specific services (i.e., youth requires day treatment). 4. Reports are made available to the CC for review prior to the hearing.
Initial Authorizations	<ol style="list-style-type: none"> 1. Prior procurement is required for each Family Court Testimony episode. Family court testimony participation is limited to two (2) units. Specific rationale for greater than two (2) units must be reviewed with the appropriate district office staff prior to the procurement of the service. 2. One (1) Unit = One (1) Hour (may be in increments with .25 units = fifteen (15) minutes). Note: Billable time is limited to time spent in court. There is no reimbursement for travel time, wait time, or cancellations.
Re-Authorization	Not applicable
Admission Criteria	<ol style="list-style-type: none"> 1. Youth has an assigned DOE CC AND 2. Youth has a scheduled court hearing. AND 3. The CC identifies that participation by the private provider would be helpful to the court in understanding in youth's case.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Continuing Stay Criteria	There are no continuation criteria for this level of care. The CC shall procure a separate service for each episode in which this service is needed.
Discharge Criteria	This service delivery ends with the completion of the court hearing, or the acceptance of the requested documentation is accepted by the State representative.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

Professional staff testifying in Family Court are required to meet the credentialing requirements of the level of care in which the original service was provided (for example, if the Court required information from an outpatient provider, the credentials of that service level would need to be met).

Clinical Operations

1. The report/testimony meets the satisfaction of the State representative.
2. The report is signed by the appropriate professional.
3. The report/testimony provided meets the CAMHD standards for report writing.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

I. EDUCATION PLANNING (IEP/MP) PARTICIPATION

Definition	Attendance and active participation in education planning with a multi-disciplinary team, including the development, review, and modification of an IEP, MP, or other education related plan.
Services Offered	This service includes <u>all</u> of the following: <ol style="list-style-type: none"> 1. Attendance at a multi-disciplinary education planning conference and organized presentation of pertinent information related to mental health issues; 2. Completion of an IEP/MP mental health insert, as needed, identifying goals; measurable objectives, and interventions based on youth/family needs; 3. Documented signature of attendance on education plan; 4. Progress note written and placed in youth's clinical record; 5. Signed and dated copy of the education plan mental health insert placed in the youth's clinical record;
Initial Authorizations	<ol style="list-style-type: none"> 1. Prior procurement by DOE CC is required for each education planning meeting. The CC identifies that participation of the contract provider in the education planning conference would be clinically beneficial. If another agency or entity requests the contract provider's presence at the meeting, CAMHD would not be the procurement agency for that service. Education planning meetings are limited to two units per episode. 2. One (1) Unit = One (1) Hour (may be in increments with .25 unit = fifteen (15) minutes). <p>Note: Billable time is limited to time spent at the education planning meeting. There is no reimbursement for travel time, wait time, or cancellations.</p>
Re-Authorization	Not applicable
Admission Criteria	<ol style="list-style-type: none"> 1. The youth has an assigned DOE CC. <p style="text-align: center;">AND</p> <ol style="list-style-type: none"> 2. The CC identifies that participation of the contract provider in the education planning conference would be clinically beneficial.
Continuing Stay Criteria	If the education planning is not completed in the initial meeting, and additional provider participation is needed, the DOE CC may procure additional units as needed.
Discharge Criteria	The service is complete when both of the following are complete: <ol style="list-style-type: none"> 1. Participation at the education planning meeting is completed. 2. A copy of the IEP and BSP are completed.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Staffing Requirements:

The credentialing of specific education planning participants shall be in accordance with the qualifications required for the particular level of care represented. For example, presentation/representation of the results of psychological testing must be made by a professional credentialed to conduct such testing.

Clinical Operations

1. The provider or designee ensures that adequate representation is available at the education planning meeting.
2. Participation in education planning is documented in youth's record.
3. A signed and dated copy of the IEP and BSP are included in the youth's record.
4. Evidence of credentialing.

Documentation

1. The provider or designee ensures that adequate representation is available at the education planning meeting.
2. Participation in education planning is documented in youth's clinical record.
3. A signed and dated copy of the IEP and BSP are included in the youth's record.
4. Evidence of credentialing.
5. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
6. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision
7. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

J. SCHOOL CONSULTATION

Definition	Consultation of a MHP with regular and special education teachers, school administrators and other school personnel regarding the behavioral management of youth within the school setting. School consultation is delivered as requested by or agreed upon by the school.
Services Offered	<ol style="list-style-type: none">1. School consultation is a collaborative process, which serves to better link a youth's BSP with his/her IEP/MP. School consultation facilitates communication between school personnel and mental health providers, between home and school, as well as between various school staff, such as between regular and special educators. While the focus of consultation is on behavioral management issues, it can include organizational management of the classroom (e.g., seating arrangements, scheduling) to boost the efficacy of inclusion of children with disabilities. The MHP can provide general and intervention-specific information on particular mental health diagnoses (e.g., Attention-Deficit/Hyperactivity Disorder, Tourette's Disorder) as well as certain mental health variables (e.g., poor achievement motivation, lack of social skills competence) and their potential impact on classroom performance.2. School consultation generally includes a face-to-face contact of a MHP with teacher, administrator or other school personnel for the purpose of sharing information and facilitating communication. The contact may, however, be made by phone if the school visitation is not feasible and the goals of that consultation can be accomplished long-distance (e.g., helping a teacher fine-tune a behavior management plan).3. The following responsibilities of the school consultant are important to insure collaboration and efficacy:<ol style="list-style-type: none">a. Obtain parental consent to visit school and share information with school personnel.b. Access and review pertinent educational and mental health data available in the youth's clinical record.c. Adhere to school protocols regarding rules and responsibilities on school campus.d. Conduct classroom observation(s), if needed, to witness youth's functioning in the school setting.e. Hold consultation meeting with appropriate school personnel to discuss specific issues/interventions related to youth's school performance.f. Complete progress note and place in youth's clinical record within twenty-four (24) hours.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Initial Authorizations	School consultation services are to be requested by or agreed upon by the school. Prior procurement by the DOE CC is required. School consultation is limited to one unit per episode. However, up to two units per episode will be allowed if a classroom observation is conducted. There is no reimbursement for travel time or wait time. One (1) Unit = One (1) Hour (may be in increments with .25 unit = fifteen (15) minutes)
Re-Authorization	Not applicable
Admission Criteria	Appropriate school personnel request the delivery of school consultation by the contract provider and the DOE CC procures the service.
Continuing Stay Criteria	There are no continuation criteria for this level of care. Each request for consultation is treated as a separate episode and follows the above (Admission Criteria) guidelines.
Discharge Criteria	A progress note is completed and placed in the youth's clinical record reflecting issues and behavior management strategies discussed, as well as school personnel's receptivity to the consultation intervention.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

School consultation services shall be provided by a mental health professional who is familiar with the youth and the youth's family. In addition to having training and/or experience with behavioral management strategies and interfacing with schools, personnel must meet credentialing requirements for an MHP.

Clinical Operations

1. Progress notes are completed according to standards and placed in the clinical record within twenty-four (24) hours.
2. Evidence of credentialing.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. Data entry into ISPED must be submitted before invoice submission and payment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

K. COMMUNITY - BASED INSTRUCTION

Definition	An alternative educational program for students otherwise directed to segregated individual educational or inpatient therapeutic programs. It is expected that CBI programs will combine educational, behavioral health, and therapeutic approaches in providing time limited interventions designed to assist the student achieve behavioral control, and therefore to participate effectively in school-based educational activities.
Services Offered	Not applicable
Initial Authorizations	Up to seven (7) units (unit = One [(1) six (6) to eight (8) hour day].
Re-Authorization	Up to three (3) units (unit = One [(1) six (6) to eight (8) hour day]. There will be no extensions beyond ten (10) days unless there is reauthorization by the FGC Clinical Director.
Admission Criteria	<ol style="list-style-type: none"> 1. Students who have been certified as having an education disability as part of IDEA or Section 504, Subpart D; 2. Who are in need of educational/mental health services to benefit from their free and appropriate public education; and 3. Students require highly specialized educational, behavioral, or mental health services beyond those available through SBBH services.
Continuing Stay Criteria	<p>Student progress shall be monitored and reported on a quarterly basis. Progress reporting shall be in a meeting that shall include the parents and the DOE staff person with care coordination/plan monitoring responsibilities. The review will address at least the following:</p> <ol style="list-style-type: none"> 1. Success of interventions; 2. Anticipated alterations in interventions; 3. Additional services; and 4. Interface with non-program provided interventions.
Discharge Criteria	<p>At least four (4) weeks prior to discharge, an IEP/MP team has determined that discharge is appropriate, based on:</p> <ol style="list-style-type: none"> 1. The student's demonstrating independence in all areas which necessitated placement in the restrictive assignment; 2. The student is demonstrating reasonable competence on applicable IEP goals and objectives; and 3. A transition plan including environmental and programmatic contextual modifications necessary to support the student's successful functioning in the less restrictive setting is in place and has been demonstrated through student participation to be successful. <p>All services and supports described above are available and activated prior to the student's return.</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	A new IEP has been developed and is in place.
Service Exclusions	Not offered at the same time as Hospital-Based Residential Services, Community-Based Residential
Clinical Exclusions	Programs will accept students identified by IEP/MP teams as meeting entrance requirements.

Staffing Requirements:

1. Multidisciplinary staffing is available to address the educational, vocational, behavioral and emotional needs of the students.
2. A psychiatrist or psychologist licensed in the State of Hawaii provides clinical supervision of the program and attends all treatment planning and review sessions.
3. MHP with a master's or doctorate degree provide empirically based interventions they are trained to provide,
4. The teacher is staff to the organization and is certified in Special Education with training in providing reading instruction.
5. Adequate care and supervision of the staff is provided at all times with differential staff: student ratios depending upon activity and student characteristics.
6. The organization's personnel include those with educational and experiential backgrounds that enable effective program delivery and who possess the characteristics and temperament necessary to work with the students.
7. Staff are available to ensure student safety for early arriving or late departing students.
8. Staff have access to interpreters in the event limited fluency in the English language inhibits a student or family's progress.
9. Staff shall have access to and participate in planned continuous staff development activities specifically designed to improve student outcomes.

Clinical Operations

1. Program supports should also be designed to ameliorate foundational academic skill deficits and enhance academic progress in the applicable general education curriculum.
2. Services provided are to be integrated with HDOE school-based behavioral health supports and services in order to ensure timely and appropriate access to a full array of educational and behavioral health resources.
3. Service plans will be developed collaboratively to assure services provided are accountable, cost effective, performance-based and result in outcomes that are measurable.
4. The applicant shall provide a structured educational and therapeutic milieu with integrated educational and behavioral health services for youth experiencing

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

serious emotional/behavioral disturbance or significant developmental disabilities that interfere with their ability to function in a structured school classroom and places them at risk for more restrictive placements. The program will last at least six (6) hours per day of instructional and therapeutic activities. Specific activities will be based on each student's unique educational needs and characteristics and will include some or all of the following:

- Specialized educational programming to address deficits in reading fluency and comprehension
 - Specially designed instruction designed to address the student's general curriculum and special education program needs
 - Positive behavioral support
 - Psycho educational services
 - Empirically based individual, group, and family interventions
 - Medication management
 - Expressive and activity therapeutic sessions
5. Services may be provided at alternative times other than the typical school day. Services must be available to accommodate any student with a need for ESY programming.
 6. Transition into the program will begin within twenty-four (24) hours of referral and will include a planning session with parents.
 7. Student active participation in the program will begin within one (1) week of referral.
 8. Individual student program planning will be completed within two (2) weeks of referral.
 9. Base line student level data collection will be completed within three (3) weeks of referral.
 10. All referral materials, including functional assessment and IEP / behavior support plans will be reviewed with all staff expected to be involved in instruction or service provision.
 11. The organization provides a system of services based on the model of "positive behavioral support." The purpose of the program is that students achieve clearly delineated behavioral goals and objectives. The support program will be based upon a functional behavioral assessment including all behaviors necessitating an intervention of this restrictive nature.
 12. The organization has clear procedures that specify its approach to achieving behavioral change in students. There are standardized methods for behavior intervention. The staff receive training in Crisis Prevention and Alternative Intervention Techniques for students with aggressive or out of control behavior as well as in all standardized intervention methods.
 13. The organization prohibits the following forms of discipline:
 - a. Degrading punishment;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- b. Corporal or other physical punishment;
 - c. Forced physical exercise solely for the purpose of eliminating behavior rather than for instructive or athletic value;
 - d. Punitive work assignments;
 - e. Group punishment for individual behavior;
 - f. Medication for the purpose of punishment;
 - g. Extended isolation of the student;
 - h. Deprivation of student rights or needs;
 - i. Painful aversive stimuli;
 - j. Use of seclusion or mechanical restraints;
 - k. Use of any locked facilities; and
 - l. The administration of noxious substances.
14. Medication and Medical Emergencies
- a. The program is prepared to deal effectively with injuries, accidents, and illnesses and other medical and behavioral crises,
 - b. The organization has established emergency procedures and has either a licensed physician available on-call during its hours of operation or has formal arrangements for emergency services with a nearby primary health care facility.
 - c. The organization promptly reports to appropriate authorities any serious accident, emergency, or dangerous situation, including immediate reporting of instances of abuse, or dangerous situation.
 - d. The organization which assists youth taking medications and establishes controls governing proper assistance and storage.
 - e. When psychotropic medication is prescribed, the physician obtains written informed consent from the proper parent or legal guardian.
15. The program will provide formative, remedial, or specialized instruction in reading to all student's reading below grade level. In the event that a student's IEP does not identify reading goals and objectives, they will be developed.
16. Programs will provide students with access to general curriculum opportunities based on collaborative planning with the student's home school, general education coursework supportive of the student's general education program will be provided.
17. Procedures will exist with the appropriate District Office to ensure proper credit is documented for entry into the student's record upon the student's return to a school-based program and that any and all required statewide testing, including the Annual Reading Comprehension Assessment of Special Education and 504 Student, be administered in a timely manner.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

18. Educational services shall be consistent with the Hawaii Content and Performance Standards II relevant to the ACCN credit desired. Documentation of the number of hours of instruction by course shall be available to the appropriate DOE school upon transition planning to assist in granting of academic credit to and the proper placement of the student.
19. The organization will hire and supervise its own educational staff, including teachers and educational assistants.
20. Evidence based interventions will be used to address student specific and family support needs
21. A process to determine the appropriateness and effectiveness of non-traditional interventions will be in place,
22. Substance abuse treatment by appropriately credentialed staff will be available to all secondary aged students requiring such an intervention.
23. A plan to provide any and all IDEA required related services, including occupational therapy, physical therapy, and transportation will be in place.

Documentation

1. Providers are required to input information in the ISPED modules such as IEP/MP, visit log, progress report and other modules that DOE requires.
2. Providers shall enter data into ISPED on a weekly basis within twenty-four (24) hours of service provision.
3. Data entry into ISPED must be submitted before invoice submission and payment.

SECTION II – PART C:

**INTENSIVE
MENTAL HEALTH SERVICES
PERFORMANCE STANDARDS**

**SECTION II – PART C: INTENSIVE MENTAL HEALTH SERVICES
PERFORMANCE STANDARDS**

III. INTENSIVE MENTAL HEALTH SERVICES

A. PSYCHOSEXUAL ASSESSMENTS

Definition	Specialized diagnostic and evaluation services involving a strengths-based approach to identify youths' needs in the specific context of sexually abusive behaviors. Service component includes provision of written assessments. These assessments should have been preceded by information gathering from existing sources and should not occur unless a comprehensive clinical assessment has been performed first. This assessment is designed to build on the clinical assessment through the use of specialized psychometric instruments designed to assess sexual attitudes and interests.
Services Offered	<ol style="list-style-type: none"> 1. Arrangements for appointment with the youth and family within one (1) week of procurement; 2. Obtain consents for assessment; 3. Review and incorporate any other relevant data including developmental, psychosocial, medical, educational, clinical, behavioral, and legal histories as provided by the CC; 4. Conduct face-to-face or phone interviews with school personnel: teachers, counselors, and/or administrators, or other persons who have first hand knowledge of the functioning of the youth; 5. Interview family/significant others and youth face-to-face; 6. Evaluation of whether the current or proposed living or educational setting affords a level of structure and supervision necessary for the youth and the safety of others. Special consideration should be given to the needs and concerns of individuals who may have been victimized by the youth (e.g., siblings); 7. Administer developmentally and clinically appropriate psychometric instruments to assess sexual attitudes and behaviors (e.g., Multiphasic Sex Inventory, Child Sexual Behavior Inventory, Adolescent Cognition Scale); 8. Upon completion of report feedback session must be conducted with family/guardian; and 9. Provide copy to MHCC within three (3) weeks of procurement.
Initial Authorizations	Up to twenty (20) units One (1) unit = fifteen (15) minutes Procurement units reflect the time required for completing the review of data and assessment process. The units do not include report-writing time, as it is incorporated in the unit cost. There is no

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	payment for travel time, wait time, no shows, or cancellations.
Re-Authorization	Any requests for additional time shall be submitted to the FGC Clinical Director's approval.
Admission Criteria	<p>The identified youth meets at least one (1) of the service Eligibility criteria for CAMHD (as defined in Service Specifications, Section 2 of the RFP)</p> <p style="text-align: center;">AND</p> <p>The youth is registered with a FGC (FGC) and has an assigned MHCC</p> <p style="text-align: center;">AND</p> <p>The youth is in need of a psychosexual evaluation because a prior comprehensive clinical evaluation has demonstrated possible disturbance in sexual behavior or attitudes that are an integral part of the youth's emotional or behavioral problems.</p>
Continuing Stay Criteria	Not applicable
Discharge Criteria	<p>The assessment has been completed in accordance with the standards.</p> <p>Written reports are submitted to the respective FGC – MHCC. Assessments not meeting service content standards will be returned by the FGC.</p>
Service Exclusions	Youth in High-Risk Community Based Residential Program, and Youth in other residential programs specifically designed for this population.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition c. Homicidal/Suicidal and/or displaying psychotic symptoms 2. Youth eleven (11) years or younger

Staffing Requirements:

The following practitioners may provide Psychosexual Assessment Services:

Hawaii licensed psychologist with a minimum of three (3) year's experience conducting psychosexual assessments.

Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care such as education, juvenile justice system, child welfare as needed to provide service.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

2. Direct service providers must obtain consents for assessments.
3. Service must be preceded by a comprehensive clinical assessment of youth.
4. Report contains all service content components.
5. Report is typed.
6. Report is submitted to MHCC within three (3) weeks of procurement.

Documentation

Complete written report within one week from date of assessment. Written report includes all of the following:

1. Date(s) of assessment and date of report.
2. Identifying information: youth name, DOB, legal guardian, home school, grade level, IDEA/504 status.
3. Reason for referral.
4. Sources of information: including review of records, interviews, and assessment tools.
5. Brief developmental, medical, family, social, educational, and psychiatric history; including past and current use of and reasons for psychotropic medications.
6. Substance use history.
7. Description and history of presenting problems.
8. Assessment results and interpretation; must include specific scores from psychometric instruments, plotted profiles when appropriate, and clear interpretations.
9. Description of youth and family strengths and how this can be utilized in treatment.
10. Clinical formulation/justification of diagnosis (including severity and duration of diagnosis; for Rule/Out or Provisional diagnoses, explain what need to occur to obtain a more definite diagnosis).
11. Diagnostic impressions: DSM IV-5 axes.
12. Statement addressing whether diagnosis impacts youth's ability to benefit from his/her educational program.
13. Summary of strengths, concerns, and description of needs that must be met for youth to benefit from his/her education.
14. Strength-based recommendations with suggested goals and measurable objectives must be included. Recommendations will conform to the following:
 - a. Supported by empirical research
 - b. Described and address the needs of the youth and family
 - c. Avoid specifying a particular services, program or eligibility status. For example, it should not be specified that youth needs day treatment, or that the youth should be certified Emotionally Impaired under IDEA. Instead, recommendations should focus on youth's particular needs, e.g. "the youth is in need of close supervision due to.." Or "the youth's symptoms include..."
 - d. Include possible lease restrictive classroom modifications and/or school-based intervention recommendations that may address the youth's needs

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- e. Report is signed by the assessor acknowledging responsibility for the assessment

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

B. INTENSIVE DAY STABILIZATION

Definition	A service that provides stabilization of psychiatric impairments and maintains youth in the community or returns youth from a more restrictive environment to home/community. The focus of the program is to provide diagnostics and focused assessments, and the development of therapeutic and functional recommendations for improved treatment outcomes. The goals of service are clearly articulated. The initial service objectives and continuing care plan are established prior to admission through a comprehensive assessment of the youth to include: a severity-adjusted rating of each clinical issue (including frequency and duration of diagnosis) and strength. Treatment is time-limited, ambulatory and active, offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Level of care for each youth should include services available six (6) hours per day, seven (7) days a week, for up to ten (10) consecutive days. Daily availability of physician and nursing services are essential components of this service, since this is considered to be an alternative to Hospital-Based Residential Services.
Services Offered	Not applicable
Initial Authorizations	Up to seven (7) units [unit = one (1) six (6) to eight (8) hour day].
Re-Authorization	Up to three (3) units [unit = one (1) six (6) to eight (8) hour day]. There will be no extensions beyond ten (10) days unless there is reauthorization by the FGC Clinical Director.
Admission Criteria	<ol style="list-style-type: none"> 1. The youth must have primary behavioral health issues that require intensive evaluation and coordination of mental health services to stabilize the child's psychological functioning and decrease risk of behavior such as suicidal and/or homicidal ideation or aggression; AND 2. The youth's clinical and behavioral issues are unmanageable in an education or school-based environment; AND 3. The youth would not benefit from traditional outpatient treatment and requires intensive, coordinated multi-disciplinary evaluation within a therapeutic milieu; AND 4. The youth is able to return home or to a temporary residence at night; AND 5. Reasonable expectation that the youth's assessment can be completed within ten (10) days with recommendations to

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p style="text-align: center;">direct the course of treatment; AND</p> <p>The youth's admission is authorized by the FGC Clinical team to include parent participation prior to authorization.</p>
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The youth must have primary behavioral health issues that continue to require intensive evaluation and related services to decrease risk of behaviors such as suicidal and/or homicidal ideation or aggression; <p style="text-align: center;">AND</p> <ol style="list-style-type: none"> 2. Additional time is required for completion of medication management, trials for assessment purposes and achievement of a plan for positive behavioral interventions.
Discharge Criteria	<p>Symptoms are improved and sufficient to allow transition to a less restrictive level of care;</p> <ol style="list-style-type: none"> 1. Medication is titrated so that there is no longer a need for daily psychiatrist/nursing oversight; 2. The youth no longer presents significant risk to self or others; and 3. The youth has a positive behavioral support plan in place that addresses discharge criteria 1-3.
Service Exclusions	<p>Not offered at the same time as Services, Therapeutic Group Homes Services, Community-Based Residential, or Hospital-Based Residential.</p>
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth who require intensive one-to-one supervision for protection of self or others are precluded from admission. 2. Severity of clinical issues precludes provision of services in this level of care. 3. Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition c. Youth who can effectively and safely be treated at a lower level of care

Staffing Requirements:

1. The services must be provided by as multidisciplinary team that is comprised of:
 - a. Child and adolescent psychiatrist;
 - b. Registered nurse;
 - c. Licensed psychologist or social worker;
 - d. Paraprofessional; and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- e. Special-Education teacher or other professional with Functional Behavior Assessment skills and licensed in Hawaii.
2. The program must be under the supervision of a child and adolescent psychiatrist that is Board certified.
3. Services must be provided and/or activities led by staff who are:
 - a. a QMHP, or
 - b. MHP, under supervision of QMHP
4. There must be an RN or QMHP present at all times the service is in operation, regardless of the number of individuals participating.
5. There must be a maximum face-to-face ratio of an average of not more than eight (8) youth to one (1) QMHP, based on average daily census.
6. There must be a maximum face-to-face ratio of an average of not more than four (4) youth to one (1) direct service/program staff, based on average daily attendance of youth. QMHPs will be included in the staff count for purposes of calculating this ratio. The program staff ratio may need to be adjusted during periods of greater activity.
7. Involvement of parent/caregiver(s) is (are) strongly encouraged in the provision of this service and is a necessary tool in enabling the youth to move to less restrictive services. This requirement, however, should not be allowed to become a barrier to the delivery of services to youth whose parent(s) or caregiver(s) is (are) not able to participate or are not available.
8. Nursing services must be available daily, but is not counted for the staff to youth ratios unless the RN is available face-to-face during the entire operation of the service.
9. All staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.
10. An RN or physician must be available within the site or program facility and be able to be face-to-face within fifteen (15) minutes of a request for assistance (rapid response).
11. An RN or physician may be shared with other programs so long as these professionals are available as required for supervision, clinical operations, and rapid response, and so long as they are not counted in youth to staff ratios in two different programs operating at the same time.
12. Staff must have at least twenty-four (24) hours of basic orientation training including, but not limited to crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

13. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. This service must operate within an established program site.
2. Each program shall not exceed the maximum capacity of eight (8) youth per center.
3. Services shall be available seven (7) days a week (including all holidays). The hours of operation should be consistent with school hours, generally six (6) hours/day.
4. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours of admission and include comprehensive current DSM version assessments on Axes I – V, assessments of patient, family, community strengths/resources, and specific multi-modal treatment recommendations that target the specific factors that precipitated the admission. The assessment also includes comprehensive evaluations of the youth's developmental milestones and course; family dynamics; current and past school, work, or other social role functioning; ability to interact socially (including peer relationships) and substance use/abuse. The assessment should also include a summary of all prior psychiatric hospitalizations, medication trials, and other mental health/psychosocial interventions including an assessment of their degree of success and/or failure.
5. A plan to include a normalized routine and an orderly schedule to help develop positive interpersonal skills and behaviors is to be developed within five (5) days with opportunities for observations and assessments.
6. A psychiatrist's participation in support of the youth must be documented at least three (3) times/week. The psychiatrist observes, assesses and/or treats the youth. The psychiatrist routinely assesses the effectiveness of treatment, coordination of treatment, management of medication trials, and medical treatment. A psychiatrist is available twenty-four (24) hours a day to direct any psychiatric emergencies (e.g., restraints, seclusion). A full-time equivalent psychiatrist is not a requirement. Utilization of psychiatric services is depended upon census and acuity.
7. Transition planning for less intensive service options must begin at the onset of this service delivery and documentation must demonstrate this planning as well as activities undertaken to support this transition process.
8. The FGC Clinical Director and MHCC shall engage in ongoing daily collaboration with the Intensive Day Stabilization staff regarding the youth's status. The program must provide the MHCC and FGC with at least twenty-four (24) hours advance notice prior to discharge. This will enable them to schedule/coordinate a treatment team meeting to discuss the achievement of the expected outcomes and the implications for the youth's treatment options/plan upon discharge.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Documentation

1. Prior to program admission a referral packet must be completed by the FGC MHCC.
2. In addition to other documentation requirements, daily progress note must be documented for each youth by respective members of the direct service/program staff.
3. A weekly summary and sign-off on supervised staff's notes must be documented by the supervising QMHP.
4. Daily attendance of each youth participating in the program must be documented showing number of hours in attendance (start and end times) for billing purposes.
5. When this service is used to transition a youth from twenty-four (24) hour intensive supports, documentation must demonstrate careful planning to maximize the effectiveness of this service as well as activities undertaken to support this transition process.
6. It is expected that transition planning for less intensive service options will begin at the onset of this service delivery. Documentation should demonstrate this planning.
7. Every physician contact, including medication prescription and administration, must be documented.
8. An RN's progress note showing participation in support of the youth must be documented daily. Every nursing contact, including medication administration, must be documented.
9. The program shall submit a weekly census report to Utilization Management (UM) Office.
10. Assessments are completed and recommendations are made to the youth's FGC team for improved treatment strategies and outcomes at the time of discharge.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

C. INTENSIVE HOME AND COMMUNITY BASED INTERVENTION

Definition	This service is a time limited approach that incorporates and supports evidence-based interventions. This service is designed to stabilize and preserve the child's functioning in the current living environment and to prevent the need for placement outside the home and/or home school (e.g., hospital-based or community - based residential). These services are delivered primarily to youth in their family's home with a family focus to: 1) facilitate, support, or newly implement the appropriate evidence-based intervention at a level of intensity that requires home-based contact with the child and family; 2) resolve any crises, evaluate their nature, and intervene to reduce likelihood of further incidence, 3) ensure and facilitate access to informal supports in the community as well as formal behavioral supports in the child's school (e.g. school-based behavioral health worker), 4) increase capacity and strengths of the child and family so as to support and facilitate gains achieved through evidence-based approaches (e.g., transitioning maintenance of behavior, support plan, to individuals within the child's family or natural support network). Services are directed towards the mental health needs of the identified youth.
Services Offered	<ol style="list-style-type: none"> 1. The program provides crisis management. 2. The program provides linkages to other needed supports through internal and external coordination activities. 3. The program provides evidence-based treatment interventions. 4. The program provides self-help and living skills training for the youth. 5. The program provides parenting skills training to help the family build skills for coping with the youth's disorder. 6. The program monitors and manages the presenting psychiatric symptoms. 7. The program works with parents in implementation of home-based behavioral support plans.
Initial Authorizations	<p>Maximum of sixteen (16) units per day Maximum of eighty (80) units per week Maximum of four (4) weeks in duration (Unit = fifteen (15) minutes)</p>
Re-Authorization	<p>All re-authorizations requests must be reviewed and approved by the FGC Clinical Director.</p> <ul style="list-style-type: none"> • Second month: Maximum of eight (8) units per day Maximum of forty (40) units per week (Unit = fifteen (15) minutes)

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<ul style="list-style-type: none"> • Third month: Maximum of four (4) units per day Maximum of twenty (20) units per week (Unit = fifteen (15) minutes) • Fourth month: Maximum of four (4) units per day Maximum of twenty (20) units per week (Unit = fifteen (15) minutes) • Fifth month: Maximum of four (4) units per day Maximum of twenty (20) units per week (Unit = 15 minutes)
<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. The youth has a known mental health diagnosis; AND 2. Treatment in a less-restrictive setting was attempted or given serious consideration but was found to be an inappropriate placement; AND 3. The youth and/or family have insufficient or severely limited resources or skills necessary to cope with an immediate crisis; AND 4. The youth and/or family issues are unmanageable in school based behavioral programs settings and require intensive, coordinated clinical and positive behavioral intervention; AND 5. The youth is at risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent; AND 6. The youth's measurable treatment goals in admission criteria 1-5 must be identified prior to admission.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The youth retains a mental health diagnosis; AND 2. It continues to be inappropriate to treat the youth in a less-restrictive setting; AND 3. The youth and/or family continue to have insufficient or severely limited resources or skills necessary to cope with an immediate crisis; AND 4. The youth and/or family issues continue to be unmanageable in school based behavioral programs and continue to require intensive, coordinated clinical and positive behavioral intervention; AND 5. The youth continues to be at risk of out-of-home placement; AND

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>6. The youth's measurable treatment goals have not been met; AND</p> <p>7. There is a reasonable expectation that the youth will continue to make progress in reaching the goals and objectives identified in the youth's MHTP within four (4) weeks.</p>
Discharge Criteria	<p>1. The youth and family/caregiver(s) have skills and resources needed to independently address the youth's and family's ongoing mental health needs; AND</p> <p>2. There is a reduction in the youth's problem behavior and/or an increase in pro-social behaviors; AND</p> <p>3. The youth requests discharge [and is not imminently dangerous to self or others]; AND</p> <p>4. Transfer to another service/level of care is warranted by change in the youth's condition; AND</p> <p>5. An adequate continuing care plan has been established; AND</p> <p>6. The youth's treatment goals have been met.</p>
Service Exclusions	<p>Cannot be provided at the same time as Therapeutic Group Home and Individualized Therapeutic Group Home, Community Based Residential, Community Based Residential High Risk, Hospital Based Residential; Overlap with MST is allowable if youth will be transitioned out of service within 30 days after referral.</p>
Clinical Exclusions	<p>1. Youth with the following conditions are excluded from admission:</p> <ul style="list-style-type: none"> a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition c. Homicidal/Suicidal and/or displaying psychotic symptoms <p>2. The youth can effectively and safely be treated at a less restrictive level of care.</p>

Additional Service Criteria:

Required Components

1. Services must be available twenty-four (24) hours a day, seven (7) days a week, through on-call arrangements with practitioners skilled in crisis intervention. A team response is preferable when a family requires face-to-face crisis intervention;
2. These services include consultation with the youth, parent/caregiver(s) regarding medications, behavior management skills, dealing with treatment responses of

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- the individual and other caregivers and family members, and coordinating with other treatment providers;
3. Team services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop;
 4. Intensive Home and Community-Based Intervention must be provided through a team approach and services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize a crisis situation as soon as possible. Services are evidence-based, family-focused, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community. Services are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in the youth and family's functioning; and
 5. The majority of services [sixty percent (60%) or more] are provided face-to-face with youth and their families and eighty percent (80%) of all face-to-face services are delivered in non-clinic settings over the authorization period.

Staffing Requirements:

1. Intensive Home and Community-Based Intervention is provided by:
 - a. One (1) MHP experienced in evidence-based treatment and having at least three years of experience working with youth with serious emotional disturbances. In many instances the MHP will be sufficient to deliver the appropriate services, however,
 - b. The MHP can as needed, partner with up to two (2) (not at the same time), paraprofessionals who work under the direct guidance of that MHP. In such instances, the MPH will serve as the team leader, guiding, refining, and administering the intervention, with paraprofessional(s) providing additional supports for practice exercises, skills training, or other child or family activities as directed by the MHP. The MHP is expected to have regular and frequent direct contact with the child and family (i.e. scheduled meetings at least every week and at least (twenty) 20% of the total face-to-face team contact time), particularly during the initial stages of intervention. As gains are consolidated, the frequency of contact by the MHP may decrease (but must remain at or above (twenty) 20%), signifying the need to transition to less intensive services. For purposes of coverage, the team may elect to include an additional MHP (not providing services at the same time). For those families who require it, the program must ensure that their Intensive Home and Community-Based Intervention Team has access to psychiatric and psychological services, as provided by a **QMHP** as per agreement with the program.
2. The Intensive Home and Community-Based Intervention Team staff to family ratio shall not exceed twelve (12), families per primary MHP (team leader) at any given time with the consideration that at least two (2) of the twelve (12) families will be stepping down to a less intensive level of care Staff to family ratio takes

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

3. Staff must have at least thirty (30) hours of CAMHD approved basic training including, but not limited to, crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
4. Staff receive at a minimum, of two (2) hours per month of individual supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
2. Services provided to youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and youth welfare, when appropriate to treatment and educational needs.
3. Providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
4. The agency has policies which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
5. The agency has established procedures/protocols for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
6. Each provider has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
7. The agency must have an Intensive Home and Community-Based Intervention organizational plan that addresses the following:
 - a. description of the particular family preservation, coordination, crisis intervention and wraparound service models utilized, types of intervention practiced, and typical daily schedule for staff;
 - b. description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
 - c. description of the hours of operation, the staff assigned and types of services provided to youth, families, parents, and/or guardians; and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- d. description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.

Documentation

1. In addition to other documentation requirements, a progress note for each billable contact must be documented by a member of the direct service/program staff.
2. A weekly summary and approval of supervised staff's notes must be documented by the supervising QMHP.
3. Every physician contact, including medication prescription and administration, must be documented.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

D. MULTISYSTEMIC THERAPY

Definition	Multisystemic Therapy (MST) is a time-limited, intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. MST addresses the factors associated with delinquency across youths' key settings, or systems (e.g., family, peers, school, neighborhood). Using the strengths of each system to foster positive change, MST promotes behavior change in the youths' natural environment.
Services Offered	<ol style="list-style-type: none"> 1. The program provides crisis management; 2. The program provides linkages to other needed supports through internal and external coordination activities; 3. The program provides evidence-based interventions; 4. The program work with parents in implementation of behavioral support plans; and 5. The program provides parenting skills training to help the family build skills for coping with the youth's behavior.
Initial Authorizations	One month at a time not to exceed five (5) months without re-authorization . [Unit = one (1) month]
Re-Authorization	Up to one (1) month. (Unit = one (1) month) by FGC Clinical Director
Admission Criteria	<ol style="list-style-type: none"> 1. The youth must be between the ages of eleven (11) and eighteen (18); AND 2. The youth displays willful misconduct behaviors (e.g., theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors); AND 3. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within thirty (30) days of referral; AND 4. The youth has an adult/parental figure that is willing to assume long term parenting role (e.g., must be willing to participate with service providers for the duration of treatment).
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. Youth continues to exhibit willful misconduct behaviors; AND 2. There is a reasonable expectation that the youth will continue to make progress in reaching the overarching goals identified at the outset of MST within four (4) weeks.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Discharge Criteria	<ol style="list-style-type: none"> 1. Youth has met at least seventy-five percent (75%) of the overarching treatment goals; OR 2. The youth/family requests discharge (and is not imminently dangerous to self/others); OR 3. Youth has met fewer than seventy-five (75%) of the overarching goals and there is no evidence that continued services will result in youth's progress towards successful completion of those goals.
Service Exclusions	Cannot be provided at the same time as Therapeutic Group home and Individualized Therapeutic Group home, Community Based Residential, Community based residential high risk, Hospital based residential . Overlap with home and community based intervention is allowable if youth will be transitioned out of service within thirty (30) days after referral.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate to Severe Mental Retardation; b. Mental Disorders due to a general medical condition; c. Homicidal/Suicidal and/or actively displaying psychotic symptoms. <p style="text-align: center;">OR</p> 2. The youth can effectively and safely be treated at a less restrictive level of care.

Additional Service Criteria:

Required Components

1. Services must be available twenty-four (24) hours a day, seven (7) days a week.
2. These services include consultation with the youth, parents or other caregivers regarding behavior management skills, dealing with treatment responses of the individual and other caregivers and family members, and coordinating with other treatment providers.
3. Services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's strengths and coping skills develop.
4. MST services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize a crisis situation as soon as possible. Services are evidence-based, family-focused, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community. Services are initiated when there is a reasonable likelihood that such

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

services will lead to specific, observable improvements in the youth and family's functioning.

5. The majority of services, sixty percent (60%) or more, are provided face-to-face with the youth and their families and eighty percent (80%) of all face-to-face services are delivered in non-clinic settings over the authorization period.

Staffing Requirements:

1. MST services are provided by a team of Masters-level therapists or Bachelors-level with five years of experience with child and adolescent mental health and are supervised by a Clinical Supervisor with a Ph.D. or at a minimum a Masters degree and should be experienced in providing individual, group, marital or family counseling or psychotherapy. The Clinical Supervisor shall have at least three (3) years post degree experience working with delinquent youth and their families in community based settings. Licensed Ph.D.'s are preferred for the Clinical Supervisor position.
2. MST therapist to family ratio shall not exceed four to six (4-6) families per therapist at any given time with the consideration that one to two (1-2) families will be stepping down to a less intensive level of care. Staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.
3. Staff must complete a five-day training program designed by MST services prior to assignment of families/clients. In addition, staff must attend quarterly booster training sessions.
4. Staff shall complete additional agency training including, but not limited to, crises field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
5. Staff shall receive at a minimum one (1) hour of group supervision and one (1) hour of MST services telephone consultation per week. Individual supervision occurs on an as needed basis.

Clinical Operations

1. Service delivery must be preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
2. Services provided to youth must include coordination with family and significant others and with other systems of care such as education, juvenile justice, and youth welfare, when appropriate to treatment and educational needs.
3. Providers must have the ability to deliver services in various environments, such as homes (birth, kin, and adoptive/foster), schools, jails, homeless shelters, juvenile detention centers, street locations, etc.
4. The agency has policies which govern the provision of services in natural settings and which document that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

5. The agency has established procedures/protocols for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
6. Upon receipt of the referral packet from the MHCC the MST team will assign a therapist that must make face-to-face contact within seventy-two (72) hours or notify MHCC of reasons why contact could not be made.
7. Each provider has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
8. The agency must have a MST organizational plan that addresses the following:
 - a. description of the particular family preservation, coordination, crisis intervention and wraparound services models utilized, types of intervention practiced, and typical daily schedule for staff;
 - b. description of the staffing pattern and how staff are deployed to ensure that the required staff-to-youth ratios are maintained, including how unplanned staff absences, illnesses, etc. are accommodated;
 - c. description of the hours of operation, the staff assigned and types of services provided to youth, families, parents, and/or guardians; and
 - d. description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.

Documentation

1. MST therapist must complete an intake and assessment form upon assignment of youth/family to MST program.
2. Therapists must complete "Case Consultation summary forms" weekly for case review during group supervision and MST case consultation sessions.
3. Monthly progress reports must be provided to assigned MHCC.
4. MST therapist must provide MHCC with a thirty (30) day written notice of intent to discontinue services.
5. MST therapist shall provide MHCC with a closing summary upon closure of assigned case.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

E. FOSTER HOMES WITH THERAPEUTIC SERVICES

Definition	<p>Foster homes with therapeutic services are intensive community-based treatment services provided to youth with emotional disturbances in a home setting. Specialized therapeutic foster care supports incorporate evidence-based psychosocial treatment services. These homes provide a home environment through therapeutic parental supervision, guidance, and support for youth capable of demonstrating growth in such a setting rather than in a more restrictive group residential setting. These youth are generally capable of attending their home school or an alternative community educational or vocational program. Such homes may also be beneficial for youths in transition from a restrictive placement as they offer a small family orientation. Specialized therapeutic foster care supports are appropriate for long-term treatment [six(6) to nine (9) months] and short-term crisis stabilization.</p>
Services Offered	<ol style="list-style-type: none"> 1. Evaluation and assessment of the youth; 2. The program provides positive behavioral and evidence-based treatment training to the therapeutic foster care parents; 3. The program shall maintain collateral contacts with the FGC MHCC; 4. The program's treatment team shall participate in face-to-face meetings with the specialized therapeutic foster parents in order to monitor the youth's progress, and discuss treatment strategies and services; 5. The therapeutic foster home provides skills development activities for youth; 6. The therapeutic foster home provides supportive counseling for youth; 7. The therapeutic foster home coordinates with school personnel to implement and provide academic support in the home setting; 8. The therapeutic foster home agency provides evidence-based family therapy as appropriate; 9. Active, on-going treatment is based on the measurable goals and objectives that are part of the youth's CSP and MHTP. The treatment is focused on returning the youth home or if in long term foster custody, are integrated with the permanency plans, and/or support successful transition to an independent living program; and 10. As a part of effective transition planning, the program provides the information and skills necessary to implement positive behavioral interventions in the home setting that have been found to be effective for the youth.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Initial Authorizations	Up to three (3) months. [Unit = one (1) day]
Re-Authorization	Monthly. [Unit = one (1) day]
Admission Criteria	<ol style="list-style-type: none"> 1. The youth has been identified as needing an out-of-home placement due to challenging behavioral and mental health issues; AND 2. The ability of the youth's family or current caregivers to safely and adequately respond to the youth's needs is significantly strained; AND 3. There is a reasonable expectation that the youth can benefit from therapeutic foster care within three (3) months; AND 4. The measurable treatment goals included in admission criteria 1-4 must be identified by the youth's CSP/IEP, or CSP and MP team prior to admission; AND 5. An adequate trial of active treatment at a less restrictive level has been unsuccessful.
Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The youth continues to need an out-of-home placement due to challenging behavioral and mental health issues; AND 2. The youth's family or current caregiver continue to be unable to safely and adequately respond to the youth's needs without significant strain; AND 3. There is a reasonable expectation that the youth can benefit from this level of foster care within one (1) month; AND 4. The youth's measurable treatment goals have not been met.
Discharge Criteria	<ol style="list-style-type: none"> 1. There is a decrease in identified behavior; AND 2. There is an increase in developmentally appropriate pro-social activities, including school, sports, and hobbies; AND 3. The youth has made progress on their goals and objectives in the CSP/MHTP such that they are able to transition to a less restrictive setting; OR 4. If the youth is in long-term foster custody or is intended to transition to an independent living program, the youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	permanent placement or independent living program.
Service Exclusions	Not offered at the same time Therapeutic Group Homes (General or Individualized), Community-Based Residential Programs (General and High Risk) or Hospital Based Residential Services
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth who require constant one-to-one supervision for protection of self-injuries or danger to others are precluded from admission. 2. Severity of the youth's clinical issues precludes provision of services in this level of care. 3. Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition

Staffing Requirements:

1. Foster parents must be licensed with the Department of Human Services before the first youth is placed in the home.
2. Training for foster parents must include twenty-four (24) hours of skills-based training before the parents receive their first youth. Additionally, another twenty-four (24) hours of in-service training is required annually after the youth is placed.
3. Therapeutic foster parents are supervised by a QMHP during weekly family/group meetings.
4. Foster parents are trained and certified in Cardiopulmonary Resuscitation and First-Aid before the first youth is placed in the foster home and maintain current certification.
5. Staff must have at least twenty-four (24) hours of basic orientation including, but not limited to, crisis field assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
6. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Agency provides twenty-four (24) hours on-call coverage, seven (7) days a week and is on-site for emergencies within one (1) hour of call.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. An interview of the youth and family must be conducted. A written social history is placed in the youth's file and provided to the foster family and the FGC at admission (within 72 hours for emergency admissions). It includes a compilation of information about past and current services, an assessment of the youth and family strengths, and an assessment of psychosocial problems that are leading to placement. The social history includes a substance use history, and an assessment of the youth's suicide and elopement risk.
4. The foster home has no more than two (2) minor youth in the home and no more than two (2) foster youth in placement with them, unless a sibling group is placed together. There shall be a minimum of one (1) adult at home whenever the youth is present. The agency shall ensure additional staff support as necessary.
5. Foster parents actively participate in the IEP/MP (along with the surrogate parent, if assigned) and other school activities. Natural families will be engaged and supported to participate unless legally inappropriate.
6. Each home will have no more than two (2) youth in placement who are clinically compatible.
7. A MHP provides evidence-based treatment services to each youth. The therapist's role is to support the youths' adjustment in the foster home where the main treatment effect is to occur. The therapist's job is to provide support for the youth and to help him/her acquire and practice the skills needed to relate successfully to adults and peers.
8. The agency must have policies that ensure that foster parents plan for regular medical and dental services, and keep the provider agency informed of any health problems or any changes that adversely affect the youth in foster care.
9. The foster care home has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate its methods for training and implementation of positive evidence-based behavioral intervention.
10. Whenever a youth is absent from the program for at least twenty-four (24) hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

Documentation

1. A written plan for providing emergency and psychiatric care is developed by the provider agency and a copy given to the foster parents prior to placement.
2. The foster parents must receive from the youth's MHCC and/or FGC Clinical Director a preliminary statement about the purpose of treatment, the goals to be

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

achieved via treatment, the anticipated length of stay, and the anticipated discharge criteria.

3. The CSP is amended prior to admission. These amendments should address the special needs of the youth.
4. Emergency contact information for the parents or legal guardians are provided to the foster home provider and the foster parents forty-eight (48) hours before admission.
5. The foster parents shall maintain progress notes that provide documentation of significant events, activities or milestones, including absences of twenty-four (24) hours or more. These notes shall be fully dated and signed by the foster parent, originals of which shall be maintained in the agency's master youth file.
6. The foster parents shall maintain a daily attendance log indicating the youth's presence or absence from the home.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

F. RESPITE HOMES

Definition	Mental health respite homes provide safe, short term and supportive environments for youth with emotional and/or behavioral disturbances. In addition these homes provide structured relief to the parent/caregiver(s) and families of these youths. These services support parent(s)/caregiver(s) in their efforts to continue caring for the youth in the home setting, thus reducing the risk of out of home placements at a higher level of care.
Services Offered	<ol style="list-style-type: none"> 1. Services are available twenty-four (24) hours/seven (7) days a week; 2. Services are provided in a twenty-four (24) hour supervised residential setting; 3. The program provides limited social skill building activities that improve social interactions, self- esteem and behavioral management; 4. The program has available on-call crisis intervention and support to respite home providers on a twenty-four (24) hour basis.
Initial Authorizations	Up to two (2) consecutive days. Additional days as agreed by the FGC Clinical Director up to a maximum of five (5) days. (Unit = one (1) day)
Re-Authorization	Not applicable
Admission Criteria	<ol style="list-style-type: none"> 1. The youth presents primary behavioral health issues which can include challenging behaviors; AND 2. The family's or current caregiver's ability to adequately respond to the youth's needs is significantly strained; AND 3. Natural community resources are needed to reduce stress factors and to stabilize the current living environment. A temporary respite will expedite the family to secure these resources; AND 4. There is a reasonable expectation that the strain on the youth's family can be significantly alleviated within the authorization period; AND 5. All admissions must be prior approved by the FGC MHCC and Branch Chief.
Continuing Stay Criteria	Not applicable

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Discharge Criteria	<ol style="list-style-type: none">1. The youth's family is able to have the youth return to the home setting;2. Appropriate natural community resources are planned or engaged to reduce stress factors and to stabilize the current living environment; and3. A supportive living environment is re-established in the youth's home setting.
Service Exclusions	Not offered at the same time as Crisis Stabilization, Foster Homes with Therapeutic Services, Therapeutic Group Homes, Community-Based Residential Programs (General or High Risk) or Hospital-Based Residential Services
Clinical Exclusions	Severity of clinical issues presenting by the youth precludes safe provision of services in this level of care. Youth needs evaluation for crisis stabilization or acute hospital care.

Staffing Requirements:

1. All respite must be provided in the homes of families trained in the provision of short-term care for youths with emotional and/or behavioral disturbances.
2. All respite home providers must have, either on staff or through a contractual relationship, a MHP to provide on-call crisis intervention and support on a twenty-four (24) hour basis.
3. Psychiatric and nursing services must be coordinated so that youth who need immediate assistance with medication can receive that assistance.
4. There is a minimum of one (1) trained respite home parent present whenever the youth is at home.
5. There can be no more than two (2) minor youth in the home AND no more than two (2) foster youth placed in the home at the same time (waivers can be applied for when siblings are involved).
6. All respite home families must receive twenty-four (24) hours of CAMHD approved skills-based training prior to providing respite home services.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The respite home provider must be licensed by the Hawaii Department of Human Services as a foster home.
3. The respite home has clear procedures, which specify its approach to positive behavior management. These procedures must clearly delineate its methods of training and implementation of positive behavioral intervention.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Documentation

1. Respite placement plans must be submitted to the program by the MHCC prior to placement and address the needs of the youth during respite services.
2. A brief written admission progress note is developed by the agency. This note must identify who brought the youth to the respite home, the circumstances leading to the admission to the respite home and documentation of the youth meeting admission criteria.
3. The respite home provider shall maintain daily attendance logs indicating the youth's presence or absence from the home, including duration of stay.
4. These amendments should address the needs of the youth during the respite services.
5. Emergency contact information for the parent(s) or caregiver(s) are provided to the respite home provider and the respite home foster parents forty-eight (48) hours before admission.
6. A written summary must be completed within seven (7) days of discharge that includes the youth's name, the length of the services, the youth's adjustments, and any significant issues/concerns that arose during the course of providing respite. The report is provided to the FGC.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

G. THERAPEUTIC GROUP HOMES

Definition	Therapeutic living program that provides twenty-four (24) hour care and integrated evidence-based treatment planning to address the behavioral, emotional and/or systemic issues which prevent the youth from taking part in family and/or community life. These homes are designed for those whose needs can best be met in a structured program of small group living in a community-based setting. The youth usually remain involved in community-based educational, recreational, and occupational activities. These homes typically provide services for three (3) to eight (8) youth per home. In this type of out-of-home residential care, youth are supervised and provided services by professional staff that have been recruited and trained to work with youth with emotional disturbance. This residential program is not required to be a secure facility.
Services Offered	<ol style="list-style-type: none"> 1. The program provides activities that support the development of age-appropriate daily living skills; 2. The program provides evidence-based interventions, including positive behavioral management; 3. The program provides medication monitoring; 4. The program provides individual and family counseling; and 5. The program provides recreational and social group activities that are rooted in evidence-based treatment and that support the development of interpersonal relating skills through modeling and coaching.
Initial Authorizations	Up to three (3) months. (unit = 1 day)
Re-Authorization	Monthly
Admission Criteria	<ol style="list-style-type: none"> 1. The youth has been identified by the FGC Clinical team as needing an out-of-home placement; AND 2. Consistently demonstrates severe emotional and behavioral disturbances such that they cannot be safely managed in a less restrictive setting; AND 3. Can participate in educational, recreational and social activities outside the residence; AND 4. There is a reasonable expectation that the youth can benefit from a therapeutic living program within three (3) months; AND 5. The youth is at imminent risk for a more intensive program/setting;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p style="text-align: center;">AND</p> <p>6. An adequate trial of active treatment at a less restrictive level has been unsuccessful;</p> <p style="text-align: center;">AND</p> <p>7. The youth's measurable treatment goals included in criteria 1-6 must be identified prior to admission.</p>
Continuing Stay Criteria	<p>1. The youth continues to need an out-of-home placement due to continued demonstration of severe emotional and behavioral disturbances such that they cannot be safely managed in a less restrictive setting;</p> <p style="text-align: center;">AND</p> <p>2. The youth continues to present behaviors that would strain the family situation in the home setting;</p> <p style="text-align: center;">AND</p> <p>3. The youth's progress is not sufficient to allow movement to a less restrictive level of care;</p> <p style="text-align: center;">AND</p> <p>4. The youth's measurable treatment goals have not been met;</p> <p style="text-align: center;">AND</p> <p>5. There is a reasonable expectation that the youth will continue to make progress in reaching the goals and objectives identified in the youth's MHTP.</p>
Discharge Criteria	<p>1. There is a decrease in challenging behaviors;</p> <p style="text-align: center;">AND</p> <p>2. There is improved, sustainable emotional, behavioral, and social functioning as evidenced by improved school attendance, pro-social peer affiliations, parent-child relationships, and participation in community recreational/leisure activities;</p> <p style="text-align: center;">OR</p> <p>3. The youth reaches a level of functioning that allows for either a return home or a transition to independent living, with low or no risk of behavior regression;</p> <p>4. If the youth is intended to transition to an independent living program, the youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or independent living program; and</p> <p>5. The youth's measurable treatment goals have been met.</p>
Service Exclusions	<p>Not offered at the same time as Foster Homes with Therapeutic Services, Individualized High Risk Therapeutic Group Homes, Community-based Residential Programs (General and High Risk); and Hospital-Based Residential Services.</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Clinical Exclusions	Individuals with the following conditions are excluded from admission: <ol style="list-style-type: none">a. Moderate or Severe Mental Retardationb. Mental Disorders due to a general medical condition.
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Staffing Requirements:

1. A ratio of one (1) staff to four (4) youths is maintained at all times.
2. Therapeutic living programs staff must be supervised by a QMHP with experience in evidence-based treatments. Staff include: childcare workers, resident counselors and teaching aides.
3. At minimum, two (2) childcare staff shall be on duty per shift in each living unit, with one (1) staff awake for all shifts.
4. Youth that are ill or otherwise unable to attend school, must be supervised by an available staff wherever the youth is located.
5. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
6. The program **must adhere to all applicable facility licensing requirements/regulations.**
7. The psychiatrist or psychologist provides twenty-four (24) hours on-call coverage, seven (7) days a week and is on-site for emergencies within one (1) hour of the call.
8. Childcare workers, resident counselors and teaching aides must have a minimum of fifty (50) hours college credit towards a degree in human services, OR complete the CAMHD approved Childcare worker training and receive one hour of weekly clinical group supervision.
9. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, nursing, disabilities, speech, occupational and physical therapy, recreation and dietetics are available to the organization.
10. Staff must have at least twenty-four (24) hours of basic orientation training including, but not limited to crisis assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
11. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youth per residence.
3. The program actively engages the youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
4. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
5. Families are actively involved and participate in team meetings, program events, therapy sessions, and so on. They are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment.
6. Specialty programs such as for substance users are expected to work with residents who present behavioral issues while at the program.
7. The therapeutic living program has clear procedures, which specify its approach to positive evidence-based behavior management. These procedures must clearly delineate methods of training and implementation of positive evidence-based behavioral intervention/s.
8. Whenever a youth is absent from the program for at least 24 hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

Documentation

1. Initial Treatment Planning will be completed by the MHCC and FGC Clinical Director. Prior to admission the group home will be provided with documentation of a preliminary statement about the purpose of treatment, the goals to be achieved via treatment, the anticipated length of stay, and the anticipated individualized transition/discharge criteria from the youth's MHCC and/or FGC Clinical Director.
2. Upon admission, the program will develop an individual treatment plan that specifies the specific strategies and positive behavioral interventions used to address the youth's goals and identify desired outcomes consistent with the stated purpose of treatment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. The therapeutic living program shall provide daily progress notes as documentation of treatment progress and/or significant events, activities or milestones, including absences of twenty-four (24) hours or more. These notes shall be fully dated and signed by the staff providing twenty-four (24) hour supervision, originals of which shall be maintained in the agency's master youth file.
4. Crisis Planning: Each youth will have a detailed crisis plan specific to his/her emotional and behavioral needs and patterns. Plans include details of triggers, setting events, functions served by the inappropriate behavior, and appropriate early interventions. Typically crisis plans are built by/around those who know the youth best and have an established relationship. Crisis plans are established prior to admission as part of the youth's treatment plan and revised as needed during the course of treatment. The agency has established protocols and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Requests for police assistance will be limited to situations of imminent risk of harm to self or others.
5. Discharge/Transition Planning: Plans are in place prior to admission. If the youth is to be discharged home, a treatment focus will be parent skills development, positive behavioral plan development and implementation with the family as an essential partner. Therapeutic home passes are directly related to transition plans toward ultimate discharge home. If the youth is not going to be discharged home, program focus and transition planning will occur toward the alternative plan, e.g., independent living or foster placement.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

H. INDIVIDUALIZED HIGH RISK THERAPEUTIC GROUP HOMES

Definition	Individualized programs that are uniquely developed for particular youth whose needs cannot be met by the existing services offered. All other appropriate options have been exhausted and documented before accessing this level of service. Teams have met over a period of time to review and adjust interventions in place but little or no progress has been accomplished thus far. This service generally requires a one to one (1:1) for parts of the program day. Program is staff intensive in a well-structured, predictable environment with clearly established routine. This program serves a maximum of three (3) youth. The youth usually remain in community based educational, recreational, and occupational activities.
Services Offered	<ol style="list-style-type: none"> 1. Program has an individualized living setting and treatment program for the youth; 2. Program has met with FGC/family to discuss needs and how best to meet them guided by evidenced-based practices; 3. Experienced staff, knowledgeable in appropriate behavioral interventions, are with the youth at all times; 4. A crisis plan, which can be implemented immediately, is in place for all youth; 5. All needs will be provided by the agency or arranged for through appropriate channels. For example, if needed assist the youth in obtaining social security; attending IEP, CSP meetings; doctor's appointments, etc.
Initial Authorizations	Up to three (3) months. [unit = one (1) day]
Re-Authorization	Up to two (2) months. [unit = one (1) day]
Admission Criteria	<ol style="list-style-type: none"> 1. The youth has been identified as needing an out-of-home placement due to behavioral and mental health issues, which can include extreme challenging behaviors; AND 2. The youth consistently demonstrates severe emotional and behavioral disturbances that cannot be safely managed in a less restrictive setting; AND 3. The youth can participate in educational, recreational and social activities outside the residence; AND 4. There is a reasonable expectation that the youth can benefit from this level of group home within three (3) months; AND 5. The youth is at imminent risk for a more intensive

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>program/setting;</p> <p style="text-align: center;">AND</p> <p>6. An adequate trial of active treatment in a less restrictive setting has been unsuccessful;</p> <p style="text-align: center;">AND</p> <p>7. The youth's measurable treatment goals included in criteria one (1) to six (6) must be identified prior to admission.</p>
Continuing Stay Criteria	<p>1. The youth continues to need an out-of-home placement due to continued demonstration of severe emotional and behavioral disturbances such that they cannot be safely managed in a less restrictive setting;</p> <p style="text-align: center;">AND</p> <p>2. The youth continues to present behaviors that would strain the family situation in the home setting;</p> <p style="text-align: center;">AND</p> <p>3. The youth's progress is not sufficient to move the youth to a less restrictive level of care;</p> <p style="text-align: center;">AND</p> <p>4. The youth's measurable treatment goals have not been met;</p> <p style="text-align: center;">AND</p> <p>5. There is a reasonable expectation that the youth will continue to make progress in reaching the goals and objectives identified in the youth's MHTP.</p>
Discharge Criteria	<p>1. There is a decrease in challenging behavior(s);</p> <p style="text-align: center;">AND</p> <p>2. There is improved, sustainable emotional, behavioral, and social functioning as evidenced by improved school attendance, pro-social peer affiliations, parent-child relationships, and participation in community recreational/leisure activities;</p> <p style="text-align: center;">OR</p> <p>3. The youth reaches a level of functioning that allows for either a return home or a transition to independent living, with low or no risk of behavior regression.</p> <p>4. If the youth is intended to transition to an Independent living program, the youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or independent living program; and</p> <p>5. The youth's measurable treatment goals have been met.</p>
Service Exclusions	<p>Not offered at the same time as Foster Homes with Therapeutic Services, Therapeutic Group Homes (General), Community-based Residential Programs (General and High Risk) and Hospital-Based Residential (Sub-acute Hospitalization) Services.</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Clinical Exclusions	Youths with the following conditions are excluded from admission: a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition c.
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Staffing Requirements:

1. Minimally, as stated for Therapeutic Group Home or as stated in the Individualized MOA developed for the identified youth. The staffing in the MOA supercedes the TGH requirements where different.
2. **The ratio of staff will be determined based on the needs of the youth.**
3. Specialized therapeutic living programs staff must be supervised by a QMHP. Staff include: childcare workers, resident counselors and teaching aides. In addition, a licensed QMHP experienced in evidence-based treatment should be on-call when the supervising QMHP is not present or available.
4. At minimum, two (2) childcare staff shall be on duty per shift in each living unit, with one (1) staff awake for all shifts.
5. At least one QMHP is trained or has a minimum of three (3) years experience with the specific population served by these programs including youth whose behavioral, emotional and/or mental health issues are serious and persistent such that they cannot be safely managed in other treatment settings.
6. Youths that are ill or otherwise unable to attend school must be supervised by an available staff wherever the youth is located.
7. Staffing schedules shall reflect overlap in shift hours to accommodate information exchange for continuity of youth treatment, provide adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
8. **The program must adhere to all applicable facility licensing requirements/regulations.**
9. The psychiatrist or psychologist knowledgeable of evidence-based treatment is responsible for the treatment program and for those in care, and provides twenty-four (24) hours on-call coverage seven (7) days a week and is on site for emergencies within one (1) hour of call.
10. Childcare workers, resident counselors and teaching aides must have a minimum of fifty (50) hours college credit towards a degree in human services, **OR** complete a CAMHD approved Childcare worker training and receive one (1) hour of weekly clinical group guidance by MHP.
11. Depending on the needs of the youth, the services of qualified professional and specialists in medicine, education, nursing, disabilities, speech, occupational and physical therapy, recreation and dietetics are available to the organization.
12. Staff must have at least twenty-four (24) hours of CAMHD approved basic training including, but not limited to crisis field assessment and intervention,

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.

13. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed **three (3)** youth per residence.
3. The program actively engages the youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
4. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youths are encouraged to appropriately decorate and maintain their personal space.
5. Families are actively involved and participate in team meetings, program events, therapy sessions, and so on. They are engaged in opportunities to gain knowledge and practice of what works in the program setting that can be transferred to the home and community environment.
6. Agencies will adhere to CAMHD's "no eject/no reject" rule. Specialty programs such as for substance users, are expected to work with residents who present behavioral issues while at the program.
7. The therapeutic living program has clear procedures, which specify its approach to positive behavior management. These procedures must clearly delineate methods of training and implementation of positive behavioral intervention/s.
8. Whenever a youth is absent from the program for at least twenty-four (24) hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

Documentation

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

1. Initial Treatment Planning will be completed by the MHCC and FGC Clinical Director and prior to admission the group home will be provided with documentation of a preliminary statement about the purpose of treatment, the goals to be achieved via treatment, the anticipated length of stay, and the anticipated individualized transition/discharge criteria from the youth's MHCC and/or FGC Clinical Director.
2. Upon admission, the program will develop an internal individual treatment plan which specifies the specific strategies and positive behavioral interventions used to address the youth's goals and identifies desired outcomes consistent with the stated purpose of treatment.
3. The specialized therapeutic living program shall provide daily progress notes as documentation of treatment progress and/or significant events, activities or milestones, including absences of twenty-four (24) hours or more. These notes shall be fully dated and signed by the staff providing twenty-four (24) hour supervision, originals of which shall be maintained in the agency's master youth file.
4. Crisis Planning--Each youth will have a detailed crisis plan specific to his/her emotional and behavioral needs and patterns. Plans include details of triggers, setting events, functions served by the inappropriate behavior, and appropriate early interventions. Typically crisis plans are built by/around those who know the youth best and have an established relationship. Crisis plans are established prior to admission as part of the youth's treatment plan and revised as needed during the course of treatment. The agency has established protocols and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Requests for police assistance will be limited to situations of imminent risk of harm to self or others.
5. Discharge/Transition Planning--Plans are in place prior to admission. If the youth is to be discharged home a treatment focus will be parent skills development, positive behavioral plan development and implementation with the family as an essential partner. Therapeutic home passes are directly related to transition plans toward ultimate discharge home. If the youth is not going to be discharged home, program focus and transition planning will occur toward the alternative plan, e.g., independent living or foster placement.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

I. COMMUNITY-BASED RESIDENTIAL PROGRAMS

Definition	<p>Community-Based Residential programs provide twenty-four (24) hour care and integrated service planning that addresses the behavioral, emotional and/or family problems, which prevent the youth from taking part in family and/or community life. These programs are designed for those youth (includes late adolescents when the a group home is not sufficient) whose needs can best be met in a structured program of small group living in a community-based setting where youth can usually remain involved in community-based educational, recreational, and occupational services.</p> <p>Community-Based Residential programs provide support and assistance to the youth and the family to enhance participation in group living and community activities, positive personal and interpersonal skills and behaviors and to meet the youth's developmental needs.</p>
Services Offered	<ol style="list-style-type: none"> 1. The program provides evidenced based treatment interventions and milieu-based programming per the youth's MHTP; 2. The program provides opportunities for the youth to engage in age-appropriate structured and community-based recreational activities; 3. The program provides for medication administration and management; 4. The program provides an on-site educational program addressing the educational goals and objectives identified in the youth's IEP/MP; 5. The program provides substance abuse counseling and education as needed; and 6. The program provides structured pre-vocational and vocational training activities as applicable.
Initial Authorizations	Up to three (3) months. [Unit = one (1) day]
Re-Authorization	Monthly for a maximum of two (2) months [Unit = one (1) day]
Admission Criteria	<ol style="list-style-type: none"> 1. The youth has been identified as needing an out-of-home placement due to behavioral and mental health issues, which can include challenging behaviors; AND 2. The youth consistently demonstrates severe emotional and behavioral disturbances such that they cannot be safely managed in a less restrictive setting; AND 3. The youth's family or current caregiver is unable to safely and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>adequately respond to the youth's needs without significant strain;</p> <p style="text-align: center;">AND</p> <p>4. There is a reasonable expectation that the youth will be able to achieve the defined measurable goals and objectives identified in his/her (MHTP) within three to five (3-5) months;</p> <p style="text-align: center;">AND</p> <p>5. The youth is at imminent risk for a more intensive program/setting;</p> <p style="text-align: center;">AND</p> <p>6. An adequate trial of active treatment in a less restrictive setting has been unsuccessful.</p>
Continuing Stay Criteria	<p>1. The youth continues to need an out-of-home placement due to behavioral and mental health issues, which can include challenging behaviors;</p> <p style="text-align: center;">AND</p> <p>2. The youth's family continues to be unable to safely and adequately respond to the youth's needs without significant strain;</p> <p style="text-align: center;">AND</p> <p>3. There is a reasonable expectation that the youth can achieve his/her defined measurable treatment goals and objectives as identified in the youth's MHTP within the next two (2) months.</p>
Discharge Criteria	<p>1. There is a decrease in challenging behavior;</p> <p style="text-align: center;">AND</p> <p>2. There is improved, sustainable emotional, behavioral, and social functioning as evidenced by improved school attendance, pro-social peer affiliations, parent-child relationships, and participation in community recreational/leisure activities;</p> <p style="text-align: center;">OR</p> <p>3. The youth reaches a level of functioning that allows for either a return home or a transition to independent living, with low or no risk of behavior/emotional regression; and</p> <p>4. If the youth is intended to transition to an independent living program, the youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or independent living program.</p>
Service Exclusions	<p>Not offered at the same time as Intensive Day Stabilization, Intensive Home and Community-Based Services, Foster Homes with Therapeutic Services, Therapeutic Group Homes (General and Specialized), Community-Based Residential (High Risk), or Hospital-Based Residential Services</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Clinical Exclusions	Youth with the following conditions are excluded from admission: a. Moderate or Severe Mental Retardation b. Mental Disorders due to a general medical condition
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Staffing Requirements:

1. A ratio of one (1) staff to four (4) youth is maintained at all times.
2. Community-based residential programs staff must be supervised by a QMHP. Staff include: childcare workers, resident counselors and classroom aides.
3. At a minimum, two (2) childcare staff shall be on duty per living unit. Staff are always in attendance whenever youth are present.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.
5. Youth that are ill or otherwise unable to attend school, must be supervised by an available staff wherever the youth is located.
6. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
7. The teacher will have the assistance of at least one behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the ratio two to eight (2:8).
8. **The program must adhere to all applicable facility licensing requirements/regulations.**
9. The program licensed staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit per month. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
10. The licensed psychiatrist or licensed psychologist must be knowledgeable in evidence-based treatment and is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day/seven (7) days a week.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

11. A licensed registered nurse is on staff to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to administer medications and proper protocols.
12. Childcare workers, resident counselors and classroom aides must have a minimum of fifty (50) hours college credit towards a degree in human services, **OR**, complete a CAMHD approved Childcare worker training and receive one (1) hour each of weekly clinical individual and group supervision.
13. Depending on the needs of the youth, the services or qualified professional and specialists in medicine, education, nursing, disabilities, speech, occupational and physical therapy, recreation and dietetics are available to the organization (either staff or contract).
14. Staff must have at least twenty-four (24) hours of basic orientation training including, but not limited to crisis assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
15. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program will not exceed eight (8) youths per unit.
3. The program actively engages the youth in planned, structured, therapeutic activities rooted in evidence-based treatment throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and pro-social behaviors.
4. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
5. Families are actively involved and participate in team meetings, program events, therapy sessions, and so on. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
6. Educational services are provided within the program and are guided by the youths' IEP/MP. The program works with the DOE to insure adherence to the youths' IEP/MP and appropriateness of the educational services being provided. The credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program also works closely with the

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

DOE to insure a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.

7. Agencies will adhere to CAMHD's "no reject/no eject" rule. Specialty programs such as for substance users, are expected to work with residents who present behavioral and emotional issues while at the program.
8. The community-based residential program has clear procedures that specify its approach to positive behavior management. These procedures must clearly delineate its methods for training and implementation for positive behavioral interventions.
9. Whenever a youth is absent from the program for at least twenty-four (24) hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

Documentation

1. Treatment Planning: Includes documentation of a preliminary statement about the purpose of treatment, the goals to be achieved via treatment, the anticipated length of stay, and the anticipated individualized transition/discharge criteria from the youth's FGC MHCC and/or FGC Clinical Director.
2. The Community-Based Residential program shall provide daily progress notes as documentation of treatment progress and/or significant events, activities or milestones, including absences of twenty-four (24) hours or more. These notes shall be fully dated and signed by the staff providing twenty-four (24) hour supervision, originals of which shall be maintained in the agency's master youth file.
3. Crisis Planning: Each youth will have a detailed crisis plan specific to his/her emotional and behavioral needs and patterns. Plans include details of triggers, setting events, functions served by the inappropriate behavior, and appropriate early interventions. Typically crisis plans are built by/around those who know the youth best and have an established relationship. Crisis plans are established prior to admission as part of the youth's treatment plan and revised as needed during the course of treatment. The agency has established protocols and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Requests for police assistance are limited to situations of imminent risk of harm to self or others.
4. Discharge/Transition Planning: Plans are in place prior to admission. If the youth is to be discharged home a treatment focus will be parent skills development, positive behavioral plan development and implementation with the family as an essential partner. Therapeutic home passes are directly related to transition plans toward ultimate discharge home. If the youth is not going to be discharged

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

home, program focus and transition planning will occur toward the alternative plan (e.g., independent living or foster placement).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

J. COMMUNITY-BASED RESIDENTIAL PROGRAMS – HIGH RISK LEVEL I

Definition	<p>High Risk Community-Based Residential programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.</p> <p>High Risk Community-Based Residential programs provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior without minimizing risk of reoffending or externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.</p>
Services Offered	<ol style="list-style-type: none"> 1. The program provides evidence-based treatment interventions and a supportive milieu therapy; 2. The program provides opportunities for the youth to engage in age-appropriate structured and recreational activities; 3. The program provides psychotherapies and other treatment that address youth in the target population defined above; 4. The program provides for medication administration and management; 5. There is an on-site educational program addressing the educational goals and objectives identified in the youth's IEP/MP; 6. The program provides substance abuse counseling and education as needed; and 7. The program provides structured pre-vocational and vocational training activities as applicable.
Initial Authorizations	Up to three (3) months. [Unit = one (1) day]
Re-Authorization	Up to two (2) months per authorization based on continuation criteria. [Unit = one (1) day]
Admission Criteria	<ol style="list-style-type: none"> 1. The youth is a male between ages 12-18 with severe emotional and/or behavioral disorders, who is educationally

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>disabled and has been adjudicated for a sexual offense/offenses; AND</p> <p>2. The youth has been identified as needing an out-of-home placement; AND</p> <p>3. The youth has been identified as needing specialized treatment; AND</p> <p>4. An adequate trial of active treatment at a less restrictive level has been unsuccessful; AND</p> <p>5. The youth's family or current caregiver(s) are unable to safely and adequately respond to the youth's needs without significant strain; AND</p> <p>6. There is a reasonable expectation that the youth will be able to achieve the goals and objectives identified in his/her mental health treatment plan (MHTP) within six (6) months; AND</p> <p>7. The youth's measurable treatment goals included in admission criteria 1-6 must be identified prior to admission.</p>
<p>Continuing Stay Criteria</p>	<p>1. The youth continues to need an out-of-home placement; AND</p> <p>2. The youth's primary behavioral health issues continues to present a risk or danger to themselves or others; AND</p> <p>3. The youth's family or current caregiver(s) remain unable to safely and adequately respond to the youth's needs without significant strain; AND</p> <p>4. The youth's measurable treatment goals have not been met; AND</p> <p>5. There is reasonable expectation that the youth can benefit from this level of care within the re-authorization period requested.</p>
<p>Discharge Criteria</p>	<p>1. There is a decrease in identified behaviors; AND</p> <p>2. There is improved, sustainable emotional, behavioral, and social functioning as evidenced by improved school attendance, pro-social peer affiliations, parent-child relationships, and participation in community recreational/leisure activities; OR</p> <p>3. The youth reaches a level of functioning that allows for either a return home or a transition to independent living, with low or</p>

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p>no risk of behavior regression;</p> <p>4. If the youth is intended to transition to an independent living program, the youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or independent living program;</p> <p>5. The youth's measurable treatment goals have been met.</p>
Service Exclusions	Not offered at the same time Hospital Based Residential Services, Community-Based Residential (General), Foster Homes with Therapeutic Services, Therapeutic Group Homes (General or Individualized), or Intensive Home & Community-Based Intervention Services.
Clinical Exclusions	<p>1. Severity of clinical issues precludes provision of services in this level of care</p> <p>2. Youth with the following conditions are excluded from admission:</p> <ul style="list-style-type: none"> a. Moderate and Severe Mental Retardation b. Mental Disorders due to a general medical condition

Staffing Requirements:

1. Program must have documentation that staff providing services is trained and experienced in treatment of the population.
2. At minimum, two (2) childcare staff shall be on duty per shift per living unit. Staff are always in attendance whenever youth are present.
3. A QMHP experienced in evidence-based treatment supervises the residential staff.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.
5. Youth that are ill or otherwise unable to attend school, must be supervised by an available staff wherever the youth is located.
6. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
7. The teacher will have the assistance of at least one behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the ratio at least one-to-four (1:4).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

8. The program **must adhere to all applicable facility licensing requirements/regulations.**
9. The program staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
10. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, nursing, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
11. The licensed psychiatrist or psychologist is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day, seven (7) days a week.
12. A licensed registered nurse is on staff to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.
13. Staff must have at least twenty-four (24) hours of basic orientation training including, but not limited to crisis assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
14. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. Services must be provided in a secure locked facility.
3. The program is cognizant of community safety and risk issues and has policies and procedures and the mechanisms to effectively manage these issues.
4. The program will not exceed twelve (12) youth.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

5. Community-Based Residential Programs staff must be supervised by a licensed QMHP knowledgeable of evidence-based treatment. Staff include: childcare workers, resident counselors and teaching aides.
6. The program is physically secure at all times. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among the staff throughout the programming.
7. Staff providing treatment must be a licensed QMHP experienced in evidence-based treatment for sexually offending youth with mental health needs and have a minimum of three (3) years direct experience in children's mental health and in this area.
8. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance interpersonal skills and behaviors.
9. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
10. Families are actively involved and participate in team meetings, program events, therapy sessions, and so on. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
11. Educational services are provided within the program and are guided by the youth's IEP/MP. The program works with the DOE to insure appropriateness of the educational services and the credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program works closely with the DOE to insure adherence to the youth's IEP/MP and a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
12. Agencies will adhere to CAMHD's "no eject/no reject" rule and are expected to work with residents who present behavioral and emotional issues while at the program.
13. Whenever a youth is absent from the program for at least twenty-four (24) hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Documentation

1. Treatment Planning--Includes documentation of a preliminary statement about the purpose of treatment, the goals to be achieved via treatment, the anticipated length of stay, and the anticipated individualized transition/discharge criteria. The youth's FGC MHCC and/or FGC Clinical Director will provide this information to the program prior to admission.
2. The Community-Based Residential program shall provide daily progress notes as documentation of treatment progress and/or significant events, activities or milestones, including absences of twenty-four (24) hours or more. These notes shall be fully dated and signed by the staff providing twenty-four (24) hour supervision, originals of which shall be maintained in the agency's master youth file.
3. Crisis Planning--Each youth will have a detailed crisis plan specific to his/her emotional and behavioral needs and patterns. Plans include details of triggers, setting events, functions served by the inappropriate behavior, and appropriate early interventions. Typically crisis plans are built by and/or around those who know the youth best and have an established relationship. Crisis plans are established prior to admission as part of the youth's treatment plan and revised as needed during the course of treatment. The agency has established protocols and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Requests for police assistance are limited to situations of imminent risk of harm to self or others.
4. Discharge/Transition Planning--Plans are in place prior to admission. If the youth is to be discharged home a treatment focus will be parent skills development, positive behavioral plan development and implementation with the family as an essential partner. Therapeutic home passes are directly related to transition plans toward ultimate discharge home. If the youth is not going to be discharged home, program focus and transition planning will occur toward the alternative plan, e.g., independent living or foster placement.
5. Program must have documentation that staff providing services is trained and experienced in treatment of the population.

For Service Content of

COMMUNITY-BASED RESIDENTIAL PROGRAM-HIGH RISK LEVEL II

PLEASE SEE ADDENDUM APRIL 2, 2002, Page A-6

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

K. HOSPITAL-BASED RESIDENTIAL

Definition	Hospital Based Residential (HBR) Services provide intensive in-patient treatment services to youth with severe emotional disturbance who require short-term hospitalization for the purposes of receiving intensive diagnostic, assessment and medication stabilization services. Services include multi-disciplinary assessment of the youth, skilled milieu of services by trained staff who are supervised by a licensed professional on a twenty-four (24) hour per day basis. Services are required to be staff secure at all times. Hospital-based Residential programs may not exceed sixteen (16) beds.
Services Offered	<ol style="list-style-type: none"> 1. Diagnostic and assessment services; 2. Psychiatric services; 3. Nursing Services; 4. Medication Management; 5. Evidenced base treatment interventions as suggested in the IEP/MP and CSP; 6. Educational activities will be implemented according to the youth's youth educational needs; 7. Individualized adjunctive therapies; and 8. Substance abuse treatment and education.
Initial Authorizations	Up to fifteen (15) units [unit = one (1) day] by FGC Clinical Director
Re-Authorization	Up to fifteen (15) units and only by prior authorization of CAMHD Central Office Medical Director/Clinical Director [unit = one (1) day]
Admission Criteria	<ol style="list-style-type: none"> 1. Youth must have primary behavioral health issues which require daily, intensive psychiatric treatment services to decrease risk factors such as suicidal and/or homicidal ideation or aggressive behavior; AND 2. The youth's clinical and behavioral issues are unmanageable in an education or school-based environment; AND 3. The youth would not benefit from SBBH treatment and requires intensive, coordinated multi-disciplinary intervention within a therapeutic milieu; AND 4. The youth is unable to return home or to a temporary residence at night; AND 5. Reasonable expectation that the youth can improve sufficiently within fifteen to thirty (15-30) days such that the youth can be treated in a less restrictive setting.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Continuing Stay Criteria	<ol style="list-style-type: none"> 1. The youth must have primary behavioral health issues which continue to require intensive, daily psychiatric treatment services to decrease risk factors such as suicidal and/or homicidal ideation or aggressive behavior; AND 2. The youth's clinical and behavioral issues continue to be unmanageable in school- or community-based environment or other less restrictive treatment setting; AND 3. There continues to be a reasonable expectation that the youth can improve sufficiently within fifteen to thirty (15-30) days such that the youth can be treated in a less restrictive setting.
Discharge Criteria	<ol style="list-style-type: none"> 1. The youth's symptoms are stabilized sufficiently to permit movement to a less restrictive treatment setting; 2. Medication is titrated so that there is no longer a need for daily psychiatric/nursing oversight; 3. The youth no longer presents significant imminent risk of harm to self or others; 4. The youth has strengthened skills, increased family involvement, and lessened need for restrictive interventions including readmission to in-patient programs; 5. The youth is capable of returning to school; and 6. The youth is capable of participating in a less restrictive level of care.
Service Exclusions	Not offered at the same time as Intensive Day Stabilization, Intensive Home and Community-Based Services, Therapeutic Foster Care Services, Therapeutic Group Homes (General and Specialized), Community-Based Residential Services (General and High Risk).
Clinical Exclusions	<ol style="list-style-type: none"> 1. Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate to Severe Mental Retardation b. Mental Disorders due to a general medical condition 2. The youth can effectively and safely be treated at a less restrictive level of care.

Staffing Requirements:

1. The services must be provided by a multidisciplinary team knowledgeable in evidence-based treatment and comprised of:
 - a. Child and adolescent psychiatrist;
 - b. Registered nurse;
 - c. Licensed psychologist and/or social worker;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- d. Paraprofessional; and
 - e. Teacher or other professional with Functional Behavioral Assessment (FBA) skills
2. The program must be under the supervision of a Hawaii licensed ABPN child and adolescent psychiatrist.
 3. Services must be provided and/or activities led by staff who are:
 - a. a QMHP, or
 - b. an MHP under the supervision of a QMHP, or
 - c. an RN under the supervision of a QMHP.
 4. There must be an RN or licensed QMHP on-site at all times the services are in operation, regardless of the number of youth participating, and psychiatric coverage with psychiatrist able to be on-site within thirty (30) minutes.
 5. There must be a maximum ratio of an average of not more than eight (8) youth to one (1) QMHP, based on average daily attendance of youth.
 6. There must be a maximum face-to-face ratio of an average of not more than four (4) youth to one (1) direct service/program staff, based on average daily attendance of youth. QMHPs will be included in the staff count for purposes of calculating this ratio. The program staff ratio may need to be adjusted during periods of greater activities.
 7. Involvement of parent(s)/caregiver(s) is/are essential in the provision of this service and is a necessary tool in enabling the youth to move to less restrictive services. This requirement, however, should not be allowed to become a barrier to the delivery of services to youth whose parent(s) or caregiver(s) is/are not able to participate or not available.
 8. Nursing and psychiatric services must be available daily, but is not counted for the staff to consumer ratios unless the RN is available face-to-face during the entire operation of the service.
 9. All staff must have an understanding of and ability to assess symptoms, medication issues, and behaviors in order to be able to identify psychiatric situations requiring additional psychiatric or nursing staff assistance.
 10. An RN or Physician may be shared with other programs so long as these professionals are available as required for supervision, clinical operations, and rapid response, and so long as they are not counted in consumer to staff ratios in two (2) different programs operating at the same time.

Clinical Operations

1. This service must operate within an accredited hospital.
2. The program must comply with all Department of Justice Settlement requirements.
3. Services must be available twenty-four (24) hours a day, seven (7) days a week.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

4. Comprehensive multi-disciplinary assessments are performed within forty-eight (48) hours and include consideration of evidence-based treatment options, current DSM version assessments on Axes I – V, assessments of youth, family, community strengths/resources, and specific multi-modal treatment recommendations that target the specific factors that precipitated the admission. The assessment also includes comprehensive evaluations of the youth's developmental milestones and course; family dynamics; current and past school, work, or other social role; ability to interact socially (including peer relationships); substance use/abuse; and a summary of all prior psychiatric hospitalizations, medication trials, and other mental health and /or psychosocial interventions including an assessment of their degree of success and/or failure.
5. A plan to include a normalized routine and an orderly schedule to help develop positive interpersonal skills and behaviors is to be developed within ten (10) days with opportunities for observations and assessments.
6. Every admission must be documented.
7. The psychiatrist's participation in support of the youth must be documented at least once a week in treatment team meetings and in progress and treatment notes at least three (3) times per week. The psychiatrist observes, assesses and/or treats the youth. The psychiatrist routinely assesses the effectiveness of treatment, coordination of treatment, management of medication, and medical treatment. A psychiatrist is available twenty-four (24) hours a day to direct any psychiatric emergencies (e.g., restraints, seclusion).
8. Transition planning for less intensive service options must begin at the onset of this service delivery and documentation must demonstrate this planning as well as activities undertaken to support this transition process.
9. The FGC MHCC and FGC Clinical Director will engage in ongoing collaboration with the HBR staff regarding the youth's status. Specifically, the HBR staff must work collaboratively with the MHCC, FGC Clinical Director, youth and family in the development of individualized treatment, discharge criteria and transition plans that are informed by current diagnostic and assessment information.
10. The HBR program has clear procedures, which specify its approach to positive behavior supports. These procedures must clearly delineate its methods training and implementation for positive behavioral intervention.
11. Staff must have at least twenty-four (24) hours of basic orientation training including, but not limited to crisis assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
12. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

13. Whenever a youth is absent from the program for at least twenty-four (24) hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

Documentation

1. The program must receive from the youth's MHCC and/or FGC Clinical Director a preliminary statement about the purpose of treatment, the goals to be achieved via treatment, the anticipated length of stay, and the anticipated individualized discharge criteria.
2. In addition to other documentation requirements, a daily progress note must be documented for each youth by a member of the direct service/program staff.
3. A weekly summary and sign-off on supervised staff's notes must be documented by the supervising QMHP.
4. Daily attendance of each youth participating in the program must be documented showing number of hours in attendance for billing purposes.
5. It is expected that transition planning for less intensive service options will begin at the onset of this service delivery. Documentation should demonstrate this planning.
6. Every physician contact, including medication prescription and administration, must be documented. Documentation of medication management requires notation of rationale for use, including diagnosis and target symptoms, expected beneficial and potential adverse effects, parental and youth consent and acknowledgment of potential adverse effects, and observations of the effects of the medication intervention.
7. An RN's progress note showing participation in support of the youth must be documented at least daily for the first week and in each subsequent three (3) day period. Every nursing contact, including medication administration, must be documented.
8. The program must provide a weekly census report to CAMHD Utilization Management Section.

SECTION II – PART D:

**SERVICES FOR CHILDREN & YOUTH WITH
PERVASIVE DEVELOPMENTAL DISORDERS and/or
SIGNIFICANT MENTAL RETARDATION**

PERFORMANCE STANDARDS

SECTION II – PART D: SERVICES FOR CHILDREN & YOUTH WITH PERVASIVE DEVELOPMENTAL DISORDERS and/or SIGNIFICANT MENTAL RETARDATION

IV. SERVICES FOR CHILDREN AND YOUTH WITH PDD and/or SIGNIFICANT MR

A. ASSESSMENT

Definition	Diagnostic and evaluation services involving a strength based approach to identify student's needs in the context of school, family, and community. These services include completion of initial assessment, triennial assessments and supplementary focused assessments as part of the Department of Education (DOE) identification and eligibility process. Service components include written assessments, feedback session and as appropriate this information serves to inform the IEP process.
Services Offered	<ol style="list-style-type: none"> 1. Diagnostic Evaluations: CHAT, CARS, ADOS-G, ADI, etc. 2. Focused Assessments related to Social Skills, Speech and Communications, Assistive Technology, Functional Behavior, etc.
Initial Authorizations	Not applicable
Re-Authorization	Not applicable
Admission Criteria	Not applicable
Continuing Stay Criteria	Not applicable
Discharge Criteria	Not applicable
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

Individuals providing assessment services must be qualified to perform the particular assessment they are implementing. A medical doctor or a licensed clinical psychologist shall perform diagnostic tests. Individuals whom are credentialed/licensed to perform those particular examinations should perform those focused assessments.

Clinical Operations

1. Assessments must be completed within Chapter 56 Timelines. Chapter 56 indicates “the department shall ensure that within a reasonable period of time [sixty (60 days)] following the receipt of parental consent to the initial assessment under section 8-56-70 (a) (a) or, within a reasonable period of time following the

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

date of a determination under section 8-56-7 that no additional assessment data is needed: 1) the student is assessed, as necessary 2) if determined eligible under section 8-56-15, special education and related services are made available to the student in accordance with an IEP. Further Chapter 56 indicates “the department shall ensure that within a reasonable period of time [sixty (60) days] following the receipt of parental consent to reevaluation under section 8-56-70 (a) (1) or the commencement of an assessment in accordance with section 8-56-7 that no additional assessment data is needed: 1) the student is assessed, as necessary; and 2) if the student continues to be eligible under section 8-56-15, special education and related services are made available in accordance with an IEP.

2. Individual who completes assessment must participate as a member of the IEP team
3. Individual must share recommendations in writing and participate in the team decision making as a face-to-face active participant or through a teleconference.
4. A billable event consists of face-to-face contact with the student and/or other team members as required to complete the actual assessment. Report writing time will be billable for up to two (2) hours per assessment. Billable time will include participation within the IEP for the time period necessary to share the assessment with the team and to integrate the assessment information into the present levels of performance and resulting goals and objectives. Contact time to schedule will not be billable. Phone contact time will not be billable with the exception of teleconference attendance at an IEP meeting.

Documentation

Written report must be provided which minimally will contain the following:

- a. Identifying demographic information;
 - b. Purpose of the assessment;
- AND/OR**
- c. Tools/Protocols used to assess;
 - d. Findings of the assessment;
 - e. Recommendations to the team; and
 - f. Definition of the assessment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

B. INTENSIVE SUPPORT BY TRAINED PERSONNEL

1. Parent Therapy/Counseling: to include training, support and community outreach

Definition	Parent Therapy/Counseling to include training, support and community outreach means assisting parents in understanding the special needs of their child; providing parents with information about child development and helping parents acquire the necessary skills that will allow them to support the implementation of their child's IEP or IFSP.
Services Offered	Topics of instruction may include, but are not limited to: child development, autism and related diagnoses, significant mental retardation and related diagnoses, chronological and developmentally appropriate self-help, academic, communication and social goals, information related to the IEP process, information related to navigating the educational and service support system, techniques to address behavioral issues, information about empirically validated strategies and working collaboratively with professionals.
Initial Authorizations	Authorization through the IEP. Initial authorization to include two (2) hours additional service to afford providers opportunity to build rapport with family prior to the onset of service delivery.
Re-Authorization	As deemed appropriate by the IEP.
Admission Criteria	Student displaying behaviors within family which are interfering with ability to learn and demonstrate progress in IEP.
Continuing Stay Criteria	Student continues to display behaviors within family which are interfering with ability learn and demonstrate progress in IEP.
Discharge Criteria	Student no longer displays behaviors within family which are interfering with ability to learn and demonstrate progress in IEP
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

Staffing Requirements:

1. The program must be under the supervision of a QMHP and work collaboratively with the District Autism and/or Significant Mental Retardation Family Consultant.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

2. At a minimum, Parent Therapy/Counseling providers must have must possess a graduate degree in psychology, psychiatric nursing, social work, guidance, psychiatry or other qualified personnel and be under the supervision of a QMHP and work collaboratively with the District Autism and/or Significant Mental Retardation Family Consultant

Clinical Operations

1. Services are available to families within the typical workday as well as in the evening.
2. The student and family are provided information about and as necessary, linked to appropriate medical, social, mental health, or other community resources.
3. A billable event consists of face-to-face contact with family members who are the recipient of the training. Fifty (50) minutes of each hour of service should be in direct contact family members with ten (10) minutes allowable for documentation. Phone contact is not considered a billable event.

Documentation

1. Prior to initial service contact service provider should have written information provided by the IEP team in regards to which specific skills family is receiving training.
2. Documentation must include specific concepts/skills in which training is being provided. A progress note should be made for each family contact and entered into ISPED within forty-eight (48) hours. Contracted agencies will be responsible for providing measurable outcome data to assess the effectiveness of this service.
3. Providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), homeless shelters, street locations, etc.
4. The agency has policies, which govern the provision of services in natural settings, and which document that it respects students' and/or families' right to privacy and confidentiality when services are provided in these settings.
5. Quarterly progress reports to DOE denoting quantifiable gains or lack thereof of the skills and concepts being taught.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

C. AUTISM AND/OR SIGNIFICANT MENTAL RETARDATION CONSULTANT

Definition	The purpose of Autism and/or significant Mental Retardation consultation is to lead and direct the activities of the Skills Trainers, while providing support, consultation and consistency for the family and related staff. The Autism and/or Significant Mental Retardation Consultant must provide direction to the Skills Trainers and communicate with the Skills Trainer supervisor.
Services Offered	<ol style="list-style-type: none"> 1. The consultant provides evidence-based individualized services; 2. The consultant develops a written plan that details the skills to be taught, the instructional strategies to be utilized across domains and the data management strategy to be implemented; 3. Monitors and trains Skills Trainers; and 4. Monitors data and provides programmatic changes as needed.
Initial Authorizations	<p>IEP teams believe more intensive services are warranted and have reviewed the following items prior to initiating service:</p> <ol style="list-style-type: none"> 1. The student is eligible for specifically designed instruction, related services (IDEA) and instructional accommodations (Section 504); 2. The student's IEP/MP plan includes a comprehensive plan to address the core deficit areas associated with a diagnosis of PDD, including but not limited to communication socialization and behavior; 3. Instructional goals and objectives are stated in measurable terms and reflect acceleration goals for desired behaviors to replace challenging behaviors; 4. The IEP team has a plan to support parents and staff in implementation instructional interventions and contextual supports (This means the plan ensures that each participant has or will develop the resources, skills and competencies needed to implement the instructional goals and objectives); 5. The student is provided with instruction at his/her developmentally appropriate and chronologically appropriate level and rate of understanding; 6. The parent/caregiver(s) are engaged as team members; 7. The IEP is current. It is developmentally and chronologically appropriate for the student. It is being implemented consistently and appropriately. The goals and objectives are being addressed as written and monitored; 8. There is a long term view of the child; and 9. In the presence of challenging behaviors, a functional behavioral assessment (FBA) has been completed, a written

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	Positive Behavioral Support Plan (PBSP) is being implemented and has been shared with the IEP team.
Re-Authorization	As deemed appropriate through the IEP
Admission Criteria	Student is exhibiting social, communication behavioral or other deficits that are limiting their ability to access their IEP.
Continuing Stay Criteria	Not applicable
Discharge Criteria	<ol style="list-style-type: none"> 1. The student, parent/caregiver(s) and or educational team have skills and resources needed to independently address the student's and family's/caregiver's ongoing needs. 2. There is a reduction in the student's behavioral challenges or increase in pro-social behaviors. 3. The student requests discharge [and are not imminently dangerous to self or others]. 4. Transfer to another service/level of care is warranted by change in the student's condition. 5. The student requires services not available in this level of care.
Service Exclusions	Not applicable
Clinical Exclusions	<ol style="list-style-type: none"> 1. There is a significant lack of community coping skills such that a more intensive level of service is needed. 2. This service is not intended to supplant other services such as Social Support services, or any day services where the student or family may more appropriately receive these services in various community settings.

Staffing Requirements:

1. The program must be under the supervision of a QMHP.
2. At a minimum, Autism and/or Significant Mental Retardation Consultant must have:
 - a. A Bachelors degree in psychology, psychiatry, social work, psychiatric nursing, speech and language pathology, occupational therapy, special education or a related field and three years direct experience working with students with Autism Spectrum Disorders (ASD) and/or Significant Mental Retardation (MR).

OR

 - b. A Doctorate degree in psychology, psychiatry, social work, psychiatric nursing, speech and language pathology, occupational therapy, special

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

education or a related field and one year direct experience working with students with ASD and/or MR.

Clinical Operations

1. ASD and/or MR Consultant must include coordination with educational team, family and significant others.
2. It is expected that ASD and/or MR Consultant will work collaboratively with the classroom teacher and all other members of a student's educational team.
3. ASD and/or MR Consultant providers must have the ability to deliver services in various environments, such as homes, schools, community, homeless shelters, street locations, etc.
4. The organization has policies and procedures that govern the provision of services in natural settings and can document that it respects students' and/or families' right to privacy and confidentiality when services are provided in these settings.
5. A billable event will be face-to-face contact with the student receiving services with ten (10) minutes per session of service delivery (to be no less than one (1) hour) dedicated to documentation. In addition two (2) hours per month will be billable if dedicated to direct face-to-face training of the Skills Trainer. In addition two (2) hours per month will be billable if dedicated to team meetings where the Classroom Teacher and if involved the Skills Trainer are in attendance. Phone contact is not considered a billable event.

Documentation

1. Prior to initial service contact service provider should have written information provided by the IEP team in regards to what areas the team is requesting support from the behavioral consultant
2. Documentation must include specific areas in which instruction is being provided. A written plan should be developed which details skills to be taught and instructional strategies to be utilized. Plans must directly relate to the curriculum and classroom strategies. The plan must include IEP Goals and Objectives to be addressed and method of data collection to assess progress or lack thereof.
3. Providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), homeless shelters, street locations, etc.
4. The agency has policies that govern the provision of services in natural settings and which document that it respects students' and/or families' right to privacy and confidentiality when services are provided in these settings.
5. Data will be taken on each IEP Goal and Objective for which Autism and/or Significant Mental Retardation Consultant is responsible one time per week. Quarterly progress reports denoting quantifiable gains or lack thereof are provided to DOE. It is expected that documentation will also occur for each instance of service delivery and entered into ISPED within forty-eight (48) hours.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

6. Documentation will occur for each consultation with a Skills Trainer. Narrative will include in what specific areas Skills Trainers received instruction.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

D. SKILLS TRAINER

Definition	The purpose of this service is to facilitate the student's participation in the school, home and community and maximize the student's independence. May be utilized after school hours to facilitate the child's social interactions and participation as a member of the community. If necessary this service may be utilized during periods of extended school year and therapeutic recreation activities.
Services Offered	<ol style="list-style-type: none"> 1. Will address issues of daily living, academic, vocational and recreation activities; 2. Responsibilities may include but are not limited to: making accommodations (schedules, work systems, visual cues, communication books) and acting as an agent to facilitate the child's interaction with the peers in the setting who are typically developing; and 3. Collect data from the implementation of the plan developed by the Autism and/or Significant Mental Retardation Consultant or the Classroom Teacher.
Initial Authorizations	Authorized through the IEP.
Re-Authorization	As deemed appropriate by the IEP.
Admission Criteria	Student is exhibiting social, communication. Behavioral or other deficits that are limiting their ability to access the IEP.
Continuing Stay Criteria	Not applicable
Discharge Criteria	<ol style="list-style-type: none"> 1. Student masters the skills as outlined in the plan developed by the Teacher or Autism and/or Significant Mental Retardation consultant; 2. The student, family/caregiver(s) and or educational team have skills and resources needed to independently address the student's and family's/caregiver's ongoing needs; 3. There is a reduction in the student's behavioral challenges or increase in pro-social behaviors; 4. The student requests discharge [and are not imminently dangerous to self or others]; 5. Transfer to another service/level of care is warranted by change in the student's condition; and 6. The student requires services not available in this level of care.
Service Exclusions	Not applicable
Clinical Exclusions	Not applicable

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Staffing Requirements:

1. The program must be under the supervision of Autism and/or Significant Mental Retardation Consultant.
2. At a minimum, Skills Trainer must have a high school diploma.
3. Provider agencies will provide information regarding how staff absences will be addressed. It is expected that a pool of substitutes will be maintained to insure continuity of service delivery.

Clinical Operations

1. Skills Trainer must include coordination with assigned classroom teacher and Autism and/or Significant Mental Retardation Consultant.
2. Skills Trainer must collect written data one time per week for each assigned IEP Objective. This data will be provided to the Classroom teacher and Autism and/or Significant Mental Retardation Consultant.
3. It is expected that Skills Trainers will work collaboratively with the classroom teacher and all other members of a student's educational team.
4. Skills Trainer providers must have the ability to deliver services in various environments, such as homes, schools, community, homeless shelters, street locations, etc.
5. The organization has policies and procedures that govern the provision of services in natural settings and can document that it respects students' and/or families' right to privacy and confidentiality when services are provided in these settings.
6. A billable event will be face-to-face contact with the student receiving services with ten (10) minutes per session of each service delivery session (to be no less than one (1) hour) dedicated to documentation. In addition two (2) hours per month will be billable if dedicated to team meetings where the Autism and/or Significant Mental Retardation Consultant and Classroom Teacher are in attendance. Phone contact is not considered billable.

Documentation

1. Prior to initial service contact service provider should have written information provided by the IEP team and Autism and/or Significant Mental Retardation Consultant in regards to what areas the team is requesting support from the Skills Trainer. It will also include an outline of a plan to fade the levels and intensity of assistance provided by the Skills Trainer.
2. Documentation must include specific areas in which instruction is being provided. A written plan should be developed which details skills to be taught and instructional strategies to be utilized. Plans must directly relate to the curriculum and classroom strategies. The plan must include IEP Goals and Objectives to be addressed and method of data collection to assess progress or lack thereof.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. Providers must have the ability to deliver services in various environments, such as homes (birth, kin, adoptive and foster), homeless shelters, street locations, etc.
4. The agency has policies which govern the provision of services in natural settings and which document that it respects students' and/or families' right to privacy and confidentiality when services are provided in these settings.
5. Data will be taken on each IEP Goal and Objective for which the ASD and/or MR Consultant is responsible one time per week. Quarterly progress reports denoting quantifiable gains or lack thereof are provided to DOE. It is expected that documentation will occur for each service delivery and entered into ISPED within forty- eight (48) hours.
6. Documentation will occur for each consultation with a Skills Trainer. Narrative will include in what specific areas student received instruction.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

E. EXTENDED SCHOOL YEAR SERVICES

Definition	The term Extended School Year (ESY) services means special education and related services that are provided to a child with a disability beyond the normal school year of the public agency in accordance with the child's IEP and at no cost to the parents of the child and meet the standards of Special Education Agency.
Services Offered	<ol style="list-style-type: none"> 1. Individual and/or group coaching, modeling, and practice of daily living skills; 2. Appropriate recreational activities that stimulate interest development according to the student's age; 3. Services can be offered after school, evenings, weekends and/or during school vacations; 4. Encouragement and facilitation of family involvement that supports learning after transition from the program to the home environment; and 5. Strong emphasis placed on utilizing local community resources that include typically developing peers.
Initial Authorizations	Authorized through IEP.
Re-Authorization	As deemed appropriate through the IEP.
Admission Criteria	<p>The IEP team shall consider ESY services which means special education and related services:</p> <ol style="list-style-type: none"> 1. Are provided to a student with a disability: <ol style="list-style-type: none"> a. Beyond the normal school year of the school the student attends or will attend; b. In accordance with the student's IEP; and c. At no cost to the parent(s) of the student; and 2. Meet the standards of the department. <ol style="list-style-type: none"> a. The department shall ensure that extended school year services are available as necessary to provide a free appropriate public education, consistent with subsection C. b. EYS services shall be provided only if the student's IEP team determines on an individual basis, in accordance with sections 8-56-30 to 8-56-42, that the services are necessary for the provision of a free appropriate public education to the student. c. The IEP team shall consider factors that include the following in determining whether a student with a disability needs EYS services: <ul style="list-style-type: none"> • The nature of the student's disabling condition • The severity of the disabling condition • The areas of learning crucial to attaining the goal of self-sufficiency and independence from

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	<p style="text-align: right;">caretakers</p> <ul style="list-style-type: none"> • The extent of regression caused by the interruption of educational programming • The rate of recoupment following the interruption of education programming <p>In implementing the requirements of this section, the department may not:</p> <ol style="list-style-type: none"> 1. Limit EYS services to particular categories of disability; or 2. Unilaterally limit the type, amount, or duration of those services. <p>Auth: HRS 302A-1112</p>
Continuing Stay Criteria	Not applicable
Discharge Criteria	<ol style="list-style-type: none"> 1. The student and family have accessed natural support services which adequately address need for student to maintain skills throughout intercession; 2. The student has improved social skills, an increase in positive peer group involvement/relationships and these skills are sustainable in age appropriate community activities; 3. The student is capable of participating in less restrictive levels of care; and 4. The student or family requests discharge from the program.
Service Exclusions	Not applicable
Clinical Exclusions	Severity of clinical issues precludes provision of services in this level of care.

Staffing Requirements:

1. A QMHP must provide supervision. Supervision by this professional should be no greater than one QMHP to twelve (12) students.
2. At a minimum individuals providing direct instruction during Extended School Year must have a high school diploma
3. Psychiatric and nursing services must be available for student who need assistance with medication, but is not counted for the staff to student ratios unless the nursing staff is available face-to-face during the entire operation of the service.

Clinical Operations

1. Ideally settings should be integrated with typically developing age appropriate peers.
2. ESY service providers will collect data on each IEP goal and objective outlined by the Autism and/or Significant Mental Retardation Consultant and classroom

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

teacher. It is also expected that documentation will occur for each occurrence of service delivery.

3. Family involvement and participation will be encouraged and supported.
4. Program will be in operation within each geographical region for each school calendar break that occurs in that region which is greater than five consecutive days.
5. Program will be in operation for a typical school day. A typical school day is described as from 8:00 a.m. to 2:00 p.m.
6. A billable event will be face-to-face contact with the student receiving services with ten (10) minutes per session of service delivery (to be no less than one (1) hour) dedicated to documentation. Partial day attendance should be noted and billed accordingly.

Documentation

1. Prior to initial service contact service provider should have written information provided by the IEP team in regards to what areas the team is requesting support from the Extended School Year Period.
2. Written data will be collected one time per week for each IEP goal and objective which was to be addressed during the ESY. This data is to be provided to the classroom teacher and ASD and or MR Consultant. It is also expected that documentation will occur for each occurrence of service delivery and entered into ISPED with forty-eight (48) hours.
3. A written summary report will be provided at the end of the ESY Period. The summary report will provide quantifiable information regarding the progress or lack thereof made during the Extended School Year Period.
4. Daily attendance of each student participating in the program must be documented showing number of hours in attendance (start and end times).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

F. THERAPEUTIC RECREATION

Definition	This includes assessment of leisure function; therapeutic recreation services, recreation programs in schools and community agencies and leisure education activities which promote generalization of skill development. Opportunities to provide students with autism access to age appropriate recreational activities in their communities with their typically developing peers. Instruction should also include a component to help student with autism and/or significant mental retardation learns to access those community recreational activities. These services may be provided on the child's home school campus. These services may also be provided in an individual basis or in a "program within a program" format where multiple individuals with autism and/or significant mental retardation are receiving supports in the same location. Focus should be placed on community-based activities that reflect the child's interests. It is expected that services will deliver both developmentally and chronologically appropriate skills and activities.
Services Offered	<ol style="list-style-type: none"> 1. Individual and/or group coaching, modeling, and practice of daily living skills; 2. Appropriate recreational activities that stimulate interest development according to the student's age; 3. Services can be offered after school, evenings and weekends; 4. Encouragement and facilitation of family involvement that supports learning after transition from the program to the home environment; and 5. Strong emphasis placed on utilizing local community resources that include typically developing peers.
Initial Authorizations	Authorized through the IEP.
Re-Authorization	As deemed appropriate by the IEP.
Admission Criteria	Student requires additional instruction than can be accessed during a typical school day to access and benefit from their IEP.
Continuing Stay Criteria	Not applicable
Discharge Criteria	<ol style="list-style-type: none"> 1. The student and family have accessed natural support services which adequately address need for student to access and benefit from their IEP; 2. The student has improved social skills, an increase in positive peer group involvement/relationships and these skills are sustainable in age appropriate community activities;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	3. The student is capable of participating in less restrictive levels of care; and 4. The student or family requests discharge from the program.
Service Exclusions	Not applicable
Clinical Exclusions	Severity of clinical issues precludes provision of services in this level of care.

Staffing Requirements:

1. Supervision must be provided by a QMHP.
2. At a minimum, individuals providing direct instruction during therapeutic recreation must have a high school diploma.
3. Psychiatric and nursing services must be available for student who need assistance with medication, but is not counted for the staff to student ratios unless the nursing staff is available face-to-face during the entire operation of the service.

Clinical Operations

1. Ideally settings should be integrated with typically developing age appropriate peers.
2. Therapeutic Recreation service providers will collect data on the goals and objectives outlined by the Autism and/or Significant Mental Retardation Consultant and Classroom Teacher.
3. Family involvement and participation will be encouraged and supported.
4. A billable event will be face-to-face contact with the student receiving services with ten (10) minutes per session of service delivery dedicated to documentation.

Documentation

1. Prior to initial service contact service provider should have written information provided by the IEP team in regards to what areas the team is requesting support from the Therapeutic Recreation.
2. Written data will be collected one time per week for each IEP goal and objective which was to be addressed during the Therapeutic Recreation. This data is to be provided to the Classroom Teacher and Autism and/or Significant Mental Retardation Consultant. It is also expected that data will be taken for each occurrence of service delivery and entered into ISPED within forty-eight (48) hours.
3. A written summary report will be provided quarterly to coincide with school of attendance reporting period. The summary report will provide quantifiable information regarding the progress or lack thereof made during the extended school day instructional period.
4. Daily attendance of each student participating in the program must be documented showing number of hours in attendance (start and end times).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

G. SPECIAL SCHOOLS

Definition	Special School services are meant to be a time limited intervention that promotes a comprehensive program development for a child who is not able to benefit from their IEP in a less restrictive setting such as their local school. The purpose of the placement is to develop and implement a systematic instructional program that promotes skill development in the areas which are leading to the placement in the Special School setting.
Services Offered	Not applicable
Initial Authorizations	Authorized through the IEP.
Re-Authorization	As determined appropriate by the IEP Team.
Admission Criteria	<p>The team should insure the following factors have been addressed at the current placement when considering a placement in a restrictive Special School setting:</p> <ol style="list-style-type: none"> 1. The IEP includes a comprehensive plan to address the core deficit areas including but not limited to communication, socialization and behavior; 2. Instructional goals and objectives are stated in measurable terms and reflect acceleration goals for desired behaviors to replace challenging behaviors; 3. The IEP team has a plan to support parents and staff in implementation of instructional interventions and contextual supports; 4. The student is provided with instruction at his/her developmentally appropriate and chronologically appropriate level and rate of understanding; 5. The parent and or care provider(s) are engaged as team members; and 6. Evident based treatments are being applied. They are being applied with quality and consistency.
Continuing Stay Criteria	As deemed appropriate by IEP team.
Discharge Criteria	<ol style="list-style-type: none"> 1. Student has developed skills in the areas for which placement occurred; and 2. Local school has developed services and supports necessary to support student in less restrictive environment.
Service Exclusions	<ol style="list-style-type: none"> 1. Not to occur in conjunction with Skills Trainer services during hours of Special School attendance; and 2. Not to occur in conjunction with Autism and/or Significant Mental Retardation Consultant services during hours of Special School attendance.
Clinical Exclusions	Not applicable

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Staffing Requirements:

1. State teacher licensure requirements must be followed.
2. One (1) licensed teacher to every six (6) children.
3. Ratio should be one (1) support staff to every two (2) children.
4. Psychiatric and nursing services must be available for student who need assistance with medication, but is not counted for the staff to student ratios unless the nursing staff is available face-to-face during the entire operation of the service.

Clinical Operations

1. Special Schools service providers will collect weekly data on all IEP Objectives.
2. Family involvement and participation will be encouraged and supported.
3. A billable event will be attendance at the Special Schools program. Partial day attendance will be noted and billed accordingly.

Documentation

1. Prior to initial service contact service provider should have written information provided by the IEP team in regards to what areas the team is requesting support from the Special Schools.
2. Written data will be collected one (1) time per week for each IEP goal and objective. This data is to be provided to the student's local school of attendance.
3. A written summary report will be provided quarterly to coincide with school of attendance reporting period. The summary report will provide quantifiable information regarding the progress or lack thereof made during the period of attendance at Special Schools.
4. Daily attendance of each student participating in the program must be documented showing number of hours in attendance (start and end times).

SECTION III:

**INTERAGENCY
PRACTICE GUIDELINES**

**For the Provision of School - Based
Behavioral Health Services & Intensive Mental Health Treatment
Services**

SECTION III: INTERAGENCY PRACTICE GUIDELINES

I. INTRODUCTION

The Child and Adolescent Mental Health Division (CAMHD), a division of the State of Hawaii Department of Health (DOH), and the Student Support Branch (SSB), a division of the Hawaii Department of Education (DOE), share the responsibility for providing behavior and or mental health services to children and families throughout the state. In joining the resources of schools, FGCs, service provider agencies and community resources, the DOE and DOH hope to establish a comprehensive system for the provision of behavior and or mental health supports and services to ALL children at risk for or experiencing behavioral and or emotional disabilities. The supports and services provided are designed to promote the capacity of youth to gainfully benefit from their education.

Under the currently emerging system of behavior and or mental health service delivery, the DOE is implementing a school-based behavior health program (SBBH) Program. The SBBH Program is embedded in the Department's Comprehensive Student Support System (CSSS) and is consistent/compliant with the requirements of the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973. The DOE's SBBH Program is designed to serve all school students and involve school wide prevention, early intervention, and intensive services for students with significant emotional and/or behavioral needs. The structure of SBBH relies on the application of evidence-based practices for identifying and addressing problem behaviors that interfere with the student's learning. In keeping with Hawaii CASSP Principles, the least restrictive and least intrusive interventions are first implemented to address problem behaviors. The DOE's SBBH Program in partnership with the DOH CAMHD system of service delivery will provide a comprehensive array of supports to meet the needs all identified students, from those requiring minimal interventions through those with highly intensive and complex behavior support requirements.

The SBBH Program focuses on the promotion of social and emotional development and the use of school based and broader community resources to support children (and their families) in becoming successful learners and community members. The determination of which specific interventions to use is based on a sequence of evidence based information gathering, planning and implementation activities including families, communities and behavior support professionals and support staff. The evidence-based practices described within these guidelines include:

- Planning strategies and formats (e.g., Positive Behavior Support Planning)
- Assessment techniques and protocols (e.g., Functional Behavior Assessment)
- Care Coordination
- Plan evaluation (e.g., outcome-focused and data-based decision making)
- Supervision
- Psychosocial interventions and supports (e.g., Cognitive Behavioral Treatment)
- Management of Prescribed Medication

The data gathered during assessment will allow the school-based (interagency) team to develop hypotheses regarding influences on the student's behavior and to develop a plan for support and intervention. The array of supports and strategies that school-based behavior personnel and others will implement will include a range of interventions from accommodations and modifications of classroom structures and procedures through

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

application of more intensive and specific behavioral approaches, and as necessary, a variety of clinical interventions, including the use of prescribed medication and/or other evidence based treatments.

These guidelines provide a framework for the identification, assessment, intervention planning, service provision, and progress evaluation of students requiring behavior and or mental health services or supports in order to remove behavioral barriers to making educational progress. The guidelines also provide direction regarding the coordination of care and the supervision of staff providing behavior and or mental health services. They are proposed as part of a renewed effort by DOH-CAMHD and DOE-CSSS to ensure quality behavior and or mental health services and supports for children. These guidelines are drawn from a multidisciplinary evaluation of research, based on a formal and scientific literature review of practice guidelines and controlled studies in psychology, psychiatry, education and related behavior health disciplines.

In general, the guidelines reflect the IDEA requirement for using evidence-based strategies and the CAMHD and DOE policies that scientific evidence is a significant criterion governing service delivery. In other words, the assessment and intervention services valued most highly are those that are supported by careful research demonstrations of their positive effects. The guidelines are intended to be used by behavior health practitioners to support children, families, and teachers in the search for those approaches with credible evidence for having helped other children in the past. The approaches described below are not to be applied mechanically in the absence of clinical judgment; however, these approaches are believed to be the most promising starting points for assessment and intervention with children and adolescents. Finally, these guidelines are intended to discourage the use of interventions or behavior plans with known risks and to encourage the use of alternative approaches only when the most promising interventions and supports have been tried with integrity and have not been successful, or when extremely compelling circumstances preclude the use of the most promising approaches first.

PLANNING STRATEGIES AND FORMATS

When a student is believed to need formal services or supports in order to reduce or eliminate emotional and/or behavioral barriers, a school-based team is convened to oversee the assessment and service provision process. The student's primary caregiver(s) are always included in each step of assessment, planning, and service provision. The team will assign a CC to assist the student and his/her family through the processes and procedures involved in assessment, planning, service provision and evaluation.

II. ACCESSING SUPPORTS

A. IDENTIFICATION AND REFERRAL

When parents or professional staff within educational settings believe a student is at risk for or in need of SBBH supports or services, they can refer the student by submitting a Request for Assistance Form to the Student Services Coordinator (SSC) assigned to the school the student attends.

The Request for Assistance initiates the informal team process. The core team interventions and decision-making may lead to a request for further evaluation, but that is not automatic. It is not appropriate for the team to immediately refer for a mental health assessment, without going through an initial information

gathering process. Based upon that initial information, referrals may be made for more comprehensive evaluation.

B. FORMAL ASSESSMENTS: FUNCTIONAL BEHAVIORAL ASSESSMENT AND MENTAL HEALTH ASSESSMENT

The type or sequence of initial assessments that a child receives should be based on an initial gathering of information and a team decision regarding the complexity of the child's problem and the need for particular types of information.

C. SUPPORT AND SERVICE PLANNING

As stated above, the primary purpose of assessment is to increase the effectiveness and efficiency of BSPs. There should always be a direct and logical connection between the gathering of assessment information and the development of behavior support plans.

BSPs developed for referred children and adolescents should always fulfill the following five (5) criteria:

- a. The plan should indicate how staff, family or support personnel would change the context within which problem behaviors occur;
- b. The plan should be directly based on all relevant assessment information;
- c. The plan should be technically sound; that is, consistent with the principles and laws of human behavior;
- d. The plan should be a good fit with the values, resources, and skills of the people responsible for implementation; and
- e. The plan should identify evidence-based approaches to behavior change.

BSPs should include the following key features:

- a. An operational description of the problem behavior;
- b. Summary statements resulting from a functional assessment;
- c. A general approach for making problem behaviors irrelevant, inefficient, and ineffective, including:
 - Setting event strategies (including all relevant medication and physical treatment supports and services as well as remedial skill development and support)
 - Immediate predictor strategies (those designed to eliminate reduce the effect of classroom and other triggers for challenging behavior)
 - Instructional interventions (what alternative behaviors/skills will be taught)
 - Consequence-based interventions (consequences for maintaining desired and alternative behaviors and reducing problem behaviors); and
- d. Specific descriptions of:
 - Typical routines and
 - Most difficult problem situations
 - A monitoring and evaluation plan.

D. ASSESSMENT TECHNIQUES AND PROTOCOLS

Behavioral and clinical assessment procedures should be accessed based on the apparent complexity of the problem and the judgment of those individuals working with the child during the initial stages of information gathering.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Behavioral and clinical approaches are designed to provide complementary information, and each draw from evidence based strategies in the identification and management of childhood behavioral and or mental health problems. The superiority of any one method is not assumed; methods chosen should be based on the problems, goals, and needs of the identified child and should begin with the simplest strategies first, unless otherwise warranted.

1. **Functional Behavior Assessment (FBA)**

Following referral, a school-based student support team will be convened to plan and implement a comprehensive FBA focusing on the student and the contexts within which problem behaviors have been observed. In the case of students receiving or referred for special education or 504 services, the school-based team will be an IEP/MP Team.

FBA is a framework for gathering both general and specific information regarding the influences on a student's behavior. The primary purpose of gathering the information is to use it in designing a comprehensive BSP. The FBA is complete when five (5) main outcomes have been achieved, as follows:

- a. Clear descriptions of the problem behaviors, including classes or sequences of behaviors that frequently occur together;
- b. Identification of the events, times and situations that predict when the problem behaviors are most likely to occur and/or least likely to occur across the full range of typical daily routines;
- c. Identification of the consequences that maintain the problem behaviors (that is, what functions the behaviors appear to serve for the person);
- d. Development of one or more summary statements or hypotheses that describe specific behaviors, a specific type of situation in which they occur, and the outcomes or reinforcers maintaining them in that situation; and
- e. Collection of data that support the summary statements that have been developed.

2. **Mental Health Assessment (MHA)**

Following referral, a school-based student support team can recommend a mental health assessment to inform the team decision-making process regarding the most appropriate services. Recommendations incorporate youth/family strengths, are evidence-based, and based on the identified strengths and needs of the youth as they relate to educational benefit. Furthermore, recommendations should describe and address the needs of the youth/family and not specify a particular service, program, or eligibility status.

The mental assessment is intended to be an information-gathering process directed at understanding the nature of the problem, its possible causes, and intervention options. This broad view of clinical assessment is consistent with the concepts and practices of behavioral assessment and incorporates diagnosis as one of many organizational components for guiding the planning of services and supports.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

The primary emphasis of the assessment is to arrive at a comprehensive understanding of the nature and the determinants of the problem. Clinicians are encouraged to use structured or semi-structured clinical interviews to arrive at a clinical diagnosis. In addition, the use of parent and child measures of general behavior problems is advised, in particular the Achenbach Child Behavior Checklist (ages 4-18) and Youth Self Report (YSR; ages 11-18). Further, the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990) is suggested as a measure of the child's level of functional impairment and life interference. Additional assessment protocols specific to certain problem areas are outlined below in the section on interventions and supports.

The mental health assessment reports are not limited to, but should include the following information:

Identifying Information	Child's name, date of birth, guardian, school, age, grade, and ethnic/cultural background
Dates	Date of interview, date of report
Interviewer Name	
Educational Status	Indicate child's 504/IDEA status
Referral Source and Reason for Referral	
Sources of Information	Records reviewed, tests given, interview format, individuals interviewed
History	Developmental, medical, family, treatment, academic performance, social/ peer
Medication	Provider and effects (if known)
Substance Use	Past and current substance use
Description of Problem	Current problem in context and brief history
Strengths and Resources	Child and family strengths and resources
Mental Status Exam	Appearance, attitude, behavior, orientation, affect/mood, thought content and process, insight/judgment, homicide/suicide risk
Review of Assessment Measures	Report of all relevant test scores, standardized scores, and interpretation
Clinical Formulation	Functional behavioral case formulation, justification, and limitations of formulation
Diagnostic Impression	DSM IV, Five Axis model
Educational Relevance	Statement of how problem impacts child's ability to learn
Recommendations for Intervention	Recommendations should be evidence-based, needs focused, and least restrictive and should not specify a particular program, person, or service by name

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Signature of interviewer and/or responsible licensed professional	Credentials must be appropriate
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The clinical assessment report should be written within one (1) week of the last interview and feedback should be provided to the child and family within one (1) week of when the report was completed.

E. CARE COORDINATION

Upon referral, each student will be assigned a CC to assure that all assessment activities, planning activities, and all planned supports and services are scheduled and provided. All services are to be provided as indicated in the BSP and/or IEP/MP developed for the student.

The comprehensive nature of the BSP will often result in the integration of community based naturally occurring and formal (contracted) supports and services within the array addressed within the plan and overseen by the CC.

F. OUTCOME-BASED PLAN EVALUATION

During and following plan implementation, the CC will ensure that the student's progress on plan goals and objectives is routinely evaluated. Evaluation will be based on review of the data gathered as indicated in the student's IEP or MP. If positive progress on plan objectives is noted, the plan will be continued and fine-tuned as agreed upon by the team. If progress is unsatisfactory, the plan should be revised based on review of assessment hypotheses and modified as needed until positive progress is observed. *See Section IV: Interagency Service Intensity Guidelines* to determine appropriate intensity of supports and services.

A record of student progress will be maintained through regular reporting of progress measures on one or more dedicated information management systems (e.g., ISPED, CAMHIS).

G. SUPERVISION

Provision of interventions and supports should be accompanied by formal supervision. In the research literature, positive outcomes have not been documented in the absence of supervision, suggesting that it represents a critical component to a BSP. Supervision is intended to provide the following to those individuals working with the child: guidance and support, acquisition of new skills, additional perspective, sharing of responsibility, and connection to a larger system of resources. Primary features of supervision are to ensure the integrity of the supports and services the child is receiving and to troubleshoot challenges as they arise. Supervision should occur on a regular basis and should involve the tracking of specific objectives and progress toward overall goals.

H. INTERVENTIONS AND SUPPORTS

The following section details a list of considerations for interventions and supports relevant to common behavioral and or mental health problem areas for children. Each area also includes information regarding additional assessment and other considerations. In general, the interventions described below collectively involve many of the following elements that are felt to be important components of school-based interventions:

- Consequence (e.g., cost) Based Strategies

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- Reward Programs
- Time Out Protocols
- Differential Reinforcement
- Social Skills Training
- Impulse Control Training
- Cognitive Strategies
- Exposure Based Strategies
- Problem Solving Training
- Attention Based Strategies
- Functional Communication Training

III. ATTENTION PROBLEMS AND HYPERACTIVITY (e.g., ADHD)

A. ASSESSMENT PROTOCOLS SPECIFIC TO ATTENTION PROBLEMS AND HYPERACTIVITY

In addition to procedures outlined in the general assessment guidelines, and congruent with the FBA framework, the following assessment protocols might be of benefit.

1. **Parent and Teacher Reports** of child's behavior are the most important, economical, and ecologically valid sources of information regarding ADHD. Such discussion with parents and teachers should focus on frequency, duration, and intensity of behaviors observed, and should attempt to identify problematic settings and events (e.g., homeroom).
2. **Rating Scales** specifically focused on ADHD that can be helpful include the following:
 - a. ADHD Rating Scale (DuPaul, 1991), ages 5 to 17
 - b. Swanson-Nolan-and-Pelham (SNAP) Checklist (Swanson & Pelham, 1988)
 - c. Child Attention Problems Scale (Barkley, 1990)
 - d. Connors Rating Scales—Revised (Teacher and Parent Versions; Connors, 1997) [note: the short forms of these scales are preferable for the specific assessment of ADHD], ages 3 to 17
3. **Behavioral Observation** of children in home or classroom settings can be very useful for identifying specific aspects of behavior related to ADHD. However, such procedures are less efficient than the above methods, and may provide limited new information beyond parent and teacher interview. Behavioral observation is most useful for cases in which diagnostic questions are unusually complex or remain unresolved following more parsimonious assessment strategies.
4. **Continuous Performance Tests (CPTs)** for ADHD have also been shown to be helpful in some instances. It should be noted, however, that the rate of false negatives for such tests is unacceptably high, so that normal CPT scores should not rule out the possibility of diagnosing ADHD. Available CPTs are as follows:
 - a. Connors Continuous Performance Test (Connors, 1995)
 - b. Gordon Diagnostic System (Gordon, 1983)
 - c. Test of Variables of Attention (Greenberg & Waldman, 1992).

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Age Appropriate Behaviors in Active Children** are sometimes difficult to distinguish from ADHD. Particular attention should be given to the intensity and pervasiveness of the behaviors to help make this discrimination. Attention, impulsivity, and/or hyperactivity need to occur across more than one setting to warrant a diagnosis of ADHD.
2. **Mental Retardation and Borderline Intellectual Functioning** are associated with attention deficits, particularly when children are placed in classroom settings that are too challenging intellectually. Special care should be taken when diagnosing children with intellectual or cognitive deficits.
3. **Academically Under-Stimulating Environments** are likely to elicit inattention in highly intelligent children. Special care should also be taken when diagnosing children with high intelligence.
4. **Oppositional Defiant Disorder** is associated with avoidance of school tasks. For a diagnosis of ADHD, the avoidance or impulsive behaviors should not be limited to the symptoms of a diagnosable disruptive behavior disorder.
5. **Pervasive Developmental Disorders and Psychotic Disorders** preclude the diagnosis of ADHD. These disorders are commonly associated with gross attention and impulsivity problems and do not allow for the additional diagnosis of ADHD.
6. **Anxiety (Including PTSD)** can affect concentration and attention, and can sometimes be mistaken for ADHD.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed within the corresponding support plan.

1. **Oppositional Defiant Disorder** has been found to occur by age 7 in 35% to 60% of clinic-referred children with ADHD.
2. **Conduct Disorder** has been found to occur in 30% to 50% of clinic-referred children with ADHD.
3. **Anxiety Disorders** have been found to occur in 25% to 40% of children with ADHD, but this rate falls almost to zero for adolescents. Coexisting anxiety disorders are associated with less impulsivity and are more common with the inattentive subtype of ADHD.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

The following interventions are recommended. The frequency, intensity, and duration of each service should be determined based on the comprehensive behavior support plan and should be listed in the student's IEP. The frequency parameters are provided only as guides. All team members should maintain a feedback loop so that optimal results can be achieved.

Behavior Therapy in various forms has been shown to be helpful for children with ADHD. Behavioral techniques have been tested mainly in children from 6 to 12 years, in clinic and school settings. Both group and individual formats have been supported by research. The two main types of behavioral interventions are as follows:

1. **Classroom Behavior Management** involves the establishment of a set of rules, rewards, and consequences within the classroom. These procedures can be implemented daily by a teacher, therapeutic aide, or educational assistant, usually under the guidance of a behavior specialist, consultant, or clinician trained in classroom behavior management strategies.
2. **Parent and Teacher Training** involves working with parents and teachers to establish a set of rules, rewards, and consequences to be applied consistently across the home and school settings. Techniques include Time Out, Communication Training, Active Ignoring, and Reward Contracts (e.g., token or sticker programs). Meetings with parents and teachers usually occur on a weekly basis.

E. ADDITIONAL CONSIDERATIONS

The following are other issues to consider regarding psychosocial interventions:

1. Other Interventions for ADHD have not been supported by research.
2. Interventions with Known Risks have not been identified for ADHD. However, the use of interventions other than those listed above is not recommended as a first choice, given the chronic nature of ADHD. Unsupported interventions for ADHD are much more likely to be associated with poor long-term academic and social adjustment for the child.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Stimulant Medication has been shown to be the most effective intervention for children with ADHD. In most cases, stimulant medication has about twice the effect of behavior therapy alone in reducing hyperactivity and inattention. There is little evidence that combining behavior therapy with medication has additional effects in reducing impulsivity and inattention. However, there might be some other benefits of adding behavior therapy, such as increasing social skills and reducing dosage of medication. (See section on Management of Psychiatric Medication below.)

IV. ANXIETY PROBLEMS AND DISORDERS (INCLUDING PTSD AND OCD)

A. ASSESSMENT PROTOCOLS SPECIFIC TO ANXIETY PROBLEMS AND DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Self-Report** of anxiety is the generally the most valid source of information. These reports may often be inconsistent with parent reports, in that anxiety is often difficult to notice or observe in others. Discussion with children should focus on frequency, duration, and intensity of anxiety,

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- and should attempt to identify problematic settings and events (e.g., bedtime).
2. **Self Report Scales** are more helpful for anxiety disorders than they are for many other childhood disorders. Well studied measures specifically focused on anxiety include the following:
 - a. Multidimensional Anxiety Scale for Children (March, Parker, Sullivan, Stallings, & Conners, 1997), ages 8 to 19
 - b. Revised Children's Manifest Anxiety Scale (Reynolds & Richmond, 1978), ages 6 to 19
 - c. Revised Child Anxiety and Depression Scale (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000), ages 8 to 18
 - d. Spence Anxiety Scale for Children (Spence, 1997), ages 8 to 12
 - e. State Trait Anxiety Inventory for Children (Spielberger, 1973), ages 9 to 12
 3. **Specific Assessment Measures** are sometimes indicated for particular anxiety disorders. Examples include:
 - a. Obsessive-Compulsive disorder: Leyton Obsessional Inventory – Child Version (Berg, Flament, & Rappoport, 1986). A card sort that requires children to identify obsessions and compulsions along with resistance and interference ratings for each.
 - b. Generalized Anxiety Disorder: Penn State Worry Questionnaire for Children (Chorpita, Tracey, Brown, Collica, & Barlow, 1997). A self-report measure of uncontrollable worry in children, ages 7 to 18.
 - c. School refusal or phobia: School Refusal Assessment Scale, Parent and Child Versions (Kearney & Silverman, 1993). Scales designed to illuminate the causes of the child's avoidance of school.
 - d. Social Phobia: Social Anxiety Scale—Revised, Child and Adolescent Versions (LaGreca & Stone, 1993). Self report measures of social anxiety, ages 6 to 12.
 - e. Specific Fears and Phobias: Fear Survey Schedule for Children—Revised (Ollendick, 1983). Checklist of feared items completed by child, ages 7 to 18.
 4. **Behavioral Observation** of children in home or classroom settings is sometimes helpful when there is discrepancy among sources of information (e.g., child says he is not afraid to go to school, but parent disagrees). As noted above, observation procedures are more demanding than other methods, and are best used when they are expected to provide important new information about the child's problem. It is important to note that IDEA requires direct observation of referred students for observation.
 5. **Self Monitoring** is an alternative to behavioral observation that may be of value in similar situations. Children are asked to keep a journal or a diary of anxiety provoking situations, which is then reviewed by the therapist.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure. Most differential diagnosis issues with anxiety disorders involve discriminating among specific anxiety disorders.

1. **Pervasive Developmental Disorders and Psychotic Disorders** preclude the diagnosis of separation anxiety, specific phobias, and social phobia. These disorders are commonly associated with impaired social functioning or excessive fears.
2. **Generalized Anxiety Disorder** is often difficult to distinguish from obsessive-compulsive disorder, social phobia, posttraumatic stress disorder, and depression. The worries associated with generalized anxiety disorder are usually not as specific as those with obsessive-compulsive disorder, and they are not accompanied by rituals. Generalized anxiety disorder needs to involve more domains of worrying than just social events. Worrying that occurs exclusively during the course of posttraumatic stress disorder or depression should not be diagnosed as generalized anxiety disorder.
3. **Oppositional Defiant Disorder** can involve avoidance of school, crying, and tantrums similar to those seen with anxiety disorders. However, these oppositional episodes are more pervasive and more controlled or purposeful and more characterized by anger than those associated with anxiety disorders.
4. **Attention Deficit Hyperactivity Disorder** may have a similar appearance to anxiety, in that such children have difficulty with concentration and tend to avoid things. However, ADHD usually does not involve the distress, agitation, or inhibition associated with anxiety disorders.
5. **Normal Anxiety** is distinguished from anxiety disorders, in that anxiety disorders are in excess of what is considered developmentally appropriate for a given situation. For example, a child who is extremely scared of a school in which there is reasonable chance of violence to him would not be considered to have an anxiety disorder for that reason alone.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Other Anxiety Disorders** occur in 50% to 80% of children with an anxiety disorder. It is not uncommon for children with anxiety disorders to have two or three diagnoses, given the highly differentiated classification of these disorders.
2. **Depression** occurs in 5% to 25% of adolescents with anxiety disorders. Depression is less common among children with anxiety disorders.
3. **Tic Disorders** occur in 30% of children diagnosed with obsessive-compulsive disorder.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

1. **Cognitive Behavior Therapy** has been shown to be helpful for children with anxiety disorders. Standard protocols involve three (3) to sixteen (16) weeks of weekly group or individual therapy, focused on cognitive exercises and assigned practice with the feared situation. These techniques have been tested in children from two (2) to seventeen (17) years, in clinic and school settings. Both group and individual formats have been supported by research. Interventions have included such disorders as social phobia, generalized anxiety disorder, separation anxiety disorder, panic disorder, and posttraumatic stress disorder.
2. **Exposure (Behavior Therapy)** has been shown to be effective in the intervention of anxiety disorders. This intervention is highly variable in frequency and duration, ranging from intensive, single session approaches to daily or weekly sessions over a period of twelve (12) weeks. The intervention involves controlled practice with the feared situation. With obsessive-compulsive disorder, exposure is often paired with “response prevention,” which involves the therapist-assisted resistance of performing compulsions during or after therapeutic practice exercises. Interventions have been found to help children between the ages of three (3) and seventeen (17). Exposure has been used most commonly with specific phobias, separation anxiety disorder, and obsessive-compulsive disorder.
3. **Modeling** involves having children observe others engaging in a feared behavior in order to overcome anxiety. Modeling procedures are commonly incorporated into cognitive behavioral or behavioral intervention approaches, but can be administered alone. Modeling has been tested in children from three (3) to thirteen (13) years, and appears to be most successful with specific phobias (e.g., fear of swimming, animals, etc.).
4. **Parent and Teacher Training** involves working with parents and teachers to establish a set of rules, rewards, and consequences to be applied consistently across the home and school settings. Techniques include Time Out, Communication Training, Active Ignoring, and Reward Contracts (e.g., token or sticker programs).

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Parent Involvement** has been shown to increase the effects of cognitive behavior therapy for children with anxiety. Specifically, if parents are anxious themselves or have an anxiety disorder, the success rates for children are found to increase substantially when parents are included in intervention. Parent interventions include teaching parents how to encourage independence in their child, how not to reward anxious behavior, how to administer rewards for the child’s successes, and may sometimes include cognitive behavioral intervention of anxiety disorders in one or both parents.
2. **Educational Support** has been shown in two studies to be helpful for children with anxiety disorders refusing to attend school. Educational support involves structured academic tutoring, and it may be a useful

alternative when the interventions outlined above have not been successful.

3. **Disruptive Behavior Disorders** (e.g., oppositional defiant disorder, ADHD) sometimes co-occur with anxiety disorders. In such instances, it is usually necessary to treat the disruptive behavior disorder first, given that successful intervention for anxiety require the cooperation of the child in some difficult exercises. These elements of intervention are often difficult to administer if the child is defiant or uncooperative. Following successful intervention of the behavior problems, a child may be considered an improved candidate for the intervention of the anxiety disorder.
4. **Interventions with Known Risks** include home schooling for anxiety disordered (usually school refusing) children. Home schooling is associated with poor long-term outcome, particularly with children who experience panic disorder, separation anxiety, or social anxiety. Once a child is removed from the school, anxiety can become more severe and pervasive, and can contribute to a sustained pattern of avoidance and poor peer relations. These known costs of home schooling an anxiety-disordered youth need to be weighed very carefully against the expected benefits. In general, the use of interventions other than those listed above is not recommended for the intervention of anxiety. Unsupported interventions for anxiety disorders are much more likely to be associated with poor long-term academic and social adjustment for the child.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Few medications have demonstrated support for the intervention of anxiety disorders in double-blind placebo-controlled studies, with the exception of Selective Serotonin Reuptake Inhibitors for obsessive-compulsive disorder. Nevertheless, case reports, uncontrolled trials, and clinical opinion suggest that benzodiazepines and Selective Serotonin Reuptake Inhibitors might be useful for some anxiety disorders. (See section on Management of Psychiatric Medication below for more detail.)

V. PERVASIVE DEVELOPMENTAL DISORDERS (INCLUDING AUTISM)

A. ASSESSMENT PROTOCOLS SPECIFIC TO PERVASIVE DEVELOPMENTAL DISORDERS

Some of the procedures outlined in the assessment guidelines above may not be entirely applicable to children with pervasive developmental disorders, and a child interview is most commonly replaced by structured observation. The following assessment protocols should be considered as useful strategies:

1. **Observation** is one of the most important aspects of assessment. Care should be taken to observe both play situations (to assess for sensory problems, stereotypy or nonfunctional object use) and social situations (to assess for communication difficulties). Although formal observation scoring systems to exist, their psychometric properties are marginal. Recording a list of symptoms observed (along with their frequency and intensity) and appropriate strategies employed (e.g. communication, self-regulation, etc.) during the assessment period and to conduct observation in conjunction with the checklist described below is integral to the assessment.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

2. **Diagnostic Interviews and Checklists** are helpful in the assessment of pervasive developmental disorders in children. Measures to consider include the following:
 - a. Childhood Autism Rating Scale (CARS; Schopler et al., 1980, 1986): the most widely used diagnostic instrument for autism. It provides 15 scales related to the child's behaviors. Designed to be used in conjunction with observation of the child.
 - b. Autism Behavior Checklist (Krug, Arick, & Almond, 1980): a 57-item measure usually completed by teachers or parents. Some evidence suggests it is more useful as a screening tool than as a diagnostic tool.
 - c. Autism Diagnostic Interview - Revised (Lord et al., 1994): a structured diagnostic interview to be used with the child's principal care provider.
 - d. Checklist for Autism in Toddlers (Baron-Cohen, Allen and Gillberg, 1992): a brief screening instrument designed specifically for early detection of autism in children of about 18 months of age.
 - e. Autism Diagnostic Observational Schedule – Generic (ADOS-G; Lord, et. Al., 1989): a semi-structured assessment of communication, social interaction, and pervasive developmental disorders (PDD). The ADOS-G consists of standard activities that allow the examiner to observe the occurrence or non-occurrence of behaviors that have been identified as important to the diagnosis of autism and other pervasive developmental disorders across developmental levels and chronological ages.
3. **Intellectual Assessment** is important in the assessment of pervasive developmental disorders. This information should be available in education records. The Stanford –Binet and Wechsler Scales can be used. For children with less adaptive skills or limited verbal skills the Bayley Scales, Leiter International Performance Scales and Ravens Coloured Progressive Matrices may be employed. It should be noted that due to the nature of pervasive developmental disorders the score derived might not be an accurate measure of the child's ability. Multiple methods of intellectual assessment should be employed and scores should be viewed with caution.
4. **Adaptive Behavior Scales** are important to help identify strengths and weaknesses. Unfortunately, such scales have not been normed for children with pervasive developmental disorders. Nevertheless, scales to consider are the following:
 - a. American Association for Mental Retardation Adaptive Behavior Scale (Lambert, Nihira, & Leland, 1993): identifies strengths and weaknesses in a large number of practical areas related to daily educational functioning, ages 3 to 19.
 - b. Vineland Adaptive Behavior scales (Sparrow et al., 1984): identifies strengths and weaknesses related to communication, daily living, socialization and motor skills in ages 0 to 18.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

5. **Communication** is a vital component of assessment. As there are no assessments that will assess all language components involved in autism multiple measures should be employed. Often it is necessary to employ portions of several standardized assessments to gather meaningful information.
 - a. Language Samples are the most important component of a communication assessment for an individual being assessed for autism. Through observation form, content, use and function of the child's communication should be reviewed.
 - b. Peabody Picture Vocabulary Test. Utilizing the expressive one-word vocabulary and receptive one-word vocabulary sections the ability to discriminate one-word out of context can be determined.
6. **FBA** is a critical component of assessment when children exhibit behavior that impedes their ability to access their education (disruptive, aggressive, self-injurious, self-isolating, internalizing, withdrawal, stereotypy, etc.). Utilizing interview, observation for purposes of data collection and record review to identify the links between setting, antecedent, behavior and its consequence. The goal is to identify factors that predict the occurrence or absence of behavior and establish factors that maintain the behavior or its absence. Some tools to assist in this regard are the following:
 - a. Motivational Assessment Scale (Durand & Crimmons, 1988): a 16 item measure for teachers or care providers, designed to identify the maintaining factors for problem behaviors in the areas of attention, escape, self-stimulation and tangible rewards.
 - b. Functional Analysis Interview Form (O'Neill, Horner, Albin, Storey and Sprague, 1990): a more time intensive protocol to develop hypothesis about the function of problem behavior in children with autism involving direct observation and scoring by multiple raters (teachers, parents, staff etc.) across multiple domains (home, school, community etc.)

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis.

1. **Schizophrenia** may appear slightly similar, but the onset of symptoms occurs much later with schizophrenia (after age of 6 and usually after puberty). Common symptoms of autism (e.g., echolalia, pronoun reversal, auditory sensitivity) are usually absent with schizophrenia. Disorganized speech and behavior and affective flattening are common among both schizophrenia and autism.
2. **Mental Retardation** is diagnosed instead of pervasive developmental disorders when the deficits in cognitive, social, language and motor functioning are all at a fairly uniform level, rather than showing peaks and valleys. Children with pervasive developmental disorders usually are less responsive to social interaction and have superior motor skills to children with mental retardation. Pervasive developmental disorders should only be diagnosed in children with mental retardation when the social and

communication problems are consistent with the child's cognitive and developmental level.

3. **Childhood Disintegrative Disorder** involves apparently normal development for the first 2 to 4 years, followed by a significant regression in multiple areas
4. **Rett's Disorder** also begins after a period of apparently normal development, lasting in this case about 9 to 12 months. It occurs only in girls (although a close variant has been observed boys). Gross motor deteriorating and stereotyped hand movements are seen between 6 and 30 months.
5. **Asperger's Syndrome** can closely resemble autism but it does not involve significant language delays in early childhood and individuals have typical or superior cognitive ability.
6. **Developmental Language Disorders** are common in children. However, they do not by themselves involve echolalia, pronoun reversal and non-contextual utterances and the comprehension deficits are less severe than with autism. Also, children with developmental language disorders typically continue to use gestures and facial expressions appropriately and are more capable of conversation than children with autism.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Mental Retardation** occurs in 70 to 85% of children diagnosed with autism.
2. **Sensory/Perceptual Abnormalities** occur in about 60% of children with autism, particularly in regard to sound.
3. **Self-injury** is relatively common in individuals with autism occurring in about 30% of children and increasing to about 70% when mental retardation is also MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

No comprehensive interventions have been identified in controlled studies that eliminate the condition of autism. The majority of interventions available are focal in nature, i.e., they are designed to address skill for the child with autism.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Applied Behavior Analysis (ABA)** while not having been shown to produce normal development does appear to confer benefits to children with autism. These benefits primarily involve the learning of new and adaptive skills, such as self-care and communication.
2. **Functional Behavior Assessment (FBA)** is a component of ABA. Assessments result in a positive behavioral support plan including: team participation, enriched environment, reduced exposure to ecological conditions associated with challenging behavior and increased exposure to environments associated with the use of adaptive behaviors, coaching

of functionally equivalent skills, eliminate or reduce gains produced by challenging behavior, expansion of reinforcers, plan for post intervention and monitoring.

3. **Discrete Trial Training (DTT)** is a component of ABA. DTT is a systematic method of instruction. Instruction is delivered in the following sequence: discriminative stimuli, prompt, behavior, consequence, and a pause between trials. Research on the relationship between the intensity of training and positive outcome has not been consistent. Intensity of services should be individualized.
4. **Functional Communication Training** has been shown to effectively reduce unsafe or challenging behaviors in children with autism. Functional communication training refers to a broad class of strategies that involve a child learning to use verbal and/or augmentative and alternative communication to make requests for immediate needs. Such training substitutes communication for previously employed unsafe or challenging behavior.
5. **Caregiver Education** programs have been shown to increase parents' feelings of confidence and ability in raising a child with autism. Such a program is typically conducted in a group format, with a focus on education about autism and support for parents.
6. **Interventions with Known Risks** have not been specifically identified for autism. However, more so than for many other areas a variety of ineffective interventions are commonly employed. Such interventions may mislead parents or create false hopes regarding the child's development, particular caution is advised when parents consider interventions that has not been supported by research. Parents should be informed that such interventions might not be of help before committing to such services.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

At least one antipsychotic medication has some support in double-blind placebo-controlled studies in the reduction of stereotypy, self-injurious behavior and aggression. (See section on Management of Psychiatric Medication below for more detail).

VI. CHILDHOOD SCHIZOPHRENIA

A. ASSESSMENT PROTOCOLS SPECIFIC TO SCHIZOPHRENIA

The procedures outlined in the general assessment guidelines may not be sufficient for children with schizophrenia. A child interview should often be supplemented by some structured observation.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Schizophrenia and Autism** may appear slightly similar, but the onset of symptoms occurs much later with schizophrenia (after age 6 and usually after puberty). Common symptoms of autism (e.g., echolalia, pronoun reversal, auditory sensitivity) are usually absent with schizophrenia.

Disorganized speech and behavior and affective flattening are common among both schizophrenia and autism.

2. **Brief Psychotic Disorder** is similar to schizophrenia, with the primary difference being that its duration is less than one month.
3. **Schizophreniform Disorder** is similar to schizophrenia, with the primary difference being that its duration is between one and six months.
4. **Schizoaffective Disorder** is similar to schizophrenia, but involves depressed, manic, or mixed mood episodes concurrent with the symptoms of schizophrenia. This requires at least two weeks of delusions or hallucinations in the absence of mood problems.
5. **Mood Disorder with Psychotic Features** can be associated with delusions or hallucinations. It is similar to schizoaffective disorder, except that it does not require a two-week display of delusions or hallucinations in the absence of mood problems.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Sensory/Perceptual Abnormalities** occur in more than 60% of children with schizophrenia.
2. **Mood Disorders** are present among approximately 37% of children with schizophrenia.
3. **Conduct/Oppositional Disorders** are present among 31% of children with schizophrenia.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

No Interventions have been identified in controlled studies that eliminate the condition of schizophrenia in children.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Family Therapy** and **Assistive Community Treatment** have clear effects on the prevention of psychotic relapse and re-hospitalization *among adults* with schizophrenia. However, these treatments have shown no consistent effects on other outcome measures (e.g., pervasive positive and negative symptoms, overall social functioning, and ability to obtain competitive employment).
2. **Social Skills Training** *among adults* with schizophrenia improves social skills but has no clear effects on relapse prevention, behavior problems, or employment status. Because these treatments have not been tested in controlled studies with children or adolescents, caution must be used in developing a similar treatment strategy.
3. **Interventions with Known Risks** have not been specifically identified for schizophrenia.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

At least one antipsychotic medication has some support in double-blind placebo-controlled studies in the reduction of stereotypy, self-injurious behavior, and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

aggression. (See section on Management of Psychiatric Medication below for more detail.)

VII. CONDUCT AND OPPOSITIONAL PROBLEMS (INCLUDING JUVENILE SEX OFFENDERS)

A. ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL PROBLEMS AND DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Parent and Teacher Reports** of child's behavior are very useful sources of information regarding conduct and oppositional problems. Such discussion with parents and teachers should focus on frequency, duration, and intensity of behaviors observed, and should attempt to identify problematic settings and events (e.g., homeroom).
2. **Clinical Interviews** should include some time that allows for observation of the child and parent interaction. Even if only briefly, such observation can yield important subjective information regarding the child's style of interaction with the parent(s), as well as more basic information about the child's cognitive, affective, and behavioral functioning.
3. **Self-Report Scales** are helpful for the assessment of conduct and oppositional disorders in children and adolescents, although these are often not the most reliable source of information and should be considered carefully. Although the Child Behavior Checklist is one of the best studied measures of child behavior problems, other more specific measures include the following:
 - a. Eyberg Child Behavior Inventory (Eyberg, 1992): a parent completed behavioral rating scale designed to assess disruptive behavior in children 2 to 16.
 - b. Sutter-Eyberg Student Behavior Inventory (Eyberg, 1992): a parallel instrument completed by teachers.
 - c. Interview for Antisocial Behavior (Kazdin & Esveldt-Dawson, 1986): a 30 item rating scale completed by parents, which assesses a variety of conduct problem behaviors.
 - d. Children's Hostility Inventory (Kazdin, Rogers, Colbus, & Sielel, 1987): a 38-item scale measuring aggression and hostility.
 - e. Adolescent Sexual Interest Cardsort [*specific to sex offenders only*] (Hunter, Becker, & Kaplan, 1995): a 64-item self report measure of sexual interest, consisting of several vignettes that are rated for their level of arousal.
4. **Peer Functioning and Family Assessment** are very important with oppositional and conduct problems. Because the most successful psychosocial interventions for these problems uniformly involve parents, it is very important that information regarding parenting practices, household chores, discipline, and rules be obtained. Information about what parenting strategies have been tried, and which have worked or failed should be carefully recorded. With respect to peer functioning,

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

information should be obtained about the child's social network, with a particular emphasis on identifying associations with problem peer groups or older children.

5. **Juvenile Court Records**, when available, can provide a reliable history of the child's problem behavior.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Conduct Disorder and Oppositional Defiant Disorder** cannot be diagnosed in the same child at a given time. If criteria of both disorders are met, the diagnosis of conduct disorder is assigned.
2. **Attention Deficit Hyperactivity Disorder** can involve impulsivity and difficulty following directions and is sometimes confused with oppositional defiant disorder.
3. **Manic Episodes** can involve highly impulsive or irritable behavior. These are distinguished from conduct or oppositional disorders by their episodic course.
4. **Normal Development** allows for children who fail to follow directions and who are often angry, particularly in adolescence. The degree of oppositional behavior should be out of proportion to the child's context and much greater than that of his or her peers.
5. **Mental Retardation** can involve oppositional behavior. A disruptive behavior disorder is only diagnosed when the problem is markedly greater than that observed among same sex individuals of comparable age and severity of mental retardation.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Attention Deficit Hyperactivity Disorder** is present in 25% to 75% of clinic-referred children and teens with disruptive behavior disorders. The onset of ADHD usually precedes the onset of serious behavior problems, but in many cases can be concurrent.
2. **Substance Use Disorders** occur in 15% to 75% of adolescents diagnosed with conduct disorder. Coexisting/co-occurring substance use diagnoses are a critical predictor of which children will have serious problems in early adulthood.
3. **Sexual Abuse History** for juvenile sexual offenders has been reported as approximately 78% for girls and 44% for boys. Abused female offenders are typically abused earlier than abused boys, by a larger number of perpetrators on average. It is important to assess for this additional information and to take appropriate steps if sexual abuse is identified.
4. **Physical Abuse History** is relatively more common among children with conduct and oppositional problems. It is important to assess for this

additional information and to take appropriate steps if physical abuse is identified.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

1. **Parent Training** has been shown to be the most helpful intervention for oppositional defiant disorder, particularly younger children. Parent training involves working with parents to develop specific behavior management strategies. These techniques have been tested in clinic and school settings, in group and individual parent formats. It may not be sufficient for adolescents with conduct disorder (see below).
2. **Multisystemic Therapy** has been shown to be superior to other available interventions for adolescent conduct disorder. It currently appears to be the intervention of choice for severe conduct and delinquency problems. It is also the only intervention approach to date that has demonstrated a positive outcome with juvenile sex offenders in controlled research.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Anger Coping** has been used with children in a group format to help with mild oppositional behaviors.
2. **Assertiveness Training** has also been shown to be helpful for children aged 13 or 14 with mild oppositional problems.
3. **Rational Emotive Therapy** is similar to cognitive behavior therapy and involves working on correcting problematic thoughts and actions. There is some evidence that this intervention may be helpful for mild oppositional problems in adolescents.
4. **Interventions with Known Risks** have been identified for disruptive behavior disorders. The collective evidence suggests that, all other things being equal, group intervention poses a risk of worsening children's aggressive and antisocial behaviors. This observation should be considered carefully when selecting from the interventions listed above.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Mood stabilizers and antipsychotic medication have some support in double-blind placebo-controlled studies in the reduction of aggressive behavior. (See section on Management of Psychiatric Medication below for more detail.)

VIII. DEPRESSION

A. ASSESSMENT PROTOCOLS SPECIFIC TO DEPRESSION

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Self-Report** of depression is the generally the most valid source of information. These reports may not always agree with parent reports, in that depression is often difficult to notice or observe in others. Discussion with children should focus on frequency, duration, and intensity of depressive episodes, and should attempt to identify problematic settings and events that intensify feelings of depression (e.g., mornings). Also, the interviewer should look for independent past episodes of major

depression, and note these accordingly using DSM course specifiers (e.g., single episode versus recurrent).

2. **Self Report Scales** are helpful for the assessment of depression in children and adolescents. Measures to consider include the following:
 - a. Children's Depression Inventory (Kovacs, 1980/1981): the most widely used measure of depression in children and teens, ages 7 to 18.
 - b. Revised Child Anxiety and Depression Scale (Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000): a measure with norms for Hawaii, which includes a depression scale that performs similarly to the Children's Depression Inventory. One advantage is its ability to assess for coexisting/co-occurring anxiety conditions, ages 8 to 18.
 - c. Reynolds Child and Adolescent Depression Scales (Reynolds, 1989): separate depression scales for children and adolescents in grades 3 through 12.
3. **Peer Functioning and Family Assessment** are particularly important with depression. The interviewer should try to identify the effects of depression on these relationships and the effects of these relationships on depression. Depression is often associated with diminished perceived support from friends or family. There should also be careful assessment of family history of mood disorders. When one parent has a mood disorder, the risk of the child having a mood disorder is about 25%. When both parents have a mood disorder, the child's risk is about 75%.
4. **Medical Information** is especially important with depression, as many of the symptoms of depression (e.g., poor sleep, no energy) may involve a separate medical condition.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Attention Deficit Hyperactivity Disorder** often involves poor concentration, irritability, and psychomotor agitation. The clinician should be careful not to over-diagnose depression in children who may have ADHD, particularly when the mood is characterized by irritability rather than by emptiness or sadness.
2. **Adjustment Disorder with Depressed Mood** is characterized by distress and feeling sad, but it requires (1) an identifiable stressor and (2) fewer than the full DSM criteria for depression.
3. **Bereavement** may have an identical appearance to depression, and should be assigned when (1) the depressed mood is in response to the loss of a loved one, (2) the duration is less than 2 months, and (3) there is no marked impairment, morbid worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

4. **Anxiety Disorders** are sometimes difficult to distinguish from depression. Specific consideration should be given to anxiety disorder criteria when diagnosing depression (see above section on anxiety disorders).
5. **Normal Sadness** is common in children. Depression should not be diagnosed when sadness is not of sufficient intensity and duration or does not cause clinically significant distress or impairment.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Anxiety Disorders** occur in 30% to 75% of children with depression. Anxiety disorders usually have an onset that precedes the depression.
2. **Oppositional and Conduct Disorders** occur in 17% to 79% of children with depression.
3. **Substance Use Disorders** occur in 23% to 25% of children diagnosed with depression. In some cases, substance use may be a response to the depression; in other cases, it may be a precipitant.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTION

Cognitive Behavior Therapy has been shown to be the most helpful intervention for depression in children from 9 to 18 years of age. Standard protocols involve 5 to 16 weeks of weekly or twice per week group or individual therapy, focused on thinking exercises and assigned homework. These techniques have been tested in clinic and school settings.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Cognitive Behavior Therapy with Parent Involvement** has also been shown to help children with depression, though in fewer studies than cognitive behavior therapy alone, and only in children from 14 to 18.
2. **Interpersonal Therapy** has also been shown to be helpful for depression. Interpersonal Therapy is a structured intervention that involves weekly individual sessions focusing on improving the impact of interpersonal relationships on mood. Interpersonal Therapy has been tested with children from 12 to 18.
3. **Relaxation** also may help some children with depression. Relaxation involves weekly group meetings for 5 to 8 weeks, designed to teach specific muscle relaxation skills, and it can be administered in a school setting. This approach may not be sufficient for more severe cases of depression.
4. **Interventions with Known Risks** have not been identified for depression. However, interventions other than those listed above are not recommended for depression. Unsupported interventions are much more likely to be associated with poor long-term academic and social adjustment for the child.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Selective Serotonin Reuptake Inhibitors have some support in double-blind placebo-controlled studies in the reduction of depression among adolescents. (See section on Management of Psychiatric Medication below for more detail.)

IX. EATING DISORDERS

A. ASSESSMENT PROTOCOLS SPECIFIC TO EATING DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols may be of benefit.

1. **Medical Information** is essential to obtain with individuals with anorexia nervosa and bulimia nervosa. A routine medical evaluation should include physical examination, standard laboratory tests, multiple-channel chemistry analysis, complete blood count, and urinalysis. A dental evaluation may also be necessary, particularly for individuals who use self-induced vomiting as a compensatory technique. Given the high rate of physical complications and high morbidity rate of eating disorders, particularly Anorexia Nervosa, physical information is vital prior to beginning outpatient intervention. Additionally, medical evaluations should be conducted on a regular basis during the course of intervention, frequency of which would be determined by the physician on the basis of the patient's general health.
2. **Self-Report Scales** are helpful for assessing symptoms of eating disorders, as well as weight and shape concerns. Measures to consider include the following:
 - a. Eating Attitudes Test-26 (EAT-26; Garner, Olmsted, Bohr, & Garfinkle, 1982): A screening instrument that assesses a range of attitudes and behaviors associated with anorexia nervosa. Suitable for use with adolescents.
 - b. Children's Eating Attitudes Test (chEAT; Maloney, McGuire, Daniels, & Specker, 1989): A children's version of the EAT, intended for use with children ages 8-13.
 - c. Eating Disorder Inventory-2 (EDI; Garner, 1991): A measure designed to assess psychological characteristics and symptoms common to anorexia and bulimia nervosa. Suitable for use with adolescents 12 and older—adolescent norms are available.
 - d. Kid's Eating Disorder Survey (KEDS; Childress, Brewerton, Hodges, & Jarrell, 1993): An assessment measure designed for children to assess symptoms of anorexia and bulimia nervosa.
 - e. The Bulimia Test-Revised (BULIT-R; Thelen, Farmer, Wonderlich, & Smith, 1991): The BULIT-R was designed to measure the symptoms of bulimia nervosa. Not suitable for children – 11th grade reading level.
3. **Food Records/Binge-Purge Diaries:** Self-monitoring of behavior, such as food intake and binge-purge episodes can provide valuable information. Food diaries delineate the type and amount of food intake,

providing a detailed history of food consumption during a specified time period. Binge-purge diaries may be helpful in ascertaining type and quantity of food consumed, antecedents and consequences of binge behaviors, onset, associated feelings, and time elapsed between binge-purge episodes.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbated or intervention failure.

1. **Anorexia Nervosa vs. Bulimia Nervosa:** In some individuals, those who restrict their dietary intake and also use compensatory techniques (e.g., self-induced vomiting, laxatives, diuretics, diet pills, excessive exercise), it is difficult to distinguish between anorexia nervosa, binge/eating purging type and bulimia nervosa. If the individual meets criteria for anorexia nervosa, then that diagnosis is given along with the specifier of “binge eating/purging type.”
2. **Medical Conditions**, such as gastrointestinal disease, brain tumors, occult malignancies, and acquired immunodeficiency syndrome, can all cause significant weight loss. Other, diseases, such as Kleine-Levin disease also causes disturbed eating behavior.
3. **Major Depressive Disorder** can involve a reduction in appetite, with accompanying weight loss.
4. **Anxiety Disorders** and anorexia nervosa have some overlapping features. For example, the fear or embarrassment associated with eating in public as in Social Phobia; the existence of obsessions and compulsions related to food intake as in Obsessive-Compulsive Disorder.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

1. **Major Depressive Disorder** is the most common co-occurring diagnosis for anorexia nervosa, occurring in 21% to 91% of individuals with the disorder. However, it should be noted that depression is a side-effect of starvation, and is often secondary to the onset of anorexia. Rates of depression are also high for bulimia nervosa.
2. **Anxiety Disorders** commonly co-occur with eating disorders. Obsessive-Compulsive Disorder has been most frequently linked with anorexia nervosa, whereas Generalized Anxiety Disorder and Social Phobia have been associated with bulimia nervosa.
3. **Substance Abuse or Dependence** has been estimated to occur in 6.7% to 23% of individuals with anorexia nervosa and 9% to 55% of individuals with bulimia nervosa. For anorexia nervosa, higher rates of substance abuse are found in the binge eating/purging subtype.
4. **Personality Disorders** have been estimated to occur in 27% to 93% of individuals with anorexia nervosa and 33% to 77% of individuals with bulimia nervosa.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTIONS

The following interventions are recommended. The frequency, intensity, and duration of each service should be determined basis on clinical necessity. The frequency parameters are provided only as guides. All team members should maintain a feedback loop so that optimal results can be achieved.

Unfortunately, there is a lack of controlled research on best interventions for children and adolescents with eating disorders. Listed below are some intervention suggestions that appear to show promise in either the reduction of eating disorder symptoms or in the intervention of adults.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Cognitive Behavior Therapy** has been shown to be the most helpful intervention in adults with bulimia nervosa. Although only a few studies have included participants under the age of 17, cognitive-behavioral techniques show promise for adolescents.
2. **Interpersonal Therapy**, which focuses on interpersonal relationships with others, has also been shown to be helpful in the intervention of adults with bulimia nervosa and binge eating disorder.
3. **Family Therapy** (based on the Structural Model of Family Therapy) has been demonstrated to reduce symptoms of anorexia nervosa in adolescents within 1 year. There is some limited evidence that this therapy may be effective for adolescents with bulimia nervosa under the same conditions. Family therapy presumes families whose members are uniformly committed to attending and participating in therapy, and thus may not be applicable to the families of all children and adolescents with eating disorders.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

No medications have support in double-blind placebo-controlled studies of child or adolescent eating disorders. (See section on Management of Psychiatric Medication below for more detail.)

X. SUBSTANCE USE

A. ASSESSMENT PROTOCOLS SPECIFIC TO CONDUCT AND OPPOSITIONAL DISORDERS

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Interview** is very important, particularly given that substance use behaviors may not be apparent to the child's parent or teachers. Discussion with the child should focus on frequency, duration, and intensity of use, and should involve discussion of matters of therapist confidentiality regarding substance use issues.
2. **Self Report Scales** can be helpful for the assessment of substance use in adolescents. Some specific measures include the following:
 - a. **Adolescent Alcohol Involvement Scale** (Mayer & Filstead, 1979): a 14-item self-report measure of severity of alcohol use problems.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- b. Adolescent Drinking Index (Harrell & Wirtz, 1990): a 24-item self report measure designed to assess loss of control over drinking, and associated psychological, physical, and social consequences.
 - c. Adolescent Alcohol Involvement Scale (Molberg, 1991): a 12-item adaptation of the Adolescent Alcohol Involvement Scale for drug use.
 - d. Personal Experience Screening Questionnaire (Winters, 1991): a 40-item scale measuring presence of substance use problems.
 - e. Rutgers Alcohol Problem Index (White & Labouvie, 1989): a 23-item self-report measure of the personal consequences of alcohol use.
3. **Peer Functioning and Family Assessment** are very important with substance use. The literature suggests that substance use is associated with low parental monitoring of child's activities (e.g., no curfew) and the adolescent's association with a substance using peer group.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

Substance Abuse and Substance Dependence are differentiated in that substance dependence often involves tolerance, withdrawal symptoms, increasing doses of the drug, or unsuccessful attempts to control substance use. Substance abuse can only be diagnosed for a given substance when there is no history of dependence for that substance.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

Conduct Disorder is present in 50% to 95% of clinic-referred teens with substance use disorders.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTION

Cognitive Behavior Therapy has been shown to be the most helpful intervention for substance use, although the evidence is not particularly strong. Studies of CBT for substance use have only been conducted in an inpatient setting, which may have contributed significantly to the positive outcomes observed in those studies.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Behavior Therapy** has been shown to help adolescents with substance use problems, and has shown the largest effects of any intervention to date. However, these findings are based on a small number of studies.
2. **Family Therapy** has also been shown to be helpful for adolescent substance use problems, and may be most appropriate for teens whose families are characterized by a high degree of conflict, hostility, or disengagement.

3. **Interventions with Known Risks** have not been identified for substance use. The evidence from the studies of related areas would suggest that, all other things being equal, group interventions should be considered with caution when such groups might involve contact with children having problems with disruptive behavior.
4. **Most Promising Psychopharmacological Interventions**—No medications have support in double-blind placebo-controlled studies of child or adolescent substance use disorders. (See section on Management of Psychiatric Medication below for more detail.)

XI. BIPOLAR DISORDER

A. ASSESSMENT PROTOCOLS SPECIFIC TO BIPOLAR DISORDER

In addition to procedures outlined in the general assessment guidelines, the following assessment protocols can be of benefit.

1. **Child Self-Report** of bipolar disorder is a very important source of information. Reports on aspects of depressed mood may not always agree with parent reports, in that depression is often difficult to notice or observe in others. Discussion with children should focus on frequency, duration, and intensity of depressive and manic episodes, and should attempt to identify problematic settings and events that intensify feelings of depression and mania (e.g., mornings). Also, the interviewer should look for independent past episodes of major depression or mania, and note these accordingly using DSM course specifiers.
2. **Parent Report and Teacher Report** can also be helpful with respect to identifying manic episodes. Again, discussion should focus on frequency, duration, and intensity of episodes, as well as a review of possible triggers.
3. **Structured Interviews** can be rather helpful with this often difficult diagnosis. The instrument with the best reliability is the Washington University in St Louis Kiddie Schedule for Affective Disorders and Schizophrenia (WASH-U-KSADS), which include detailed mania and rapid cycling sections.
4. **Self Report Scales** can be helpful for the assessment of the depressed phase of bipolar disorder in children and adolescents. There are no well-validated measures of mania for children or adolescents. Specific depression measures are listed below in the depression guidelines.
5. **Family History** is important to assess, as bipolar disorder has been shown to be highly familial. The presence of any mood disorders in a first degree relative increases the child's risk of bipolar disorder approximately 5 times, and the presence of bipolar disorder in a first degree relative increases that risk about 15 times. When one parent has a mood disorder, the risk of the child having a mood disorder (depression or bipolar) is about 25%. When both parents have a mood disorder, the risk is about 75%.
6. **Medical Information** is extremely important with bipolar disorder, as many of the symptoms may involve a separate medical condition.

B. OTHER CONSIDERATIONS

The conditions listed below are to be considered during or prior to the initial diagnosis, or upon exacerbation or intervention failure.

1. **Attention Deficit Hyperactivity Disorder** often involves poor concentration, irritability, and psychomotor agitation. There is much debate about whether some cases of ADHD are actually bipolar disorder, and the evidence is rather mixed. The most recent evidence has shown that mania in childhood among children with ADHD is not associated with bipolar disorder in adulthood. This suggests that the clinician should be careful not to over-diagnose bipolar disorder in children who may have ADHD along with some symptoms of mania.
2. **Mood Disorder due to General Medical Condition** can cause symptoms similar to bipolar disorder to appear in individuals with such medical conditions as multiple sclerosis and hyperthyroidism. A careful medical screening is often appropriate when bipolar disorder is suspected.
3. **Substance Induced Mood Disorders** may have an identical appearance to bipolar disorder. These, however, are assigned when fluctuations in mood are due to chemical substances, including abused drugs, medication, or exposure to toxins.

C. COEXISTING/CO-OCCURRING CONDITIONS

The following conditions should be targeted during assessment and if identified should be addressed with the corresponding service plan.

Attention Deficit Hyperactivity Disorder has shown some association with bipolar disorder, with clinical attention problems evident in as many as 60% of children with bipolar disorder.

D. MOST PROMISING PSYCHOSOCIAL INTERVENTION

No Therapy has been shown to be helpful for bipolar disorder in children or adolescents, other than medication.

E. ADDITIONAL INTERVENTION CONSIDERATIONS

1. **Family psychoeducational interventions**, and **interpersonal and social rhythm therapy** have received some modest support in experimental trials *in adults only*. These approaches, when combined with medications, appeared effective in improving long term functioning. A beginning literature also supports the utility of individual cognitive-behavioral and psychoeducational approaches *in adults*, particularly in enhancing medication adherence. Because these interventions have not been tested with children or adolescents, caution must be used if a similar intervention strategy is being considered.
2. **Managing Safety** is an important issue with individuals with bipolar disorder, as about 10 to 15% of these individual commit suicide at some point in their life. Caution must be taken to ensure that the risk of suicide is being managed appropriately.
3. **Interventions with Known Risks** have not been identified for bipolar disorder.

F. MOST PROMISING PSYCHOPHARMACOLOGICAL INTERVENTIONS

Mood stabilizers have some support in double-blind placebo-controlled studies of bipolar disorder. In addition, case reports, uncontrolled trials, and clinical opinion suggest that anticonvulsants might also be helpful. (See section on Management of Psychiatric Medication below for more detail.)

XII. MANAGEMENT OF PSYCHIATRIC MEDICATIONS

The research in pediatric psychopharmacology describes the safety and efficacy of medications for a variety of child and adolescent neurological and mental disorders. Prior to a medication approval by the Food and Drug Administration (FDA), extensive tissue culture and animal studies are conducted to establish probable safety, followed by human studies with adult patients who consent to inclusion in studies with placebo controls and randomization to active and placebo intervention groups. After the human safety and efficacy are established, the medication may be dispensed with literature that lists the specific indications and disorders for which the medication has demonstrated efficacy. Caveats in this dispensing literature specify for which ages the medication is not recommended due to lack of studies; this information is updated at least annually in standard pharmaceutical manuals. This approval process requires research that includes randomized, double-blind, placebo-controlled (DBPC) trials which are replicated in several studies and which document in detail the side effects and risks of the medication. Almost all of this preliminary research is conducted on adults with the mental disorders for which the medications are being developed. Research has been conducted less frequently for specific age groups below 12.

Improved antipsychotic medications, anticonvulsant medications with mood stabilizing effects and a new generation of antidepressant medications continue to be introduced in the US at an ever-increasing rate. However, studies in adolescent and pediatric populations have only rarely been conducted to verify both safety and efficacy in younger patients. Research is limited by a number of factors; a serious limitation is the reluctance of parents to expose a seriously disordered child to a randomized intervention, which may be either a placebo or the active medication, when that medication has already been approved for the same disorder in adults. Clinicians raise ethical concerns about conducting long-term safety studies with a control group of children and adolescents receiving a placebo when an active medication has been demonstrated to be effective in other age groups. Pharmaceutical companies generally are satisfied to achieve approval for adults as this approval allows physicians to prescribe for disorders and populations other than those that the original research supports. This practice is called "off label" use. The pharmaceutical industry is not inclined or obligated by FDA requirements to conduct further research. Added costs, consent factors and parental resistance in younger populations related to having a child used in a research study under the necessary conditions result in disincentives to research with younger subjects.

Few studies are long-term, although long-term safety is an important issue with medications for disorders that present in younger patients and persist into adulthood. In the US, the FDA approval process is more detailed and complex, allowing many years of use to accumulate in other countries prior to approval for use in the US. The FDA has an adverse reaction reporting mechanism that continues to collect reports of adverse reactions and other side effects after a medication is approved. As FDA data accumulates, the pharmaceutical dispensing literature and the scientific literature are

updated. This includes changes in the recommendations for monitoring medications. Rare adverse effects and effects which take long exposure to emerge often appear only after many years. In recent years, this process has resulted in profound changes in prescribing practices for medications that continue to be approved for use. In the mid-1980s, a medication for depression had serious, potentially lethal, hematological side effects emerge shortly after release; it was very quickly withdrawn from the US market. In the past three years, pemoline (Cylert®) has changed from an occasionally prescribed second order medication to a rarely prescribed long-acting stimulant medication because of reports of a rare and potentially lethal hepatotoxicity. The recommendation for frequent liver function blood tests is a further disincentive to prescription of this medication.

In this document, generic names of medications will also be matched with their more common brand names. Medication management is not a service provided in isolation from other interventions or instead of other interventions. Studies of combined medication management with intensive case management and additional psychosocial rehabilitation services document better intervention compliance and better outcomes. This guideline summarizes reviews of the major classes of medications used with child and adolescent mental disorders.

A. PSYCHOSTIMULANTS

The medications of this class have similar side effects and safety. All have been in use in the US for more than twenty years. This class includes:

1. Methylphenidate, available as Ritalin® and numerous generic brand names,
2. Dextro-amphetamine, available as Dexedrine®, and mixed salts of dextro-amphetamine and inactive levo-amphetamine, available as Adderall® and
3. Pemoline, available as Cylert®.

The literature of over 160 replicated randomized controlled trials demonstrate robust short-time efficacy and a good safety profile when used for the symptoms of Attention Deficit Hyperactivity Disorder (ADHD); five of these studies were conducted in preschool age children. Few studies lasting longer than 24 months have been conducted which demonstrate longer-term efficacy. Side effects are manageable with monitoring, dose and timing adjustment and matching medication to the needs of the patient. Generally, patients continue to respond to the same dose over time without a need to increase the dose; there is little evidence for the development of tolerance. As most of these medications have rapid absorption and rapid metabolism, they are short in duration with onset of effect within 30 minutes, peak within one to three hours, and rarely have an effect beyond five hours. Thus, most patients require multiple doses and demonstrate some “roller-coaster” effect; some have a “rebound” effect with short-term intense “wear off” effects. These effects are related to the short duration of effect and account for much of the reported poor compliance with use as prescribed on a multiple-dosing schedule. A multiple dosing of schedule II controlled medications also complicates management in schools, leading to further problems with compliance. Thus, compliance with the multiple doses that produce improved school and home behavior and performance is a concern with these short-acting medications.

Stimulant-related adverse effects may occur early in intervention and are generally mild, short-lived, and responsive to dose and timing adjustments. Severe adverse effects, which necessitate discontinuation of medication, occur in less than 10% of patients. The most common adverse effects are delayed sleep onset, reduced appetite, stomachache, headache, and jitteriness. Rare side effects include perseverative behaviors, cognitive impairments, and motor and/or vocal tics, which usually respond to dose and timing adjustments. Hallucinations, psychotic reactions, and mood disturbance have been reported only in overdoses and in patients receiving high doses of stimulants.

Abuse is a concern, although emergency room reporting in the Drug Abuse Warning Network documents the prescription stimulant abuse rate at less than 1/40th of the rate for cocaine. Abusers generally prefer substances, which produce euphoria such as methamphetamine and cocaine. The majority of studies do not suggest that the use of prescribed stimulants for ADHD increases the risk of abuse.

Pemoline is the only stimulant that has a longer effect than the approximately five-hour effect described with methylphenidate and dextro-amphetamine. Long-term use of pemoline has been associated with rare, but increased, risk of hepatotoxicity, which has resulted in cautionary recommendations for frequent liver function testing as noted in the Introduction.

Methylphenidate has recently been released in a longer-acting product, Concerta®, which may improve compliance with stimulant medication.

In the NIMH Collaborative Multisite Multimodal Treatment Study (MTA) of children with ADHD, compliance was highest in the study group receiving monthly physician monitoring, school and family behavioral management training. Compliance studies with a variety of medications demonstrate improved compliance with less frequent dosing; once a day dosing produces the greatest rate of compliance.

Monitoring of stimulant medication includes observation and mental status monitoring as well as focused physical examinations with particular attention to movement disorders, tics, tremors, and a regular schedule of monitoring heart rate and blood pressure as well as stature and weight changes. After titration to an effective dose and timing schedule, monitoring can be reduced to less than five follow-ups per year, with parents and teachers aware of the medication and potential adverse effects. The regularity of schedule follow up is a factor in improving compliance. Parent and teacher completion of rating scales and school progress reports are important components of assessing the effects of stimulants and other interventions. Continuous performance testing may also be helpful in documenting changes in inattention, impulsivity, and distractibility related to medication dose and timing.

B. TRICYCLIC ANTIDEPRESSANTS

The medications of this class have been in use for more than twenty years. Tricyclic antidepressants (TCAs) affect a number of neurotransmitter/receptor systems in the central nervous system, but their action is believed to be primarily based on effects on the serotonergic system. This class includes medications such as the following (not a complete listing), which are all available in generic form:

1. Imipramine (Tofranil®), the most-studied TCA,
2. Desipramine (Norpramin®),
3. Amitriptyline (Elavil®),
4. Nortriptyline (Pamelor®), and
5. Clomipramine (Anafranil®), a TCA with many specific studies related to obsessive-compulsive disorder.

Early research in child and adolescent mental disorders investigated imipramine in DBPC studies of efficacy with school phobia and separation anxiety; imipramine was superior to placebo in reducing anxiety and school refusal. Subsequent studies were conducted, investigating imipramine and desipramine for ADHD in comparisons with placebo, methylphenidate and clonidine in patients randomly assigned to intervention or placebo groups; imipramine and desipramine proved superior to placebo and variable in efficacy relative to methylphenidate, with all three active medications superior to placebo. Many other DBPC studies have been conducted with imipramine, desipramine, amitriptyline, and nortriptyline for efficacy with major depressive disorders; all of these TCAs studies demonstrated superiority to placebo in reducing depressive symptomatology.

Clomipramine has been investigated in DBPC and double-blind crossover studies for efficacy with obsessive-compulsive disorder, depression, and autistic disorder. Clomipramine had superior efficacy to placebo and to desipramine in four studies for depression and one study for ritualized, repetitive behaviors of autism. Many DBPC studies have demonstrated the efficacy of imipramine for control of nocturnal enuresis.

Despite demonstrable efficacy for a number of child and adolescent mental disorders in randomized controlled studies, concerns persist about the safety of these medications in children. Overdoses of these medications are potentially lethal. Cardiovascular adverse effects have been reported including rare reports of sudden death in youth treated with desipramine and imipramine. Similar arrhythmias have been noted with clomipramine including persistent tachycardia. Sweating, dry mouth, urinary retention, and constipation are reported adverse effects with this class of medications. Psychiatric and medical complications can include serotonergic syndrome and induction of mania.

With the availability of a new generation of medications with potential efficacy in the same disorders and a much-decreased incidence of adverse reactions, these medications have become useful only after intervention failures or for specific contra-indications with other safer medications. These medications require careful monitoring for medical and psychiatric adverse reactions.

C. NONTRICYCLIC ANTIDEPRESSANTS

This group includes medications with greater neurotransmitter and receptor specificity in the nervous system than the TCAs, which affect multiple neurotransmitters and receptor sites; with this greater specificity, fewer unwanted effects occur. This class includes:

1. Selective serotonin reuptake inhibitors (SSRIs - not a complete listing)
 - a. Fluoxetine (Prozac®),
 - b. Sertraline (Zoloft®),
 - c. Fluvoxamine (Luvox®),

- d. Paroxetine (Paxil®)
- e. Citalopram (Celexa®)
- 2. Other antidepressant medications, affecting alternative
 - a. neurotransmitter/receptor systems (partial listing)
 - b. Bupropion (Wellbutrin®)
 - c. Venlafaxine (Effexor®)
 - d. Nefazodone (Serzone®)
- 3. Monoamine oxidase inhibitors (MAOIs - partial listing)
 - a. Phenelzine (Nardil®)
 - b. Tranylcypromine (Parnate®)
 - c. Pargyline (Eutron®)

The SSRIs: the majority of the studies involve the efficacy of fluoxetine for the intervention of major depressive disorders. The data in double-blind, placebo-controlled studies support the effectiveness of SSRIs in the short-term intervention of relatively severe, persistent major depressive disorders in children and adolescents. Fluvoxamine and sertraline have been studied in DBPC studies involving children and adolescents with obsessive-compulsive disorder with demonstrated superiority in symptom reduction compared to placebo. Both are approved for the intervention of obsessive-compulsive disorder in children. A single DBPC study of fluoxetine supports effectiveness with selective mutism in children aged 5 to 14. For Tourette's disorder and ADHD, the data for effectiveness for SSRI intervention is mixed and lacks DBPC studies.

The second group including bupropion, venlafaxine and nefazodone are not impressive for child and adolescent patients with ADHD, depression, or anxiety in published studies. Almost all of these studies are small, open label, and lack controls, except for a single unreplicated DBPC study of bupropion demonstrating efficacy for ADHD.

The MAOIs: adult experience reserves the use of MAOIs to TCA-refractory severe psychiatric disorders in adults. These medications require careful attention to the avoidance of foods and medications containing the amino acid tyramine, which in combination with MAOIs may precipitate potentially lethal hypertensive crises. Newer MAOIs with reduced risk of food and medication interactions are under investigation in Europe. Only five limited studies of MAOI use in children have been published.

Few data are available on the safety of SSRIs, MAOIs, and bupropion, venlafaxine, and nefazadone in children and adolescents. Bupropion in high doses has been reported to increase the risk of seizures. All of the currently available antidepressants have a risk of induction of mania. Many of the SSRIs and TCAs have a risk of the emergence of a serotonergic syndrome. In addition, there are concerns that efficacy studies in adults may not be appropriately generalized to children with differing metabolisms, differing presentations, and possibly differing etiologies for similarly presenting disorders.

D. MOOD STABILIZERS

During the 1980s and 1990s, the efficacy of anticonvulsant mood stabilizers in adult bipolar disorder was demonstrated in multiple DBPC studies, adding these medications to lithium and antipsychotics as effective medications for bipolar disorder. The mood stabilizers include:

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

1. Lithium salts (Lithobid®, Eskalith®, Lithonate®)
2. Anticonvulsants
 - a. Carbamazepine (Tegretol®)
 - b. Valproate (Depakote® and Depakene®) and
 - c. Novel anticonvulsants including gabapentin (Neurontin®) and lamotrigine (Lamictal®)

These medications have been studied for use in treating bipolar disorder, conduct disorder, severe aggression, and ADHD.

Lithium: Lithium previously was the most commonly used FDA approved medication for bipolar disorder before the anticonvulsant mood stabilizing effect was demonstrated. Only a single lithium study appears which is DBPC and demonstrates efficacy of lithium with bipolar disorder in adolescents. The FDA has approved lithium for adolescents who are 12 or older for the indication of bipolar disorder. Lithium use requires lithium blood level monitoring and blood tests for renal and thyroid toxicity on a regular schedule. Overdose is potentially lethal.

Carbamazepine (CBZ) and valproate: There are two NIMH ongoing controlled studies of mood stabilizers in adolescents. Four DBPC studies on children and adolescents with aggression and conduct disorder have mixed results. Carbamazepine has been used for seizure disorders for many years and its safety and side effects are well documented. Common side effects include drowsiness, loss of coordination, and vertigo. Rarely, hematological, dermatological, hepatic, and pancreatic effects occur. The FDA labeling does not include approval for any psychiatric disorders although the adult literature has demonstrated its effectiveness for bipolar disorders in DBPC studies. Valproate also has a long history as an anticonvulsant with known side effects. Common side effects include sedation, nausea, blood dyscrasias, tremor, and weight gain. Rarely, hepatotoxicity has occurred in very young children, predominantly those under two years of age, who have seizures and other complex medical problems. Psychiatric use of valproate generally has not involved children this young. A metabolic syndrome with obesity, hyperinsulinism, lipid abnormalities, polycystic ovaries, and hyperandrogenism has been reported in women under 20 who have been treated with long-term valproate for seizures.

Lithium, CBZ, and valproate require regularly scheduled and careful medical monitoring, blood levels, and laboratory tests for adverse effects.

Novel anticonvulsants including gabapentin (Neurontin®) and lamotrigine (Lamictal®): These medications lack data for efficacy in child and adolescent mental disorders in DBPC studies. Although there are many open trials and case studies presented in the literature and the disorders for which these medications are prescribed are considered severe, chronic, or intractable, insufficient data exist concerning both efficacy and safety.

E. ANTIPSYCHOTICS

Antipsychotics are used in children and adolescents for psychotic disorders and a variety of more severe and intractable disorders including autism, Tourette's disorder, and disorders in the mentally retarded that include severe behavioral and mood disorders and psychosis. These medications include:

1. First generation antipsychotics (not a complete listing)

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- a. Haloperidol (Haldol®)
 - b. Chlorpromazine (Thorazine®)
 - c. Thiothixene (Navane®)
 - d. Pimozide (Orap®)
 - e. Thioridazine (Mellaril®)
2. Atypical antipsychotics (not a complete listing)
- a. Clozapine (Clozaril®)
 - b. Risperidone (Risperidal®)
 - c. Olanzapine (Zyprexa®)
 - d. Quetiapine (Seroquel®)

Over 68 well-designed efficacy studies with DBPC and crossover studies comparing antipsychotics have been published.

Autism: Studies targeting stereotypies, self-injurious behaviors, aggression, temper tantrums, and hyperactivity have demonstrated the superiority of haloperidol over placebo in children from 2 to 8 years of age. Other open label medication trials are suggestive that other antipsychotics, including two of the atypical antipsychotics, have similar efficacy, but these studies lack the scientific rigor of the haloperidol studies.

Schizophrenia: Many well-designed studies confirm the superiority of haloperidol over placebo in adolescents with this disorder. A single DBPC study involving children from 5.5 to 11.75 years of age also demonstrated haloperidol superiority over placebo for controlling psychotic symptomatology. Other more limited studies have compared haloperidol with other first generation antipsychotics; haloperidol and the comparison antipsychotics were similarly effective and had similar side effects. Sedation and the development of Parkinson syndrome are the most common adverse effects; however, serious long-term and potentially irreversible extrapyramidal effects such as tardive and other dyskinesias remain a concern with the first generation antipsychotics. Generally, they are less effective with the negative signs of schizophrenia. Clozapine has been compared with haloperidol in a DBPC study involving adolescents and is superior to haloperidol on all measures of psychosis including negative signs. The incidence of extrapyramidal side effects is rare with clozapine; however, seizures, neutropenia, and other hematological complications are increased in incidence with clozapine use. Risperidone, another atypical antipsychotic with a similar profile to clozapine, is associated with a higher rate of extrapyramidal complications but fewer hematological complications. Weight gain and an increased risk of developing diabetes is a concern with most of the first generation and atypical antipsychotics.

Tourette's disorder: Three DBPC studies demonstrate superiority of antipsychotics over placebo for control of the motor and vocal tics of Tourette's disorder. Most of the published research on antipsychotic efficacy in Tourette's disorder involves either haloperidol or pimozide, both of which have similar efficacy. Pimozide, has, in addition to the above-noted adverse reactions, the potential for serious arrhythmias, which necessitate ECG monitoring before intervention, periodically during intervention, and at dose changes.

Conduct disorder: The use of an antipsychotic medication in the intervention of a conduct disordered youth is justified only in situations with co-occurring severe and intractable disorders such as psychosis or Tourette's disorder that are not

responsive to other interventions and medications with lower risk for adverse reactions. Haloperidol has demonstrated superiority over placebo in controlling the severe aggressiveness of some conduct-disordered youth in a DBPC study. Comparison with lithium: lithium has demonstrated a similar efficacy as haloperidol and superiority over placebo. Other first generation antipsychotics, including thioridazine and molidone have a similar efficacy reported in less rigorous studies.

Mental Retardation: Hyperactivity and aggressiveness respond moderately to haloperidol and thioridazine in DBPC studies. The haloperidol study patients were adolescent and older, and the thioridazine study included patients between 4.1 and 16.5 years with a mean age of 10.0 years.

ADHD: DBPC studies in the 1970s demonstrated superiority of chlorpromazine, haloperidol and thioridazine over placebo in controlling hyperactivity and aggression. In this age, the use of an antipsychotic in the intervention of ADHD is justified only in situations with co-occurring severe and intractable disorders such as psychosis or Tourette's disorder that are not responsive to other medications with lower risk for adverse reactions.

Antipsychotics have significant risks of adverse effects and require careful medical and psychiatric monitoring. A thoughtful risk/benefit analysis is appropriate and usually limits the use of these medications to intervention of specific severe and intractable disorders.

F. ANXIOLYTICS AND OTHERS

Many other medications have been prescribed for child and adolescent mental disorders. Few DBPC studies are reported, but the scant information from the literature is summarized by various classes of medications.

1. Anxiolytics
 - a. benzodiazepines
Alprazolam (Xanax®)
 - b. Clonazepam (Klonopin®)
 - c. Diazepam (Valium®)
 - d. Midazolam (Hypnovel®)
2. 5-HT_{1A} agonists
Buspirone (Buspar®)
3. β -blockers
 - a. Propranolol (Inderal®)
 - b. Metoprolol (Lopressor®)
 - c. Nadolol (Corgard®)
4. α -adrenergic agonists
 - a. Clonidine (Catapres®)
 - b. Guanfacine (Tenex®)
5. Opiate antagonists
Naltrexone

Although benzodiazepines have been prescribed for children and adolescents, only clonazepam and alprazolam have been demonstrated to have superiority over placebo in DBPC studies for panic disorder and anxiety disorders. Anxiety associated with medical procedures responds to midazolam in DBPC studies; this medication is available only as a parenteral injection solution. Generally,

these medications are safe and non-lethal even in overdose. The major side effects are drowsiness and sedation. In adults on long-term medication, there are concerns about the development of tolerance and dependency; this concern has not been adequately addressed in studies in children and adolescents.

Bupirone has been studied in open trails for anxiety, aggression, pervasive developmental disorders, and ADHD, but no DBPC studies have demonstrated efficacy for these or any other mental disorders of childhood or adolescence. Medications of this class are generally quite safe with only mild side effects of dizziness, stomachache, sedation, asthenia, or headache. There are no problems with withdrawal even after prolonged use.

The beta-blockers have been used for children and adolescents with anxiety and dyscontrol with aggression, but no systematic DBPC studies have been published. Adverse reactions include sedation, hypotension, bradycardia, and bronchoconstriction. There are reported concerns that growth hormone regulation may be disrupted, leading to over-release of growth hormone.

Clonidine and guanfacine are α -adrenergic agonists that have been used to treat hypertension since the 1960s. Since the 1970s, these medications have been used in Tourette's disorder, ADHD, ADHD complicated by Tourette's disorder or motor tics, autistic disorder, aggression, and sleep disorders related to stimulant intervention. DBPC studies have produced inconsistent results with these disorders. Adverse effects include cardiac arrhythmias, particularly when these medications are used in combination with others medications. Sudden deaths have been reported in children receiving the combination of methylphenidate and clonidine. Less serious adverse effects include sedation and hypotension.

Naltrexone is an opiate antagonist. Four DBPC studies demonstrate superiority over placebo in reduction of hyperactivity associated with autism. No significant effect on reduction of self-injurious behavior has been substantiated. There are no long-term studies on the safety of naltrexone in children; adult use has been associated with hepatotoxicity in patients with a history of alcohol and drug abuse. Common mild side effects include drowsiness, anorexia, and vomiting. A single study on the use of naltrexone in Rett's disorder was associated with a more rapid decline in motor performance and a more rapid progression of the disorder in ten patients in the intervention group compared to a control group. Thus, the use of naltrexone is contraindicated in children with Rett's disorder.

XIII. SUMMARY

This set of guidelines is based on published literature reviews that are referenced below. The use of pediatric psychopharmacology should be guided by basic principles:

1. Medication decisions should be based on a careful diagnosis, an understanding of co-existing medical and mental disorders, consideration of potential interactions with other substances, and empirically based studies concerning efficacy and safety.
2. Most medications with established efficacy have known risks for adverse effects. Medication choices should be based on a careful risk/benefit analysis, weighing potential benefits against potential risks.
3. Medication effects and adverse effects should be monitored with data from multiple sources, including parents, teachers, school nurses, physical and

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- neurological examination, mental status, and laboratory studies. Revise medication, doses, and scheduling of medication based on monitoring data.
4. When an empirically-based choice of medication appears to be ineffective, the team should reevaluate diagnosis, including co-existing disorders, doses and timing of doses, and medication compliance before considering an alternative medication or a combination of medication which lacks substantial empirical support for effectiveness or safety.
 5. When involved in the intervention of severe and intractable mental disorders, an attitude of humility and honesty leads to better parental cooperation and understanding and to better outcomes. A second opinion with a colleague can be most helpful.
 6. Studies that involve coordinated teams in combined psychosocial and medical interventions for the most complex disorders have generally resulted in better outcomes with improved compliance.
 7. Intensive case management is the essential agent of change in complex mental disorders.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

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The preparation of this section of the CAMHD Practice Guidelines was greatly assisted by two publications of major reviews related to psychopharmacology:

1. The May 1999 Special Section of the *Journal of the American Academy of Child and Adolescent Psychiatry* on Current Knowledge and Unmet Needs in Pediatric Psychopharmacology, and
2. The February 2001 Technical Report on Psychiatric Medications, prepared by the National Association of State Mental Health Program Directors Medical Directors Council and the National Association of State Medicaid Directors, with funding provided by the Center for Mental Health Services of SAMHSA.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Table 1.
Scientific Knowledge in Pediatric Psychopharmacology

Category	Indication	Level of Supporting Data ^a			
		Short-Term Efficacy	Long-Term Efficacy	Short-Term Safety	Long-Term Safety
Stimulants	ADHD	A	B	A	A
SSRIs	Major depression	B	C	A	C
	OCD	A	C	A	C
	Anxiety disorders	C	C	C	C
Central adrenergic agonists	Tourette's disorder	B	C	B	C
	ADHD	C	C	C	C
Valproate and carbamazepine	Bipolar disorders	C	C	A ^b	A ^b
	Aggressive conduct	C	C	A	A ^b
TCAs	Major depression	C	C	B	B
	ADHD	B	C	B	B
Benzodiazepines	Anxiety disorders	C	C	C	C
Antipsychotics	Childhood schizophrenia & psychoses	B	C	C	B
	Tourette's disorder	A	C	B	B
Lithium	Bipolar disorders	B	C	B	C
	Aggressive conduct	B	C	C	C

Note: SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant; ADHD = attention-deficit hyperactivity disorder; OCD = obsessive compulsive disorder.

^a A = adequate data to inform prescribing practices; for efficacy and short-term safety: ≥ 2 randomized controlled trials (RCTs) in youth; for long-term safety: epidemiological evidence and/or minimal adverse incident report to the Food and Drug Administration. B = for efficacy and short-term safety: 1 RCT in youth or mixed results from ≥ RCTs. C = no controlled evidence.

^b Safety data based on studies of children with seizure disorder.

The table above is adapted with permission from Jensen et al. (1999), Psychoactive Medication Prescribing Practices for U.S. Children: Gaps Between Research and Clinical Practice, *Journal of the American Academy of Child and Adolescent Psychiatry*, 38: 557-565.

SECTION IV:

**INTERAGENCY
SERVICE INTENSITY GUIDELINES**

**CHANGING THE INTENSITY OF SUPPORTS AND
SERVICES**

DOE & DOH INTERAGENCY PROCEDURES

SECTION IV: INTERAGENCY SERVICE INTENSITY GUIDELINES**I. INTRODUCTION**

Quality assurance procedures within the DOE and DOH are multifaceted and multileveled. An integral part of the Child and Adolescent Mental Health Division (CAMHD) plan is the requirement for MHCCs (MHCC) to review their cases regularly and, at least quarterly, report to their supervisor on the status. The DOE, through provisions of the Individuals with Disabilities in Education Act (IDEA), and through school and district Quality Assurance Plans, requires a similar periodic review of student progress on behavioral goals and objectives. A student's status may warrant review on a more frequent basis due to instability or change in the student's need for more or less complex or intense services. Continuous monitoring of student progress and effective team planning and participation will quickly identify the need for and promote quality programming for students at these critical decision making points.

On occasion an appropriate student behavior support plan will require supports and interventions beyond the scope of school-based behavioral health services. Conversely, a student receiving services identified in a Coordinated Service Plan will not always require a high level of services provided by multiple state agencies. The purpose of this document is to set forth procedures and guidelines to assist stakeholder decision-making regarding changes in the level or intensity of supports needed by a student. In the past, these changes may have been referred to as change in the "Level of Care" provided by school based and community based service providers.

Changes in the level and intensity of services will involve staff from both the Departments of Education and Health. Meaningful participation by the appropriate representatives is critical to ensure appropriate decisions are made to support the educational, behavioral, and mental health needs of the student. This is necessary because the decision encompasses a number of professional disciplines and multiple federal and state statutes and regulations. An actual decision to change a student's behavior plan is the result of team decisions in either an Individualized Education Program Meeting or a Section 504 MP Meeting.

A. PROCEDURES

1. Either the MHCC or DOE CC (behavior support plan manager or school's designee) may request an interdepartmental staff discussion. Some schools have regularly scheduled student support or review meetings to discuss student status on an ongoing basis. If these meetings involve DOE and DOH personnel, these discussions are likely to occur in this venue.
2. A discussion is requested based upon the following:
 - a. A student's progress indicates that a more restrictive or intensive level of service or support is no longer needed.
 - b. A student's need for support indicates that a more restrictive or intensive level of service or support may be necessary.
 - c. The student's parent(s), guardian, or surrogate parent requests a change in the level of service or support.
3. The purpose of the discussion is to assure that there is adequate information available to the IEP or MP team meeting to determine the following:

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

1. If a change in the level of service or support is appropriate.
2. What new level of service or support is now appropriate?
4. The attached team guidelines, as well as a continual perspective that is child-centered and family-focused, are an important starting point for all team discussions.

B. SCHEDULING

The discussion to consider whether a child needs more or less intensive services should be scheduled at least two weeks prior to any IEP or MP meeting in which a change in level of intensity is considered. The meeting should be scheduled to ensure that additional information is obtained or adequate research regarding the provision of the anticipated level of service is available to the IEP or MP team. It is in the IEP or MP team meeting that the actual decision regarding the needed services and supports is reached.

This does not mean that a properly convened IEP or MP meeting that is in process should be halted if the need for change in a behavior plan surfaces as a topic for discussion nor should the need to have a “Staffing” be used to cause a delay in scheduling an IEP or MP meeting to address a student’s recognizable need for an increase in support. In the event that a student’s level of service intensity is changed through an IEP or MP meeting without an interagency staff discussion, it is an indicator that either or both departments should institute a Peer Review to determine a need for corrective action.

C. WHO SHOULD ATTEND

Any and all department representatives necessary to establish the need for change should attend a discussion about the need for change in a student’s behavior plan. The need for change should be based on providing adequate answers to questions designed to (1) determine if a change in intensity of supports may be appropriate and (2) to assess what information will be necessary in developing a new plan that includes more or less intense behavior supports or services. In most cases it will require the CAMHD MHCC, DOE CC (or designee), and the relevant DOE staff. In situations involving complex student needs the FGC Branch Chief and District SBBH staff may also need to attend.

D. REVIEW PROCESS

Attached are two sets of review questions associated with more intensive services. One set of questions for most students experiencing behavioral and emotional difficulties. The second set is for students with Autism Spectrum Disorders or Developmental Disabilities/Mental Retardation.

E. RELATIONSHIP TO CARE COORDINATION RESPONSIBILITIES

The determination of the intensity of supports a student receives is made independently of which agency has, or may have, care coordination responsibilities. A change in care coordination will follow and be based on the student’s progress or need for change in intensity of support. The change will be done according to established agency criteria for the provision of care coordination.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

F. RELATIONSHIP TO OTHER SUPPORT SERVICES

In all situations, the determination of the intensity and type of supports provided students is made based on a student's Behavior Support Plan (BSP) stemming from a Functional Assessment of the student's Behavior. Significant change in progress or need leading to changes in the intensity of supports may require the addition or deletion of more than one type of support. When this occurs, the discussion must clearly identify where the responsibility for support lies and the relationship of each support to the other supports and its basis in the student's BSP.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

II. SCHOOL BASED BEHAVIOR SUPPORT SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH

If the IEP or MP Team determines that a student's behavior is interfering with his/her learning, the team shall review the following items in determining whether school based behavior services are needed:

1. The student has been evaluated for eligibility for specially designed instruction or related services (IDEA / Chap 56), or instructional modifications/accommodations (section 504 / Chap 53).
2. The student's IEP/MP includes a comprehensive behavior support plan. (If the student does not yet have an IEP/MP but is found eligible, the student's comprehensive behavior support plan been developed.)
3. The behavioral goals and objectives are stated in measurable terms.
4. The IEP/MP includes a plan to support staff (and parents as appropriate) in implementation of instructional interventions and contextual modifications (i.e., the plan ensures each participant has or will develop the resources, skills, and competencies needed to implement the BSP.)
5. The student has been provided instruction at his/her level and rate of understanding.
6. The parent/parents are engaged as team members.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

II. INTENSIVE COMMUNITY BASED MENTAL HEALTH SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH

If additional supports appear to be needed beyond those that have been attempted, the team shall review the following discussion points prior to initiating services:

1. The IEP/MP is current, and is being implemented consistently. It is evident that appropriate adjustments have been made as warranted.
2. The goals and objectives as written on the IEP/MP have been reviewed.
3. The team is clear about the reasons for lack of progress or regression. Data is available to support the concerns.
4. The parent/parents are engaged as member(s) of the team.
5. A Functional Behavioral Assessment (FBA) has been completed, and a comprehensive Behavioral Support Plan (BSP) is in place. The goals and objectives as written on the BSP have been reviewed. The time period that supports have been in place have been reviewed.
6. The core issues of the child are understood. There is a long-term view of the goals of the child.
7. The team believes that the student requires more support to be maintained within the current classroom environment. The rationale for this has been outlined.
8. Evidenced-based treatment interventions have been implemented. (If not, why not?) The evidence-based interventions have been applied with quality and consistency. The results of these interventions have been reviewed.
9. The team identified quarterly objective measures and a schedule for review.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

IV. OUT OF HOME MENTAL HEALTH TREATMENT SERVICES FOR EMOTIONALLY &/OR BEHAVIORALLY DISRUPTIVE YOUTH

If the team believes out of home services may be warranted for a youth, the MHCC shall request clinical consultation from their supervisor and FGC Clinical Director, as well as request an intensive behavioral consultation. The team should consider the following items before seeking consultative supervision.

1. The IEP/MP and CSP are current. The plans are being implemented with consistency and quality. The goals and objectives as written on these plans have been reviewed. (If progress is not occurring, the team is clear about the reason(s), and have they made appropriate adjustments.)
2. The parent/parents are engaged as team members.
3. The team has isolated the underlying/core issue(s) involved.
4. The CAFAS has been conducted and the graph is available for review.
5. The Achenbach CBCL has been completed and is available for review.
6. A Functional Behavioral Assessment (FBA) has been completed and Behavioral Support Plan (BSP) is in place. The time period that supports have been in place have been reviewed.
7. The team has defined measurable goals that are to be addressed by out of home treatment.
8. The team has described the supports that will be necessary to return the youth back home. There is a clear transition plan outlined.
9. Evidenced-based interventions have been implemented. (If not, why not?) The evidenced-based interventions have been applied with quality and consistency. The results of these interventions have been reviewed.
10. There is a clear long-term view of the supports/services needed.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

V. SCHOOL-BASED BEHAVIOR SUPPORT SERVICES FOR YOUTH WITH AUTISM/PDD

When a child meets the IDEA/Chapter 56 criteria for Autism, the team shall review the following in determining the scope of necessary school based services.

1. The student is eligible for specifically designed instruction, related services (IDEA), and instructional accommodations (Section 504).
2. The student's IEP/MP plan includes a comprehensive plan to address the core deficit areas associated with a diagnosis of pervasive developmental disorder, including but not limited to communication, socialization and behavior.
3. Instructional goals and objectives are stated in measurable terms and reflect acceleration goals for desired behaviors to replace challenging behaviors.
4. The IEP team has a plan to support parents and staff in implementation of instructional interventions and contextual supports (This means the plan ensures that each participant has or will develop the resources, skills, and competencies needed to implement the instructional goals and objectives).
5. The student is provided with instruction at his/her developmentally appropriate and chronologically appropriate level and rate of understanding.
6. The parent/parents are engaged as team members.
7. Evidence based treatments are being applied. They are being applied with quality and consistency.
8. There is a long-term view of the child.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

VI. INTENSIVE HOME AND COMMUNITY SUPPORTS FOR YOUTH WITH AUTISM/PERVASIVE DEVELOPMENTAL DISORDERS

If the team believes more intensive services are warranted, an IEP meeting should be convened. The IEP team shall review the following items prior to initiating services.

1. The student is eligible for specifically designed instruction, related services (IDEA), and instructional accommodations (Section 504).
2. The student's IEP/MP plan includes a comprehensive plan to address the core deficit areas associated with a diagnosis of PDD, including but not limited to communication, socialization and behavior.
3. Instructional goals and objectives are stated in measurable terms and reflect acceleration goals for desired behaviors to replace challenging behaviors.
4. The IEP team has a plan to support parents and staff in implementation of instructional interventions and contextual supports (This means the plan ensures that each participant has or will develop the resources, skills, and competencies needed to implement the instructional goals and objectives).
5. The student is provided with instruction at his/her developmentally appropriate and chronologically appropriate level and rate of understanding.
6. The parent/parents are engaged as team members.
7. The IEP is current. It is developmentally and chronologically appropriate for the student. It is being implemented consistently and appropriately. The goals and objectives are being addressed as written and monitored.
8. There is a long term view of the child.
9. In the presence of challenging behaviors, a functional behavioral assessment (FBA) has been completed, a written Positive Behavioral Support Plan is being implemented and has been shared with the IEP team.
10. Empirically based approaches are being used with the student. If not, why not? If empirically based approaches are being used, fidelity does exist within their implementation.
11. The team has documented attempts to adjust programs to address lack of progress or regression.
12. Child is at risk of being moved to a more restrictive placement.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

VII. OUT OF HOME EDUCATIONAL/THERAPEUTIC SUPPORTS FOR CHILDREN WITH AUTISM/PERVASIVE DEVELOPMENTAL DISORDERS

When the IEP team is considering moving a student from his or her current living and/or educational environment, the team has received intensive behavioral consultation and support to maintain the student in the current setting.

1. The student is eligible for specifically designed instruction, related services (IDEA), and instructional accommodations (Section 504).
2. The student's IEP/MP plan includes a comprehensive plan to address the core deficit areas associated with a diagnosis of autism, including but not limited to communication, socialization and behavior.
3. Instructional goals and objectives are stated in measurable terms and reflect acceleration goals for desired behaviors to replace challenging behaviors.
4. The IEP team has a plan to support parents and staff in implementation of instructional interventions and contextual supports (This means the plan ensures that each participant has or will develop the resources, skills, and competencies needed to implement the instructional goals and objectives).
5. The student is provided with instruction at his or her developmentally appropriate and chronologically appropriate level and rate of understanding.
6. The parent/parents are engaged as team members. Efforts to engage the family in the educational process have been documented.
7. The IEP is current. It is developmentally and chronologically appropriate for the student. It is being implemented consistently and appropriately. The goals and objectives are being addressed as written and monitored.
8. There is a long term view of the child.
9. In the presence of challenging behaviors, a functional behavioral assessment (FBA) has been completed, a written Behavioral Support Plan is being implemented and has been shared with the IEP team.
10. Evidenced based approaches are being used with the student. If not, why not? If evidenced based approaches are being used, fidelity does exist within their implementation.
11. The team has documented attempts to adjust programs to address lack of progress or regression.
12. The team has written goals, objectives and strategies to be implemented during the period of out of home support services.
13. There is a transition plan into the out of home support. The team has described supports necessary to return the student back home.

SECTION V:

GLOSSARY

SECTION V: GLOSSARY

Accreditation

Authorization granted by the Hawaii State Department of Health for a non-governmental program to provide mental health services to children and/or youth as a result of demonstrated compliance with the standards established to provide such services (see section 321-193 (10), HRS (Hawaii Administrative Rules)). Also, a designation conferred by any one of several national professional organizations, indicating that the Hawaii State Department of Health/Child and Adolescent Mental Health Division has met high professional standards for the provision of mental health services to youth. Accrediting bodies relevant to CAMHD include the Council on Accreditation (COA), the Council on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Accreditation Council on Graduate Medical Education (AAGME)

A professional entity that establishes national standards for graduate medical education and that assesses and approves educational programs under its aegis. It uses the most effective methods available to evaluate the quality of graduate medical education programs. It strives to improve evaluation methods and processes that are valid, fair, open, and ethical.

Achenbach Child Behavior Check List (CBCL)

A standardized child behavior checklist completed by the primary caretaker(s), scored and interpreted by an evaluator.

Achenbach Teacher Report Form (TRF)

A standardized child behavior checklist completed by the primary teacher(s), scored and interpreted by an evaluator.

Achenbach Youth Self-Report (YSR)

A standardized youth behavior checklist completed by youth aged 11 to 18, scored and interpreted by an evaluator.

American with Disabilities Act (ADA)

A federal Act that gives civil rights protections to individuals with disabilities, similar to the rights provided to individuals on the basis of race, color, sex, national origin, age, and religion. The ADA guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and in telecommunications.

Adjunctive Therapy

The individual, group, family, occupational, and milieu therapy that is given to a youth in a hospital-based residential treatment facility.

Advanced Practice Registered Nurse (APRN)

A professional designation indicating a high level of expertise in the assessment, diagnosis, and treatment of complex responses of individuals, families, or communities to actual or potential health problems, prevention of illness and injury, maintenance of wellness, and provision of comfort. The APRN holds a master's or doctoral degree in a specific area of advanced nursing practice, received supervised practice during graduate education, and has ongoing clinical experience. APRNs continue to perform many of the same interventions used in basic nursing practice but they have a greater depth of knowledge and a higher skill level than non-APRN

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

nurses. APRNs include clinical nurse specialists, nurse practitioners, nurse anesthetists, and nurse-midwives.

American Board of Psychiatry and Neurology (ABPN)

An independent, non-profit organization that certifies doctors practicing psychiatry and neurology and certifies individuals in subspecialties of those areas of practice.

Authorization

CAMHD and DOE staff approval for procurement of provider agency service units based on interventions specified in a youth's IEP/MP and CSP, as indicated..

Axis I Diagnosis

Clinical Disorders; defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Axis II Diagnosis

Personality Disorders; Mental Retardation; defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Bed Hold

A space reserved in a residential treatment program for a youth who is absent from that program for more than 24 hours but who is expected to return to that program within a predetermined amount of time. This procedure may be used with prior written service authorization from the appropriate Department of Health FGC.

Behavior Support Plan (BSP)

A plan specifying support services for a youth that emanates from the functional assessment of that person's behavior, detailing the antecedent management, teaching, and consequence strategies designed to mediate specific challenging behavior in a specific individual. The plan should include ecological (environmental, dynamic, goodness of fit), communication and social skills interventions as well as molar (global) interventions such as social network interventions where applicable.

Best Practice

Those strategies or interventions that have the highest level of evidence supporting their effects for a particular problem and context. For example, for some problems and contexts, there might be multiple "evidence-based" interventions from which to choose (see "Evidence-Based" in this Glossary). The principle of "best practice" would dictate choosing the approach that demonstrates the greatest promise for positive outcomes given the ranking of the evidence. Thus, an "empirically-supported" approach (see "Empirically-Supported" in this Glossary) would usually be the choice over another "evidence-based" approach, and would always be preferred to a non-evidence-based approach. Also, in the absence of any evidence for a particular problem and context, "best practice" would then refer to those strategies that draw from strongest professional consensus. The principle of "best practice" therefore does not confine practice choices or dictate a list of approved interventions, but rather requires one to start with the strongest sources of evidence as the principle guide to selecting and designing interventions for youth.

Board Certified Diplomat (BCD) in Clinical Social Work

A professional designation for Clinical Social Work emblematic of advanced practice competency that is issued by the American Board of Examiners of Licensed Clinical Social

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Work to those who have achieved high levels of specified clinical education, training, and experience.

Child and Adolescent Functional Assessment Scale (CAFAS)

One of the assessments that must be completed on a quarterly basis for all youth served by CAMHD FGCs. To administer and use a CAFAS, an individual must first receive reliability certification.

CAMHD Clinical Review Team

A group of individuals consisting of the FGC Medical Director, a Clinical Psychologist and CAMHD Clinical Services Office staff who meet to review the status of services for a youth.

Case Management

Coordinating the provision of mental health services for children and their families who require services from more than one public or private provider.

Certified Substance Abuse Counselor (CSAC)

A professional designation conferred by the State of Hawaii Department of Health/Alcohol & Drug Abuse Division, indicating an individual has successfully completed three years of clinically supervised experience in the area of substance abuse and has successfully completed a certificate program in substance abuse at the Associates degree level.

Child and Adolescent Service System Program (CASSP)

A program established by Congress in 1984 to improve the way in which children and adolescents with or at risk of developing serious emotional or mental disorders and their families are offered multi-agency services. The core values of CASSP are that services be 1) child and family centered, 2) community based, and 3) culturally competent. The guiding principles of CASSP are to provide 1) access to an array of services, 2) individualized services, 3) least restrictive environment, 4) full family participation, 5) integrated services, 6) care coordination, 7) early identification and intervention, 8) smooth transitions, 9) protection of the rights of the child, and 10) non-discrimination and cultural appropriateness.

Childcare Worker

A person supervised by a mental health professional who assists that professional in providing direct care mental health services to youth.

Clinical Note

A summary of a clinical supervision session that includes the date, amount of time, attendees and content.

Clinical Supervision

Regularly scheduled assistance given by a Mental Health Professional to a staff member who is providing direct, therapeutic intervention to a youth. Clinical supervision is provided to insure that each youth receives appropriate treatment consistent with his/her needs and with accepted standards of practice. Clinical supervision is held face-to-face in an individual or group setting for a minimum of two hours a month unless otherwise specified and is documented by a clinical note placed in the staff member's personnel file.

Commission on Accreditation of Rehabilitative Facilities (CARF)

See "Accreditation" in this Glossary.

Community-Based Residential (CBR)

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

An out-of-home placement for a high risk youth that is located in a local community and that provides 24-hour care and integrated service planning to address the behavioral, emotional and/or family problems that prevent the youth from taking part in family and/or community life.

Community Children’s Council Office (CCCO)

The organizational and resource foundation for community participation in the child and adolescent mental health system of care in Hawaii. The CCCO coordinates and supports the work of the regional Community Children’s Councils throughout the State.

Coordinated Service Plan (CSP)

A written design for service that describes the roles and responsibilities of multiple agencies or programs that provide therapeutic or supportive interventions or activities essential to the youth’s and family’s treatment.

Coordinated Service Planning Process

A process of bringing together the family, multiple agencies and providers, and the child/youth, when appropriate, to develop a comprehensive and integrated plan of individualized care for the child/youth that is based on the child’s/youth’s strengths and needs.

Council on Accreditation (COA)

See “Accreditation” in this Glossary.

Counseling Therapy

The use of special skills to assist individuals or groups of individuals in achieving objectives through the exploration of a problem and its ramifications, examination of attitudes and feelings, consideration of alternative solutions, and decision-making.

Credentialing

The review and approval of qualifications and other relevant information pertaining to a health care professional who seeks appointment (in the case of an organization directly employing health care professionals) or who seeks a contract with the organization.

Crisis Plan

A plan to insure the safety of the youth, when the youth is acutely dangerous to him/herself, is threatening to harm someone else, or is gravely disabled to the point of being unable to care for him/herself. The intent of the crisis plan is to stabilize the youth’s condition and take steps to prevent further decompensation. The crisis plan includes persons to contact in case of an emergency and other specific action plans.

Department of Education (DOE)

A State agency responsible for a “public school system that holds high expectations of what students should know, be able to do and care about. . . focuses attention, effort and resources on promoting student learning. . . holds each school accountable for meeting high standards of performance. . .”

Department of Health (DOH)

A State agency that provides the leadership to monitor, promote, protect, and enhance the health and environmental well being of all of Hawaii’s people.

Designee

A professional staff person with professional credentials equivalent to the person for whom they are substituting and familiarity with the client about whom they are reporting.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Diplomat in Clinical Social Work

See “Board Certified Diplomat (BCD) in Clinical Social Work” in this Glossary.

Direct Care Staff

Any person who provides face-to-face treatment, care, supervision, and/or other services for a youth, in support of that youth’s individual service plan or treatment plan.

Discharge Plan

A plan specifying the process by which a youth’s active involvement with a mental health or substance abuse service is terminated and the program no longer maintains active responsibility for services to the resident. A discharge plan is a required component of a youth’s treatment plan that is created when the youth is admitted to a program and is reviewed and revised as needed on a regular basis by the youth’s treatment team.

Discharge Summary

A written report by a qualified professional involved in the youth’s treatment that states the salient points of treatment progress and the outcomes and recommendations for any further mental health interventions needed. This document is made available at the time of discharge.

DOE Diagnostic Packet

A report from the Department of Education on a given student that includes a social history, educational assessment, speech/language evaluation, intellectual test and other related educational information.

Domain

An area of a youth’s life. Domains considered in developing a service plan for a youth are Family, School, Community, Individual, Social/Peer and Legal.

DSM-IV

A publication titled the Diagnostic and Statistical Manual of Mental Disorders.

DSM Version of Diagnoses

Diagnosis obtained through the use of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Elopement

Running away; absent without permission; failure to return from authorized or permitted leaves.

Empirically-Supported

A specific term that refers to a subset of “evidence-based” techniques (see “Evidence-Based” in this Glossary) that have met a particular set of more demanding criteria for their support and use as mental health treatments. These criteria were outlined nationally by the American Psychological Association Task Force on Psychological Intervention Guidelines (1995) and have been adapted locally by CAMHD. The two criteria that distinguish “empirically-supported” from other “evidence-based” techniques are: 1) efficacy, or how well a treatment is known to bring about change in the problem, and 2) effectiveness, or the clinical utility of the intervention. Whereas efficacy is mainly concerned with the quality of treatment in controlled, often university-based programs, effectiveness refers to the expected or observed performance of a treatment in a “real world” setting.

Evidence-Based

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Those strategies and interventions for which credible, published research exists demonstrating positive effects, including uncontrolled, open trials or case studies. For the purposes of the CAMHD, such evidence typically is found only in peer-reviewed scientific journals.

Family Guidance Center (FGC)

One of seven Department of Health regional centers that utilize DOH/CAMHD CCs to coordinate and procure services for youth in need of more intensive mental health services than can be provided by school-based behavioral health services.

Felix Consent Decree (FCD)

A 1994 ruling (Felix v. Cayetano Consent Decree) from the U.S. District Court for Hawaii stating that "qualified handicapped children" in Hawaii were not receiving mental health services necessary to enable them to benefit from their education, and requiring the State Department of Education and State Department of Health to come into compliance, by June 2000, with the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Vocational Rehabilitation Act regarding services to these children. The date of compliance is now later than June 2000.

Felix Youth/Felix Class Member

All children and adolescents with mental health disabilities residing in Hawaii, from birth to 20 years of age, who are eligible for and in need of education and are also in need of mental health services.

Free Appropriate Public Education (FAPE)

An entitlement of all youth in the U.S., as specified in the Individuals with Disabilities Education Act and in Section 504 of the Vocational Rehabilitation Act. These regulations require a school district to provide special education and related services, at no cost to a child or his or her parents, so any child needing these services may take advantage of his or her public education.

Functional Behavioral Assessment (FBA)

A process that provides a framework for developing effective programs for students who present serious problem behavior. It examines the events that reliably predict and maintain problem behavior while using a strength-based approach that considers the "whole child" and the context in which the behavior occurs. It addresses problem behavior by developing behavior support plans (BSP) that move away from being reactive and punitive in nature, to plans that are proactive with research-validated practices. The approach is geared at utilizing a student's strengths to provide a basis for plan development, instructional programming, and behavior management that are geared to each individual's needs, preferences, and long-term goals.

Health Insurance Portability and Accountability Act of 1996 (HIPPA)

An Act of Congress that amends the Internal Revenue Code of 1986 in order to improve the portability and continuity of health insurance coverage. The Act authorizes the development of a health information system, including the standards and requirements for the electronic transmission of certain health information.

Hospital Based Residential (HBR)

A type of placement for severely emotionally disturbed youth who are unable to function in a less restrictive setting and require 24 hour medical staffing. Daily services are highly structured and include intensive diagnostics; multi-disciplinary assessments; close supervision; educational services; individual psychotherapy and/or counseling; individualized adjunct therapies (individual, group, family, occupational, and milieu therapy); integrated, interdisciplinary treatment and service planning; and substance abuse education and counseling

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

as appropriate. Services are administered by trained staff who are supervised by a licensed mental health professional on a 24-hour per day basis.

Independent Psychiatrist

A psychiatrist who is not an employee or under contract with an agency needing his/her services.

Individual Crisis Plan

See "Crisis Plan" in this Glossary.

Individualized Education Program (IEP)

A written statement for each child with a disability that is developed, reviewed and revised in accordance with Section 614 (d) (Individualized Education Programs) of the Individuals With Disabilities Education Act, as amended in 1997. The statement includes a description of the student's present levels of educational performance, annual goals including short-term objectives, special education and related services, dates for beginning and duration of services, and measure for how progress on implementation of the services will be evaluated.

Individuals with Disabilities Education Act (IDEA)

An Act of Congress to insure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

See "Accreditation" in this Glossary.

License

A document issued by the Hawaii State Department of Health, indicating that a facility, program, and staff meet the standards set by the State for a given level of mental health care.

Licensed Marriage and Family Therapists (LMFT)

A therapist who has received a State of Hawaii professional license indicating that he or she has a Masters degree in Marriage and Family Therapy from a nationally accredited training program and has at least two years of clinically supervised experience in providing mental health services to youth.

Licensed Professional

Refers only to an individual in Hawaii who has State approval to provide mental health services in his/her respective area of expertise.

Medicaid or Quest Eligibility

The process by which an individual is eligible for Medicaid Fee-for-Service or QUEST.

MED-QUEST Division (MQD)

The State office which has the responsibility for administering the medical assistance programs for the Department of Human Services.

Mental Health Professional (MHP)

- **Must be a physician in training in an ACGME (Accreditation Council on Graduate Medical Education) accredited residency program in child and adolescent psychiatry under program faculty supervision OR**

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

- **Must have a Ph.D. in Clinical, Counseling or School Psychology from a nationally accredited university OR**
- **Must have a Master's degree from a nationally accredited university as a national board certified behavior analyst, marriage and family therapist, Nationally Certified Counselor, psychologist, social worker, school psychologist, or psychiatric nurse OR**
- **Must be a Ph.D. student in clinical psychology studying in an accredited program under program faculty supervision AND**
- **Must have at least one year of full-time, clinically supervised progressive work experience inclusive of residency, internship or practicum in the care or treatment of youth in a mental health or educational setting (experience may be substituted with certificates in a specialty such as Certified Substance Abuse Counselors (CSAC) or Registered Professional Nurses certified in psychiatric nursing). AND**
- **Must be supervised by a QMHP.**

Mental Health Treatment Plan (MHTP)

A comprehensive plan to address the mental health needs of a youth and his/her family that includes specific goals, measurable objectives, target dates to reach objectives, appropriate interventions to

achieve these objectives, a crisis plan identifying specific actions to take in case of a mental health emergency, and a discharge plan to prepare for a smooth transition to eventual termination of services.

Milieu Therapy

The type of treatment in which the patient's social environment is manipulated for his/her benefit.

Modification Plan (MP)

A written statement describing the specific regular or adapted regular educational services and related services to be provided to a student who does not require special education, but whose disability requires modifications to prevent exclusion from full participation in his/her education program as per Section 504 of the Vocational Rehabilitation Act of 1973.

Multisystemic Therapy (MST)

An intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The Multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems.

No Eject/no Reject Rule

A stipulation that upon admission into a mental health treatment program, a youth remains in treatment until clinically discharged by the treatment team. If there are difficulties managing the youth's behavior, strategies are adjusted to meet the youth's needs, or a functional behavioral assessment is conducted and positive behavior support plan is developed.

Paraprofessional

A trained aide who assists and is supervised by a Mental Health Professional (MHP) and/or a Qualified Mental Health Professional (QMHP) in providing direct mental health services to youth. (See "Mental Health Professional" and "Qualified Mental Health Professional" in this Glossary.)

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Primary Source

An organization or entity with legal responsibility for originating a document and ensuring the accuracy of the information it conveys.

Psychotherapy

An intervention strategy that helps people with their emotional/social/mental processes. An individual providing psychotherapy usually has a Masters level degree either in social work or psychology and is licensed or certified by their state licensing board.

Qualified Clinical Social Worker (QCSW)

A professional designation for those social workers who have met national standards of knowledge, skill and experience in clinical social work practice and who have agreed to abide by the National Association of Social Workers Code of Ethics, the National Association of Social Workers Standards for the Practice of Clinical Social Work, and the National Association of Social Workers Continuing Education Standards.

Qualified Mental Health Professional (QMHP)

An individual who has the educational and experiential background to provide direct mental health services to youth and children and who is licensed by the State of Hawaii in his or her respective area of expertise. The QMHP supervises Mental Health Professionals (MHP) (see "Mental Health Professional" in this Glossary). A QMHP must be licensed in the state, hold an advanced professional degree in behavioral science, social work, nursing, or psychology; or a medical degree.

Quality Assurance Improvement Plan

A methodical and objective approach to monitoring and evaluating the appropriateness and quality of individual care in order to improve an organization's performance. A written and comprehensive plan that establishes and coordinates review mechanisms.

Quality Assurance Reform Initiative (QARI)

The Quality Improvement System for Managed Care (QISMC) standards and guidelines pertaining to quality measurement and improvement and the delivery of health care and enrollee services. These standards and guidelines were developed by the Health Care Financing Administration (HCFA), which is now known as Centers for Medicare and Medicaid Services.

QUEST

A Hawaii State government program that provides medical assistance coverage through managed care plans for eligible, lower-income Hawaii residents.

QUEST Reimbursement

A capitated rate by which CAMHD is reimbursed per member per month for each QUEST eligible, CAMHD-registered youth.

Re-Authorization

A formal procedure that extends the procurement of service units for a youth beyond the initial authorization for services and is based on criteria for continued treatment within specified levels of services.

Referral

The process of informing an agency or provider of youth who need mental health services.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

Related Human Services Field

The behavioral sciences, social work, nursing, psychology, and medicine. Any Associate's, Bachelor's, Master's or Doctorate degree in any area not specifically listed above must be reviewed by the CAMHD Licensing and Credentials staff for consideration as an acceptable "related human services field" for the purpose of providing mental health services to youth in Hawaii.

Risk Assessment

An assessment of a youth's potential to be harmed by others or to cause significant harm to self or others. This includes suicide, homicide, and unintentional harm from misinterpretations of reality, inability to adequately care for oneself or temper impulses with judgment, intoxication, or inability to perceive threats to safety. It may include a hostile environment where a youth would be unable to protect himself or herself. A history of dangerous behaviors and/or abuse and/or neglect can be considered in a risk assessment.

Restraint

Restricted movement through the use of physical holds, devices or medication to prevent injury to self or others. (See CAMHD Sentinel Events Policy and Procedures for event code definitions and reporting requirements.)

School-Based Behavioral Health (SBBH)

Behavioral and mental health services provided to students in their respective school environments. Also, a section of the Hawaii Department of Education Comprehensive Student Support System that administers these services and whose goal is to support the healthy social and behavioral development

of all students by providing clearly communicated social, behavioral and academic expectations and supported learning environments.

Seclusion

Involuntary confinement of a person in a room or an area, physically prevented from leaving, and under constant staff observation and supervision. (See CAMHD Sentinel Events Policy and Procedures for event code definitions and reporting requirements.)

Section 504

A section of the federal Vocational Rehabilitation Act of 1973 that protects qualified individuals from discrimination based on their disability. Section 504 defines the rights of individuals with disabilities to participate in, and have access to, all program benefits and services of employers and organizations who receive financial assistance from any federal department or agency, including the U.S. Department of Health and Human Services (DHHS), hospitals, nursing homes, mental health centers and human service programs.

Sentinel Event

An occurrence involving serious physical or psychological harm to anyone or the risk thereof. (See CAMHD Sentinel Events Policy and Procedures for event code definitions and reporting requirements.) A Sentinel Event includes 1) any inappropriate sexual contact between youth, or credible allegation thereof; 2) any inappropriate, intentional physical contact between youth that could reasonably be expected to result in bodily harm, or credible allegation thereof; 3) any physical or sexual mistreatment of a youth by staff, or credible allegation thereof; 4) any accidental injury to the youth or medical condition requiring transfer to a medical facility for emergency treatment or admission; 5) medication errors and drug reactions; 6) any fire, spill of

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

hazardous materials, or other environmental emergency requiring the removal of youth from a facility; or 7) any incident of elopement by a youth.

Social History

A report on a youth that includes information about the school, home, peer, and community domains of the youth's life over time. The report is a result of interviews with the youth, family, significant others, and a thorough review of available formal documents.

State Procurement Office (SPO)

A Hawaii government unit that serves as the central office for obtaining certain goods and services for all governmental bodies of the State and its counties.

Strength-Based Service

Any mental health service for a youth that is based on the individual strengths of that person rather than on their problems or the availability of services.

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 adolescents with severe emotional disturbances and their families.

Telephone Device for the Deaf (TDD or TTY)

A technology device that allows those with hearing problems to send and receive text-based messages through phone lines.

Text Telephone Display (TTD)

Assistive technology device used with telephones to allow text-based messages to be delivered through phone lines.

Therapeutic Group Homes (TGH)

A type of residential placement for youth that provides 24 hour care and integrated service planning addressing the behavioral, emotional or family problems that prevents the youth from taking part in family and/or community life. These homes are designed for students whose needs can best be met in a structured program of small group living in a community-based setting where they can remain involved in community-based educational, recreational and occupational activities.

Title IV-E Training Activity and Cost Reports

Quarterly provider trainer and trainee activity and cost reports that are reviewed by the CAMHD Resources Development Section for eligibility under Title IV-E federal funding.

Transition Plan

That section of the Individualized Education Program (IEP) or other support plan for a youth that specifies the supports and services to be provided to prepare that person for a change from one type of service or placement to another or from status as a youth to an adult.

The 1997 amendments to the Individuals with Disabilities Education Act (IDEA) emphasized that students with disabilities are to be prepared for employment and independent living as they transition to adulthood and that specific attention is to be paid to the secondary education they receive so they may be prepared for this change. Section 300.29 of the IDEA regulations

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

defines transition service as a coordinated set of activities for a student with a disability that 1) is designed within an outcome-oriented process, that promotes movement from school to post-school activities, including post secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation; 2) is based on the individual student's needs, taking into account the student's preferences and interests; and 3) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and if appropriate, acquisition of daily living skills and functional vocational evaluation.

Treatment

The broad range of emergency, out-patient, intermediate, domiciliary, and in-patient services and care, including diagnostic evaluation, medical psychiatric, psychological, and social services care, vocational rehabilitation, career counseling, and other special services that may be extended to individuals with mental health disorders.

Treatment Plan

See "Mental Health Treatment Plan" (MHTP) in this Glossary.

Treatment Team

A multi-disciplinary team consisting of the youth, family, service providers, FGC MHCC, school personnel and other individuals involved in the welfare of the youth.

Treatment Team Meeting

A meeting of members of a youth's treatment team for the purpose of developing, coordinating, reviewing, and/or updating that youth's treatment plan.

Waiver

An exemption for a period of one year or less, from a specific rule, standard, or accreditation requirement which may be permitted a facility for a specified period of time, at the discretion of the CAMHD Chief or designee.

Weekly Census Report on Youth Status, CAMHD

A form that tracks the status of youth in out-of-home placements. The form is submitted to CAMHD on a weekly basis by appropriate providers and includes the date of admission, youth's name and gender, the referring FGC, projected discharge date, actual discharge date, discharge placement, and wait-listed youth at that placement.

Youth

Any person who is no younger than 3 years of age and no older than 20 years of age.

SECTION VI:

APPENDIX

APPENDIX A

STATE OF HAWAII

**CHILD AND ADOLESCENT
SERVICE SYSTEM PROGRAM
PRINCIPLES (CASSP)**

**STATE OF HAWAII
CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM
(CASSP) PRINCIPLES**

- 1. The system of care will be child and family centered and culturally sensitive, with the needs of the child and family determining the types and mix of services provided.**
- 2. Access will be a comprehensive array of services that addresses the child's physical, emotional, and educational, recreational, and developmental needs.**
- 3. Family preservation and strengthening along with the promotion of physical and emotional well-being shall be the primary focus of the system of care.**
- 4. Services will be provided within the least restrictive, most natural environment that is appropriate to individual needs.**
- 5. Services which require the removal of a child from his/her home will be considered only when all other options have been exhausted, and services aimed at returning the child to his/her family or other permanent placement are an integral consideration at the time of removal.**
- 6. The system of care will include effective mechanism to ensure that services are delivered in a coordinated and therapeutic manner, and that each child can move throughout the system in accordance with his/her changing needs, regardless of points of entry.**
- 7. Families or surrogate families will be full participants in all aspects of the planning and delivery of services.**
- 8. As children reach maturity, they will be full participants in all aspects of the planning and delivery of services.**
- 9. Early identification of social, emotional, physical and educational needs will be promoted in order to enhance the likelihood of successful early interventions and lessen the need for more intensive and restrictive services.**
- 10. The rights of children will be protected and effective advocacy efforts for children will be promoted.**

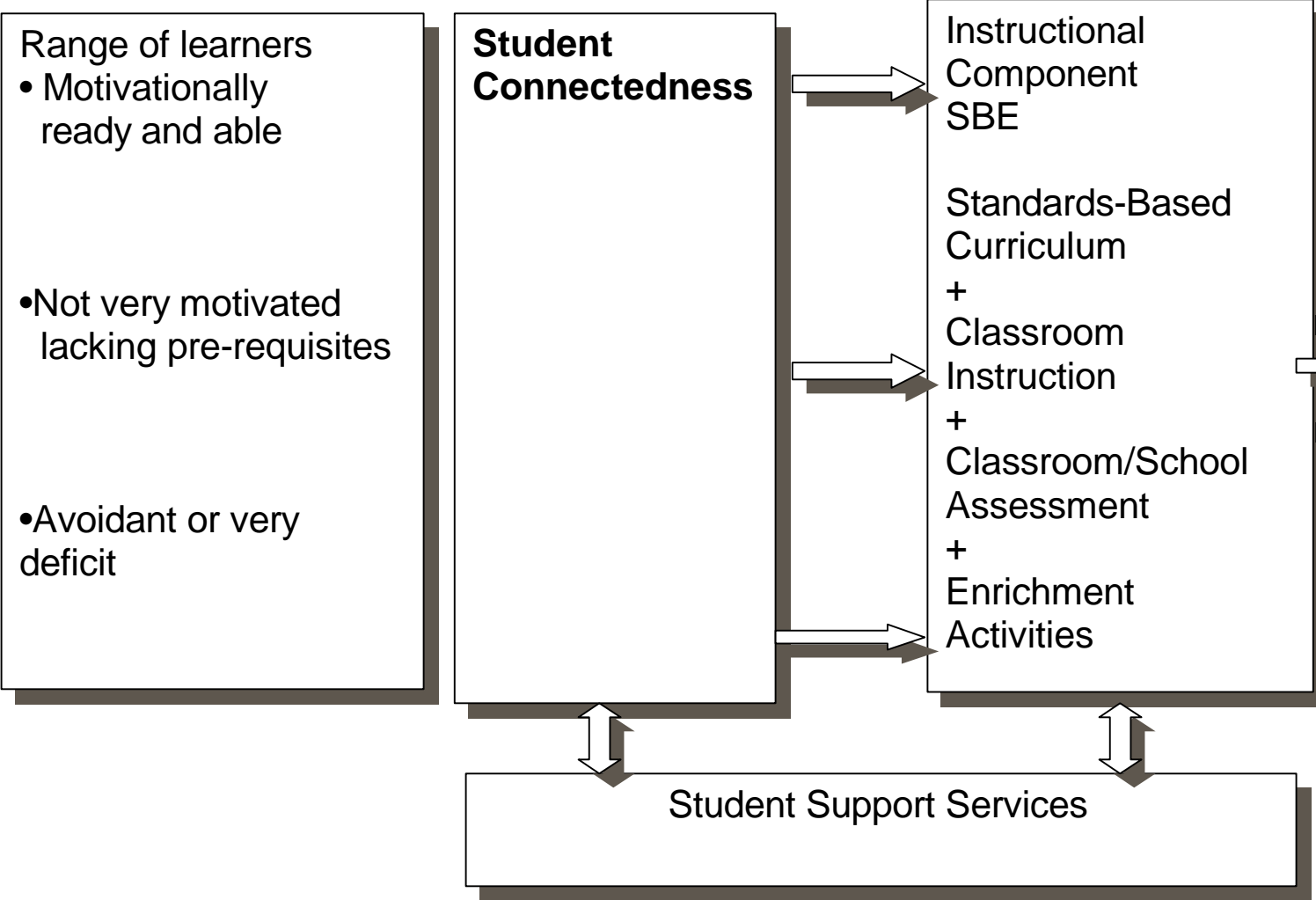
Developed by Hawaii Task Force, 1993

(Adapted from Stroul, B.A., & Friedman, R.M., 1986).

APPENDIX B

Comprehensive Student Support System Conceptual Model

Comprehensive Student Support System Conceptual Model



APPENDIX C

Addendum April 2, 2002:

Community - Based
Residential Programs

High Risk Level II

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

COMMUNITY-BASED RESIDENTIAL PROGRAMS – HIGH RISK LEVEL II

Definition	<p>High Risk Community-Based Residential II programs provide twenty-four (24) hour care and integrated evidence-based services that address the behavioral and emotional problems related to sexual offending, that prevent the youth from taking part in family and/or community life. These programs are designed for those youth whose need can best be met in a structured program of small group living that includes educational, recreational, and occupational services.</p> <p>High Risk Community-Based Residential II programs provide support and assistance to the youth and the family to: 1) promote healthy sexual values and behaviors; 2) reduce and control deviant sexual arousal patterns; 3) help youth to develop victim empathy and appreciate feelings of others; 4) help youth accept full responsibility and be accountable for sexually abusive or antisocial behavior without minimizing risk of reoffending or externalizing blame; 5) identify and change cognitive distortions or thinking errors that support or trigger offending ; 6) develop and integrate relapse prevention strategies; 7) identify family dysfunction, issues, or problems that act to support minimization, denial, disruption of treatment, or trigger reoffending and; 8) provide management of other behavioral or emotional problems.</p>
Services Offered	<ol style="list-style-type: none"> 1. The program provides evidence-based treatment interventions and a supportive milieu therapy; 2. The program provides opportunities for the youth to engage in age-appropriate structured and recreational activities; 3. The program provides psychotherapies and other treatment that address youth in the target population defined above; 4. The program provides for medication administration and management; 5. There is an on-site educational program addressing the educational goals and objectives identified in the youth's IEP/MP; 6. The program provides substance abuse counseling and education as needed; and 7. The program provides structured pre-vocational and vocational training activities as applicable.
Initial Authorizations	Up to three (3) months. [Unit = one (1) day]
Re-Authorization	Up to two (2) months per authorization based on continuation criteria. [Unit = one (1) day]

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

<p>Admission Criteria</p>	<ol style="list-style-type: none"> 1. Youth has severe emotional and/or behavioral disorder(s), which include sexual aggressive behavior; AND 2. The youth has been identified as needing an out-of-home placement; AND 3. The youth has been identified as needing specialized treatment; AND 4. An adequate trial of active treatment at a less restrictive level has been unsuccessful; AND 5. The youth's family or current caregiver(s) are unable to safely and adequately respond to the youth's needs without significant strain; AND 6. There is a reasonable expectation that the youth will be able to achieve the goals and objectives identified in his/her mental health treatment plan (MHTP) within six (6) months; AND 7. The youth's measurable treatment goals included in admission criteria 1-6 must be identified prior to admission.
<p>Continuing Stay Criteria</p>	<ol style="list-style-type: none"> 1. The youth continues to need an out-of-home placement; AND 2. The youth's primary behavioral health issues continues to present a risk or danger to themselves or others; AND 3. The youth's family or current caregiver(s) remain unable to safely and adequately respond to the youth's needs without significant strain; AND 4. The youth's measurable treatment goals have not been met; AND 5. There is reasonable expectation that the youth can benefit from this level of care within the re-authorization period requested.
<p>Discharge Criteria</p>	<ol style="list-style-type: none"> 1. There is a decrease in identified behaviors; AND 2. There is improved, sustainable emotional, behavioral, and social functioning as evidenced by improved school attendance, pro-social peer affiliations, parent-child relationships, and participation in community recreational/leisure activities;

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

	OR
	<ol style="list-style-type: none"> 3. The youth reaches a level of functioning that allows for either a return home or a transition to independent living, with low or no risk of behavior regression; 4. If the youth is intended to transition to an independent living program, the youth has the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful transition to a permanent placement or independent living program; 5. The youth's measurable treatment goals have been met
Service Exclusions	Not offered at the same time Hospital Based Residential Services, Community-Based Residential (General) or High Risk, Foster Homes with Therapeutic Services, Therapeutic Group Homes (General or Individualized), or Intensive Home & Community-Based Intervention Services.
Clinical Exclusions	<ol style="list-style-type: none"> 1. Severity of clinical issues precludes provision of services in this level of care 2. Youth with the following conditions are excluded from admission: <ol style="list-style-type: none"> a. Moderate and Severe Mental Retardation b. Mental Disorders due to a general medical condition

Staffing Requirements:

1. Program must have documentation that staff providing services is trained and experienced in treatment of the population.
2. At minimum, two (2) childcare staff shall be on duty per shift per living unit. Staff are always in attendance whenever youth are present.
3. A QMHP experienced in evidence-based treatment supervises the residential staff.
4. Additional personnel are available and called to duty in emergencies or are scheduled to meet any special needs during busy or more stressful periods such as for one-to-one (1:1) watches, new admissions, staff escort to emergency units, etc.
5. Youth that are ill or otherwise unable to attend school, must be supervised by an available staff wherever the youth is located.
6. Staffing schedules shall reflect overlap in shift hours to accommodate the exchange of information for the continuity of the youths' treatment, adequate numbers of staff reflective of the tone of the unit, appropriate staff gender mix, and the consistent presence and availability of a professional staff.
7. The teacher will have the assistance of at least one behavioral support staff at all times in each classroom to provide necessary therapeutic redirection and interventions. In the event that staff needs to leave an educational activity for any length of time, the program provides additional staff to keep the ratio at least one-to-four (1:4).
8. The program **must adhere to all applicable facility licensing requirements/regulations.**

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

9. The program staff psychiatrist or consultant provides psychiatric services at intervals of at least one (1) face-to-face visit a week. The psychiatrist is available for medical emergencies, assessments, and consults. The psychiatrist is on-site for those emergencies that merit face-to-face services within one (1) hour of the call for assistance, and makes direct arrangements with a community hospital in the event a youth is in need of possible hospitalization. This will be duly documented and kept on file at the program. There is established protocol for appropriate qualified medical coverage in the absence of the designated psychiatrist. The psychiatrist has current courtesy or staff privileges at the community hospital within the same county as the program.
10. Depending on the needs of the youth, the services of qualified professionals and specialists in medicine, education, nursing, recreation, dietetics, etc., are available among the organization's personnel or through cooperative arrangements.
11. The licensed psychiatrist or psychologist is responsible for the treatment program and for those in care, and provides on-call coverage twenty-four (24) hours per day, seven (7) days a week.
12. A licensed registered nurse is on staff to establish the system of operations for administering or supervising residents' medications, and medical needs or requirements, monitoring the residents' responses to medications, tracking and attending to dental and medical needs, and training direct care staff to medications and proper protocols.
13. Staff must have at least twenty-four (24) hours of basic orientation training including, but not limited to crisis assessment and intervention, suicide assessment, clinical protocols, documentation, knowledge of community resources as well as the court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consents that must be completed prior to performing crisis outreach services.
14. Staff receive at a minimum, two (2) hours per month of group supervision by a QMHP utilizing a combination of methods such as direct observation, coaching, and role modeling to improve the level of staff skill. The amount and frequency of supervision may be reduced as authorized by the clinical supervisor on the basis of documented individual aptitude, experience, and satisfactory performance.

Clinical Operations

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The program is cognizant of community safety and risk issues and has policies and procedures and the mechanisms to effectively manage these issues.
3. The program will not exceed eight (8) youth .
4. Community-Based Residential Programs staff must be supervised by a licensed QMHP knowledgeable of evidence-based treatment. Staff include: childcare workers, resident counselors and teaching aides.
5. The program is physically secure at all times. Twenty-four (24) hour supervision is provided to the youth. Behavioral/treatment plans are closely adhered to with consistency among the staff throughout the programming.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

6. Staff providing treatment must be a licensed QMHP experienced in evidence-based treatment for sexually offending youth with mental health needs and have a minimum of three (3) years direct experience in children's mental health and in this area.
7. The program actively engages youth in planned, structured, therapeutic activities throughout the day, seven (7) days a week. There is a predictable and orderly routine that allows youth to develop and enhance interpersonal skills and behaviors.
8. The physical setting is home-like and furnished appropriate to the youths' developmental age. The youth are encouraged to appropriately decorate and maintain their personal space.
9. Families are actively involved and participate in team meetings, program events, therapy sessions, and so on. They are engaged in opportunities to gain knowledge and practice of what works in the program that can be transferred to the home and community environment.
10. Educational services are provided within the program and are guided by the youth's IEP/MP. The program works with the DOE to insure appropriateness of the educational services and the credits earned while in treatment will be accepted by the receiving school and counted towards school credits. The program works closely with the DOE to insure adherence to the youth's IEP/MP and a smooth transition back to the home school or alternative transition plans for those who are not returning to their home schools.
11. Agencies will adhere to CAMHD's "no eject/no reject" rule and are expected to work with residents who present behavioral and emotional issues while at the program.
12. Whenever a youth is absent from the program for at least twenty-four (24) hours, CAMHD may elect to hold the bed for up to seven (7) consecutive days at fifty percent (50%) of the unit rate with prior written CAMHD authorization. The provider must agree to accept the return of the client into the program unless it is determined, at the cost of the agency, through an evaluation by an independent psychiatrist (not the agency psychiatrist) that an alternate placement option is necessary. The selection of the psychiatrist shall be agreed upon by CAMHD. The results of this evaluation must be provided to CAMHD prior to any action being taken. CAMHD reserves the right to execute contractual action if the provider agency is unable to meet the need of the Felix youth.

Documentation

1. Treatment Planning--Includes documentation of a preliminary statement about the purpose of treatment, the goals to be achieved via treatment, the anticipated length of stay, and the anticipated individualized transition/discharge criteria. The youth's FGC MHCC and/or FGC Clinical Director will provide this information to the program prior to admission.
2. The Community-Based Residential program shall provide daily progress notes as documentation of treatment progress and/or significant events, activities or milestones, including absences of twenty-four (24) hours or more. These notes shall be fully dated and signed by the staff providing twenty-four (24) hour supervision, originals of which shall be maintained in the agency's master youth file.

INTERAGENCY PERFORMANCE STANDARDS AND PRACTICE GUIDELINES

3. Crisis Planning--Each youth will have a detailed crisis plan specific to his/her emotional and behavioral needs and patterns. Plans include details of triggers, setting events, functions served by the inappropriate behavior, and appropriate early interventions. Typically crisis plans are built by and/or around those who know the youth best and have an established relationship. Crisis plans are established prior to admission as part of the youth's treatment plan and revised as needed during the course of treatment. The agency has established protocols and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Requests for police assistance are limited to situations of imminent risk of harm to self or others.
4. Discharge/Transition Planning--Plans are in place prior to admission. If the youth is to be discharged home a treatment focus will be parent skills development, positive behavioral plan development and implementation with the family as an essential partner. Therapeutic home passes are directly related to transition plans toward ultimate discharge home. If the youth is not going to be discharged home, program focus and transition planning will occur toward the alternative plan, e.g., independent living or foster placement.
5. Program must have documentation that staff providing services is trained and experienced in treatment of the population.