Child and Adolescent Mental Health Performance Standard

State of Hawaii

Department of Health
Child & Adolescent Mental Health Division

Effective December 28, 2024

SECTION III: APPENDIX

INTRODUCTION

The Hawai'i State Department of Health's (DOH) Child & Adolescent Mental Health Division (CAMHD) provides supports and services through an integrated public-private partnership consisting of contracted community-based agencies, state managed community-based Family Guidance Centers, and a centralized state office to provide administrative, clinical and performance oversight functions. The system of care has developed a comprehensive array of evidence-based supports and services for children and youth with the most challenging emotional and behavioral difficulties, and their families.

The 2024 Edition of the Child and Adolescent Mental Health Performance Standards (CAMHPS) is a manual developed by CAMHD for use in the development and provision of behavioral health services for youth in Hawai'i. It is the sixth such manual issued by the division, and informally named after the color of its cover; in this case it will be known as the "Pink Book." This manual is part of the contractual agreement between CAMHD and its contracted provider agencies for delivering behavioral health services to youth and families in Hawai'i. These standards are designed to describe the array of mental health services available, and to ensure the efficiency and effectiveness of those services. Unless granted a written waiver from CAMHD, all Contracted Providers Agencies, their employees and subcontractors are required to comply with these standards and with their specific contracts which delineate additional requirements for each service. The CAMHPS will be available in electronic form on the CAMHD website, and all updates will be published (under Performance Standards).

Through its seven (7) Family Guidance Centers and the Family Court Liaison Branch, herein after referred to as Centers, the CAMHD provides clinical oversight and case management services to youth and families throughout the state through an assigned Clinical Lead and Care Coordinator. CAMHD also procures needed services from its Contracted Provider Agencies to meet the treatment needs of youth. CAMHD provides services to youth who meet clinical criteria for serious emotional or behavioral disturbance and who qualify for funding support from the state based on one or more of the following: 1) they have QUEST-Integration insurance; or 2) they have been certified as qualifying for special education services under the Individuals with Disabilities Educational Act (IDEA) and their Individual Educational Plan (IEP) team requests CAMHD services; or 3) they are involved in the Juvenile Justice system and are referred to CAMHD by the Office of Youth Services. Small numbers of other youth may become eligible for CAMHD services based on their qualifying for a particular special program, usually grant-funded.

At its first publication in July 2024, this version of the CAMHPS is designed to present all the relevant regulations and standards that apply currently to Contractors. Nonetheless, CAMHD and its Contracted Provider Agencies operate in a rapidly changing healthcare environment, and frequent updates to the CAMHPS are anticipated. In particular, CAMHD is committed to the development of health information systems in alignment with healthcare policies at the National level. Since these policies can change frequently, Contracted Provider Agencies are expected to comply with new billing and documentation practices as they develop. CAMHD expects to introduce many improvements to its information system over the proposed contract period, and Contracted Provider Agencies will be expected to cooperate with the implementation of these improvements. There is an exciting and challenging future ahead for CAMHD and its Contracted Provider Agencies. Let's go forward together.

SECTION I:

GENERAL PERFORMANCE STANDARDS

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OVERVIEW

The General Performance Standards are requirements for all Child and Adolescent Mental Health Division (CAMHD) services and apply to all services. They are set forth to guide effective practices in the delivery of behavioral health supports and services for eligible youth in the State of Hawai'i.

CAMHD reserves the right to amend this book in the future by adding new services or revising existing service standards as necessary to meet the needs of the youth of Hawai'i. Any changes that may occur in the future will be posted on the CAMHD website under Performance Standards. Additionally, CAMHD will periodically revise its policies and procedures to comply with department policies, changing laws, regulations and rules as required. All contracted providers will be notified of any policy and procedure change that may affect their operations.

A. CORE COMPONENTS OF CURRENT CAMHD SYSTEM

These core components underlie the values CAMHD strives to operationalize in its practices. The CAMHD expects the same commitment from contracted providers to support these components in their respective practices.

1. **Commitment to the Hawaii CASSP Principles**
   Nationally, the CASSP principles (Stroul, B.A. and Friedman, R.M., 1986) were developed in accordance with the original work of Jane Knitzer in an effort to provide a framework of principles for newly created systems of care. Early in the 1990s, Hawai'i communities and stakeholders made minor language revisions to these CASSP principles to effectively address the relevant cultural issues as they presented in Hawai'i. CAMHD is committed to the CASSP Principles and expects the same commitment from contracted providers.

2. **Commitment to Interagency Collaboration & Coordination**
   Most of the youth served by CAMHD attend public schools, and may be involved with the child welfare system, juvenile justice system, or other DOH Divisions, including Alcohol & Drug Abuse ("ADAD"), and Early Intervention Services ("EIS"). A large percentage of the CAMHD population is enrolled in one of the QUEST Integration Health plans and may receive special healthcare services. Because most of the CAMHD population is involved with one or more child-serving agency, The CAMHD prioritizes Family Guidance Center (FGC) staff working collaboratively with these agencies to best meet the treatment needs of youth and their families.

   CAMHD works closely with state agencies through the Hawaii Interagency State Youth Network of Care (HISYNC) group. HISYNC meets monthly and brings together leaders from the state child-serving agencies including: Department of Education, Department of Health, Department of Human Services, and Judiciary along with the Parent Partner and Youth Partner service providers for CAMHD. HISYNC meetings provide opportunities for these groups to share and compare data about service system outcomes, and to discuss policy changes that could improve the system. There are several active Hawaii Interagency Local Youth Network of Care (HILYNC) groups that bring the same agencies together on a local/regional level. Contracted providers who experience difficulties collaborating with one of these state child-serving agencies are encouraged to raise their concerns with CAMHD leaders for discussion at HISYNC, and to attend their local HILYNC meetings.

3. **Commitment to Evidence-Based Practices**
   Mental health services provided within the CAMHD system are expected to be evidence-based. Interventions with youth are meant to incorporate elements of those treatments identified as

most promising based on credible scientific data. The proposed array of services provides a medium through which evidence-based interventions can be applied at high levels of intensity and in a variety of settings, depending on the needs of the youth. The CAMHD regularly reviews, summarizes, and disseminates relevant research data to support agencies in their selection and implementation of services. All treatment planning for psychosocial and pharmacological interventions should stem from careful consideration of the most current research. The following resources offer up to date summaries of the youth mental health treatment literature: (a) Blue Menu of Evidence-Based Psychosocial interventions for Youth the evidence-based child and adolescent psychosocial intervention matrix and (b) the practices derived from the evidence base, organized by problem area (scroll to the "See What Works" sections within the specific links for Common Issues of the Help Your Keiki website).

In addition, agencies are encouraged to make data-based decisions throughout the entire treatment process. This might include gathering and evaluating CAMHD or agency-collected data on client outcomes and functioning to further inform clinical decisions and the design of appropriate interventions.

a. Definition of Evidence-Based Practice

Evidence-based practices include all those treatment strategies and interventions for which observable, objective data exist demonstrating positive effects. Using evidence-based treatment means using interventions that have been shown to work. CAMHD contracted providers are expected to utilize data about an individual youth's progress along with the best available information about "what works" in planning and revising treatment. The data (or evidence-bases) showing the positive effects of mental health treatment practices can take one of four complimentary forms, listed below: general services research, case-specific historical information, local aggregate data, and causal mechanism research (Chorpita & Daleiden, 2018). Higher priority should be given to more reliable or stronger forms of evidence in making treatment decisions see CAMHD's Measurement-Based Care: Values, Vision, & Procedures 2023 Update (download from Clinical Tools). Information about the evidence base for various practices should be considered within the context of the client and family's lives and utilized throughout the course of treatment to make clinical decisions.

i. General Services Research

General service research is data typically found in peer-reviewed scientific journals (e.g., in the form of randomized clinical trial outcomes), and summarized in reports such as the (1) Blue Menu of Evidence-Based Psychosocial Interventions for Youth; (2) Help Your Keiki website; and (3) Percent in research protocols @columns (specific to particular problem areas) in the Practice Element Matrix. Defined this way, evidence-based practice can include large proprietary protocols (e.g., Multisystemic Therapy), broad-based therapeutic approaches (e.g., Cognitive- Behavioral Therapy), and discrete clinical techniques or practice elements (e.g., Caregiver Psychoeducation). When there is limited or weak published research evidence about an approach, but it appears promising, the strategy is often referred to as a "best practice."

ii. Case-Specific Historical Information

Case-specific historical information is case-specific data from repeated clinical interactions in the form of standardized (e.g., Ohio Scales, CAFAS, RCADS, ASEBA) or idiographic (individualized) assessment strategies (e.g., treatment target progress ratings, mood or SUDS ratings, etc.). The usefulness of such data increases as the number of routine assessment points increases over time, and the data can be displayed graphically to help demonstrate strategies that are helpful to an individual youth on a case-by-case basis. Examples of this evidence-base include data on the client-level

dashboard that will be provided within the client's electronic health record via a CAMHD MAX Provider Portal when it becomes available.

iii. Local Aggregate Evidence

Local aggregate evidence is case-specific data aggregated across numerous children/youths into meaningful composite units, such as treatment providers. Such evidence includes not only positive clinical outcomes (e.g., a specialty provider may have high rates of success with children/youth with severe substance abuse concerns; a program that uses traditional Hawaiian cultural practices may have a high rate of success with children/youth who are of Native Hawaiian descent), but also critical incidents (e.g., a certain provider may have higher than average elopement rates, and care should be taken before child/youth at risk for elopement are placed there). These types of data are sometimes referred to as practice-based evidence. Within the CAMHD, examples of this evidence-base include (1) findings from the local evidence for particular problem areas and levels of care within the Practice Element Matrix and (2) data found on the Provider Feedback Reports shared at the biannual Decision Support Collaborative (DSCo) party. Examples of this evidence-base include data found on the provider-level dashboard that will be provided within the client's electronic health record via the MAX Provider Portal when it becomes available.

iv. Causal Mechanism Evidence

Memory, judgment, and the professional knowledge of team members regarding the various causal mechanisms associated with the developmental psychopathology and treatment trajectory associated for a given child/youth can be used to guide treatment. Many times, such expertise is sought to help construct interventions for children/youth who have received empirically supported treatments but have not yet met treatment goals. Say for example, that a team has an agreed-upon case conceptualization that a youth's treatment for her trauma is not progressing adequately because the youth has an overall poor sense of control over her environment. Therefore, in addition to exposure-based strategies, the team recommends that extra care should be taken for cognitive restructuring and parenting strategies that help the youth exert personal control over her environment. Given potential information-processing biases and other concerns associated with human memory and judgment, care should be taken when relying on this evidence-base and the other forms of data above should first be strongly considered.

As outlined above, the term "evidence-based practice" extends well beyond brand-name packaged programs such as Multisystemic Therapy and Functional Family Therapy. The term "evidence" can and should take on many forms and exists within a broader culture of data-informed decision making. CAMHD is committed to developing resources to support families in becoming informed consumers of mental health services. As a result, CAMHD encourages providers to direct clients and families to the Help Your Keiki website to learn more about evidence-based practices.

4. Commitment to Ethical and Inclusive Service Delivery

The CAMHD is committed to providing services in an ethically upstanding manner, consistent with the ethics codes of the American Psychological Association, National Association of Social Workers, American Psychiatric Association, and those of other national organizations relating to the provision of mental health services. The CAMHD employees and Contracted Service Providers are expected to provide services in a non-discriminatory manner, consistently maintain appropriate professional boundaries, regularly seek informed consent, and respect the youths' and families' rights, prioritizing the benefits to the client of any therapeutic intervention over personal or professional gain.

Any sexual contact between Contracted Service Providers staff members and youth is strictly forbidden, and any incident of this kind can be grounds for immediate termination of a Provider's contract. Contracted Service Providers are expected to supervise all agency staff closely and to be attuned to the risks of boundary violations by staff.

The CAMHD remains commitment to serving all eligible youth, regardless of race, ethnicity, national origin, religion, culture, sex, sexual orientation, gender identity and expression, and disability. The CAMHD and its Contracted Service Providers continually strive to provide eligible youth and families with services sensitive to and nurturing of each individual youth's and family's identity, language, and culture. Services are to be provided in a youth and family centered culturally appropriate manner, and inclusive of the youth identified name and pronoun (See CAMHD's Non-Discrimination Policy-Lesbian Gay Bisexual Transgender (LGBT).

5. **Commitment to Quality Improvement**
The CAMHD is committed to ongoing evaluation of performance, compliant billing practices, and the use of data to improve Contracted Service Providers and CAMHD system development. Its quality improvement practices involve an extensive system for examining performance and using findings to make informed decisions about services and needed adjustments to program implementation. The CAMHD tracks and analyzes performance data across all aspects of service delivery and care. CAMHD uses this information to determine how well the system is performing for youth, how well Contracted Service Providers are serving the youth and how well youth are progressing. It is sensitive enough to determine if the system is performing better or worse for certain populations, and comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring. Services are monitored through tracking of trends and patterns found in utilization, outcome and satisfaction data, and examinations of practice and quality of services.

   Additionally, CAMHD is committed to the development of a health information system which is in alignment with healthcare policies at the National level. Since these policies can change frequently, Contracted Provider Agencies are expected to comply with new billing and documentation practices as they develop. Developments are aimed at the long-range goal of a centralized electronic health record, efficient and immediate information sharing, real time data for a variety of indicators (i.e. census, utilization, sentinel events, demographics, credentialing, etc.) and efficient billing of services that is compliant with national requirements. CAMHD expects to introduce many improvements to its information system over the proposed contract period, and contracted providers will be expected to cooperate with the implementation of these improvements.

6. **Commitment to Information System Performance**
CAMHD is committed to the development of health information systems as tools to improve youth services. These systems are developed in alignment with healthcare policies at the National level. Since these policies can change frequently, contracted providers are expected to comply with new federal and state-required billing and documentation practices as they develop. CAMHD system developments are aimed at the long-range goal of a paperless care system, a centralized electronic health record, efficient and immediate secure information sharing, availability of real time data for a variety of indicators (i.e. census, utilization, sentinel events, demographics, credentialing etc.), and efficient billing of services in compliance with national requirements and standards. CAMHD expects to introduce many improvements to information systems over the proposed contract period, and Contracted Provider Agencies will be expected to cooperate with the scheduled implementation of these improvements. Contracted Service Providers will be expected to adjust the schedules, systems, and formats by which they send administrative, clinical, and billing documentation to CAMHD with these system changes. These systems changes are to reach the goal of near-real time availability of information for decision-

making by those providing services to specific youth and managing the CAMHD systems of care as a whole.

7. Commitment to Continuity of Care

The CAMHD believes that every child/youth is capable of recovery and resiliency. CAMHD seeks to promote individualized care which empowers youth and their families to achieve their goals and maximizes their opportunities to live full lives in their own communities. The CAMHD is committed to the philosophy of providing treatment at the most appropriate and least restrictive treatment setting necessary for effective and efficient treatment to meet the youth's bio-psychosocial needs. We see the continuum of care as a fluid treatment pathway, where youth may enter treatment at any level and be transitioned to more or less restrictive treatment setting as their changing clinical needs dictate. In any treatment setting, care should be individualized and should take into consideration the youth's stage of readiness to change and participate in treatment.

CAMHD's commitment to treating youth in the least restrictive environment includes utilizing out-of-home locations that are near their family if they can't be appropriately treated in their family home. Nonetheless, there are a few specialized situations that warrant sending youth to specialized treatment facilities out-of-state. These situations are utilized only when CAMHD cannot provide for the youth's needs in Hawai'i, and only with careful consideration by the treatment team and approval by the CAMHD Medical Director. Out-of-state treatment is utilized only until the youth can be safely returned to Hawaii to continue their treatment at or near their family home.

CAMHD does not treat young adults (those over 18 years old) in out-of-home or out-of-state residential programs. Youth up to 17 years of age may be treated in an out-of-home residential program in Hawai'i. If the youth turns 18 while in treatment, the young adult must exit that residential program before their 19th birthday. Likewise, youth up to 17 years of age may be considered for out-of-state treatment, but if the youth's anticipated course of treatment extends into their 18th year of life, out-of-state treatment is not an option.

Medical Necessity criteria will dictate the admission, continuing stay, and discharge criteria for each service CAMHD provides. While these criteria are designed to assign the most effective and least restrictive treatment setting in nearly all instances, an infrequent number of cases may fall beyond their definition and scope. Thorough and careful review of each case, including consultation with Family Guidance Center Clinical Lead, will identify these exceptions. As in the review of other cases, these decisions should be made based on all available clinical data and clinical judgment consistent with the standards of good medical practice will be used in making medical necessity determinations.

Medical necessity decisions about each youth are based on the clinical information provided by the treating practitioner or facility, the application of the medical necessity criteria and available treatment resources. We recognize that a full array of services is not available everywhere. When a medically necessary level of care does not exist or is not available, we may authorize a higher than otherwise necessary level of treatment so that services are available that will meet the youth's essential needs for effective treatment.

8. Commitment to Providing Medically Necessary Services

CAMHD as a Medicaid Provider may only authorize treatment that is Medically Necessary and will use this definition of Medical Necessity to guide its service delivery:

a. The medical goods or services provided or ordered must:
   i. Be necessary to protect life, to prevent significant illness or significant disability;

ii. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness under treatment, and not in excess of the youth's needs;
iii. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
iv. Be reflective of level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
v. Be furnished in a manner not primarily intended for the convenience of the youth, the youth's caretaker, or the provider.

b. "Medically necessary" or "medical necessity" for hospital services require that those services furnished on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished on an outpatient basis.
c. The fact that a provider has prescribed, recommended, or approved medical or allied goods, or services does not, in and of itself, make such care, goods or services medically necessary or a medical necessity.

9. Commitment to Clinical Excellence and Co-management of Care

To ensure clinically appropriate, effective and efficient treatment is provided, CAMHD maintains clinical oversight of each youth served. Upon enrollment at a Family Guidance Center (FGC), each youth is assigned a "team" of mental health professionals which minimally consists of a Care Coordinator (CC) and a Clinical Lead (CL), moving forward referred to as the FGC Team. The FGC Team works together with families, contracted providers and other stakeholders to promote wellness and assure the highest quality care for the youth they serve.

Clinical Lead

Within each Family Guidance Center, either a Clinical Psychologist or a Child Psychiatrist serves as the Clinical Lead on a youth's FGC Team. Clinical Leads are responsible for providing clinical case formulation, treatment direction and service authorization via collaboration and consultation with the youth's assigned Care Coordinator and contracted service provider over the course of a youth's care.

Clinical Leads begin a youth's care by determining their eligibility into CAMHD. Frequently, Clinical Lead's will perform a youth's Initial Mental Health Evaluation (IMHE) and use those findings to make their eligibility determination. Other times, a Clinical Lead will review an evaluation written by a non-CAMHD clinician and perform a functional assessment to determine eligibility.

The Clinical Lead documents the broad direction of treatment for each assigned youth using a Clinical Management Plan (CMP). The CMP is initially based on the Initial Mental Health Evaluation (IMHE), along with feedback from the youth and family, and is updated to reflect changes in the direction of treatment over time. The CMP outlines the major areas of focus for the proposed treatment and serves as the clinical insert to the youth's Coordinated Service Plan (CSP). Service providers are expected to utilize treatment focus areas and treatment targets from the CMP in developing their Mental Health Treatment Plans (MHTP).

The Clinical Lead's co-management of a youth's care is ongoing throughout treatment with CAMHD. Co-management includes direct communication between the Clinical Lead and contracted service provider and/or their supervisor to obtain information about the status of the youth in treatment, as well as consult and collaborate to develop individualized and clinically indicated treatment and crisis plans. In addition, Clinical Leads and Care Coordinators work together to understand all the systems and issues impacting a youth's therapeutic progress to facilitate proactive and effective treatment planning for the youth they serve. To accomplish this, on a regular basis, the Clinical Lead reviews each youth's

case with the Care Coordinator at a minimum, once a month. This case review process includes a review of all available clinical data and helps to assure that the services are appropriate to address the youth's identified needs and that they meet "medical necessity" criteria.

Care Coordinator

The Care Coordinator (CC) is the case manager on the youth's FGC Team who promotes family and youth engagement in treatment, facilitates access to services and provides interagency collaboration and coordination to ensure timely, appropriate, and integrated service delivery.

Upon enrollment, a youth's Care Coordinator serves as the main point of contact for family members and other stakeholders in a youth's life such as school officials, probation officers, and contracted service providers. Care Coordinators establish rapport with families via psychoeducation, system navigation assistance, as well as modeling and guidance to empower parents to advocate for their child's best interests in a variety of interagency settings. Care Coordinators work collaboratively with other child serving agencies to engage in a Coordinated Service Plan (CSP) that outlines all pertinent parties involved with the youth and family, each entity's goals, strategies, and plans. The initial CSP, however, is developed in the Welcome Meeting with the Clinical Lead and family present with the purpose of determining treatment direction and the appropriate service for the family. The Care Coordinator is responsible for making the referral to the contracted provider agency in a timely manner to ensure service delivery within thirty (30) days of eligibility determination, or immediately, if the youth has immediate needs. Within thirty (30) days of the Welcome Meeting, the Care Coordinator is responsible for convening a full CSP meeting with all stakeholders at the table. Contracted providers are expected to participate in the CSP development and meetings when they are involved with the youth.

The Care Coordinator maintains contact with the family and providers monthly to facilitate the integration, coordination, and monitoring of behavioral health services. Quarterly CSP meetings are arranged by the Care Coordinator to ensure that all parties involved are working together congruently and in the best interest of the child. The Care Coordinator is responsible to bring CSP team updates and other pertinent information related to the youth and family to the attention of the Clinical Lead via the case review process so adjustments can be made as needed and medical necessity can be assessed.

Co-Management

CAMHD youth and their families receive most of their direct clinical services from Contracted Provider Agencies, based on the performance standards included in this manual. The services provided should reflect the best clinical thinking of both the contracted service providers and the FGC Team of the Clinical Lead and the Care Coordinator. The Contracted Service Provider and the FGC Team should work together to develop a clear formulation of the youth and family difficulties, and to pursue optimal outcomes.

Although the FGC Team maintains authority over decisions about authorizing treatment, including the type of care, number of hours, etc., the youth's treating Contracted Service Provider and their supervisor maintain authority over the clinical choices made in the day-to-day work with the youth and family. The FGC Team gathers ongoing information from the Contracted Service Provider about the youth's clinical presentation, strengths, problematic events, and response to treatment interventions to help inform decisions about treatment authorization. The Clinical Lead's consultation may help the team consider different treatment options and suggest ways to improve the ongoing therapeutic approach.

Contracted Service Providers are responsible for coordination of services provided within their agency and for maintaining regular communication with the FGC Team. Coordination and communication are particularly important in settings where there are multiple staff providing services for a youth. Contracted Service Provider are also expected to coordinate efforts with the youth's school and community settings. Ongoing engagement, communication and coordination with families are a necessary practice as families are an integral part of the therapeutic process.

Threshold

The CAMHD analyzed its own local data to determine appropriate length of stay guidelines for most service in its array. By using local aggregate outcome data as entered by CAMHD and its contracted providers, CAMHD has determined the point in treatment at which youth, on average, stop showing significant improvements in their clinical progress. Information about these time frames for each type of care are stated in the service reauthorization section for each service specific standard.

CAMHD analyzed the Child and Adolescent Functional Assessment Scale (CAFAS) and Monthly Treatment and Progress Summary (MTPS) data from the past five years to determine the time frame in which the majority of youth showed maximum improvement based on these measures. This time frame is provided to guide service authorization decisions, based on available data, but are not meant to be an absolute end point in any treatment service. Treatment must have ongoing review by the Clinical Lead to ensure the youth will continue to benefit from further treatment. As CAMHD continues to use data to improve its practices and inform clinical decision making, the use of a secondary review may be necessary if supported by data and will be implemented to ensure effective and efficient service delivery.

B. ELIGIBILITY

CAMHD is committed to providing timely services, individualized planning, and access to an array of services. CAMHD services, whether they are delivered by employees or contracted providers, are expected to be initiated and provided in a timely and consistent manner, as guided by the standards and practice guidelines defined in this manual.

1. Eligibility Criteria

CAMHD serves Hawai'i youth aged 3 through 17 with "intensive" mental health treatment needs, sometime referred to as youth who have Severe Emotional and Behavioral Disturbances (SEBD). To be eligible, youth must:

a. Meet criteria for a qualifying mental health diagnosis as determined by a Qualified Mental Health Professional (QMHP).
    i. The diagnosis must be listed in the Diagnostic and Statistical Manual of Mental Health Disorder, 5th Edition, Text Revision (DSM5-TR)
        1. Substance Use Disorders on their own do not qualify a youth for CAMHD services, but they can co-occur with a psychiatric disorder.
        2. Youth who have moderate to severe Intellectual and Developmental Disorders or who qualify for service from the Hawaii State Developmental Disabilities Division are not eligible for CAMHD services.

b. Demonstrate significant functional impairment. This means the youth is showing significant difficulties functioning in several life domains.

i. CAMHD uses the Child and Adolescent Functional Assessment Scale (CAFAS) to determine whether youth meet this criterion.

c. Be funded by one of the following:
   i. Their QUEST-Integration insurance;
   ii. Office of Youth Services (OYS) with approval from the Director of OYS;
   iii. State General Funds for youth who are referred by their Department of Education (DOE) via the youth's Individual Educational Program (IEP) Team; or
   iv. Qualifying for a CAMHD grant funded program. These programs may have additional criteria and age requirements that are beyond CAMHD's eligibility requirements. More information about these programs and their admission criteria can be obtained on CAMHD website (See Other Programs under Our Services).

2. Eligibility and Co-occurring Disorders

Many youth receiving services from CAMHD have mental health disorders that co-occur with substance abuse, mild Intellectual and Developmental Disabilities, or medical impairments (e.g. blindness, deafness, diabetes, etc.). The presence of co-occurring disorders is assessed with all youth at the point of initial assessment, as well as routinely during the course of ongoing treatment. CAMHD does not provide services that are appropriate for youth with moderate or severe Intellectual and Developmental Disabilities.

It is required that all contractors will provide integrated treatment for co-occurring substance abuse disorders and mental health treatment with appropriate accommodations for youth with medical impairments.

3. Application

The Application Form for CAMHD Services is available on the CAMHD website (See How to Apply) and from every Family Guidance Center (FGC). All DOE referrals for non-QUEST youth must include an Emotional-Behavioral Assessment or other diagnostic evaluation.

The parent or legal guardian must sign the application consenting to have their child evaluated to determine eligibility for CAMHD services. Any family interested in applying for CAMHD services can get help completing the form through their local Family Guidance Center. Applications should include an existing Mental Health Evaluation that is less than twelve (12) months old when one is available to help expedite the process.

4. Intake

The intake process for a new application is coordinated by the Mental Health Supervisor (MHS1) in the local Family Guidance Center. The MHS1 will conduct a brief phone or in-person interview with the parent/guardian requesting services to gather basic information about the youth and the help being sought. When appropriate, the MHS1 will schedule a Mental Health Evaluation, with one of the FGC's Clinical Leads or with an outside Provider to determine an initial working diagnosis and to assess functional impairment. Referrals from IEP Team must be accompanied by an evaluation with a mental health diagnosis within the past twelve (12) months. Once an adequate Mental Health Evaluation is available, the Clinical Lead uses the information to assess functional impairment of the youth to make an eligibility determination before the MHS1 completes the enrollment process. Youth who are eligible are assigned to a Care Coordinator and a Clinical Lead, and parents/guardians are contacted to begin CAMHD services with a Welcome Meeting. Youth who are not found ineligible, parents are contacted and informed of the decision. They are provided information both about the CAMHD appeals process and about ways to get alternative help for their child.

5. Welcome Meeting

A Welcome Meeting is the introductory meeting between the family and the FGC Team. This meeting is the FGC Teams initial opportunity to engage the family in their treatment via psychoeducation and rapport building. The FGC Team members engage in shared decision making with families by explaining the clinical findings of their child's evaluation, presenting a range of medically necessary treatment options, and providing guidance around which service would be the best fit for the family based on the family's treatment goals as documented in the CMP and initial CSP.

6. Use of Telehealth to Improve Access

Telehealth technology may be used to help deliver needed services by MHPs or QMHPS to remote areas when travel distances and costs make in-person delivery impractical. All services provided by telehealth shall be consistent with Hawaii Revised Statute 226 (2016), CMS regulations, and Med-QUEST guidelines. In general, telehealth services shall be used to serve families when the CAMHD Clinical Lead deems it clinically appropriate and the family/youth agrees to the use of telehealth services, and necessary equipment and telecommunications services are available to them. If the family/youth do not agree to the use of telehealth, services must be provided in-person only.

Telehealth service delivery must be clinically appropriate as evidenced by the CAMHD Clinical Lead's approval thru incorporation of telehealth on the youth's Clinical Management Plan (CMP). The Clinical Lead may modify the plan for telehealth use based on service effectiveness or outcomes. Some aspects of the treatment plan may be better suited to the use of telehealth than others. For example, parenting skills work with a parent may work well, whereas play therapy with a young child probably will not.

In most cases, there should be an initial in-person meeting with the youth and family to plan future services and discuss use of telehealth. This may also be during the "pre-admission meeting" that includes the Care Coordinator and/or the Clinical Lead. Following this, direct services may include use of the telehealth modality for the majority or even all of the clinical contacts. However, the FGC Clinical Lead may set case-specific requirements for an increased proportion of onsite services to ensure good youth outcomes. The Contracted Service Provider must detail the plan for telehealth use on the MHTP and discuss it in treatment team meetings. The Contracted Provider Agency's supervising QMHP is expected to oversee some portion of direct telehealth services via "sitting in" virtually on a percentage of youth visits. The Contracted Provider Agency QMHP and MHP conducting telehealth services are required to have training in therapeutic service delivery via telehealth.

a. Telehealth facilities.

   Contracted agencies that wish to provide services via telehealth must meet a number of technical requirements. Each Agency is required to use <u>one</u> single technical platform for all telehealth services delivered by the agency (examples: Zoom, VSee, Microsoft Teams, etc.) The technical platform must allow full-screen bi-directional video and audio communication, sufficient for therapeutic use by CAMHD-credentialed contracted agency therapists. The agency must ensure youth-serving staff training and support in the equipment and platform used.

   Billing for this service must include clinical notation of the services as via telehealth. Telehealth equipment must allow for audio and video transmission and receipt without noticeable issues of lagging audio/video. Provider agencies may choose to supply their technical equipment or communication services, to youth or families for

telehealth service provision. The CAMHD Clinical Leads and/or the Clinical Services Office may require stricter terms for telehealth video size or video/audio quality and in-person provision, based on the particular needs of the youth.

A HIPAA-compliant secure platform is required (with minimum 128-bit encryption), under a signed Business Associate Agreement (BAA) with the telehealth service technical platform provider. Copies of this agreement and technical service details shall be supplied to CAMHD on request.

C. EVALUATIONS

Clinical Evaluations of youth are vital to the development and implementation of effective treatment plans for youth with complex needs. At the same time, overly lengthy or complex assessment procedures can interfere with the timely provision of services and undermine the treatment process. Within CAMHD's system, there has been an attempt to strike a balance between thoroughness and timeliness of mental health evaluations. Individualized decisions about the need for in-depth testing and data collection guides the process. Evaluation reports provide integrated clinical formulations of the youth's strengths and difficulties that can provide guidance for treatment planning. Recommendations describe and address the strengths and needs of the youth and detail treatment targets and intervention strategies without specifying a particular service, service provider or program.

1. Initial Mental Health Evaluation

When families first apply for CAMHD services for a youth, they may be referred to a CAMHD Clinical Lead or contracted service provider for an Initial Mental Health Evaluation (IMHE) if no diagnostic evaluation is available from previous mental health providers. These evaluations are specifically designed to provide a picture of a youth's presenting symptoms, diagnosis, strengths, needs, and environment, so that decisions can be made regarding the most effective treatment interventions, including decisions about the youth's eligibility for CAMHD services. Evaluations are part of the set of information that is used in planning strategies for treatment interventions and are necessary prior to initiation of any treatment. IMHE reports are completed using the IMHE template (download from Clinical Forms) and provide information about the youth's developmental course, family history, trauma history, school functioning, social roles, substance use, psychiatric and medical history, current diagnoses, and recommendations for treatment within the context of an integrated clinical formulation.

The IMHE is designed to be completed in a relatively brief period of time. The IMHE template utilizes checkboxes and drop-down menus in lieu of paragraphs of complex text in order to expedite the production of the written report. Some youth who enter CAMHD based on this somewhat cursory evaluation will need additional mental health evaluations to guide treatment. In this case, the treatment team may refer for additional evaluations such as a General Mental Health Evaluation.

2. General Mental Health Evaluation

At any point in a youth's treatment when the Clinical Lead and/or the treatment team has additional questions about a youth's diagnosis, clinical formulation, treatment needs, etc., a General Mental Health Evaluation (GMHE) may be authorized and conducted. As part of the GMHE, more extensive Psychological Testing may be performed when there is a clear need for additional data to answer referral questions or clarify diagnoses. Psychological Testing is only performed as part of a GMHE and is described in the GMHE Performance Standard.

CAMHD may also perform or authorize a GMHE when there is a specific clinical question to be addressed or when treatment has been unsuccessful, and a clearer formulation of the youth's

difficulties is needed. All recommendations incorporate youth/family strengths, are evidence-based, and are based on the identified needs of the youth.

3. **Summary Annual Evaluation**
   To remain eligible for CAMHD services, youth must have an annual evaluation to establish that they still have a qualifying diagnosis and to determine their ongoing need for intensive mental health services. All Contracted Service Providers must perform a Summary Annual Evaluation (SAE) as part of their service delivery as specified in the performance standard for youth in their care at the time the annual evaluation is due. The Contractor Service Provider is obligated to perform this evaluation for youth who have been in service for at least three (3) months. The SAE addresses significant changes, current status, confirms diagnosis and consequent recommendations. Contracted Service Providers must utilize the SAE template (download from Clinical Forms).

D. SERVICE/TREATMENT PLANNING

Each youth's treatment will be directed by a set of inter-related plans that supports the use of medically necessary evidence-based interventions in the least restrictive environment. CAMHD service planning is an individualized and ongoing process that is youth guided and family centered.

1. **Clinical Management Plan (CMP)**
   The CMP provides an overview of CAMHD's planned clinical approach to a youth's care. It includes recommended focus areas for treatment and specifies appropriate treatment targets that are consistent with these focus areas and the youth's diagnostic picture. It provides recommendations about the level of care most suitable to address the youth's needs, the probable length care and alternative treatments that the family may consider. This plan also looks further into the future and provides recommendations about likely types of care to follow the current services.

   The Initial CMP is developed by the Clinical Lead assigned to the youth, based on the Initial Mental Health Evaluation and/or any past reports available when the youth is found eligible for CAMHD services. A draft CMP is prepared for discussion with the youth and family during the Welcome Meeting and is revised based on the youth's and family's input. The CMP is included in the referral packet that is sent to prospective Contracted Provider Agencies and serves as a description of what the Family Guidance Center is requesting from the Contracted Provider Agencies. As the youth progresses in treatment, the CMP is updated regularly to reflect changes in the team's understanding of the clinical situation and changes in the overall Clinical Management Plan.

2. **Coordinated Service Plan (CSP)**
   The CSP provides a summary of all the services being provided to a youth and family by the larger child-serving system, including services provided by Dept. of Education, Child Welfare, Family Court, Office of Youth Services, etc. It includes contact information for all the workers involved with the youth. The Coordinated Service Planning process builds upon the strengths of the youth and family and requires the full engagement and involvement of youth, family/guardian, and key individuals involved in the youth's life including existing or potential service providers. The CSP notes resources available through the service system and shall include some naturally occurring resources in the youth's family and community. The purpose of the CSP process is to coordinate efforts across public agencies and other supports and services.

The initial CSP is developed by the Care Coordinator assigned to the youth. The Care Coordinator develops a draft CSP based on intake information to share with the youth and family in the Welcome Meeting and edits the plan based on their input. A CSP meeting with all the team members shall be convened within the first quarter of services. The Care Coordinator convenes monthly treatment team meetings with Contracted Service Provider(s), the parent/guardian and youth are always invited to participate with the Clinical Lead included as needed. CSP meetings that include the larger team shall be convened quarterly, and the CSP meeting may substitute for that month's treatment team meeting. Treatment team and CSP meetings may be held via telephone or videoconferencing when necessary.

The CSP includes transition planning that should begin early (ages 15-17) and shall be documented in the youth's CSP for all youth seventeen (17) years and older.

3. Pre-Admission Meeting

A pre-admission meeting introduces the family to the Contracted Service Provider who will be providing their treatment. Present at this meeting are, at a minimum, the legal guardian, Contracted Service Provider and CC with the CL if possible. The goal of this meeting is to engage the family in the treatment process from the point of entry into the service by establishing lines of communication and clarifying treatment expectations. This discussion includes outlining treatment targets, family participation in treatment, discharge criteria and safety/crisis planning which will be documented in the Mental Health Treatment Plan.

4. Mental Health Treatment Plan (MHTP)

The Contracted Service Provider is responsible for the development, implementation, review, revision and adjustments to the MHTP at least quarterly. The MHTP should be individualized for each youth and should be developed through a collaborative process driven by the family/guardian and youth that includes the service provider, family and the Care Coordinator. The major areas of focus for the treatment plan are derived from the CMP. Within these areas, the Contracted Service Provider is expected to work with the family and youth to articulate measurable goals that are meaningful to them. In out-of-home care, the MHTP goals should identify realistic, measurable outcomes that are directly related to the youth's ability to move into a more normalized, less restrictive setting. The MHTP will identify evidence-based treatment interventions that are the most promising options for meeting a youth's individual goals and objectives. Progress on plans shall be tracked continuously and treatment revised as necessary with youth, family/guardian and FGC Team collaboration. The treatment planning process begins with the Pre-admission Meeting and culminates in a document that includes expected intensity of treatment and treatment timelines, crisis and discharge plans. The initial plan must be developed within ten (10) calendar days of the first billable encounter.

Specific treatment strategies and services delivered by Contracted Service Provider are clearly described in the MHTP. Targets of treatment should be selected following CAMHD's Instructions and Codebook for Treatment Targets, Practice Elements, and Progress Ratings (download from Clinical Tools).
It is the role of the Contracted Service Provider to regularly monitor and adjust treatment plans, with input from the youth, family/guardian, and the FGC Team. Treatment strategies shall be reviewed at least monthly with the Care Coordinator, and the entire CSP team shall review them at least quarterly.

a. Crisis Prevention and Intervention Planning

The crisis prevention and intervention plan document the individual's problematic behaviors, setting events, triggers, the youth's preferred methods of calming and regaining control, and the steps caregivers will take if behaviors begin to escalate out of control. The crisis prevention and intervention plan are an expected component of the MHTP that builds on the

safety plan. The safety plan should be updated in collaboration with the youth when possible and should detail their preferences for handling potential crises. Crisis plan component must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. The use of police or crisis hotline services shall be utilized only after all preventive strategies and program policies have been followed.

b. Discharge Planning

Discharge planning begins at the time of the pre-admission meeting to ensure that any potential obstacles to discharge are recognized and addressed before the anticipated discharge date. Contracted Service Provider, Care Coordinator, youth/family/guardian and other involved parties are expected to work together in this process. The discharge component of the MHTP should spell out specific, realistic, measurable discharge criteria that are consistent with the behaviors or other symptoms that resulted in the admission, describe a projected timeline for meeting them, and identify any aftercare resources needed. As treatment progresses, all involved parties are expected regularly to review discharge plans, discharge dates, step-down components, new admission dates, etc., to avoid unnecessary delays.

c. Discharge Summary Progress Note

The contracted provider must complete a Discharge Summary Progress Note (submitted via the MAX Provider Portal) within ten (10) calendar days of service termination. A preliminary discharge summary may be necessary in emergency situations if imminent services are needed. Informal discussions between discharging and admitting contracted providers about the youth's needs, successful strategies, etc. are also encouraged with proper consents. The discharge summary shall include at least the following components:

i. The duration of service provided by the contractor and the level(s) of care.
ii. The reason(s) for discharge.
iii. History of medication use in the contractor's program and discharge medications.
iv. Information about the status of the youth in relation to the prescribed Mental Health Treatment Plan. This should include information about the youth's adjustment to the program/service, significant problems and concerns that arose during the treatment episode and significant youth and family accomplishments in the course of the treatment. This section should highlight interventions and/or coping strategies that were especially effective and areas of strength upon which future providers can build.
v. Description of the transition process, including any work done with the planned new treatment providers and/or caregivers to facilitate the transition.
vi. Recommended aftercare services and specific recommendations regarding treatment targets and useful interventions.

E. REFERRAL PROCESS FOR CONTRACTED SERVICES

CAMHD provides an array of intensive mental health services through its Family Guidance Centers and Contracted Service Providers. The Care Coordinator is a vital link in the referral process and makes referrals to Contracted Provider Agencies. The referrals are made to all Contracted Provider Agencies who provide the needed service within five (5) business days after the determination of strengths and needs through the youth's CMP with written consent from the youth/family to release information. The CC will ensure that services are initiated in a timely manner. Routine services are to be initiated within thirty (30) days of need identification.

All contracted services require prior authorization from CAMHD before services can be provided, except for Emergency Services that must be provided immediately. Without service authorization Contracted Service Provider cannot bill for services rendered. Service authorization represents an upper limit on the amount of service that may be billed. CAMHD relies on the clinical judgement of contracted provider therapists to determine whether or not to utilize all of the time authorized. Contracted Service Providers are expected to avoid providing more hours or days of treatment than is clinically appropriate to meet the youth's needs. In cases requiring crisis response that causes the provider to go over the allotted authorization, the provider must contact the Care Coordinator or Clinical Lead within 30 days of the services rendered to request a retro-authorization. The Clinical Lead will write a clinical justification note to support the retro-authorization.

It is expected that all youth will have access to needed services. The role of the Care Coordinator is to make referrals to Contracted Provider Agencies based on a full review of the youth's current strengths and needs and to ensure that services are initiated in a timely manner. If a youth from one (1) island is referred to and accepted by an out-of-home Contracted Service Provider on another island, CAMHD will pay for the travel costs for admission, discharge and for CAMHD approved therapeutic passes.

1. Referral Process

The Contracted Provider Agency is expected to accept all appropriate service referrals in accordance with contractual requirements. All referrals will include recommended focus areas for treatment and appropriate treatment targets that are consistent with the youth's diagnostic picture and anticipated duration of treatment. Within five (5) working days of need identification, the Care Coordinator will submit a referral packet as follows.

a. Referrals packets for all services will include the most recent and relevant clinical information including these items:

i. Current Coordinated Service Plan (CSP)
ii. Current Clinical Management Plan (CMP)
iii. IEP (as applicable)
iv. Current mental health/emotional behavioral assessment (within twelve (12) months)
v. Current FBA (if applicable)
vi. Any recent admission/discharge summaries (if applicable)
vii. Additional out-of-home requirements provided with referral or at intake:
    1. Tuberculosis (TB) test results within 12 months. A positive TB must be accompanied by written medical clearance from the treating physician indicating the youth is safe to participate in out-of-home treatment.
    2. Physical Examination within the last 12 months.
    3. Immunization Record (for youth under age 12).

2. Contracted Provider Referral Acceptance Protocol

The Contracted Provider Agency is expected to follow the referral acceptance process outlined below:

a. Within three (3) calendar days of receipt of the referral packet from the Care Coordinator, the Contracted Provider Agency shall respond to the referral via the MAX Provider Portal. If the requested service is available, the admission/start date shall be as soon as possible, but must be within fourteen (14) days of acceptance otherwise the youth must be placed on the agency's waitlist.

b. Waitlist Protocol
   i. If the requested service in not available with fourteen (14) days, then the Contracted Provider Agency will add the youth to the waitlist by documenting the youth as Accepted as Waitlist in the Provider Referral Status.
      1. If CAMHD determines that a youth needs to be prioritized for clinical or administrative reasons, the Clinical Services Office will contact the provider to prioritize the youth.

c. If, for any reason, a contracted provider's Clinical Director believes a youth is not appropriate for their level of care, the contracted provider's Clinical Director must contact the Family Guidance Center Clinical Lead, verbally and in writing to explain why they believe the youth is not appropriate for that level of care. Within three (3) days, the Family Guidance Center Clinical Lead will review and discuss the concerns with the Contracted Provider Agency's Clinical Director in an attempt to resolve the issues. If the Contracted Provider Agency's Clinical Director and Family Guidance Center Clinical Lead come to an agreement that the level of care is appropriate, the contracted provider will give the Care Coordinator an anticipated date for the initiation of services.
   i. If the concerns cannot be resolved in this manner, the Contracted Provider Agency or CAMHD has the option to request an independent evaluation. The evaluation needs to be completed within fourteen (14) days at the Contracted Provider Agency's expense. The independent evaluator must be an American Board of Medical Specialties Board Certified Child and Adolescent Psychiatrist who has no association with either the contracted provider or CAMHD and must be approved, in advance, by the CAMHD's Medical Director. The Contracted Provider Agency must complete the CAMHD Independent Psychiatrist Consultation From (See Appendix 1) and submit it to the Clinical Services Office (CSO). The CSO will respond with the Medical Director's approval or disapproval to the Contracted Provider Agency within three business days of receipt of the form.
   ii. If the independent evaluation determines that the level of care is not appropriate, the Family Guidance Center and its Clinical Lead will accept and review the independent psychiatrist's recommendations. The FGC Team will determine the appropriate level of care and send out referral packets to other appropriate contracted providers. CAMHD will reimburse the Contracted Provider Agency the cost of an independent evaluation if the level of care is determined to be inappropriate and CAMHD procedures have been followed for the procurement of the independent evaluation.
   iii. If the independent evaluation determines that the level of care is appropriate, the Contracted Provider Agency will accept the youth as soon as possible and will be responsible for the cost of the independent evaluation.
   iv. CAMHD reserves the right to execute contractual action if the contracted provider is unable or unwilling to meet the needs of CAMHD youth.

F. COMMITMENT TO SERVE ALL YOUTH

Contracted providers will be expected to provide all youth accepted for services with continuity of care until the youth meets the criteria for appropriate discharge or transition to another service as indicated by team decisions.

The Contracted Provider Agency may not abruptly terminate services or eject a youth from out-of-home services. If a Contracted Provider Agency seeks to terminate services for a youth already in out-of-home program:

1. The Contracted Provider Agency is required to complete a full internal review that includes a review documented by the Contracted Provider Agency's Psychiatrist.
2. The Contracted Provider Agency is required to report the results of this review to CAMHD and the FGC Team prior to any further action being taken.
3. If a Family Guidance Center receives notification that a Contracted Provider Agency wants to eject a youth, the Family Guidance Center Clinical Lead will contact the Contracted Provider Agency's Clinical Director to review and discuss the issue. If the Contracted Provider Agency's Clinical Director and the Family Guidance Center Clinical Lead come to an agreement that the level of care continues to be appropriate, the contracted provider is expected to maintain the youth in its program.
4. If the Family Guidance Center Clinical Lead and the Contracted Provider Agency's Clinical Director are not in agreement, the Contracted Provider Agency's Clinical Director has the option to request an independent assessment, at the Contracted Provider Agency's cost, from a Hawai'i licensed, American Board of Medicine Specialties Board Certified Child and Adolescent Psychiatrist, who is independent of the contracted provider and CAMHD. The contracted provider must complete the "CAMHD Independent Psychiatric Consultation Form" (See Appendix 1) for the CAMHD Medical Director's approval of the independent consultant. The Contracted Provider Agency is expected to keep the youth until the result of the independent evaluation.
5. If the independent evaluation determines that the current level of care is no longer appropriate, the Family Guidance Center will accept the determination and initiate appropriate and timely transition services for the youth. The Contracted Provider Agency will be requested to maintain the youth for at least ten (10) days to allow for transition preparation.
6. CAMHD will reimburse the Contracted Provider Agency for the cost of an independent evaluation if the level of care is determined to be inappropriate and CAMHD procedures have been followed for the procurement of the independent evaluation.
7. If the independent evaluation determines that the level of care continues to be appropriate, the Contracted Provider Agency is expected to maintain the youth in its program.

CAMHD reserves the right to execute contractual action if the contracted provider is unable or unwilling to meet the needs of CAMHD youth.

G. TRAINING

To ensure quality of services provided, all Contracted Service Providers must adhere to their respective professional standards as set forth in professional practice guidelines and standards, ethical principles, and codes of conduct in addition to the following requirements.

1. Orientation and Training Requirements for Contracted Providers

a. Contracted Provider Agencies are responsible for providing appropriate training for their staff/contracted consultants on the use of evidence-based treatments and services for the CAMHD youth populations they serve.

b. Periodically, CAMHD will offer training on select evidence-based treatments and services for Contracted Service Providers with an emphasis on training for provider staff who can train others within their agencies.

c. Contracted Provider Agency must designate a staff person responsible for staff and/or sub-contracted provider training in all aspects of the delivery of services. The Contracted Provider Agency'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 following discussion points:

i. The topic, name and credentials of trainer;
ii. Names and titles of trainees that attended the training;
iii. The date, time, place and duration of the training; and
iv. An evaluation of the quality and effectiveness of the training.

d. The Contracted Provider Agency must have a specific training plan detailing how and when staff will be trained.

e. At least thirty (30) hours of training are required every year for all full-time direct service staff. Those working fifteen (15) hours or less may reduce to fifteen (15) hours annually.

f. At a minimum, each Contracted Provider 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. The orientation process must be completed prior to serving youth. These twenty-four (24) hours can be applied towards the thirty (30) hours of ongoing professional development required for the year. The orientation must include:

i. An understanding of the agency's mission, goals, structure, lines of accountability/authority and with its policies and procedures;
ii. Orientation to the population served and the model of care of the program;
iii. An understanding of the employee's job description;
iv. An understanding of all laws and regulations regarding confidentiality including Health Insurance Portability and Accountability Act (HIPAA) requirements;
v. A review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide;
vi. An overview of IDEA, Hawai'i CASSP principles and Client's rights and responsibilities;
vii. An introduction to psychiatric medications used with youth;
viii. The use of non-coercive behavior management approaches including positive behavioral support techniques;
ix. Evidence-based treatment approaches;
x. Crisis intervention procedures, including suicide precautions to ensure safety of clients and staff;
xi. Clinical Record Documentation requirements, CAMHD reporting requirements including sentinel events documentation and reporting;
xii. CAMHD policies and procedures that are included in the Request for Proposal and the CAMHD Performance Standards;
xiii. Family engagement and cultural consideration including LGBTQ+ culture;
xiv. Telehealth: how to use the platform and how to deliver therapeutic service via the platform; and
xv. Overview of CAMHD Performance Monitoring.

2. All staff providing direct services to youth must annually attend, successfully complete, and document in their personnel file at least thirty (30) hours of training, in service, and/or approved continuing education professional development seminars and/or conferences with curricula tailored to the mental health treatment focus of children/adolescents and/or their families. First Aid and Cardiac Pulmonary Resuscitation (CPR) training/recertification also count toward training hours. Annual training must include HIPAA refresher training.

i. The documentation for in-service training must include:

1. Name, date, place, and duration of the training;
2. The topic of the training and an outline of the discussion points;
3. Name/credentials of the instructor and of the organization sponsoring the training; and
4. Names and titles of trainees who attended the training.

ii. The documentation for outside training attended must include:

1. The name, date, place, and duration of the training;
2. A brochure, conference agenda, or webinar announcement;
3. Information about the professional organization that approved the training for continuing education;
4. Name(s) and title(s) of the staff member(s) who attended the training; and
5. Certificates of continuing education credits or certificates of attendance when available.

3. Treatment team meetings and individual supervision, although expected, do not apply towards the required (thirty) hours. Training may be provided as part of regular staff meetings or during group supervision sessions.

4. These training requirements apply to all personnel providing direct services to youth including sub-contractors and consulting staff (e.g. psychiatrists, psychologists, etc.)

5. Qualified Mental Health Professionals (QMHP) whose licensure requires continuing education for license renewal may submit evidence of license renewal for documentation of ongoing professional development.

H. SUPERVISION

CAMHD is committed to quality service through regular, ongoing, competency-based, skill building supervision of all staff that provide direct services to youth. CAMHD and each Contracted Provider Agency shall have clear lines of accountability and a clearly described supervision structure for all employees and independent contractors.

Contracted Provider Agencies must have policies and procedures and the mechanism to ensure supervision of all clinical services and staff. The Contracted Provider Agency is responsible for maintaining and tracking supervision records. Supervision shall include review of clinically relevant case details, present and planned treatment targets, interventions employed, assessment of youth progress, assessment of effectiveness of interventions, and follow-up on previous recommendations. Supervision documentation must include the supervisee's actions, supervisor's recommendations and follow-up between sessions.

Supervision shall also include professional development of appropriate boundaries, power differential and appropriate use of authority, as well as transference and countertransference issues. Supervision includes utilizing a combination of methods such as case reviews, direct observation (including "sitting in" virtually for telehealth services), coaching, and role modeling/training to improve the skills and enhance job performance.

Contracted Provider Agencies shall have a process for evaluating 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 including resolutions, corrective actions taken, and supports provided to improve practice. Contracted Provider Agency shall monitor the staff evaluation process for its effectiveness in helping staff acquire the needed skills.

All Contracted Provider Agency personnel (employees or subcontractors) must have an individualized supervision plan based on a needs assessment completed annually, at minimum

unless stated otherwise, by their respective supervisor. Documentation of individual supervision session must include date, duration, name and credentials of supervisor, along with the goals, interventions, and summary of the sessions. Documentation must be included in the individual's supervision file and must include documentation of follow-up and consistency from previous supervision sessions.

1. Qualified Mental Health Professional (QMHP) Requirements:

A QMHP shall participate in at least two (2) hours group supervision per month with other QMHPs or MHPs within the agency as evidenced by documentation in their supervision file. QMHPs working half-time or less may adjust the supervision requirements to one (1) group supervision per month. QMHP's may credit regular participation in CAMHD's Evidence-Based Services Committee (EBS), HBR Rounds or CBR/HBR Clinical Lead meetings towards the QMHP supervision requirements. Documentation of attendance shall be maintained by the QMHP and submitted to their respective agency for inclusion in the supervision file. A QMHP may supervise the equivalent of no more than ten (10) full-time MHP's or Paraprofessionals.

2. Mental Health Professional (MHP) Requirements:

A MHP shall receive at least three (3) hours of supervision a month from a QMHP. At least one (1) hour must be individual, clinical, youth-specific supervision. MHPs working half-time or less may adjust the supervision schedule to one (1) hour individual and one (1) hour group. A MHP may supervise the equivalent of no more than ten (10) full-time Paraprofessionals. A Supervising MHP Exception may be requested through the CAMHD Credentialing Office and if approved, will allow certain MHPs to supervise other MHPs and/or Paraprofessionals up to the ten (10) full-time equivalent. Supervising MHPs must be supervised by a QMHP.

3. In-Home Paraprofessional (IH Para) Requirements:

In-Home Paraprofessional services can only be provided by those Paraprofessionals credentialed at level 2. The In-Home Paraprofessionals must receive at least four (4) hours of supervision a month from a QMHP or an MHP. At least one (1) hour must be individual, clinical, youth-specific supervision and three (3) hours may be group supervision that may be conducted in conjunction with MHPs. In-Home Paraprofessionals working fifteen (15) hours or less a week may adjust the supervision schedule to one (1) hour individual and one (1) hour group. An IH Para shall not supervise other paraprofessionals.

The Contracted Provider Agency shall develop an individualized supervision plan based on a needs assessment of the In-Home Para skills. The skills and knowledge of In-Home Paras shall be assessed by a MHP or QMHP at the beginning of their employment and at least annually thereafter. Assessments shall focus on skills in effectively providing therapeutic behavior management techniques. Contracted Provider Agency are expected to develop an assessment instrument that meets the needs of their program. Competency Assessment for Paraprofessionals in Residential Programs (See Appendix 2) is an example which may be adapted as necessary, if desired.

4. Out-of-Home Paraprofessional (OOH Para) Requirements:

Paraprofessional workers in residential programs work on a team with colleagues, and seldom need to function completely independently, therefore problematic attitudes toward youth or faulty behavior management efforts are observed by others for the most part. As a result, the supervision needs of these workers are different from those of In-home paraprofessionals who work independently with families and youth in their homes or in the community. CAMHD has

developed the following supervision standards specifically for paraprofessional workers in residential programs.

Out-of-Home Paraprofessional services may be provided by Paraprofessionals credentialed at Level 1 or 2. The Out-of-Home Paraprofessionals must receive at least once a week clinical group supervision focused on treatment goals and interventions including de-escalation techniques for youth within the milieu by a MHP or QMHP and can be part of a shift-change meeting. At least a half hour once a month individual professional development supervision that is based on an assessment of the OOH Para skills and attitudes shall be conducted by an MHP, QMHP or Paraprofessional in the role of shift leader or charge nurse. Paraprofessionals working fifteen (15) hours a week or less may adjust the supervision schedule to a half hour individual and one (1) clinical group per month. OOH Paras shall not supervise other paraprofessionals unless the OOH Para is a shift leader or charge nurse.

The skills and knowledge of OOH Paras shall be assessed by a MHP or QMHP at the beginning of their employment and every six (6) months thereafter for their first two (2) years and continued annually thereafter. Assessments shall focus on skills in effectively providing therapeutic behavior management techniques. Contracted Provider Agencies are expected to develop an assessment instrument that meets the needs of their program. Competency Assessment for Paraprofessionals in Residential Programs (See Appendix 2) is an example which may be adapted as necessary, if desired.

These assessments shall be based on direct observations from the paraprofessional's supervisor(s) working in the milieu, as well as an analysis of relevant program data such as youth grievances about staff and staff involvement in restraints and other sentinel events and incidents that may be decreased by effective behavior management techniques. Assessment results shall be used to develop a supervision plan for the OOH Para, which may include a higher frequency of supervision meetings or other specific training procedures when skills are found to be lacking as well as additional assessments of skills. These assessments shall be documented and kept with the supervisee's clinical supervision documentation.

5. Supervision Summary Table

Supervision Requirements Summary		
Credential Level	**Individual Supervision**	**Group Supervision**
QMHP		2 hours per month
QMHP < .5 FTE		1 hour per month
MHP	1 hour per month	2 hours per month
MHP < .5 FTE	1 hour per month	1 hour per month
IH Para 2	1 hour per month	3 hours per month
IH Para 2 <15 hrs. wk.	1 hour per month	1 hour per month
OOH Para 1 or 2	½ hour per month	4x a month
OOH Para 1 or 2 <15 hrs. wk.	½ hour per month	1x a month

I. CREDENTIALING

CAMHD is committed to ensuring that staff are competent and qualified to provide the intervention/services to youth as evidenced by meeting the following credentialing requirements. CAMHD requires all contracted providers to adhere to federal and state standards for healthcare services that include Medicaid, Hawaii revised statutes, The Social Security Act of 1935, and the Prison Rape Elimination Act (PREA). Contracted Provider Agencies are advised to provide their

prospective employees/sub-contractors the CAMHD credentialing packet at time of application or hiring to ensure adequate time for processing of CAMHD credentialing. Employment will be contingent on meeting CAMHD credentialing requirements. No employee/sub-contractor shall have direct access to CAMHD youth until they have been credentialed.

1. **Comprehensive Background Screening**
   A comprehensive background check is required for every individual that has direct contact with children and youth receiving contracted services. A comprehensive background check for a shall include:

   a. A Federal Bureau of Investigation fingerprint check using Next Generation Identification and a State criminal history check using the individual's current, legal name. Inquiries must be conducted in accordance with current Federal and State timelines for Criminal Background Checks.

   b. State-based Child Abuse or Neglect (CA/Ns) registry and database screening inclusive of each state the individual has resided in for the previous five (5) year.

   c. State-based Adult Protective Services (APS) registry and database screening inclusive of each state the individual has resided in for the previous five (5) years.

   d. A search of the National Crime Information Center's National Sex Offender Registry inclusive of all known names.

   e. List of Excluded Individuals/Entities (LEIE) database check.

   f. Additional required primary source verification required for any individual who holds or has held a vocational license nationally.

   CAMHD delegates the primary source verification as noted in P&P 80.308.3 Delegation of Credential Primary Source Verification (download under Administrative Tools, Credentialing). This is documented in the employee's personnel file. The Contracting agency is responsible for reviewing the documentation, taking actions as needed, and promptly notifying CAMHD of any changes that may affect the individual's credentialing status.

2. **Credentialing Requirements:**
   Credentialing requirements apply to all individuals providing direct services including sub-contractors of a Contracted Provider Agency whose activities include the care or supervision of children, or any individuals that have unsupervised access to children. All Contracted Provider Agencies shall have written policies and procedures that reflect their responsibility to credential and re-credential their direct care staff, sub-contracted individuals, trainees, volunteers, and clinical supervisory staff prior to provision of services. Contracted Provider Agencies shall be guided by CAMHD's credentialing policies and procedures in developing their policies and procedures (download under Administrative Tools, Credentialing).

   a. All professionals contracted or employed by Contracted Provider Agency to provide direct services to youth and families must be at least 18 years of age and fully credentialed prior to provision of services to youths. They must have completely met initial credentialing requirements through submittal of required documents and satisfactory verification of primary sources.

   b. The process of re-credentialing must occur at a minimum of every two (2) years, to maintain consistent adherence to both federal and state credentialing requirements. In addition to routine re-credentialing documentation, the CAMHD Credentialing section will evaluate various reports. These encompass but are not limited to internal provider and CAMHD performance reports, complaints received, involvement in critical incidents or sentinel

events, licensing prerequisites, malpractice insurance coverage and claims history, as well as clearances regarding child and adult abuse or neglect.

c. Contracted Provider Agencies shall ensure prompt and accurate reporting of current staff and contractors as well as terminations. Evidence of Contracted Provider Agency's accountability is exhibited through CAMHD Credentialing Reporting. Contracted Provider Agency's compliance with this requirement is used in the yearly delegation of credentialing agency oversight evaluation.

d. Individual credentialing files for each direct care and supervisory employee and subcontractors shall be established separately from general personnel files.

e. Licensed individuals shall meet continuing education requirements as outlined by the Hawaii State Professional and Vocational Licensing Division and will not be individually monitored by CAMHD. The renewal of the licensure by the respective licensure board shall constitute completion of all required continuing education requirements.

3. Individual Practitioner Credentialing Information

a. Qualified Mental Health Professional (QMHP) must have a valid Individual National Provider Identifier (NPI):

i. A Hawai'i-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); or board eligible in Child/Adolescent Psychiatry. Psychiatrists in hospital-based settings must be ABPN board certified in Child/Adolescent Psychiatry.

OR

ii. A Clinical or Educational Psychologist with a current Hawai'i license in Psychology.

OR

iii. An Advanced Practice Registered Nurse (APRN) certified as a Psychiatric Clinical Nurse Specialist with a current Hawai'i license/certification.

OR

iv. A Hawai'i Licensed Clinical Social Worker (LCSW).

OR

v. A Hawai'i Licensed Marriage and Family Therapist (LMFT).

OR

vi. A Hawai'i Licensed Mental Health Counselor (LMHC).

AND

vii. Must maintain licensure in the State of Hawaii to remain credentialed at a QMHP.

b. Mental Health Professional (MHP) must have a valid Individual National Provider Identifier (NPI):

i. 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

A Ph.D. or Psy.D. student in clinical psychology studying in an accredited program under program faculty supervision.

AND

Must have at least one (1) year of full-time, clinically supervised progressive work experience inclusive of residency, internship, or practicum in the treatment of youth in a mental health or behavioral health setting.

ii. A Ph.D. or Psy.D. in Clinical, Counseling or School Psychology from a nationally accredited university who is not currently licensed in the State of Hawaii.

OR

A Hawai'i Licensed Social Worker (LSW).

OR

Personnel with a master's degree from a nationally accredited university that is eligible for Professional and Vocational Licensing (PVL) in Hawaii. Included are national board-certified behavioral analyst, marriage and family therapist, mental health counselor, psychologist, social worker, school psychologist, or psychiatric nurse.

And

Must have at least one (1) 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 behavioral health setting. Experience may be substituted for certificates in a specialty such as Certified Substance Abuse Counselors (CSAC).

AND

iii. All MHPs must be supervised by a QMHP or Supervising MHP.

c. Paraprofessional Level 2 must have a valid Individual National Provider Identifier (NPI):

i. Personnel with a bachelor's degree from a nationally accredited university in Psychology, Social Work, Nursing, Mental Health or Behavioral Health Counseling.

OR

ii. Personnel with an associate degree or equivalent from a nationally accredited university in either Psychology, Social Work, Nursing, Counseling, with at least two (2) years of full-time, clinically supervised work experience in the treatment of children or adolescents in a mental health or behavioral health setting.

OR

iii. Personnel with a high school diploma must have at least four (4) years of full-time, clinically supervised work experience in the treatment of children and adolescents in a mental health or behavioral health setting.

AND

iv. Must be supervised by a QMHP, MHP or Supervising MHP

d. Paraprofessional Level 1:

i. Licensed in related service areas to include (but not limited to) Speech language Pathologist or Occupational Therapists.

OR

Personnel with a college degree from an accredited university in a field of study other than Psychology, Social Work, Nursing, Mental Health or Behavioral Health Counseling.

AND

At least one (1) year experience providing direct care to children and adolescents.

OR

Completion of thirty (30) hours of orientation and documented shadowing of at least three shifts before being allowed to work independently. This training shall be completed within three (3) months from the initial credentialing date.

ii. A High School diploma or equivalent.

AND

At least one (1) year experience providing direct care to children and adolescents.

OR

Completion of thirty (30) hours of orientation and documented shadowing of at least three shifts before being allowed to work independently. This training shall be completed within three (3) months from the initial credentialing date.

AND

iii. Must be supervised by a QMHP, MHP, or Supervising MHP or Paraprofessional

4. Submission requirement

a. The primary method for submitting credentialing application packets is electronically in Portable Document Format (PDF). These should be securely emailed to the CAMHD Credentialing section at DOH.CAMHD.CRED.Clerk@doh.hawaii.gov. As an alternative, submissions can also be accepted via fax, postal mail or hand delivered as a secondary approach.

b. Credentialing application packets shall include all required documents and verifications necessary for the CAMHD to evaluate the applicant's eligibility and risk associated with the services they provide. A complete application packet shall include or meet the following requirements:

   i. All empty fields in the application form must be completed and additional explanations provided, where applicable;

   ii. All requested attachments and information have been submitted;

   iii. Verification of the information is complete and done through primary sources when required; and

   iv. All information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided in the application.

c. Re-credentialing submission packets must be submitted and received by the CAMHD no later than three (3) weeks prior to the CAMHD credentialing expiration date.

d. Updates to approved credentialing records must be requested using the CAMHD Credentialing Request to Update/Change form. The form template must be obtained from the CAMHD Credentialing section and appropriately filled out by an assigned staff member of a Contracted Provider Agency. The completed CAMHD Credentialing Request to Update/Change form must be supplemented with appropriate corroborative documentation and emailed directly to the CAMHD Credentialing section at DOH.CAMHD.CRED.Clerk@doh.hawaii.gov.

J. BILLING

Contracted Provider Agencies are anticipated to align documentation and billing practices with national best-practices, and federal standards for healthcare services. The authorization of any services or treatment is not a guarantee of payment. The Contracted Provider Agencies' staff or subcontractors providing care must meet all the CAMHD, Federal and State requirements to ensure documentation produced substantiates services provided. Contracted Provider Agencies are expected to engage in comprehensive internal compliance programs of internal clinical documentation review, feedback, and auditing. Contracted Provider Agencies are equally expected to cooperate with ongoing CAMHD quality assurance, compliance, and audit programs. Contracted Provider Agencies shall allow CAMHD, Med-QUEST or their audit contractors to conduct unannounced on-site inspection of any and all provider locations. These are required to ensure appropriate reviews of documentation for compliance, and to foster cycles of continuing quality improvement.

As discussed, in the Core Components of the current CAMHD System section of this book, CAMHD has a Commitment to improving our information system performance, and contracted providers must anticipate that methods and schedule requirements for electronic submission of data such as the MTPS are expected to change over the next several years as our information system develops, in keeping with national standards. The system access and mechanisms for submitting this information are anticipated to change in future contract years, based on scheduled systems changes to be identified in future CAMHPS revisions.

All Contracted Provider Agencies are required to adhere to the CAMHD billing and reporting requirements. Contracted Provider Agency's submission must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), CAMHD, applicable federal Medicaid, and Hawaii Med-QUEST policies and procedures for healthcare services billing. Contracted Provider Agencies are also responsible for planning, implementing, and maintaining their own information systems. Contracted Provider Agencies must also provide to CAMHD a functional e-mail address that can receive documents as well as notices. CAMHD does not provide technical support for provider information systems or e-mail.

Contracted Provider Agencies are required to have computer hardware that supports Internet connectivity, Internet services, email, and maintain compliance with standards for employees and contractors with access to Electronic Protected Health Information (ePHI). Contracted Provider Agencies are responsible for maintaining all documentation and systems in compliance with the HIPAA and associated security standards. Please reference https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html for further information. Contracted Provider Agencies are required to maintain a current and updated Security Risk Assessment (SRA) for their information technology assets, and a System Security Plan (SSP) for their Electronic Health Record or Case Management System, in alignment with national best-practices for privacy and information risk mitigation. Please reference https://www.healthit.gov/providers-professionals/security-risk-assessment-tool for additional information. Further, under DOH policy, all contractors are required to provide appropriately redacted copies of their SRA to the State for evaluation and assurance.

CAMHD electronic billing systems and interfaces are anticipated to change over the course of the next few years, with the associated details posted and training provided in advance. Contracted Provider Agencies shall utilize electronic billing as the standard mechanism, and paper billing requests may be granted on a limited case-by-case basis.

All Contracted Provider Agencies shall be required to provide detailed clinical and encounter-based case encounter documentation to the CAMHD on demand, per services timeline expectations, and for further billing or quality reviews. This is to substantiate the appropriate documentation for proof of services, and to ensure quality of the care provided. Example documents may include but are not limited to: Mental Health Treatment Plans, Therapy Progress Notes, Treatment Team Meeting Notes, Mental Health Assessments, Summary Annual Assessments, Residential Treatment Center Shift Notes, and Daily/Weekly Census Reports. Once CAMHD electronic systems are modernized and notice given, contracted providers shall be required to submit these documents electronically via either an electronic interface or secure file transfer (SFTP) from the contracted provider systems, and/or via a login to a State-offered Provider Portal into the CAMHD system. Once this capability is made available and training provided, contracted providers shall be expected to supply CAMHD with this full set of case-specific documents, to ensure State staff have the appropriate information to improve youth outcomes, case progress, and program compliance. Contracted providers are required to ensure all staff provisioned access to State systems requires compliance with and audit of the State-defined IT Acceptable Use Policies, set by the State Enterprise Technology Services Offices (ETS) and DOH. CAMHD technical staff may provide additional training on request, and contracted providers shall ensure their staff are available on a regular, no less than annual, schedule to ensure appropriate system and billing procedures are followed.

Original monthly claims must be submitted within thirty (30) calendar days after the last day of each calendar month. All submissions and corrections must be properly received by CAMHD (electronic system or limited paper billing under written exception terms) ninety (90) days after the last day of the billing month. No claims will be accepted by CAMHD standard after the 90-day billing period and contracted provider shall insure that no claim is from a provider who is on the List of Excluded Individual/Entities (LEIE) or the Excluded Parties List System (EPLS) from the Office of Inspector General (OIG).

Should a provider have an issue and require billing for services beyond the 90-day standard period, documented contact in the form of a written appeal for billing extension must be made to CAMHD (sent to Provider Relations for HSMO Billing Section approval) before the end of the 90-day period or no extension will be granted. The written billing extension appeals may be granted by CAMHD for an additional period up to 180 days after the services date. No claims for services shall be accepted and paid by CAMHD after 180 days, for any circumstances other than State errors.

K. MAINTENANCE OF SERVICE RECORDS

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, including HIPAA statutes, national 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.

The youth's full name and CAMHD youth identification number (ID#), must be on each page of the youth's record. Any adverse drug reactions and/or medication or other allergies or absence of allergies must be posted in a prominent area on the youth's file. Each youth's file contains easily identifiable past and current medical history including serious accidents, surgeries and illnesses. Diagnostic information, medication information, and substance use information are also included. Consultations and special referrals require documentation including resultant reports. Records also contain emergency care rendered with physician follow-up as well as hospital discharge summaries.

Contractors and professionals must maintain master youth 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 in accordance with HIPAA regulations. Files in authorized use must be maintained securely.

1. Progress Notes

a. Progress notes are written for each activity/event by the staff/professional providing the service. Every physician contact including medication prescription, administration and monitoring must also be documented. Every therapy session must be documented. Progress notes shall be entered in the youth's file within three (3) days of the service. Daily progress notes are required for all youth receiving out-of-home services.

b. All progress notes must contain the following minimal documentation requirements and must be contained together in a single, continuous note:

   i. Youth name and ID#;
   ii. Complete date of service (including month, day and year);
   iii. Start time, end time, and total units;
   iv. Place of service;
   v. Type of service (Individual Therapy, Family Therapy, Group Therapy);

vi. CAMHD Does not pay for travel time. When meeting with a client in a different location than the one before, there must be at minimum, a fifteen (15) minute break between encounters. If the travel time takes more than fifteen (15) minutes, then the actual time must be accounted for;
vii. Data, Assessment, Plan (DAP) sections including:
1. Plan of treatment to include goals/objectives being addressed;
2. Diagnostic tests conducted;
3. Treatment interventions implemented and other prescribed regimens;
4. Interpretation of the effectiveness of the intervention(s);
5. Follow up notes, including results of referrals and subsequent plan of action;
6. Specific time interval for next "visit" or session;
7. Unresolved concerns from previous visit addressed in subsequent visits; and
8. Other health care visits.
viii. Full name, title, signature and signature date of service provider; and
ix. Full name, title, signature and signature date of supervisor (if applicable).
x. Contracted Provider Agency shall audit home and community-based therapist and paraprofessional support notes to ensure compliance with CAMHD standards.

c. Electronic medical records are permitted, and must meet the following criteria:
i. Electronic records must be backed-up in full, via offsite disaster recovery capacity as required under HIPAA, and it is NOT necessary to maintain a printed copy of the full record in a print file for each youth;
ii. The electronic record must meet all Medicaid documentation standards;
iii. Each note must include an electronic signature;
iv. Each note must have the date, time and duration of services;
v. Each note must have a clear description of the services provided;
vi. An exported or printed record must have agency and/or CAMHD Center letterhead or headings on each page; and
vii. The agency must maintain the systems in compliance with HIPAA, including regularly updated Security Risk Assessment (SRA) that is to be submitted to the CAMHD.

d. The focus in the content of notes shall clearly evidence the relationship of the intervention(s) to the youth's MHTP. Progress notes need to reference the goals and objectives stated in the youth's MHTP 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.

e. Progress notes also describe collateral communications pertinent to the treatment of the youth (e.g., treatment-related telephone conversations, treatment team meetings, consultations with ancillary service providers).

L. SERVICE QUALITY

CAMHD is committed to ensuring appropriate and effective services for eligible youth and their families. Services are designed to promote healthy functioning, increase independence, and to build upon the natural strengths of the youth, family/guardian and community. Families/guardians must 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 and

progress/outcomes are to be regularly reviewed and modified, as needed, to effectively achieve goals.

Contracted Provider Agencies/employees shall participate with the integration of services across domains as needed. Contracted Provider Agencies/employees shall assist with transition planning (as it relates to greater and lesser levels of support and services) in collaboration with the youth, family/guardian and other team members. CAMHD encourages individuals with specific concerns regarding service quality to bring them to the attention of the Contracted Provider Agency, Family Guidance Center, and/or CAMHD Central Administrative Office, as appropriate.

Contracted Provider Agencies shall assume responsibility for the quality of services provided by employees or subcontracted providers. All Contracted Provider Agencies shall implement a Quality Assurance and Improvement Program and demonstrate commitment to ongoing quality improvement activities. The quality program must meet Medicaid standards. Contracted Provider Agencies must submit quarterly reports of quality monitoring to CAMHD.

CAMHD personnel, including Care Coordinators, Clinical Leads, Facilities Certification Specialists, Grievance Specialists, Provider Relations Specialist and Program Monitoring Specialist 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 shared decision-making between the FGC Team and Contracted Service Provider) for any youth that is receiving services, and conducts regular reviews of child status, treatment practices, and Contracted Provider Agency performance as part of its accountability and oversight functions.

M. PERFORMANCE MANAGEMENT

The CAMHD Performance Management Unit conducts continuous monitoring of performance data for all Contracted Provider Agencies. Performance data in CAMHD are tracked and analyzed across all domains of service delivery and care. Services are monitored through tracking of trends, patterns, and quality of services. Contracted Provider Agencies are expected to engage in ongoing quality assurance activities to improve their services and integration with the system. Site visits are an integral part of the program monitoring process; Contracted Service Providers are expected to cooperate with CAMHD's monitoring efforts, including accommodating both scheduled and unannounced visits.

1. **Program Monitoring**

   The Program Monitoring Section provides on-going oversight and technical support to Contracted Provider Agencies. Program Monitors work closely with Contracted Provider Agencies to continually evaluate program performance, provide feedback and recommendations, monitor implementation of strategies for improvement and provide technical assistance or referrals for assistance. Standard monitoring activities include:

   a. Administrative Reviews

      Administrative Reviews are conducted to evaluate the adequacy of quality assurance and performance improvement processes within agencies, the quality of supervision and training practices, policies and procedures, the ability to implement necessary corrective actions, and the effectiveness of internal response to consumer concerns. Administrative Review results, reported in the Annual Program Review, will include program strengths, opportunities for improvement, and activities to sustain program success. Agencies with demonstrated patterns of administrative compliance will not be monitored as intensely or as frequently as agencies needing more intensive oversight.

b. Case-Based Reviews

Case-based Reviews provide an in-depth look into the status of youth served, and how well programs and local service systems are performing for them. Reviewers examine child status and program performance for a chosen sample of youth through interviews with multiple respondents and review of case records. Determinations with the support of a structured protocol are made regarding how well youth are doing along dimensions of child well-being, and how well basic program functions (e.g. understanding of the youth's situation, treatment planning and implementation, producing effective results, etc.) are being carried out. Aggregate data is analyzed to glean patterns of performance across program functions, and to provide a context for the overall determination of performance for the agency.

c. Investigations

When necessary, investigations will be conducted in response to clinical and/or programmatic concerns as identified by sentinel event reports or complaints. CAMHD Program Monitoring staff may make unannounced visits to any/all Contracted Provider Agency locations for investigational purposes.

d. Quarterly Quality Assurance Reports

Contracted Provider Agencies must submit Quarterly Quality Assurance Reports that are based upon the agency's quality assurance and improvement program that define measurable 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 quarterly review.

Contractors must report the following components, to the CAMHD Program Monitoring Section every quarter, no later than forty-five (45) calendar days following the end of each quarter. The Quarterly Quality Assurance Report is to include the following information:

i. Sentinel Events / Reportable Incidents
ii. Clinical Supervision & Training Activities
iii. Clinical Documentation

2. Sentinel Event and Reportable Incident System

The CAMHD Sentinel Event and Reportable Incident reporting system is designed to track and document the occurrence of sentinel events and reportable incidents as reported by Contracted Provider Agencies. All Contracted Provider Agencies must have internal policies and procedures regarding sentinel events and reportable incidents in accordance with CAMHD's Sentinel Events and Reportable Incidents Policy and Procedure 80.805.

a. Sentinel Events

Contracted Provider Agencies shall notify the youth's parent/legal guardian, CC and the Sentinel Events reporting line of all sentinel events, within twenty-four (24) hours of occurrence. Contracted Provider Agencies must also submit a written hard copy report on the CAMHD Sentinel Event Report Form (download at https://health.hawaii.gov/camhd/clinical-tools/ under Clinical Forms) to CAMHD Clinical Services Office and the CAMHD Family Guidance Center within three (3) business days of the event.

b. Reportable Incidents

Contracted Service Provider must notify youth's parent/legal guardian and CC of Reportable Incidents within twenty-four (24) hours of occurrence. Contracted Service Provider must also submit a written hard copy report on the CAMHD Reportable Incident form (download at https://health.hawaii.gov/camhd/clinical-tools/ under Clinical Forms) to the CAMHD Clinical Services Office and the respective CAMHD Family Guidance Center within five (5) business days of the event.

3. Grievance and Complaints

The CAMHD respects 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 among the Family Guidance Center, Contracted Service Provider (if applicable), and the family. If resolution is not possible in direct exchange, families and providers have additional recourse through the CAMHD Clinical Services Office. Youth and/or families are informed of these processes upon registration at a Family Guidance Center.

N. RISK MANAGEMENT

All Contracted Provider Agencies must have policies and procedures that address critical risk management activities that include the following:

1. Safety

CAMHD requires Contracted Provider Agencies to have procedures to ensure the safety and well-being of youth at all times. Safety is relative to known risks, and no procedure can provide an absolute protection from all possible risks.

Contracted providers shall manage, control, or alter potentially harmful conditions, situations, or operations including those which can lead 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 procedures shall apply to settings in the natural community, as well as to any special care or treatment setting.

2. Restraints and Seclusion

The State of Hawai'i is committed to fostering violence-free and coercion-free treatment environments for children and adolescents. As part of this commitment, CAMHD advocates that Contracted Provider Agencies seek to minimize the use of restraint and seclusion, and work to increase the effective use of positive behavioral support strategies. Restraint and seclusion are emergency interventions that are used only to assure safety in situations where there is imminent risk of physical harm. Each youth has a right to be free from restraint or seclusion in any form that is used as a means of coercion, discipline, convenience, or retaliation.

Historically, seclusion and restraint have been seen as a necessary and even therapeutic part of treatment for those with emotional and behavioral difficulties. Over the past several decades, however, there has been an increasing recognition nationally that: 1) restraint and seclusion can lead to youth injury and even death, 2) youth usually experience significant psychological trauma in the course of seclusion or restraint interventions, and 3) treatment environments that minimize use of these methods are safer for both youth and staff members.

Because incidents of restraint and seclusion represent a significant risk to youth and staff members, CAMHD and all Contracted Provider Agencies shall have internal policies and

procedures regarding restraints and seclusion. The policies and procedures must include, but are not limited to, the following:

a. The training that staff must receive prior to using restraint or seclusion with an emphasis on the serious potential for restraint or seclusion to cause injury or death;
b. Reviewing and updating restraint and seclusion policies and procedures regularly, based on clinical outcomes;
c. Agency-wide priority to use restraint or seclusion only when there is no safe alternative to prevent harm to self or others, safely and in accordance the agency's restraint and seclusion policies and procedures;
d. Adequate allocation of resources to prevent the frequent use of restraint or seclusion; and
e. Appropriate decision making guidelines for when the use of restraint or seclusion is necessary.

The current Centers for Medicare and Medicaid Services accreditation standards set the minimal requirements with regards to the use of restraints and seclusion, but CAMHD goes beyond these minimum requirements in keeping with its commitment to violence-free and coercion-free treatment environments that ensures the safe treatment of youth. CAMHD requirements are outlined in its Seclusion and Restraint Policy and Procedures 80.602. CAMHD reserves the right to revise its policies and procedures periodically or as new requirements are established by the Center for Medicare and Medicaid Services.

3. Police

Requests for police assistance should be 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. CAMHD's out-of-home Contracted Provider Agencies are to follow their internal crisis management procedures including consultation with their QMHP prior to, during, or after requesting police assistance. The QMHP must follow-up to ensure the crisis has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.

O. ADDITIONAL REPORTING REQUIREMENTS

CAMHD requires submittal of the following reports as determined by the respective department outlined below.

1. **Weekly Census Report:**
   All out-of-home levels of care are required to submit a Weekly Census Report by Wednesday of each week. See MAX Provider Portal Instructions.

2. **Attendance Record:**
   Residential facilities must maintain a log of whole day and/or night absences from both program whether authorized or not and made available to CAMHD upon request.

3. **Title IV-E Administrative Reports:**
   In accordance with CAMHD's efforts to maximize federal reimbursement, quarterly submission of Title IV-E Contracted Agency Quarterly Training Report (See Appendix 3) and Room and Board Report will be submitted by applicable Contracted Provider Agencies to the CAMHD Fiscal Section as required.

4. **Accreditation:**
   All Contracted Provider Agencies are required to have at minimum at least one national accreditation such as The Joint Commission (formerly known as JCAHO), Council on Accreditation of Rehabilitation Facilities (CARF), or Council on Accreditation (COA) is required.

All Contracted Provider Agencies shall submit evidence of current accreditation to CAMHD Performance Management Section.

5. **Facilities Information Requirements:**
   Applicable Contracted Provider Agencies are required to meet all facilities certification requirements as requested by the CAMHD's Facility Certification Specialist including:
   a. Staff schedules
   b. List of key facility personnel/consultants with location/phone numbers
   c. Copy of written information regarding residents/client rights
   d. Abuse Prohibition Review
   e. Medication pass time
   f. List of CAMHD clients' admissions during the past three (3) months
   g. Copy of facility's physical layout
   h. Tracking system for incidents/accidents/sentinel events
   i. List of new employees hired in the last six (6) months
   j. Credential of licensed/registered/certified personnel
   k. Contract for arrangement of services not provided by facility
   l. Policy and Procedure Manuals
   m. Program/Plans and Committee minutes for the past year
   n. Prevention Maintenance Records
   o. Pre-employment and annual health evaluation/TB clearance of employees
   p. In-service education records
   q. Other documents as requested
6. **Summary of Licensing Corrective Actions and Any Required Deliverables:**
   Applicable Contracted Provider Agencies must provide a summary of corrective actions and required deliverables that result from desk or site reviews conducted by CAMHD's Facilities Certification Specialist to Department of Health CAMHD and Office of Health Care Assurance (OHCA).
7. **Other Requested Materials:**
   CAMHD may periodically request specific information or documents to address specific issues or system needs. In making these requests CAMHD will be sensitive to the anticipated resources required of Contracted Provider Agencies to respond to such requests. Nevertheless, Contracted Provider Agencies are expected to provide such information upon request by CAMHD.

P. YOUTH RIGHTS AND CONFIDENTIALITY

CAMHD recognizes the rights of all youth and families accessing behavioral health services.

Consumer Rights
All Contracted Provider Agencies and their employees or subcontracted professionals are required to recognize CAMHD Consumer Rights and Responsibilities that states:

- You have the right to be treated with respect. You also have the right to your privacy.
- You have this right regardless of your age, race, ethnicity, national origin, sex, sexual orientation, gender identity and expression, religion, culture, ability to communicate, disability or other dimension of diversity.
- You have the right to know about the CAMHD services you can receive and who will provide the services. You also have the right to know what your treatment and service choices are.

- You have the right to know all your rights and responsibilities.
- You have the right to get help from CAMHD in understanding your services.
- You are free to use your rights. Your services will not be changed, or you will not be treated differently if you use your rights.
- You have the right to receive information and services in a timely manner.
- You have the right to be a part of all choices about your treatment. You have the right to have your treatment plan in writing.
- You have the right to disagree with your treatment or to ask for changes in your treatment plan.
- You also have the right to ask for a different provider. If you want a different provider, we will work with you to find another provider in our network.
- You have the right to refuse treatment.
- You have the right to get services in a way that respects your culture and what you believe in.
- You have the right to look at your records and add your opinion when you disagree. You can ask for and get a copy of your records. You have the right to expect that your information will be kept private within the law.
- You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.
- You have the right to be free from being restrained or secluded unless an allowed doctor or psychologist approves, and then only to protect you or others from harm. Seclusions and restraints can never be used to punish you or to keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

All CAMHD employees and Contracted Service Providers must adhere to these rights in the provision of behavioral health services to eligible youth. Each Contracted Provider 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 Provider 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. The Care Coordinator is required to review the Service Principles and Consumer Rights & Responsibilities https://health.hawaii.gov/camhd/brochures-factsheets with parents and youth (as appropriate) as well as the Notice of Privacy Practices.

Q. BED HOLDS AND THERAPEUTIC PASSES

1. Bed Holds

Bed holds are used by CAMHD to hold a bed space for a youth not currently in an out-of-home program when the billing day begins at 12:00 am. Up to a maximum of three (3) bed hold units will be issued per episode of care. The bed hold is reimbursed at one hundred percent (100%) of the unit rate. Bed holds are utilized for youth who:

a. elope from a program or
b. require an acute admission, or
c. require short-term detainment in the Detention Home or Hawaii Youth Correctional Facility

The Contracted Provider Agency must accept the youth back into the program, unless it has been determined, at the cost of the Contracted Provider Agency, through an evaluation by a CAMHD approved Independent Psychiatrist that an alternate service is necessary. Results of this evaluation must be provided to CAMHD in writing prior to any action being taken. If the

youth returns after the 3-day bed hold has been utilized, the contractor is obligated to accept the return of the youth immediately, if there are vacant beds. The youth shall be given a priority and expedited readmission if the admission is being sought within a thirty (30) day period from end of the bed hold. No new referral packet shall be required in these instances as the youth will resume treatment under the same episode of care. If there is no vacant bed, the contractor is obligated to put the youth on the waitlist. CAMHD reserves the right to execute contractual action if the Contracted Provider Agency is unable or unwilling to meet the needs of the youth. The program prioritizes the "Waitlisted Youth" list by date of referral. If there is a clinical or administrative need, CSO will prioritize the youth with the program.

2. Therapeutic Passes

Therapeutic passes are used by CAMHD to hold a bed space for a youth in an out-of-home program who is temporarily out of the program to visit family/caregiver. Therapeutic passes will be authorized whenever a youth will not be present at the program when the billing day begin at 12:00 am. Therapeutic passes are reimbursed at one hundred percent (100%) of the unit rate for the number of days specified in the service-specific standard.

A therapeutic pass is defined as a pass to assist the youth in achieving their MHTP goals. Therapeutic passes are used to assist youth in maintaining/improving family relationships, generalizing skills to the home/community and transitioning to home/community living. The therapeutic pass must be a planned therapeutically structured pass to the youth's home or post-treatment environment and requires prior authorization by the Clinical Lead. Each therapeutic pass must be scheduled and planned with the youth and parent/guardian prior to the pass. The out-of-home program must have contact with the youth and parent/guardian during the pass to ensure compliance with the plan for the therapeutic pass and must debrief each therapeutic pass with the youth and parent/guardian either directly after the therapeutic pass or during the next scheduled family therapy session.

R. PROVIDER RELATIONS LIAISON

The CAMHD recognizes that our Contracted Provider Agencies and their staff play an important and vital role in the provision of quality services to our consumers. This role calls for a strong partnership between CAMHD and it contracted network of providers.

The CAMHD Provider Relations Liaison serves as CAMHD's continuous communication linkage with the Contracted Provider Agencies to promote positive relationships and satisfaction with the CAMHD staff, including its Centers. The broad goal of Provider Relations Liaison is to strengthen the relationship between CAMHD and its network of Contracted Provider Agencies.

If a Contracted Provider Agency or one of its staff has an issue or concern regarding their contracted provision of services, the agency or staff may submit the issues by phone 808-733-9857, U.S. Postal Service (to the Provider Relations Liaison at 3627 Kilauea Avenue, Honolulu, Hawaii 96816). The fax is: 808-733-9357.

1. Issues or concerns must contain at minimum:
    a. Providers Name
    b. Providers Contact Information
    c. Clear Explanation of the Issue/Concern
    d. Providers Position on Such Issue/Concern
    a. The Provider Liaison will acknowledgment receipt of the issue/concern and will respond back to you, if the issue or concern has been referred to a specific department, specializing

in your area of concern/need, the Provider Liaison will follow-up to ensure the issue/concern has been resolved.

2. Below is a description of the activities and services of the Provider Relations Liaison:
   a. Resolve Provider Related Issues;
   b. Review issues considering patterns/trends for improvement opportunities and from the perspectives of both CAMHD and the Contracted Provider Agencies and bring them to the attention of the various CAMHD Sections and Leadership;
   c. Assist and support providers to effectively and efficiently work through the labyrinth of CAMHD processes and systems;
   d. Respond to Provider inquiries and concerns regarding CAMHD policies and procedures.
   e. To communicate CAMHD activities that impact the providers through coordinating the annual Provider Satisfaction Survey and the twice-yearly Decision Support Collaborative (DSCO) Party, as well as, through routinely scheduled provider meetings.

S. ACCOUNTABILITY/SERVICE STANDARDS

All Contracted Provider Agencies will remain obligated to (a) aspects of the contract as agreed upon by CAMHD, and the Agency; (b) to general professional practice and ethical standards as dictated by the various State professional and vocational licensing standards; (d) and to service standards as delineated in this manual.

SECTION II:

SERVICE SPECIFIC PERFORMANCE STANDARDS

SECTION II – PART A:

EMERGENCY MENTAL HEALTH SERVICES PERFORMANCE STANDARDS

A. CRISIS MOBILE OUTREACH (CMO)

Definition	This service provides telephone stabilization and mobile outreach assessment and stabilization services face-to-face 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, school, and other related settings. Immediate response is provided to conduct a thorough assessment of risk, mental status, immediate crisis resolution/stabilization and de-escalation if necessary.
Goals	1. Prompt assessment and evaluation in the community. 2. Stabilization in the least restrictive environment. 3. Crisis resolution. 4. Linkage to appropriate services. 5. Reduction of inpatient and law enforcement interventions.
Services Offered	1. Brief initial screening by phone to ascertain the nature of the crisis and determine if in-person response is required. When an in-person response is required, on-site arrival within of forty-five (45) minutes of concluding the initial screening. 2. Resolution/stabilization of immediate concern, prioritizing safety. 3. Completion of standard inventories and measures to thoroughly assess mental status, risk factors (e.g., harm to self and others, safety, etc.), and general wellbeing. 4. Identification of formal and informal resources in place and/or available. 5. Development of a safety plan. 6. Specific recommendations and/or service referrals. 7. Admission to Therapeutic Crisis Home if needed. 8. Follow-up contact within twenty-four (24) hours.
Admission Criteria	At least **one** (1) of the following criteria is met: 1. Age 3-17. 2. All requests for Crisis Mobile Outreach Services must originate from the Hawaii CARES 988 Crisis Call Center. 3. The youth demonstrates suicidal/assaultive/destructive ideas, threats, plans or attempts which represent a risk to self or others as evidenced by the degree of intent, lethality of plan, means, hopelessness or impulsivity. 4. The youth may be displaying acute psychotic symptoms such as delusions, hallucinations, and thought disorganization that are unmanageable. 5. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.
Authorizations	Prior authorization is not required for this level of care.
Discharge Criteria	At least **one** (1) of the following criteria is met: 1. Appropriate community or natural resources are planned and/or engaged to reduce stress factors and to stabilize the current living environment and the youth's symptoms/behaviors abated to a level no longer requiring outreach services. 2. The youth is admitted to Therapeutic Crisis Home service because the situation could not be stabilized in the home. 3. The youth is escorted to a hospital-based emergency unit for medical

	disposition.
Service Exclusions	Not to be utilized by Hospital-Based Residential and/or Community-Based Residential programs.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards, these requirements will take precedence.

1. The entire program must be under the purview and supervision of a single QMHP who is directly responsible for ensuring staff are adequately trained and the services delivered are safe, ethical and situationally appropriate.
2. An on-call QMHP must be available at all times for consultation as well as in-person response assistance as necessary.
3. All staff must be CAMHD credentialed prior to responding to any calls. At a minimum, crisis mobile outreach staff must be:
    a. An MHP with one (1) year supervised clinical experience in providing direct crisis response for youth.

    OR

    b. A Paraprofessional Level 2 with a bachelor's degree either in Social Work, Psychology, Counseling, Nursing, or another related area of study, with two (2) years specialized crisis response experience.
4. A CAMHD-approved Training Plan may substitute for experience.
5. The CAMHD Credentialing CMO Supplemental form must accompany all Paraprofessional and MHP credentialing packet submissions. The CAMHD Credentialing CMO Supplemental form template must be obtained from the CAMHD Credentialing section and appropriately completed and submitted by an assigned staff member of a contracted provider agency.
6. The program must have the capacity to adjust staffing whenever necessary to ensure an adequate number of CMO staff are available to simultaneously manage multiple calls / service requests within required response times.
7. 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.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. CMO staff must establish contact with the caller within five (5) minutes of notification from the Hawaii CARES 988 Crisis Call Center and complete a brief initial screening (not to exceed 15 minutes) to ascertain the nature of the crisis and determine if an in-person response is required.
3. When an in-person response is required, staff are expected to arrive on-site within of forty-five (45) minutes of concluding the initial screening. For more remote or small geographic locations such as Hana or Ka'u, arrival 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. The use of Telehealth or video conferencing may be utilized for assessment and crisis intervention in remote locations.

4. Assessment and therapeutic stabilization/resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Families/caregiver(s) and other involved providers/agencies, if not already involved, are sought and informed by the next business day.
5. If the youth is registered with a Family Guidance Center, the crisis worker contacts the Care Coordinator (CC) at the time of the crisis or leaves a telephone message for the CC with a full report of the occurrences, including any requirements for CC follow-up. Information exchanges guide the collaboration process toward stabilization/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 or at minimum provided with a community resources card with contact information for accessing the resources.
7. Prior to arranging for emergency room assessments, the crisis worker shall seek consultation with the on-call QMHP.
8. Staff are expected to remain with the youth at any emergency unit until the youth is released to an identified caregiver, transported to a Therapeutic Crisis Home, or the decision is made to admit the youth to acute.
9. Prior to arranging admission to a Therapeutic Crisis Home, the crisis worker shall seek consultation with the on-call QMHP.
10. The contracted provider will have a Memorandum of Understanding with the local Therapeutic Crisis Home contracted provider to allow for the efficient admission of youth determined to be in need of crisis placement.
11. The contracted provider shall have internal operational guidelines and procedures documenting how staff will interact and collaborate with CAMHD Family Guidance Centers and key service partners (e.g., Therapeutic Crisis Home provider), including plans to ensure seamless communication with the Hawaii CARES 988 Crisis Call Center.
12. The agency must make a follow-up call to the family within twenty-four (24) hours of the CMO encounter to ensure that the crisis has stabilized, and referral sources (if needed) were contacted and document the results.
13. Staff must have at least twenty-four (24) hours of orientation training including: crisis field assessment and intervention techniques, self-harm and suicide assessment, clinical protocols, documentation, local community resources, court processes and legal documents relative to emergency procedures, and specific legal issues governing informed consent in crisis intervention services. Training should promote evidenced-based services and best practice procedures for urgent and emergent situations.
14. The program must have documented ongoing training on a quarterly scheduled basis, to expand the 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 CMO workers.
15. Staff must partake in at least two (2) hours of group supervision per month. Sessions should include discussion of recent outreach encounters (grand rounds-style) and opportunities to practice/roleplay new skills and different approaches. CMO staff shall also receive at least one (1) hour of individual supervision every three (3) months to address clinical and administrative needs (e.g., encounter documentation, professional development, etc.).

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. An outreach service note must be completed for every call dispatched by the Hawaii CARES 988 Crisis Call Center and submitted to CAMHD (via the MAX Provider Portal) within 24-hours of the CMO encounter. The note must include all of the following:

a. Youth's name, date of birth, address, school and grade, legal guardian's name and phone number.
b. The date, time (start, arrival, and end times) and location of encounter.
c. Description of the nature of the crisis, assessments completed, and interventions made, including natural community resources utilized in diminishing the crisis and ensuring the safety of the youth.
d. The involvement of additional staff in the provision of service, particularly the on-call QMHP.
e. The youth's status and disposition (location) at the conclusion of the outreach encounter.
f. Specific recommendations, referrals for continued services, and resources provided.
g. The outreach service worker rendering the service.
h. Documentation of follow-up phone call to the family twenty-four (24) hours later with date and time of call and follow-up results.

2. If admitted to a Therapeutic Crisis Home, the CMO worker shall provide a summary of pertinent information to facilitate assessment, communication, and continued stabilization.

B. THERAPEUTIC CRISIS HOME (TCH)

Definition	Therapeutic Crisis Home provides short-term crisis stabilization interventions in a safe, structured setting for youth with urgent/emergent mental health needs. This service includes observation and supervision for youth who do not require intensive clinical treatment in a psychiatric setting and can benefit from a short-term, structured stabilizing setting. Youth who are experiencing a period of acute stress that significantly impairs their capacity to cope with normal life circumstances and who cannot be safely managed in his/her natural setting are appropriate for Therapeutic Crisis Home. The primary objective of this service is to provide crisis intervention services necessary to stabilize and restore the youth's functioning and return them to their natural setting.
Services Offered	1. Services are available twenty-four (24) hours, seven (7) days a week. 2. Services are provided in a Transitional Family Home setting. 3. Assessment of each youth that leads to the development of a treatment plan to stabilize the crisis and transition to him/her back to the natural setting. 4. Safety planning and discharge planning are part of the treatment plan. Concrete and specific discharge criteria are established as part of the initial planning along with timeframe for discharge and any aftercare resources needed. 5. Crisis intervention stabilization and counseling for youth and family. 6. Family based interventions. 7. Skills development directed at improving the youth's ability to cope with daily stressors; manage emotions and behaviors; improve communication and strengthen interpersonal relationships. 8. 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 CSP team as applicable.
Admission Criteria	At least **one** (1) of the following criteria is met: 1. The youth may pose a danger to self or others, is expressing some suicidal ideation without intent or is engaging in some self-destructive or self-injurious behaviors without high level of imminent risk. 2. The youth evidences lack of judgment, impulse control, or cognitive/perceptual abilities.
Initial Authorizations	One (1) to three (3) units may be provided with no prior authorization required. Youth may be admitted via Crisis Mobile Outreach or via Center Clinical Lead with parental consent.
Reauthorization	Clinical Lead may reauthorization up to four (4) units. This is a crisis stabilization service and is not expected to have stays of longer than seven (7) days. Unit = one (1) day
Continuing Stay Criteria	At least **one** (1) of the following criteria is met: 1. The youth continues to pose a potential danger to self or others. 2. The youth continues to lack judgment, impulse control, or cognitive/perceptual abilities.

Discharge Criteria	At least **one** (1) of the following criteria is met: 1. The youth's targeted symptoms and/or behaviors have abated and can be managed in his/her natural environment with the necessary support services. 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. 3. Appropriate natural community resources have been mobilized or are planned to reduce stress factors and to stabilize the current living environment.
Exclusions	Therapeutic Crisis Home is **not** considered medically necessary and will not be authorized in the following circumstances: 1. No admissions for youth who meet criteria for an acute admission. 2. Not offered at the same time as Hospital-Based Residential, Community-Based Residential programs. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of the youth. 4. No admissions that are being sought solely for convenience of child protective services housing, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards, these requirements will take precedence.

1. Transitional family parents must be licensed with the Department of Human Services prior to service initiation.
2. The program has a QMHP who is experienced in providing crisis service to youth/families, is knowledgeable of evidenced-based and best practice treatments. This professional is responsible for the Therapeutic Crisis Home program and for those in care and provides on-call coverage twenty-four (24) hours per day/seven (7) days a week.
3. Transitional families are required to receive at least two (2) hours a month of supervision from a contracted providers QMHP or a QMHP supervised MHP. One (1) hour of the required supervision may be multi-family or group supervision.
4. The contracted provider ensures the provision of necessary additional personnel, to meet the needs of the youth receiving services for emergencies including escorts and remaining with the youth at an emergency unit.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The Therapeutic Crisis Homes contracted provider and the Crisis Mobile Outreach contracted provider will have a memorandum of understanding which allows for the efficient admission of youth determined to be needing crisis placement.
3. The contract provider will have policies and procedures that delineate the admission process into Therapeutic Crisis Homes from Crisis Mobile Outreach.

4. The program provides transitional parents with a written plan for providing emergency and psychiatric care prior to youth being treated in the Therapeutic Crisis Home.
5. In addition to all requirements for licensure of transitional families, contract provider will ensure that all transitional family parents receive at least twenty (20) hours of initial orientation to include: orientation to the contractor agency; orientation to the Hawaii Child-Serving System; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the transitional youth's parents and family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; and be trained in CPR and First Aid.
6. On an on-going basis, transitional family parents shall receive at least twenty (20) hours of training annually on topics related to mental health special needs youth. Documentation of all transitional family training is the responsibility of the contract provider.
7. The transitional family home will have no more than two (2) CAMHD youth in placement with them unless a waiver is requested and approved by CAMHD. 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 to meet this requirement.
8. Youth must be always in line of site supervision of transitional family parent during awake hours.
9. The physical structure of living premises shall, to the extent possible, prevent the youth's elopement during sleep hours.
10. In conjunction with the anticipated short duration of stay, youths' education is not considered a primary focus. However, transition planning shall consider youths' educational needs such that loss of academic credits is minimized.
11. All efforts are made to ensure the assessment, stabilization, and treatment efforts continue to be family centered in accordance with CASSP. Family members and naturalistic supports are included in all aspects of planning.
12. Assessment and therapeutic resolution and/or disposition of the youth in crisis are timely, appropriate, and effective. Parent(s)/caregiver(s) involved agencies/providers, if not already involved, are immediately sought and informed when located.
13. There is daily communication between the Therapeutic Crisis Home agency, the CSP team, and the family, through the Care Coordinator (CC) if the youth is registered with CAMHD, to keep everyone apprised of the youth's status and progress.
14. Contact with the CC should occur at the time of admission to the Therapeutic Crisis Home and daily contact with the CC is maintained if the youth is registered with CAMHD.
15. For youth who are not registered with CAMHD, the program assists families with referral for eligibility determination including referrals of non-IDEA youth for DOE identification.
16. Follow-up services for youth who do not qualify for CAMHD are arranged through the families' medical insurance or community resources.
17. Upon contract execution, all contract providers of Therapeutic Crisis Home services shall submit a list of families with all the following information required on the TFH Profile Form (See Appendix 4). The contract provider will provide updates to this list as they occur to the CAMHD Utilization Management Section of the Clinical Services Office that shall maintain the information in accordance with all confidentiality requirements.
18. The contract provider must have written policies and procedures and train staff on securing and storing medications; labeling and administering medications as ordered by a physician; recording medication administration, youth request for adjustment or change, and any side effects and notifying physician or advanced practice registered nurse immediately of possible side effects; and disposing of medications.
19. The contract provider has established policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical staff and transitional parents. Included in these procedures are descriptions of methods for handling

emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis has stabilized, debrief the incident, and provide triage for youth needing more intensive interventions and document their effort in the youth's chart.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. An MHTP that identifies targets of treatment connected to stabilization goals, objectives, and discharge criteria will be developed.
2. A brief written discharge summary shall accompany 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.
3. Individual and Family Therapy progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of treatment, length of the session, type of therapy provided, and specific treatment goals addressed. The notes shall be fully signed by the writer and supervisor if needed. The original note must be maintained in the youth file within seventy-two (72) hours of service.
4. Transitional family parents shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and signed by the transitional parent, originals of which shall be placed in the agency's master youth file within seven (7) calendar days. These transitional home progress notes may be in the form of a checklist or written note.

SECTION II – PART B:

INTENSIVE MENTAL HEALTH SERVICES PERFORMANCE STANDARDS

A. ANCILLARY SERVICES

<table>
<tr><td>Definition</td><td>Ancillary services are services that are not available through existing contracted mental health services for youth. The funding for such services is limited and closely monitored to assure that disbursement is completed in the most clinically appropriate and fiscally responsible manner.</td></tr>
<tr><td>Services Offered</td><td>Supportive services that facilitate mental health treatment delivery as outlined in the CMP/CSP for time-limited interventions that are not available through existing contracted services. Examples include transportation services, interpretive services, specific clinical services that are not available through contracted providers and special community programs or classes. The ancillary service must clearly support the youths improved functioning in their home/community and/or prevent the likelihood of movement to a higher level of care.</td></tr>
<tr><td>Admission Criteria</td><td>The clinically appropriate requested services/items are required to allow the youth to meet the goals identified in the CMP/CSP and improve his/her functioning in the home/community or likely prevent the movement to a higher level of care. The services are procured after all other resources are exhausted.</td></tr>
<tr><td>Authorizations</td><td>The need for clinically appropriate services/items is identified in the CMP/CSP, approved by the Clinical Lead.
<table>
<tr><th>Description</th><th>Unit</th><th>Credential</th><th>HCPCS Code</th><th>Modifier</th></tr>
<tr><td>Interpreter</td><td>15 minutes</td><td></td><td>T1013</td><td>HA</td></tr>
<tr><td>Mainland Tx</td><td>Day</td><td></td><td>H0019</td><td></td></tr>
<tr><td>Travel</td><td>Dollar</td><td></td><td>A0140</td><td></td></tr>
</table>
The approval of the amounts greater than 5000 units requires the Division Administrator approval.

Unit = One (1) Dollar</td></tr>
<tr><td>Continuing Stay Criteria</td><td><u>All</u> <u>the following criteria are met as determined by clinical review at least quarterly</u>:
1. Services/items are being provided as indicated in the CMP and documented in progress notes and in plan reviews.
2. There are regular and timely assessments and documentation of youth/family response(s) to services. Timely and appropriate modifications are made to plans as needed.
3. Goals, objectives, and discharge planning as related to ancillary funded services/items are reviewed at least quarterly.
4. The youth/family continues to be actively involved in treatment interventions and treatment planning.
5. The youth/family continues to need ancillary funded services/items.</td></tr>
</table>

Discharge Criteria	Ancillary funded services/items are terminated when **one** (1) of the following criteria are met: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible. 2. The youth is no longer eligible for services/items (i.e., does not meet admission criteria). 3. The clinical review determines that services/items are no longer needed. 4. Services/items are obtained through alternative sources.
Service Exclusions	1. No educational or basic health services are to be provided through ancillary services. 2. Ancillary services are not stand-alone services. Ancillary services must augment and compliment other intensive mental health treatment services.

Staffing Requirements
1. If the ancillary service is a direct mental health service to youth and families, then only a practitioner credentialed by CAMHD shall be allowed to perform this service.
2. Individual Practitioner Credentialing information if applicable.

Clinical Operations
If providing direct mental health services, then the practitioner is bound by all professional licensing requirements, professional ethics as well as CAMHD practice guidelines.

Documentation
1. The Administrative Specialist (AS) must submit a Manual Service Authorization Form to the CAMHD fiscal office.
2. Original receipts for services/item must be provided as appropriate.

B. THERAPEUTIC ONE-TO-ONE (1:1) SUPPORT

Definition	Therapeutic One-to-One (1:1) Support is to assist youth in an out-of-home treatment program with additional support while transitioning into treatment, to assist with stabilization of youth in treatment, to avert hospitalization or prevent treatment failure. *This is a short-term, time-limited service that must be clinically justified.*
Services Offered	Time-limited supportive service for Transitional Family Home or Community-Based Residential treatment program. The 1:1 service must clearly support the youth's improved functioning and prevent the likelihood of movement to a higher level of care.
Admission Criteria	**All** the following criteria must be met: 1. The clinical team (the contracted program therapist and/or clinical director and FGC Clinical Lead) meet (by phone or in person) to discuss the clinical issues warranting this service. Upon agreement that Therapeutic 1:1 Support is justified; the program therapist or clinical director submits the Ancillary Service One-to-One (1:1) Request Form (download from Clinical Forms) to the Care Coordinator. 2. The Clinical Justification must include the following: a. Reason for the request (describe the behaviors and issues that support the request for Therapeutic 1:1 Support.) b. Paraprofessional support functions – describe what the Therapeutic 1:1 will do to address the crisis, transition, or stabilization issue(s). c. Requested number of hours per week and length of time. The requested start date must be no earlier than two working days from the submission of the request. d. Requested start date. Retro-authorizations are not permitted. 3. Upon receipt of the Request Form the Care Coordinator forwards the request to CAMHD's Clinical Services Office. Direct requests to Resource Manager.
Authorizations	Therapeutic 1:1 Support may be authorized for up to thirty-two (32) units [eight (8) hours] per day, seven (7) days per week for a period of six (6) weeks. All requests require CAMHD Medical Director or Chief Psychologist approval. Unit = Fifteen (15) minutes
Reauthorization	Upon reassessment of the need, an additional six (6) week period may be authorized, for a total of twelve (12) weeks.

Staffing Requirements

1. The Therapeutic 1:1 Support is provided by a CAMHD credentialed Paraprofessional level 1 or 2. Credentialing is required prior to initiating services.

Clinical Operations

1. The practitioner is bound by all professional licensing requirements, professional ethics as well as CAMHD practice guidelines.

Documentation

1. Providers of direct mental health services, please see Section I General Standards for additional documentation requirements:
    - K. Maintenance of Service Records:

C. PEER SUPPORT SERVICE - PARENT PARTNER (PSS-PP)

Definition	Face-to-face supportive interactions with the caregiver for a CAMHD youth, focused on helping the family participate fully in and benefit from mental health treatment. This service is provided by Parent Partner (PP) who: 1) who have lived experience as a caregiver within the mental health system of care for youth and 2) who have been certified to provide peer support by the National Federation of Families or another certifying body. The need for Parent Support Services shall be documented by Clinical Lead in the Clinical Management Plan (CMP) as part of the comprehensive, individualized plan of care for the youth and their family
Services Components	Peer Support Services – Parent Partner (PSS-PP) include all the following components: 1. Accepting referrals from Family Guidance Center (FGC) Care Coordinator (CC) to work with parents, including contacting families and setting up an initial pre-admission meeting. When possible, PP will be introduced to the family by the CC as part of the intake process, and the CC will obtain the caregiver's written consent to share information with the PP. 2. Meeting with the caregiver face-to-face to identify the family's needs and goals, and to provide encouragement and emotional support. 3. Attending treatment planning, CSP development, or other multi-agency meetings with the parent to support them in communicating their needs/goals to the treatment team, and to help professionals understand the family perspective. 4. Helping the caregiver find ways of meeting their needs and navigating the complicated system of care. This may include helping parents to identify and connect with community resources, qualify for government benefits, and seek out adult mental health/substance abuse treatment resources. 5. Facilitating group support opportunities for parents (parent groups must have a ratio no greater than 8 participants per facilitator). 6. Providing education, training and mentoring to caregivers including orienting them to the CAMHD, educating them about mental health issues and the system of care, providing training in areas such as advocacy skills, parenting skills, and leadership skills. 7. Mentoring emerging parent leaders in new roles such as serving on the board of a local agency or on a statewide committee related to Children's services.
Admission Criteria	PSS may be provided to the caregiver (parent, grandparent, formal or informal foster parent, stepparent, etc.) of any youth who is eligibility for CAMHD or who is in the process of eligibility determination.
Authorizations	Clinical Lead may authorize up to thirty-two (32) units [eight (8) hours] per month for up to three (3) months at a time. Unit = fifteen (15) minutes
Reauthorization	Clinical Lead reauthorization shall be based on a Family Support Plan (FSP) submitted by the PP. Reauthorization may be up to thirty-two (32) units [eight (8) hours] per month for up to three (3) months at a time.

Continuing Stay Criteria	**All** the following criteria must be met as determined by clinical review of service documentation, plans and progress: 1. The FSP includes clear goals to be addressed through PSS. 2. The caregiver wants to continue with PSS. 3. There is evidence that the family is benefitting from PSS. 4. The youth and family continue to be engaged in treatment through CAMHD.
Discharge Criteria	The caregiver is no longer in need of or eligible for the service due to **one (1)** of the following: 1. The youth is no longer eligible for CAMHD services. 2. The goals on the FSP are completed. 3. The caregiver no longer desires the service.
Service Exclusions	PSS is not a stand-alone service. PSS must augment and compliment other intensive mental health treatment services.
Clinical Exclusions	None

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program has a part-time Qualified Mental Health Professional either on staff or on contract to provide administrative and clinical oversight.
2. The program has a Mental Health Professional (MHP) on staff who has oversight and supervision responsibilities for all staff decisions made regarding services to families.
3. PSS shall be provided by personnel that meet all the following requirements:
   a. Parent Partners have lived experience as the primary caregiver for a youth with serious mental health challenges.
   b. Is credentialed by the CAMHD as a Paraprofessional:
      i. Level 1 with no Peer Support Certification, but must achieve certification within two years of the initial credentialing period; or
      ii. Level 2 with Peer Support Certification.
   c. Parent Partners must be in the process of obtaining or maintaining Peer Support Certification from the National Federation of Families or CAMHD approved equivalent. Any Parent Partner who is not certified within two years of the initial credentialing period will no longer be credentialed.

      AND

   d. Is working under the supervision of an MHP. The supervisor is expected to review all the supervisees work in detail.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. PP shall coordinate with the CC and with other system of care agencies such as education, juvenile justice system, and/or child welfare as needed to provide services.
2. The PSS Organization shall 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.

3. The PSS Organization shall establish written policies which govern the provision of services in natural settings and which document that the organization respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings either in person or via telehealth technology.
4. The PSS Organization shall establish written procedures/protocols for handling emergency and crisis situations that describe methods for assuring the safety of staff and family members, guidelines for when to consult with the program MHP and what to document in the youth's chart.
5. The PSS Organization shall establish written policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
6. The PSS Organization shall establish written policies and procedures around the use of personal vehicles for outreach services and for transporting caregivers.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The PP develops a written FSP with the caregiver, identifying the kinds of support the caregiver would like to receive. The written FSP shall be submitted to the CAMHD FGC within ten (10) calendar days of the PP's first meeting with the family.
2. PP shall provide a written service note for each face-to-face contact with a caregiver, and for indirect service activities (e.g., team meeting attendance, phone calls with team members). Service notes shall document the types of support provided, who was present in the meeting, the goals addressed, and the start time and end time of each encounter.

D. PEER SUPPORT SERVICE - YOUTH PARTNER (PSS-YP)

Definition	Peer Support Service (PSS) provides individual support to youth who are at least 14 years old. The goals of this service are to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural support, self-awareness, and values of the youth to support their treatment to attain and maintain recovery in their community. The Youth Partner (YP) supports the youth by building a strong relationship based on mutual respect and strategic self-disclosure to increase hope, confidence, and decision-making abilities. The YP assist the youth to successfully navigate challenges, support opportunities for youth to have a voice in planning and decision-making, empower youth to communicate wants and needs to those involved in their lives, and encourage participation in treatment and daily activities.
Services Components	The exact nature of each PSS will be determined by the needs of individual youth. YP do not force or coerce others to participate in peer support services or any other service. The following are components: 1. Provide individualized direct support according to the youth's preference by supporting the individual's choice and building confidence, leading to a greater degree of independence. 2. Strategic sharing of the YP's personal journey to promote hope and acceptance, reduce stigma and increase youth voice and ownership in treatment. 3. Respects an individual's right to choose the pathway to recovery that will work best for the individual. 4. Practices effective listening skills that are non-judgmental. 5. Coach the youth to identify and describe their needs and goals in the Mental Health Treatment Plan. 6. Assist youth in understanding components of recovery and resiliency and in applying skills to achieve their goals. 7. Collect and share information about community resources. 8. Assist and support youth to identify and a build community of natural and informal support. 9. Collaborate with youth to strategize around effective self-advocacy within public systems such as Juvenile Justice, Child Welfare, Schools, and Mental Health. 10. Attending treatment planning, CSP development, or other multi-agency meetings with the youth to support them in communicating their needs/goals to the treatment team, and to help professionals understand the youth perspective.
Admission Criteria	The youth is between the ages of fourteen (14) and twenty (20). On a case-by-case basis, youth as young as twelve (12) may be considered if deemed mature enough to participate in and benefit from self-direct treatment.
Authorizations	Clinical Lead may authorize up to sixty-four (64) units [sixteen (16) hours] per month for up to three (3) months at a time. Unit = fifteen (15) minutes

Reauthorization	Clinical Lead reauthorization shall be based on the MHTP submitted by the YP. Reauthorization may be up to sixty-four (64) units [sixteen (16) hours] per month for up to three (3) months at a time.
Continuing Stay Criteria	**All** the following criteria must be met as determined by clinical review of service documentation, plans and progress: 1. The Mental Health Treatment Plan includes clear goals to be addressed through PSS. 2. The youth wants to continue with PS. 3. There is evidence that the youth is benefitting from PSS. 4. The youth continues to be engaged in treatment through CAMHD.
Discharge Criteria	The youth/caregiver are no longer in need of or eligible for the service due to **one (1)** of the following: 1. The youth is no longer eligible for CAMHD services. 2. The goals on the MHTP are completed. 3. The youth no longer wants to participate in the service.
Service Exclusions	PSS is not a stand-alone service. PSS must augment and compliment other intensive mental health treatment services.
Clinical Exclusions	None

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program has a Mental Health Professional (MHP) on staff who has oversight and supervision responsibilities for all staff decisions made regarding services to youth.
2. PSS shall be provided by personnel that meet all the following requirements:
   a. Youth Partners are young adults between 18-27 years old with lived experience in systems (foster care, mental health, juvenile justice) who have faced challenges of coping with a mental health condition.
   b. Is credentialed by the CAMHD as a Paraprofessional:
      iii. Level 1 with no Peer Support Certification, but must achieve certification within two years of the initial credentialing period; or
      iv. Level 2 with Peer Support Certification.
   c. Youth Partners must be in the process of obtaining or maintaining Peer Support Certification from a CAMHD approved certification program. Any Youth Partner who is not certified within two years of the initial credentialing period will no longer be credentialed.

      AND

   d. Is working under the supervision of an MHP or Para 2 with three years of supervised certified Peer Support experience as a YP. The supervisor is expected to review all the supervisees work in detail.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. YP shall coordinate with the CC and with other system of care agencies such as education, juvenile justice system, and/or child welfare as needed to provide services.

2. The PSS Organization shall 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.
3. The PSS Organization shall establish written policies which govern the provision of services in natural settings and which document that the organization respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings either in person or via telehealth technology.
4. The PSS Organization shall establish written procedures/protocols for handling emergency and crisis situations that describe methods for assuring the safety of staff and family members, guidelines for when to consult with the program MHP and what to document in the youth's chart.
5. The PSS Organization shall establish written policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
6. The PSS Organization shall establish written policies and procedures around the use of personal vehicles for service activities.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The YP develops a written MHTP with the youth, identifying goal and support the youth would like to receive. In addition. The draft MHTP shall be submitted to the CAMHD FGC within ten (10) calendar days of the YP's first meeting with the family.
2. YP shall provide a written progress note for each contact with a youth and for indirect service activities (e.g. team meeting attendance, phone calls with team members) that are billed. Progress notes shall document the types of support provided, who was present in the meeting, the goals addressed, and the start time and end time of each encounter.

E. INITIAL MENTAL HEALTH EVALUATION (IMHE)

Definition	An Initial Mental Health Evaluation (IMHE) provides information concerning a youth's functional impairment, mental health diagnoses and current mental health needs. The IMHE template (download from Clinical Forms) will be used to assure collection of the information required to make a determination regarding eligibility for CAMHD services. This strengths-based evaluation process produces a document that is based on the CAMHD IMHE template. The template includes dropdowns and check boxes to make it easier for evaluators to complete it efficiently in order to expedite entry into CAMHD services. This service includes review of available records, interviews with the youth and caregiver(s) and production of a written report using the CAMHD IMHE template. Feedback about the results of the report may be provided to the youth and caregiver(s) during a meeting with the evaluator or in a CAMHD welcome meeting with the family and Care Coordinator.
Services Components	Collect data needed to complete the IMHE template within twenty-one (21 days) of the referral and authorization: 1. Review any available records about the youth and incorporate their findings. 2. Interview the caregiver(s) about their presenting concerns, their family situation, youth's history, and youth's current functioning in the domains specified by the Child and Adolescent Functional Assessment Scale (CAFAS) for youth who have started kindergarten and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) for youth who have not yet started kindergarten. 3. Administration of the CAMHD version of the youth and parent Ohio Scales (download from Evidence-Based Assessment Resources). 4. Interview the youth individually and perform a mental status exam, documenting findings in the IMHE template. 5. Be attentive to information that may suggest an imminent risk of some kind (e.g. suicidal thoughts, self-harming behavior) and intervene as clinically appropriate. Develop a Safety Plan (download from Clinical Forms) with the youth and family if indicated. 6. Summarize and synthesize the available information in a clinical formulation and provide a diagnosis based on the current ICD/DSM. 7. Offer treatment recommendations, including suggestions regarding the need for additional assessment, treatment modality, priority problems to be targeted, ways to utilize strengths, etc. a. Recommendations should describe the youth's needs to be addressed, the intensity of the interventions and restrictiveness of the treatment setting, but MAY NOT name specific levels of care, programs, or organizations. (e.g. you may specify that a youth is at high risk of elopement, needs 24/7 line of sight supervision in a self-contained highly structured setting, etc., but do not specify "a locked residential program" or "the Happy Trails program"). b. Recommendations shall include treatment interventions that are provided in the least restrictive manner that will address the needs of the youth and family. 8. Submit the signed typed IMHE template report to the FGC within twenty-one (21) days from the date of referral. If more time is needed, the evaluator shall contact the Intake Coordinator with his/her reasons for the time

	extension requested. 9. When the IMHE is completed by a contracted provider: a. The QMHP who writes or supervises the evaluation retains full responsibility for the content, decisions about diagnoses, etc. b. The report must comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal. c. Results will be shared with the family during the Welcome Meeting. The Clinical Lead will explain IMHE results and can request that the contracted provider be available to answer questions about the report.
Admission Criteria	The youth is enrolled with a CAMHD and is in the process of eligibility determination for CAMHD services;
Authorizations	Clinical Lead may authorize may be up to twelve (12) units [three (3) hours] for evaluation activities. Billing limits: Procurement units reflect the time required for completing the review of data and the evaluation interviews. The 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.
Reauthorizations	If the evaluator requests additional units with a clear justification for why this is needed, the Clinical Lead may determine that the more comprehensive General Mental Health Evaluation (GMHE see Standard p. II-29) is needed and changes the initial authorization to reflect this more intensified need for the GMHE. Feedback session: Once the Clinical Lead confirms that the evaluation report adheres to these standards, an additional four (4) units [one (1) hour] may be authorized for a feedback session with the youth/family.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The evaluation sessions are completed, the typed report, using the IMHE template, has been submitted to the intake coordinator, the report has been accepted by the Clinical Lead, and the feedback session has been held. 2. The youth/family no longer wants to participate in this service and stops attending assessment meetings or revokes consent in writing prior to the completion of the report[1].
Service Exclusions	The IMHE generally should NOT be conducted on youth who have already been found eligible for CAMHD services. When more assessment information is needed regarding CAMHD youth, a General Mental Health Evaluation should be conducted. The Summary Annual Evaluation should be conducted to update the IMHE. An Initial Mental Health Evaluation is not considered medically necessary and

[1] The youth/family may revoke consent to be evaluated any time during the evaluation process, but once the assessment is complete, they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

	will not be authorized under the following circumstances: 1. The youth is actively under the influence of a substance, experiencing substance withdrawal, or similar circumstances that may invalidate evaluation results. 2. Intended use is primarily for educational/vocational purposes. 3. Intended use is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior are excluded. Once stable, a youth who otherwise meets the eligibility criteria may be referred into this service;

Staffing Requirements
In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The provider of a Mental Health Evaluation shall meet one of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP).

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP).

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the evaluation.
2. Evaluators are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations
In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Direct service providers must coordinate with family/significant others and with other system of care partners such as education, juvenile justice, child welfare as needed to provide service.
2. Direct service providers must obtain consents to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian that they may revoke the consent to be evaluated any time during the evaluation process, but once the report is complete, they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release it further. However, this may impact service delivery.

Documentation
In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Progress notes document all evaluation activities.
2. The complete IMHE template is submitted to the Intake Coordinator within twenty (21) days from date of referral and authorization. Requests for an extension of this timeline should be directed to the Clinical Lead and should include an explanation for why the extension is needed.
3. The completed IMHE template is typed and includes:

a. Identifying information: youth name, date of birth (DOB), legal guardian, home school, grade level, IDEA status.
b. Reason for referral, including any specific referral question(s).
c. Diagnostic impression and justification for the diagnosis.
d. Recommendations that speak to the youth's treatment needs and do not specify particular types of care or treatment programs.
e. The report is signed by the evaluator (and his/her supervisor when applicable) acknowledging responsibility for the evaluation).

4. Professionally recognized standards of ethical practices are followed in all evaluations.

F. GENERAL MENTAL HEALTH EVALUATION (GMHE)

Definition	This service standard provides guidelines for the General Mental Health Evaluations that can be performed for a range of purposes. The GMHE provides needed information concerning a youth's psychosocial functioning, mental health diagnoses and current mental health needs. This general-purpose evaluation may be performed: • When an in-depth evaluation is needed to establish the correct diagnosis and determine treatment needs for a youth newly referred for CAMHD services. • When comprehensive clinical and historical information about a CAMHD youth is needed to assist with coordination of services and treatment planning at a later point in the treatment process; and/or • When focused clinical information is needed to address specific issues being considered by the youth's treatment team. This may include diagnostic questions, questions about personality functioning, or concerns about risk management. This strengths-based evaluation seeks to identify the needs of the youth in the context of his/her family, community, school and/or current treatment program. This service includes interviews, use of standardized assessment instruments, a written report, and feedback to the youth and the caregiver(s). When a mental health professional determines that psychological testing is needed to address the team's concerns, additional authorization for the testing may be requested and the General Mental Health Evaluation report shall incorporate any psychological testing data collected.
Services Components	1. Complete the collection of data and write the evaluation report within thirty (30) days of the referral and authorization. 2. Document the reason for referral, referral source, and presenting concerns based on information provided by the person who initiated the referral and/or the guardian. 3. Review past mental health records, educational records and evaluations and synthesize the findings. 4. Interview the youth and perform a mental status exam. 5. Interview the parent(s), guardian, or other caregiver. 6. When performing the evaluation, ensure that the following information is included in the report: a. Information regarding psychosocial history, trauma and adverse events, family psychiatric and medical histories, including prenatal and developmental history, and descriptions of the individual's educational, legal and substance abuse status, based on the guardian interview and from other available sources. b. Information regarding previous mental health and related services received including medications if any, and their impact. Note previous diagnoses given, and if possible, include dates of these services and diagnoses. c. Ratings on the Child and Adolescent Functional Assessment Scale (CAFAS) must be completed, based on the data collected. 7. Be attentive to information that may suggest an imminent risk of some kind (e.g., suicidal thoughts, self-harming behavior) and intervene as clinically appropriate. Develop a Safety Plan (download from Clinical

	Forms) with the youth and family if indicated. 8. Administer questionnaires to the youth and caregiver(s), utilizing instruments appropriate to the referral questions; initial evaluations should utilize the CAMHD version of the Youth and Parent Ohio Scales questionnaire (download from Evidence-Based Assessment Resources). 9. Incorporate the results of any Psychological Testing if completed as part of this evaluation. 10. Summarize and synthesize the available information in a clinical formulation and provide current DSM/ICD diagnoses. 11. Offer treatment recommendations, including suggestions regarding treatment modality, priority problems to be targeted, ways to utilize strengths, etc. a. Recommendations should describe the youth's needs to be addressed, the intensity of the interventions and restrictiveness of the treatment setting, but MAY NOT name specific types of care, programs, or organizations (e.g. you may specify that a youth is at high risk of elopement, needs 24/7 line of sight supervision in a self-contained highly structured setting, etc., but do not specify "a locked residential program" or "the Happy Trails program"). b. Recommendations should include treatment interventions that are provided in the least restrictive manner that will address the needs of the youth and family. 12. Submit the signed typed report to the CC within thirty (30) days from the date of referral. If more time is needed, the provider must contact the CC with his/her reasons for the time extension requested. 13. The QMHP who writes or supervises the evaluation retains full responsibility for the content, decisions about diagnoses, etc. a. The report must comply with CAMHD standards as determined by Clinical Lead before results or recommendations are shared with the youth/caregivers or other team members. If there are concerns about adherence to the standards, the report will be returned to the evaluator for amendment. The Clinical Lead will review the report within one (1) week of submittal. b. Upon CL's acceptance of the report, a feedback session will be authorized and must be conducted with the youth and family/guardian within two (2) weeks. If, after extensive efforts are made (i.e., three attempts), the provider is not able to schedule a face-to-face feedback session, a phone feedback session is permissible.
Admission Criteria	**One** of the following criteria must be met: 1. The youth is enrolled with a CAMHD Center and is in the process of eligibility determination for CAMHD services. 2. The youth is registered with a CAMHD Center and the Clinical Lead, in consultation with the treatment team determines there is a need for additional clinical information on the youth to inform treatment planning, and/or to address specific clinical questions.
Authorizations	Clinical Lead may authorize up to twenty-four (24) units [six (6) hours] for the GMHE. If Psychological Testing is being requested along with the GMHE, the Clinical Lead may authorize up to an additional to sixteen (16) units [four (4) hours]

	for testing. The total authorization is forty (40) units [ten (10) hours]. Unit = fifteen (15) minutes Billing limits: Procurement units reflect the time required for completing the review of data and the evaluation process. The 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.
Reauthorizations	Evaluator may request additional units to complete the GMHE with a clear justification for why this is needed. The Clinical Lead may authorize up to an additional sixteen (16) units [four (4) hours] if clinically justified. Feedback session: Once the Clinical Lead confirms that the evaluation report adheres to these standards, an additional four (4) units [one hour] may be authorized for a feedback session with the youth/family.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The evaluation sessions are completed, the typed report has been submitted to the CC, the report has been accepted by the Clinical Lead, and the feedback session has been held. 2. The youth/family no longer wants to participate in this service and stops attending assessment meetings or revokes consent in writing prior to the completion of the report[2].
Service Exclusions	General Mental Health Evaluation is not considered medically necessary and will not be authorized under the following circumstances: 1. There is a current Mental Health Evaluation within the past 12 months and no new clinical questions have been raised. 2. The youth is actively under the influence of a substance, experiencing substance withdrawal, or similar circumstances that may invalidate evaluation results. 3. Intended use is primarily for educational/vocational purposes. 4. Intended use is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, a youth who otherwise meets the eligibility criteria may be referred into this service;

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The provider of a General Mental Health Evaluation shall meet one of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP)

OR

[2] The youth/family may revoke consent to be evaluated any time during the evaluation process, but once the assessment is complete, they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

b. Credentialed by CAMHD as a Mental Health Professional (MHP)

AND

c. Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the evaluation.

2. Evaluators are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Direct service providers must coordinate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide service.
2. Direct service providers must obtain consents to be evaluated and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated any time during the evaluation process, but once the report is complete, they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release it further. However, this may impact service delivery.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Progress notes document all evaluation activities.
2. The complete written report is submitted to the CC within thirty (30) days from date of referral and authorization. Requests for an extension of this timeline should be directed to the Clinical Lead and should include an explanation for why the extension is needed.
3. The typed written report includes:
   a. Date(s) of evaluation sessions and date of report.
   b. Identifying information: youth name, date of birth (DOB), legal guardian, home school, grade level, IDEA status.
   c. Reason for referral, including any specific referral question(s).
   d. Sources of information: including review of records, interviews, and assessment tools.
   e. Results of psychological testing if a separate authorization for testing has been issued.
   f. Diagnostic impression and justification for the diagnosis (DSM5/ICD10)
   g. Recommendations that speak to the youth's treatment needs and do not specify particular types of care or treatment programs.
   h. The report is signed by the evaluator (and his/her supervisor when applicable) acknowledging responsibility for the evaluation; and
   i. The written report includes all the clinical information outlined in the standard, above.
4. Professionally recognized standards of ethical practices are followed in all evaluations.

G. SUMMARY ANNUAL EVALUATION (SAE)

Definition	The Summary Annual Evaluation (SAE) is designed to provide an annual update on the diagnosis, level of functional impairment, primary problems, risk of harm to self or others, treatment barriers and progress for a youth and family. This evaluation is performed when the Clinical Lead determines that there are no clinical concerns that would call for a more in-depth General Mental Health Evaluation to be performed instead. Contracted service providers must complete a Summary Annual Evaluation when requested by the Family Guidance Center if youth has been in the service for at least three (3) months.
Services Components	1. Obtain written informed consent before conducting evaluation, if applicable. 2. Evaluation activities may include a record review and brief interviews with the youth, family members or other collaterals as needed to complete the summary. 3. The CAMHD Summary Annual Evaluation template (download from Clinical Forms) will be used to assure collection of required information. a. Demographic Information b. Description of Current Service (format, frequency, setting, goals, etc.) c. Reason for Treatment (main issue that brought family into treatment) d. Current Level of Functioning (CAFAS domains, ACES, significant life changes) e. Risk Assessment f. Assessment Data (findings from measures used in treatment or completed for evaluation) g. Treatment Progress h. Treatment Barriers i. Diagnostic Impression (confirm current diagnosis or need for further evaluation, observed symptoms and behaviors that support recommendation) j. Recommendations for Treatment (treatment modality suggestions, priority problems to target, ways to utilize strengths, etc.) 4. The completed SAE will be submitted to the Family Guidance Center within thirty (30) days of request or referral acceptance. 5. The SAE will be reviewed by the Clinical Lead within one (1) week of submission. Incomplete or inadequate SAE will be returned to the evaluator for revision. 6. Upon approval of the report, a treatment team meeting will be scheduled with the youth and family/guardian within two (2) weeks to present evaluation results and just MHTP if needed.
Admission Criteria	All the following criteria are met: 1. Youth needs a SAE as part of the comprehensive delivery of services.
Authorizations	**Authorizations will only be issued if the evaluator completing the SAE is not the current service provider. For SAE completed by the current service provider, evaluation activities shall be billed on the existing service authorization.** Clinical Lead may authorize up to eight (8) units [two (2) hours] for evaluation activities.

	Unit = fifteen (15) minutes Billing limits: Procurement units reflect the time required for completing the review of data and evaluation process. The 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.
Reauthorization	Once the Clinical Lead confirms that the SAE adheres to these standards, an additional four (4) units [one (1) hour] may be authorized for a presentation of findings at a treatment team.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The evaluation sessions are complete, the typed report has been submitted to the CC, the report has been approved by the Clinical Lead and discussed in a treatment team meeting. 2. The youth/family no longer wants to participate in this service and revokes consent in writing prior to the completion of the report[3].
Service Exclusions	SAE will not be considered medically necessary and will not be authorized under the following conditions: 1. The youth has been receiving a service for at least three (3) months – the Contracted Service Provider is required to complete the SAE. 2. There is a current Mental Health Evaluation (completed within the las twelve (12) months), or youth has been referred for a more in-depth evaluation. 3. The youth is actively under the influence of a substance, experiencing substance withdrawal, or similar circumstances that may invalidate evaluation results. 4. Intended use is primarily for educational/vocational purposes. 5. Intended use is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, a youth who otherwise meets the eligibility criteria may be referred for this service.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The provider of a Summary Annual Evaluation shall meet one (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP)

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP)[4]

   AND

[3] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is completed, they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

[4] MST therapists who are credentialed as paraprofessionals may complete summary annual evaluations under supervision of their MST supervisor.

Working under the supervision of a QMHP. The supervisor is expected to review all data on which the current report is based and participate in the interpretation of data and the development of the diagnoses and recommendations. The supervisor is to co-sign the report acknowledging supervisory responsibility for the evaluation.

2. Evaluators are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Direct service providers shall collaborate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide coordinated services.
2. Direct service providers must obtain consents to conduct the evaluation and consent to release information to CAMHD. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete, they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Evaluator will use the CAMHD Summary Annual Evaluation template (download from Clinical Forms).
2. Evaluator will submit completed SAE within thirty (30) days of request or referral acceptance.
3. Assessment activities will be documented in a Direct Service Progress Note.

H. **PSYCHIATRIC EVALUATION**

Definition	Psychiatric diagnostic examination, specifically completed by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist, includes history, mental status exam, physical evaluation or exchange of information with the primary physician, and disposition. This service can be an initial or follow-up evaluation for medically complex or diagnostically complex youth. In CAMHD a Psychiatric Evaluation is the first step before starting medication Management service.
Services Components	1. The youth and family will be contacted to set up an appointment within one (1) week of the Service Line being created in the Clinical management Plan. 2. The psychiatrist is expected to review all previously collected data prior to interviewing youth and family. 3. Psychiatric diagnostic evaluation of a patient includes examination of a patient or exchange of information with the primary physician, current mental health treatment providers, the child's school, other informants such as nurses or family members, and the preparation of a report. This baseline initial evaluation includes vital signs (blood pressure and pulse), height, weight, and neurological examination for abnormal movements (using a standardized format such as the AIMS) as well as mental status finding and other appropriate clinical measurements. A detailed history of previous medication trials and the results of such trials is a necessary component of service. The use of systematic and thorough diagnostic interviewing is encouraged. 4. The report is generated to document the nature, chronicity and severity of the disorder, DSM5/ICD-10 diagnosis and Biopsychosocial recommendations regarding treatment interventions/medication. All recommendations shall be based on the presenting needs of the youth and family following evidence-based practices and AACAP practice guidelines. 5. The report is to be completed in the New Customer Visit of the Center Medication Management Note in MAX. The report should include the following: a. Behavioral observations and general presentation. For adolescents this would include time spent interviewing guardians and youth separately. b. Description and history of presenting problems including psychiatric review of systems, past medical history, past psychiatric history, social history, history of development, educational achievement, involvement with juvenile justices, out of home placements or DHS involvement, and family history. c. Description of youth and family's strengths and resources. d. Description of current medical issues. e. Any ongoing substance use. f. Current medications. g. Complete mental status examination. h. Safety evaluation for suicide, self-harm, aggression, homicidal thoughts, and for evidence of ongoing or past trauma. i. Biopsychosocial 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) and expected prognosis. j. DSM5/ICD-10 diagnostic impression.

	k. Discussion of findings and recommendations with youth and family including fully explaining the benefits, risks, and alternatives. l. Recommendations must include what benefits may or may not be expected from the medication in a manner measurable by client, family, and significant members of the treatment team, and how the medication may specifically assist any other concurrent treatments. 6. Assure that services are provided to youth in a safe, efficient manner in accordance with accepted standards and clinical practice. 7. The service should be completed and documented in MAX within fourteen (14) days of initial appointment with the youth and family.
Admission Criteria	**All** the following criteria are met: 1. Youth presents as medically complex or diagnostically complex and needing an initial or follow-up evaluation. 2. Clinical case review with the Clinical Lead results in the determination that Psychiatric Diagnostic Evaluation may be beneficial to the client.
Authorizations	This service is provided by CAMHD staff and fellows, no authorization is needed.
Discharge Criteria	**One** (1) of the following criteria is met: 1. The Psychiatric Diagnostic Evaluation is complete and documented in the New Customer Visit template within the Center Medication Management Note in MAX. 2. The youth/family no longer wants to participate in this service and revokes consent with no imminent danger to self or others[5].
Service Exclusions	Psychiatric Evaluation is not considered medically necessary and will not be authorized under the following circumstances: 1. Intended use is primarily for educational/vocational purposes. 2. Intended use is primarily for legal purposes including custody evaluations, parenting assessments, or other court ordered testing. 3. The youth has received a Psychiatric Evaluation within the past twelve (12) months and no new clinical questions have been raised. 4. Youth is currently in a Hospital Based Residential, Sub-Acute Residential, or Community-based Residential program. 5. As a stand-alone service, must be part of a larger treatment plan.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meets the eligibility criteria may be referred into this service.

Staffing Requirements

1. The provider of the Psychiatric Evaluation must be a CAMHD credentialed QMHP meeting the following:

[5] The youth/family may revoke consent to be evaluated anytime during the evaluation process, but once the assessment is complete, they may only revoke consent for further release of the report beyond CAMHD. CAMHD as the owner of the report will keep a copy on file.

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

Clinical Operations

1. Direct service providers must coordinate with family/significant others and with other systems of care partners such as education, juvenile justice, child welfare as needed to provide service.
2. In keeping with informed consent, providers are required to inform the parent/guardian (or the youth if over age 18) that they may revoke the consent to be evaluated anytime during the evaluation process, but once the report is complete, they can only revoke the consent to further release beyond CAMHD. CAMHD as owner of the report will still maintain a copy in the file but will not release further. However, this may impact service delivery.

Documentation

1. Progress notes document all assessment activities.
2. The report is to be completed in a New Customer Visit Center Medication Management Note in MAX within fourteen (14) days of initial appointment with the youth and family.

I. MEDICATION MANAGEMENT

Definition	The ongoing assessment of the youth's response to medication, symptom management, side effects, adjustment and/or change in medication and in medication dosage. Routine medication management is provided by an American Board of Psychiatry and Neurology Board Eligible/Certified Child Psychiatrist or a Licensed Advanced Practice Registered Nurse with prescription privileges.
Services Components	1. Assessing the youth's ongoing need for medication. 2. Assessing for General Medical Conditions that could account for, or impact, symptoms and making appropriate referrals to medical specialists when needed. 3. Making an appropriate plan with the youth and family that outlines the initiation, maintenance, and discontinuation phases of pharmacotherapy. 4. Monitoring for drug-drug interactions and adjusting medications as necessary. This includes utilizing the smallest number of medications as well as the smallest dosages necessary to achieve optimal results. 5. Reference and adherence to evidence-based psychopharmacological practices. 6. Determining overt physiological effects related to the medications used in the treatment of the youth's psychiatric condition, including side effects. 7. Determining psychological effects of medications used in the treatment of the youth's psychiatric condition using appropriate Rating Scales. 8. Monitoring compliance to prescription medication. 9. Determining impact of medication use on other components of the client's treatment. 10. Renewing prescription(s). 11. Appropriate monitoring of height, weight, vital signs, laboratory tests, and neurological findings in a standardized format such as the AIMS when appropriate. 12. Direct observation and assessment as described above are necessary components of medication monitoring and can be achieved through telehealth. 13. A center medication management note documents that risks, benefits, side effects, and alternatives to a medication were reviewed and the youth and/or guardian have provided consent to treatment. 14. Services should be started as soon as possible following a referral. Generally, medication management visits for children and adolescents are thirty (30) minutes to sixty (60) minutes in length, occur monthly, and last for 7-9 months.
Admission Criteria	**All** the following criteria are met: 1. The youth has been evaluated by a psychiatrist and is deemed in need of medication to treat a behavioral, or other psychiatric disorder to prevent admission to a more restrictive or intensive service level. 2. Once prescribed medication, the youth requires ongoing monitoring for effectiveness and adverse reactions and renewing prescriptions at frequencies consistent with accepted practice. 3. The CMP includes this service as part of a larger treatment plan and not as a standalone service.

Authorizations	This service is provided by CAMHD staff and fellows, no authorization is needed.
Continuing Stay Criteria	**All** the following are met as determined by clinical review: 1. Treatment planning is individualized and appropriate to the individual's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems involvement unless contraindicated. 2. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms, but the goal of treatment has not yet been achieved, or adjustments in the treatment plan to address lack of progress are evident; 3. There is a documented active attempt at coordination of care with relevant providers when appropriate. If coordination is not successful, the reason(s) are documented; and 4. Unless contraindicated, family/guardian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** of the following criteria: 1. The youth's symptoms have stabilized, and all medications have been discontinued. 2. The youth and family no longer desire psychopharmacological interventions and have withdrawn consent; therefore, the medications have been discontinued. 3. Youth no longer meets eligibility criteria for CAMHD. As part of discharge, psychiatrist will coordinate the transfer of the youth to appropriate treatment services in the least disruptive manner possible. 4. The youth or parent is not participating in treatment and the non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple (at least 3) documented attempts to address non-participation issues.
Service Exclusions	Medication Management is not a standalone service but is part of a larger treatment plan and both youth and family are actively engaged in treatment.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred for medication monitoring.

Staffing Requirements

The provider of the Medication Management must be a CAMHD credentialed QMHP meeting the following:

1. Must be a current Hawaii-licensed psychiatrist; board certified by the American Board of Psychiatry and Neurology (ABPN); and board certified or board eligible in Child/Adolescent Psychiatry; or
2. An Advanced Practice Registered Nurse (APRN) certified as a Psychiatric Clinical Nurse Specialist with a current Hawaii license/certification with prescription privileges.

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.
2. Direct service providers must obtain consents for treatment.
3. Service should be preceded by assessment of youth with either an Initial Mental Health Evaluation or a Psychiatric Evaluation.

Documentation

1. The treatment plan for Medication Management is documented in the Center Medication Management Note and is updated at each visit.
2. The Center Medication Management Note must include all of the following information:
   a. Current medications the youth is taking including dosage and intervals.
   b. Side effects or adverse reactions the youth is experiencing.
   c. 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.
   d. Whether the medication (s) is effectively controlling symptoms.
   e. Implications for other components of the client's treatment.
   f. Any results from laboratory testing.
   g. Results of any Rating Scales employed.
   h. The note must be in the youth's file within seventy-two (72) hours of service.
   i. The notes shall be fully dated and signed by the supervisor if needed.

J. INDIVIDUAL THERAPY

Definition	Regularly scheduled face-to-face therapeutic services with a youth focused on improving his/her individual functioning. Individual therapy includes interventions such as attachment focused play-based interventions, cognitive-behavioral strategies, motivational interviewing, psychoeducation of the youth, skills training, safety and crisis planning, and facilitating access to other community services and supports. Data are gathered regularly through self-monitoring, parent monitoring, or frequent administration of brief standardized measures to track progress toward meeting treatment goals. 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 the youth and family can function more effectively. The usual course of treatment is six (6) to twenty-four (24) sessions or six (6) months. This service should be provided in conjunction with at least occasional family therapy sessions and may include a brief "check-in" with the parent or guardian as part of the individual session.
Services Components	The provider must initiate services within two (2) weeks of referral and authorization unless otherwise indicated by the CC. Individual therapy includes <u>all</u> the following: 1. Access and review all historical and assessment data available in the youth's clinical record. 2. Meet with the youth and relevant family member(s) to engage them in the treatment process, review confidentiality and consent[6] and assess and identify relevant issues, needs, and goals for treatment planning. 3. Develop a written MHTP in collaboration with the youth and family. 4. Involve other relevant parties in treatment planning (such as schools, psychiatric providers, extended family members) as indicated and with the permission of the parent/guardian. Regular consultation sessions with the parent(s) or guardian(s) will be conducted as appropriate. 5. Conduct regular sessions to work with the youth to facilitate his/her ability to cope and function in a healthy manner through positive engagement, encouragement, support, evidenced-based interventions, psychoeducation, skills training, and linkages to appropriate community services and resources. 6. Review interventions, needs, goals and progress with the youth and family monthly utilizing data regarding the major treatment targets. These data should be collected regularly via self-monitoring, parent monitoring, client/parent ratings, or brief standardized measures. 7. Adjust the treatment plan as needed based on the youth's progress. 8. Assist with discharge planning in collaboration with CC. This may include participation in transitional therapy sessions if the youth is transferred to a new level of care or new provider(s).
Admission Criteria	**<u>All</u>** <u>the following criteria are met:</u> 1 The CMP includes this service and with identified treatment targets and objectives for this service prior to admission. 2 The youth must be identified as needing extra support to increase

[6] *Review specific issues regarding confidentiality and consent for services for adolescents.*

	developmentally appropriate peer and adult interactions, coping skills and/or manage psychiatric illness. 3 There is reasonable expectation that the youth will benefit from this service, i.e., that therapy will remediate symptoms and/or improve functioning. 4 The youth is willing to participate in the service and the parent or guardian provides consent.
Authorizations	This service is provided by CAMHD staff and interns, no authorization is needed.
Continuing Stay Criteria	**All** the following criteria must be met as determined by clinical review: 1 Youth and family are actively involved in treatment. 2 There are regular and timely progress reviews and documentation of youth's response to interventions. Timely and appropriate modifications to the MHTP are made that are consistent with the youth's status. 3 An appropriate evidenced-based approach is being utilized and it is being provided with adequate fidelity to the model. 4 At least one (1) of the following criteria must be met: a. Youth is demonstrating progress, but goals have not yet been met, there is reason to believe that goals can be met with ongoing therapy services. b. Minimal progress toward treatment goals has been demonstrated, there is reason to believe that goals can be met with ongoing therapy services. c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals has not been reached. However, a less restrictive service would not adequately meet the youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches. d. New symptoms have developed, and the behaviors and the behavior can be safely and effectively addressed through individual therapy services with an updated treatment plan.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following: 1 Targeted symptoms and/or maladaptive behaviors have lessened to a level of severity which no longer requires this level of care as documented by substantial attainment of goals in the treatment plan. 2 Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period and appropriate modifications of plans have been made and implemented with no significant success, suggesting the youth is not benefiting from individual therapy services at this time. 3 Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through individual therapy services. 4 Youth or family is not willing to continue to participate in the services and revoke consent with no imminent danger to self or others. 5 The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment

	services in the least disruptive manner possible.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred to this service.

Staffing Requirements

1. Individual Therapy services must be provided by personnel that meet one (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all the supervisees work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

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

Documentation

1. A written MHTP and current safety plan identifying targets of treatment with realistic goals, objectives and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Center within ten (10) calendar days of admission. This documentation is required for any reauthorization of Individual Therapy.
2. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided, and specific treatment goals addressed. The note must be in the youth's file within seventy-two (72) hours of service. The notes shall be fully dated and signed by the supervisor if needed.

K. FAMILY THERAPY

Definition	Regularly scheduled face-to-face interventions with a youth and his/her family, designed to improve family functioning and treat the youth's emotional and behavioral challenges. The family therapist helps the youth and family improve the quality of their connection by increasing the use of effective coping strategies, healthy communication, constructive problem-solving skills, and positive engagement. Data are gathered regularly through self-monitoring, parent monitoring, client/parent ratings or frequent administration of brief standardized measures in order to track progress toward meeting treatment goals. Family Therapy sessions may be held in the course of on-going Individual Therapy with the youth in order to provide opportunities for the therapist to consult with the parent(s) or guardian(s) and review progress toward goals either conjointly with the youth present or separately without the youth present. Family Therapy services are designed to be time-limited with interventions reduced and then discontinued as the youth and family are able to function more effectively.
Services Components	1. The youth is almost always present for family therapy sessions. There are occasions where it is clinically indicated that the youth is not present, the reasons are documented in progress notes and monthly progress summaries. Specific interventions may include: a. Assist the family with developing and maintaining appropriate structure within the home. b. Assist the family to develop effective parenting skills, and child behavior management techniques. c. Assist the family to develop increased understanding of the youth's symptoms and problematic behaviors, to develop effective strategies to address these issues, and to build upon strengths. d. Facilitate positive engagement, effective communication and problem solving between family members. e. Facilitate effective communication between family members and other community agencies. f. Facilitate linkages to community supports and resources. 2. Interventions are evidence-based and tailored to address identified youth and family needs. Services are designed to promote healthy functioning and build upon the natural strengths of youth, family, and community. 3. The provider must begin service within two (2) weeks of referral and authorization unless otherwise indicated by the CC. Specific services the therapist will provide include: a. Review the CMP and all historical and assessment data available in the youth's clinical record. b. Meet with the youth and relevant family members to engage them in the treatment process and identify relevant issues, needs, and related goals for treatment planning. 4. Review interventions, needs, goals and progress with the youth and family monthly utilizing data regarding the major treatment targets. These data should be collected regularly via self-monitoring (e.g. monitoring urges to self-harm), parent monitoring (e.g. monitoring incidents of disobedience), client/parent ratings (e.g. parent's rating of behavior over the past week), or brief standardized measures. 5. Adjust the treatment plan as needed based on the youth's progress.

	6. Assist with discharge planning in collaboration with the mental health treatment team, including participation in transitional therapy sessions if the family moves on to new providers.
Admission Criteria	**All** the following criteria are met: 1. The CMP includes this service and with identified treatment targets and objectives for this service prior to admission. 2. There is reasonable expectation that the youth and family will benefit from this service, i.e., that family therapy will remediate symptoms and/or improve functioning in the home and community. 3. Youth and family agree to active participation in treatment.
Authorizations	This service is provided by CAMHD staff and interns, so no authorization is needed.
Continuing Stay Criteria	**All** the following criteria must be met as determined by clinical review: 1. Youth and family are actively involved in treatment. 2. There are regular and timely assessments and documentation of the youth/family's response to interventions, utilizing the data collected by the therapist. Timely and appropriate modifications to the treatment plan are made that are consistent with the youth/family's status. 3. At least one (1) of the following criteria must be met: a. Youth is demonstrating progress, but goals have not yet been met, and there is reason to believe that goals can be met with ongoing therapy services. b. Minimal progress toward treatment goals has been demonstrated and there is reason to believe that goals can be met with ongoing therapy services. c. Symptoms or behaviors persist at a level of severity that was documented upon admission, and the projected time frame for attainment of treatment goals as documented in the treatment plan has not been reached. However, a less restrictive level of care would not adequately meet the youth's needs, and other more intensive services are not considered appropriate at this time. The treatment plan has been adjusted and there is reason to anticipate improved response to the planned approaches. d. New symptoms have developed, and the behaviors can be addressed safely and effectively through outpatient therapy services with an updated treatment plan.
Discharge Criteria	Youth and family are no longer in need of or eligible for this level of service due to **one** (1) of the following: 1 Targeted symptoms have improved to a point where the youth no longer requires this level of care as documented by substantial attainment of goals in the treatment plan; 2 Youth and family have 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 and family is not benefiting from family therapy services at this time. 3 Youth exhibits new symptoms and/or behaviors which cannot be addressed safely and effectively through Family Therapy services.

	4 Youth and family are not willing to continue with the service and/or have revoked consent with no imminent danger to self or others. 5 The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into this service.

Staffing Requirements

1. Family Therapy services must be provided by personnel that meet <u>one</u> (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
2. Providers are to follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

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

Documentation

1. A written MHTP and current safety plan identifying targets of treatment with realistic goals, objectives and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Center with ten (10) calendar days of admission. This documentation is required for any reauthorization of Family Therapy.
2. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of session, type of therapy provided, and specific treatment goals addressed. The note must be in the youth's file within seventy-two (72) hours of service. The notes shall be fully dated and signed by the supervisor if needed.

L. GROUP THERAPY

Definition	Regularly scheduled, face-to-face therapeutic services for groups of three or more youth for the purpose of addressing symptoms/problems that prevent the development of healthy functioning in the home, school or community. These therapy services are designed to teach specific skills for addressing the symptoms associated with defined disorders or challenges, to provide support for the use of these skills and to provide psychoeducation about mental health issues. Group Therapy services are focused and time limited. This service can include groups that address youths' needs utilizing a "multi-family group" format, in which the parents or guardian attend the group along with the youth.
Services Components	1. Group therapy services include regularly scheduled face-to-face interventions with three (3) or more youth that are designed to improve home and community functioning in the most natural and appropriate setting. A co-therapist is required for groups of six (6) or more. Groups are focused and time-limited, youth may be discharged from the group as targeted goals are reached depending on the structure of the group. 2. Evidence-based treatments are utilized to structure groups. Group therapies may involve verbal instruction and education, modeling, coaching, role-playing, behavioral practice, and other group-oriented experiential modalities. 3. Specific goals may include symptom reduction; increased behavioral control; or improved communication, social, coping, anger management, emotion-regulation, problem solving, or other daily living skills. Interventions should be 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. 4. Because of the research evidence that group therapy may have risks for disruptive behavior, delinquency, willful misconduct, substance abuse, and some types of eating disorders, particular care is to be used to assure that only appropriately structured, evidence-based treatments are used with these youth and that inappropriate youth are not included in groups. 5. The provider must begin contacting the youth/family within one (1) week of referral and initiate service within four (4) weeks of authorization, unless otherwise indicated by the CC. 6. Specific services include <u>all</u> the following: a. Accessing and reviewing all historical and assessment data available in the youth's clinical record. b. Meeting with the youth and family to identify relevant issues, needs, and related goals to aid in treatment planning and determine whether a planned group will meet the needs of the youth. c. Participating in phone consultation with the CC/CL to promote the integration of services across domains (home, community) as needed. d. Implementing, monitoring, and adjusting interventions as needed to address needs and accomplish objectives and goals of the group. e. Conducting regular group sessions to work with the youth to address identified needs and goals per the treatment plan.
Admission Criteria	**<u>All</u>** <u>the following criteria are met</u>: 1. The CMP include this service and identifies targets and objectives for this service prior to admission. 2. There is a reasonable expectation that the youth will benefit from this service, i.e., that group therapy will remediate symptoms and/or improve functioning

	that relate to improved ability to function in the most natural environment. 3. Group therapy should not be used as a substitute for normalized community youth activities such as organized sports, scouting, paddling, etc. If the goals of the group potentially could be met through such activities, (for example: developing social skills and friendships, increasing self-esteem, gaining mastery), Group Therapy may be used only if there is documented evidence that the youth has not been able to be successful in this kind of normalized activity.
Authorizations	This service is provided by CAMHD staff and interns, so no authorization is needed.
Continuing Stay Criteria	**All** the following criteria must be met: 1. The evidence-based group therapy program has not been completed. 2. Youth actively involved in treatment. 3. There are regular and timely assessments and documentation of the youth's response to the treatment. 4. At least one (1) of the following criteria must be met: a. Youth is demonstrating progress, but goals have not yet been met, and there is reason to believe that goals can be met with ongoing therapy services. b. Minimal progress toward treatment goals has been demonstrated, and there is reason to believe that goals can be met with ongoing therapy services. c. New symptoms have developed, and the behaviors can be safely and effectively addressed through therapy services with an updated treatment plan.
Discharge Criteria	Youth is no longer in need of or eligible for this level of service due to **one** (1) of the following: 1. The evidenced based, group therapy program has been completed. 2. Targeted symptoms and/or maladaptive behaviors have abated to a level of severity which no longer requires this level of care as documented by substantial attainment of goals. 3. Youth has demonstrated minimal or no progress toward treatment goals for a three (3) month period**,** suggesting the youth is not benefiting from group therapy services at this time. 4. Youth exhibits new symptoms which cannot be safely and effectively addressed through group therapy services. 5. Youth is no longer willing to participate in this service. 6. The youth is no longer eligible for CAMHD. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Clinical Exclusions	1. Because group interventions pose risks for youth with disruptive behavior, delinquency, willful misconduct, substance abuse, and some types of eating disorders, youth with these diagnoses should be offered only well-structured, evidence-based group interventions and only when the potential benefits are judged to outweigh the potential risks (e.g. a highly structured coping skills group for youth who engages in self-harm behavior when upset and who also shows conduct problems).

Staffing Requirements

1. Group Therapy services must be provided by personnel that meet one (1) of the following requirements:
   a. Credentialed by CAMHD as a Qualified Mental Health Professional (QMHP);

   OR

   b. Credentialed by CAMHD as a Mental Health Professional (MHP);

   AND

   c. Working under the supervision of a QMHP. The supervisor is expected to review all of the supervisees work in detail.
2. A co-therapist is required for groups of six (6) or more.
3. Follow all applicable professional practice standards and ethical guidelines.

Clinical Operations

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

Documentation

1. A written MHTP and current safety plan identifying targets of treatment with realistic goals, objectives and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Center with ten (10) calendar days of admission.
2. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must be in the youth's file within seventy-two (72) hours of service. The notes shall be fully dated and signed by the supervisor if needed.

M. FUNCTIONAL FAMILY THERAPY (FFT)

Definition	This is an evidenced-base family treatment system provided in a home or clinic setting for youth experiencing one of a wide range of externalizing behavior disorders (e.g., conduct, violence, drug abuse) along with family problems (e.g., family conflict, communication) and often with additional co-morbid internalizing behavioral or emotional problems (e.g., anxiety, depression). The goals of FFT are: 1. Phase I: Engagement of all family members and motivation of the youth and family to develop a shared family focus to the presenting problems; 2. Phase II: Behavior change – target and change specific risk behaviors of individuals and families; and 3. Phase III: Generalize or extend the application of these behavior changes to other areas of family relationships. FFT services range from twelve to fourteen (12 to 14) one-hour sessions for mild challenges, up to 30 hours of direct service (i.e., clinical sessions, telephone calls, and meetings involving community resources) for more difficult situations and are usually spread over a three to six (3 to 6) month period. FFT can be conducted in a clinic setting, as a home-based model or as a combination of clinic and home visits.
Service Components	1. One (1)-to-two (2) hour therapy sessions with the clinician and the youth/family scheduled one (1) or two (2) times per week. 2. Phase Task Analysis – a systemic and multiphasic intervention map used to identify treatment strategies. 3. Ongoing assessment of family functioning to understand the ways in which behavioral problems function within the family. 4. The use of formal and clinical tools for model, adherence, and outcome assessment. 5. Clinical Services System (CSS) – an implementation tool that allows therapists to track the activities such as process goals, essential to successful outcomes. 6. FFT therapist maintains collateral contacts with the CC. 7. FFT therapist develops a MHTP in collaboration with the youth and family that includes a crisis plan and a discharge plan. 8. Active, on-going treatment is based on measurable goals and objectives that are part of the youth's CMP and MHTP.
Admission Criteria	**All** the following criteria are met: 1. Youth is age eleven (11) to through seventeen (17). 2. There must be a reasonable expectation that the youth and family can benefit from FFT services within three to six (3 to 6) months; 3. The youth must have an adult/parental figure able to assume the long-term parenting role and to actively participate with FFT service providers for the duration of treatment; and 4. The CMP include this service and identifies targets and objectives for this service prior to admission.

Authorizations	Unit = fifteen (15) minutes Clinical Lead may authorize up to sixty-four (64) units [sixteen (16) hours] per month for up to three (3) months. Billing limits: No billing for no shows, cancellation, or travel time.
Reauthorization	With evidence of continued medical necessity documented in the Case review, Clinical Lead may reauthorize up to sixty-four (64) units [sixteen (16) hours] per month for up to two (2) months. Threshold – The average length of FFT treatment is five (5) months with most youth reaching a point of diminishing progress between the third (3) to fifth (5) month.
Continuing Stay Criteria	**All** the following criteria are met as determined by clinical review: 1. All admission criteria continue to be met. 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved. 3. The documented treatment plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. 4. There is documented evidence of active family involvement in treatment as required by the treatment plan or there are active documented efforts being made to involve them unless it is documented as contraindicated. 5. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.
Discharge Criteria	Youth is no longer in need of or eligible for services due to **one** (1) of the following: 1. The youth no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible. 2. The youth's documented treatment plan goals and objectives have been substantially met and can be transitioned to a less intensive level of treatment. 3. The youth/family no longer wants to participate in this service and revokes consent with no danger to self or others. 4. The youth or parent/guardian is not participating in treatment or in following program rules and regulations. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues. 5. Youth has demonstrated minimal or no progress toward treatment goals for a two (2) month period and appropriate modifications of the MHTP have been made and implemented with no significant success,

	suggesting the youth in not benefiting from Functional Family Therapy at this time. 6. Youth exhibits new symptoms and/or maladaptive behaviors which cannot be safely and effectively addressed through this service.
Service Exclusions	<u>Functional Family Therapy is not considered medically necessary and will not be authorized under the following circumstances</u>: 1. Not offered at the same time as any out-of-home service, except in cases where the youth has a planned discharge from out-of-home care within thirty (30) days. FFT can work with the youth and family for up to thirty (30) days when the transition plan calls for FFT to aid in family reunification following out-of-home care. 2. Not provided at the same time as any Intensive Outpatient services (IIH, IILS, MST, ABI). 3. No acceptance of youth for whom a primary long-term caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred for FFT services.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Contractor must have a QMHP that oversees all program staff is and responsible for all clinical decisions made.
2. FFT services are provided by a team of QMHP supervised clinicians, who must meet the requirements for MHP. A Paraprofessional 2 with a minimum of five (5) years of appropriate supervised experience may provide the service if FFT Service deems it appropriate.
3. Staff must complete the required FFT training program from a licensed trainer of FFT services prior to assignment of families/clients. In addition, staff must attend quarterly booster training sessions.
4. Therapists must be supervised by an FFT team supervisor. Supervisors must have training and experience in providing FFT.
5. Staff shall receive at a minimum one (1) hour of group supervision and one (1) hour of FFT services telephone consultation per week.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

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. Contractors must have the ability to deliver services in a home setting; they may deliver some of the services for each youth and family in a clinic setting.
3. The Contractor has policies that govern the provision of services in natural settings and documents the Contractor respects the youths' and families' right to privacy and confidentiality when services are provided in these settings.

4. The Contractor has established written policies and procedures in place for managing crises effectively and efficiently through the direct interventions of its professional clinical and medical staff. Included in these procedures is the handling of emergency and crisis situations that describe methods for triaging youth who require more intensive interventions. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others.
5. Upon receipt of the referral packet from the CC the Contractor will assign a therapist who must make face-to-face contact with the youth/family within seventy-two (72) hours or notify CC of reasons why contact could not be made.
6. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
7. These outreach activities 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.
8. 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.
9. FFT 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 in a clinic. 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.
10. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
11. The majority of the service (80% or more) is provided face-to-face with the youth and their family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
12. The Contractor must have an FFT 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.
13. The Contractor must perform a Summary Annual Evaluation (SAE) for youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Progress notes must document the course of treatment including a description of the interventions implemented, youth's response, and interpretation of the effectiveness of the intervention in addressing treatment plan goals/objectives. The note must include the date of service, the length of

session, type of therapy provided, and specific treatment goals addressed. The notes shall be fully dated and signed by the writer and supervisor if needed. The note must be in the youth's file within seventy-two (72) hours of service.

2. FFT therapists must complete an intake and assessment form upon assignment of youth/family to FFT services.
3. FFT therapists must complete "Case Consultation summary forms" weekly for case review during group supervision and FFT case consultation sessions.
4. FFT therapists must provide CC with a thirty (30) day written notice of intent to discontinue services.
5. FFT therapists must provide the CC with a copy of MHTP goals or overarching goals, so the Branch has in the youth's record what the Contractor goals are.
6. Contractor must complete all documentation requirements specific to FFT.

N. 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 (including crimes against others and property, aggression and other disruptive behaviors, substance use, and status offenses such as truancy, and curfew violations). Treatment averages 60 hours, over the course of 3-to-5 months. MST treats the youth's entire ecology – home and family, school, peers, and community. MST works to improve the following targets: • Keep youth in their homes, reducing out-of-home placements. • Keep youth in school. • Keep youth out of trouble, reducing re-arrest rates. • Improve family relations and functioning. • Decrease adolescent psychiatric symptoms. • Decrease adolescent drug and alcohol use.
Service Components	1. Intensive family-centered treatment delivered in-home and other community settings. 2. 24/7 availability to families for treatment, crisis response and management. 3. Ongoing assessment of youth behavior and patterns of interactions within the family, and between the family and others in the community. 4. Evidence-based interventions to address unique factors contributing to negative youth outcomes and problematic family interactions, including addressing safety risks, youth school attendance and behavior, negative peer alliance, aggression, substance use, and other status offenses. 5. Evidence-based interventions to address barriers to caregiver effectiveness (e.g., depression, anxiety, substance abuse), as well as supports to seek and utilize psychiatric care when indicated. 6. Evidenced-based interventions to address individual youth risk factors (e.g., aggression, impulsivity, social skills deficits) including specific disorders common among youth receiving MST (e.g., ADHD, trauma-related symptoms) as well as support to seek and utilize psychiatric care when indicated. 7. MST therapist maintains collateral contact with FGC CC and other key participants in the school and community. 8. MST therapist assists family to access needed supports, through internal and external linkages. 9. MST therapist work with families to create and implement behavior support plans. 10. Provide parent skills training to help the caregiver cope with youth behavior. 11. Create MHTP in collaboration with family that includes crisis, safety and discharge planning. Significant Quality Assurance training and support to MST and feedback to ensure model-fidelity. 12. Ongoing treatment planning, based on measurable behavioral goals, reflected in youth CMP/CSP and MHTP.

Admission Criteria	**All** the following criteria must be met: 1. Youth is age twelve (12) through seventeen (17). 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). 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. 4. MST services are required to allow the youth to meet the goals identified in the CMP and improve his/her functioning in the home/community preventing movement to a higher level of care. 5. The youth has an adult/parental figure that is willing to assume a long-term parenting role (e.g., must be willing to participate with service providers for the duration of treatment).
Authorizations	Clinical Lead may authorization up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. Unit = fifteen (15) minutes Billing limits: No billing for no shows, cancelation or travel time.
Re-Authorization	Clinical Lead may reauthorization up to ninety-six (96) units [twenty-four (24) hours] per month for up to two (2) months. Not to exceed five (5) months from date that consents to treatment are signed by caregiver unless approved by the CAMHD Medical Director via the MST System Supervisor. Threshold – The average length of FFT treatment is four (4) months.
Continuing Stay Criteria	**All** the following criteria are met as determined by clinical review: 1. Youth is actively involved in treatment and all admission criteria continue to be met. 2. Youth does not require a more or less intensive level of care. 3. The treatment plan has been developed, implemented and to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated. 4. Progress is clearly evident in objective terms, but the goals of treatment have not yet been achieved, or adjustments have been made in the treatment plan to address the lack of progress are evident. 5. Family/guardians are actively involved in treatment, or there are active, persistent efforts being made that are expected to lead to engagement in treatment.
Discharge Criteria	Youth is no longer in need of or eligible for service due to **one** (1) of the following: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible. 2. Youth no longer meets admission criteria, or meets criteria for a less or more intensive level of care. 3. Youths documented treatment plan goals have been substantially met,

	including discharge plan. 4. The youth/family requests discharge and is not imminently dangerous to self/others. 5. Youth and/or family has not benefited from MST despite documented efforts to engage and there is no reasonable expectation of progress at this level of care. 6. Youth's CSP team determines that out of home placement is more appropriate for youth and/or the CC is seeking such placement (in this case, MST services will be terminated within seven (7) days).
Service Exclusions	Multisystemic services is not considered medically necessary and will not be authorized under the following circumstances: 1. Not provided at the same time any out-of-home service, except in cases where the youth has a planned discharge from out-of-home service within thirty (30) days. MST can work with the youth and family for up to thirty (30) days prior to discharge when the transition plan calls for MST to aid in family reunification. 2. Not provided at the same time as any Intensive Outpatient services (IIH, IILS, ABI, FFT).
Clinical Exclusions	1. Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred to MST. 2. Youth with an active thought disorder or severe mental illness, or Pervasive Developmental Disorder. 3. The youth with relatively mild behavioral problems that can effectively and safely be treated at a less intensive level of care. 4. Youth living independently or for whom no primary caregiver can be identified. 5. Juvenile Sex Offenders where the sex offense occurs in the absence of any other delinquent behavior. 6. Youth who have previously received MST services, regardless of outcome, unless specific conditions have been identified that have changed in the youth's ecology compared to the first course of MST, which would suggest that more favorable or generalizable outcomes could be obtained with a second course of MST. Such conditions are assessed by the MST supervisor with review by the System Supervisor.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. MST services are provided by a team of QMHP supervised clinicians, who must meet the requirements for MHP. A Paraprofessional 2 with a minimum of five (five) year of appropriate supervised experience may provide the service if MST Services deems it appropriate.
2. MST Clinical Supervisors must meet CAMHD requirements for QMHP. Licensed Ph.D. is preferred for the Clinical Supervisor positions.
3. 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.

4. Staff must complete a five (5)-day training program designed by MST Services prior to assignment of families/youth. In addition, staff must attend quarterly booster training sessions.
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.
6. MST therapists must be assigned on a full-time basis to MST services. MST supervisors must be assigned on at least a half-time basis to MST services, except where by provider contract they are committed as full-time (100% FTE) to MST services.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

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 services will lead to specific, observable improvements in the youth and family's functioning.
5. The majority of the service eighty percent (80%) or more, is provided face-to-face with the youth and family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
6. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
7. 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.
8. Contractors 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.
9. The Contractor 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.
10. The Contractor has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric hospitalization.
11. Upon approval/acceptance of referral, the MST team will assign a therapist who must attempt to make face-to-face contact within twenty-four (24) hours (immediately if an emergency). If unable to make face-to-face contact within seventy-two (72) hours, the referring CC will be notified immediately regarding reasons for lack of contact. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.

12. The Contractor must perform a Summary Annual Evaluation for youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance.
13. The Contractor must have an 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

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. MST therapist must complete MST Clinical Intake Assessment**:** list of reasons for referral, genogram, desired outcomes of key stakeholders, ecological strengths and challenges, "fit" assessment of referral behaviors.
2. The MST therapist must submit to the CC the Service Plan within five (5) days of intake. The MST Service Plan includes the MST Clinical Intake Assessment (see above), the MST Overarching Treatment Goals, the anticipated discharge date and the anticipated individualized transition/discharge criteria.
3. Therapists must complete "Case Consultation summary forms" weekly for case review during group supervision and MST case consultation sessions.
4. Progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all treatment activities These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.

O. INTENSIVE IN-HOME (IIH)

Definition	This service is used to stabilize and preserve the family's capacity to improve the youth's functioning in the current living environment and to prevent the need for placement outside the home or a DHS resource family home. It also may be used to re-unify the family after the youth has been placed outside the home, or to support the transition to a new DHS resource family for youth with mental health needs. This service is a time-limited focused approach that incorporates family-and youth-centered evidence-based interventions and adheres to CASSP principles. It is preferred that sessions be conducted in-person. However, the use of telehealth will be allowed when the treatment team agrees that it is clinically appropriate, it is approved by the Clinical Lead, it is practical given the specific needs of the client and family, and the family agrees to the use of telehealth services. This service also assists families in incorporating their own strengths and their informal support systems to help improve and maintain the youth's functioning. When a high level of support is needed in the home or community, Intensive In-Home Paraprofessional Support Worker (PSW) service should be authorized to augment this level of care.
Service Components	1. Therapy services include family-and-youth-centered interventions that target identified treatment outcomes. Services are provided in the home or community at a level that is more intensive than outpatient services. Interventions include: a. Intensive Family Therapy interventions. b. Psychoeducation with family member and the youth to help them understand the youth's particular difficulties. c. Work with families to set up and maintain consistent, strength-based interactions in the household, including training parents in behavior management skills, other parenting skills and working with parents on implementing home based behavioral support plans. Caregiver Skills Menu can help parents identify skills they to develop or strengthen (See Appendix 5). d. Individual work with youth who have internalizing problems (depression, anxiety, post-traumatic stress disorder) utilizing evidence-based therapy approaches. e. Work with youth to support the building of positive coping skills. The Life Skills Menu (See Appendix 6) can be helpful in guiding youth to identify the areas where they need support or are motivated to acquire enhanced skills. f. Crisis management interventions. g. Support the youth and parents to connect with other needed formal and informal supports in the community and school. This includes cultural and land-based activities that can help facilitate the youth/family connection to place and community. h. If the youth is involved in treatment with another behavioral health provider(s) then, with proper consent, the therapist will notify any other behavioral health provider(s) of the youth's current status to ensure ethical and coordinated care. 2. Development of a Mental Health Treatment Plan (MHTP) that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting. The MHTP will be evaluated and revised as necessary

as treatment proceeds and the planning process will include the youth, family/guardian and other relevant treatment team members.
   a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps.
   b. The discharge component of the MHTP specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to support the youth in the home and community. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date.
   c. If the services of a PSW for skills training is needed, the therapist will develop a clear plan for the PSW's service in collaboration with the family. This should include the estimated length of the service and how the support provided by the PSW will be transitioned to family members and/or natural community supports.
   d. Regularly schedule treatment team meetings to review progress, barriers, and ensure coordination across all team members is important to keeping treatment on track.
3. Monitoring of the youth/family's progress on a regular basis using reliable and valid data gathering strategies. The monitoring strategy shall be noted on the MHTP and shall take one or both of these forms:
   a. Frequent and repeated assessment (at least monthly) of individually determined and behaviorally observable treatment targets (e.g. monitoring the frequency and intensity of temper outbursts); and/or
   b. Regularly scheduled administration of reliable and valid measures that are meaningful to the youth's presenting concerns (e.g. giving the Child Depression Inventory to a youth whose depressed mood is a major concern).
4. If the services of a paraprofessional support worker (PSW) for skills training is needed and recommended by the treatment team, then the IIH therapist will provide clinical direction to the PSW as follows:
   a. The PSW works conjointly with the therapist to plan interventions and to develop agreements with the family about the paraprofessional's schedule and activities. This can include the therapist's modeling the specific ways the paraprofessional should work with the youth/caregiver, demonstrating skills for them to practice, etc. Concurrent work may not be more than two (2) hours a month.
   b. Works with the youth and/or caregiver to support skill-building interventions being offered by the therapist. For example, practicing problem-solving skills with the youth while engaging in a community activity, practicing the use of praise and selective ignoring with the caregiver during the bed-time routine.
   c. Model behavior management skills and parenting approaches with parents during daily routines in the home.
   d. Implements crisis and safety plan, providing de-escalation interventions

	as outline in the plan. e. Collects detailed information about problematic behavior to help the therapist design effective interventions. For example, recording incidents of non-compliance during the morning routine or recording details about a temper incident to help identify obstacles to utilizing planned coping skills in the heat of the moment. f. Provides "line of sight" supervision and works with the youth to support emotional regulation and acceptable behavior during community-based activities or household routines. g. Accompanies the client or caregiver in order to support their participation in important appointments or activities may be a part of this service when necessary, with a clear clinical rationale included in the treatment plan.
Admission Criteria	**All** the following criteria must be met: 1. The youth is displaying behavioral or emotional challenges in the home/community and there is a reasonable likelihood that IIH services will lead to specific observable improvements in the youth and family's functioning. 2. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment members to identify treatment targets to be addressed in the MHTP and crisis plan with realistic discharge criteria along with expectations of family/guardian involvement in the treatment process. 3. If the youth's primary problem is a disruptive behavioral disorder, and the youth is age 12 or over, there must be documentation of the use of one of the available evidenced-based treatments for disruptive behavior disorders (i.e. Multisystemic Therapy or Functional Family Therapy) unless there is documentation of clear and compelling clinical evidence that the youth is inappropriate for one of these approaches at this time. 4. If the youth is stepping down from Multisystemic Therapy or Functional Family Therapy, Intensive In-Home Therapy can be a step-down only if recommended as part of the discharge plan or there are specific non-disruptive symptoms that are identified for treatment by this service. 5. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.
Authorizations	Unit – fifteen (15) minutes Pre-admission meeting authorization: Clinical Lead may authorize up to eight (8) units [two (2) hours] for an IIH therapist to attend a pre-admission meeting with the youth/family present for initial planning and match. Authorization for Therapist: Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. Authorization for PSW: The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month for up to three (3) months.

	Billing limits: Daily billing must not exceed sixteen (16) units [four (4) hours] per day, including combined billing for the Therapist and PSW. No billing for no shows, cancellation, or travel time. No billing for collateral contacts unless youth or caregiver is present during contact.
Overlapping Services	Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours for a month allowing the therapist to begin engaging with a youth and his/her out-of-home treatment team. IIH services provided while overlapping with any out-of-home treatment will be billed under an overlapping service authorization.
Conjoint Services	Clinical lead may authorize up to eight (8) units [two (2) hours] per month for conjoint work. When the Therapist and the PSW work conjointly with the youth and/or family, only the therapist's time will be counted toward the daily and monthly maximums and will bill as usual. The PSW time will be billed under the conjoint service authorization for sessions with therapist present and attendance at treatment team meetings.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize the Therapist for up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. The number of hours authorized each month should be determined by the needs of the youth and family, should meet medical necessity criteria, and should decrease as progress is made.
Continuing Stay Criteria	Threshold – The average length of IIH treatment is eight (8) months with most youth reaching a point of diminishing progress by the sixth (6) month. When the youth's treatment will exceed six (6) months, continued reauthorization must be preceded by a clinical review and **all** the following conditions are determined to be true: 1. All admission criteria continue to be met. 2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but the goals of treatment have not yet been achieved. Data on progress have been presented in a visual or tabular format showing changes over time and reviewed with the family and treatment team. 3. The MHTP and safety plan are individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed towards maintenance with family and community supports. 4. The MHTP includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post Intensive In-Home resources. 5. There is documented evidence of active family involvement in the treatment as required by the MHTP or there are active documented efforts being made to involve them unless it is documented as contraindicated. 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behavior or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the

	following criteria: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible. 2. Targeted symptoms and/or maladaptive behaviors have lessened to a level of severity which no longer requires this level of care as documented by substantial attainment of goals in the MHTP. 3. Youth exhibits new symptoms and/or maladaptive behaviors that cannot be addressed safely and effectively through this service as determined by clinical review. 4. Youth/family has demonstrated minimal or no progress toward treatment goals for at least a two (2) month period, and clinical review has determined that the youth is not benefiting from this service at this time. 5. The youth or parent/guardian is not participating in treatment. Non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3), documented attempts to address the non-participation issues; or 6. The youth/family no longer wants to participate in this service and revokes consent.
Service Exclusions	Intensive In-Home service is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same time as any out-of-home services except in cases where the youth has a planned discharge from out-of-home care within thirty (30) days. Intensive In-home therapy can begin to work with the youth and family for up to thirty (30) days to aid in family reunification following out-of-home care. 2. Not offered at the same time as Intensive Independent Living Skills, Multisystemic Therapy, Functional Family Therapy or Adaptive Behavioral Intervention. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth. 4. No admission that is being sought solely for child protective services, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or simply as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program. IIH may be provided to hospitalized youth who are still stabilizing as part of a transition back to the home.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A QMHP experienced in evidence-based treatment and family-based interventions has oversight and supervision responsibilities for all staff decisions made regarding youth/family treatment.
2. The Contractor is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.

3. Therapists must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges.
4. PSWs must be credentialed as a paraprofessional level 2.
5. In many instances, the IIH Therapist will be sufficient to deliver the appropriate services, however; the IIH Therapist working directly with the family may partner with a PSW or team of PSWs as needed with the recommendation of the treatment team and authorization by the Center Clinical Lead.
6. The PSW will work under the direct guidance of the IIH Therapist to meet the specific identified needs.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

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 and family-based interventions.
2. A pre-admission meeting is required to obtain youth, family, CC, CL and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan developed in the CSP identifies effective youth self-calming strategies that shall be incorporated into the youth's MHTP/crisis plan. The pre-admission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
3. The Contractor has an intake process that includes integration of information available on youth/family in the treatment planning to ensure appropriate and effective treatment. Contractor also has an established protocol for orienting the youth and family to the service.
4. 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.
5. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of admission as part of the initial assessment process and pre-admission meeting. The MHTP and crisis plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
6. The discharge plan component of the MHTP will document realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to maintain the youth with the family in the community.
7. Intensive In-Home Therapy services are individually designed for each youth, in full partnership with the family, to minimize intrusion and maximize strengths and 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.
8. Intensive In-Home Therapy must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize the crisis situation as soon as possible. Services are evidence-based, family-centered, strengths based, culturally competent, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community.
9. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
10. The majority of the service (80% or more) is provided face-to-face with the youth and family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.

11. The Contractor 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.
12. The Contractor has policies, which govern the provision of services in natural settings and which documents that it respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
13. The Contractor has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric consultation or hospitalization. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others and requires consult with the program QMHP prior to, during or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.
14. The Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
15. The Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
16. The Contractor must have an Intensive In-Home Intervention organizational plan that addresses the following:
    a. Description of the particular family centered interventions, 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/family 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;
    d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
17. The Contractor must perform a Summary Annual Evaluation for youth in their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The MHTP is submit to the Family Guidance Center within ten (10) days of admission. Using information gathered from the referral and pre-admission meeting. This initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan). This documentation is required for any reauthorization of Intensive In-Home services.
    a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
    b. The transition/discharge component of the MHTP will document realistic discharge criteria aligned with the youth's treatment goals/objectives, projected timeframe, and anticipated aftercare supports (see General Performance Standards, D4b. Discharge Planning).

2. The MHTP is updated on a quarterly basis. MHTP updates should summarize gains/achievements from the previous three (3) months and the treatment goals/objectives adjusted to reflect the youth's changing condition.
3. Progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all treatment activities These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
4. A Discharge Summary Progress Note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

P. INTENSIVE INDEPENDENT LIVING SKILLS (IILS)

Definition	A comprehensive treatment service provided to youth at least 16 years old who need to work intensively on developing a range of skills to prepare for independent living. The youth live in their home setting while participating in the service. This service focuses on developing skills and resources related to life in the community and to increasing the participant's ability to live as independently as possible. Service outcomes focus on maximizing the youths' ability to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational, and vocational opportunities. The amount of time any individual spends in these services will vary, depending on the individual needs. When a high level of support is needed, Intensive Paraprofessional Support for Independent Living Skills should be authorized to augment this level of care).
Service Components	1. Therapy aimed at helping the youth with emotional and behavioral challenges while developing independent living skills include the following: a. Each youth will be given assistance in accessing community resources such as: i. Assistance is provided with accessing needed financial assistance and benefits (e.g., applying for Social Security Disability benefits, obtaining housing subsidies, etc.). ii. Assistance is provided with obtaining appropriate services (e.g., vocational rehabilitation services; adult mental health services). iii. Assistance is provided with obtaining support with any legal concerns (e.g., guardianship issues, birth certificate etc.). b. Skills training interventions will be provided based on the initial and on-going assessment of the individual's needs in at least the following areas (See Appendix 7 for Transition Shopping List and Life Skills Inventory Independent Living Skills Assessment Tool as potentially useful tools): i. Social skills, including communication and problem-solving in personal relationships. ii. Emotion regulation skills, including anger control and conflict management. iii. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene). iv. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit). v. Developing life goals and planning for the future, including career planning. vi. Understanding and taking charge of your own mental health treatment. vii. Taking charge of your own physical health including nutrition, healthy lifestyles, smoking cessation, and sexual and reproductive health. viii. Chemical dependency education. ix. Parenting skills training. c. Assistance developing vocational skills is provided in a practical, hands-on way: i. Investigating fields and jobs that might be of interest. ii. Doing volunteer work in areas consistent with career goals. iii. Assessing one's own job-relevant skills and writing a resume. iv. Obtaining job applications and interviewing for jobs.

	v. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc. vi. Coaching and support to help the youth stick with challenging training and job experiences. d. Specific efforts to engage and support parents and other family members with the challenges of parenting a young person through the transition from adolescence to adulthood are part of the service. Specific interventions may include: i. Psychoeducation for parents addressing concerns such as benefits, changes in confidentiality requirements, guardianship options etc. ii. Family therapy interventions (biological and/or foster). e. Individual Therapy focused on mental health challenges utilizing evidenced-based approaches. 2. Each youth will have his/her services proceeded by an intake assessment focusing on the young person's needs in the areas of housing, employment, education, social, financial and health/mental domain in support of acquiring independent living skills. This intake assessment along with pre-admission meeting and existing documents will result in: a. A documented MHTP that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria as related to independent living skills will be developed as part of the initial assessment process and includes information from the pre-admission meeting. The MHTP will be evaluated and revised as necessary as treatment proceeds and the planning process will include the youth/family/guardian and other relevant treatment team members. b. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps. c. The discharge component of the MHTP specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to independence. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date. d. If the services of a PSW for skills training is needed, the therapist will develop a clear plan for the PSW's service in collaboration with the youth. This should include the estimated length of the service and how the support provided by the PSW will be transitioned to family members and/or natural community supports. e. Regularly schedule treatment team meetings to review progress, barriers, and ensure coordination across all team members is important to keeping treatment on track. 3. Monitoring of the youth/family's progress on a regular basis using reliable and valid data gathering strategies. The monitoring strategy shall be noted on the MHTP and shall take one or both of these forms:

	a. Frequent and repeated assessment (at least monthly) of individually determined and behaviorally observable treatment targets (e.g. monitoring the frequency and intensity of temper outbursts). b. Regularly scheduled administration of reliable and valid measures that are meaningful to the youth's presenting concerns (e.g. giving the Child Depression Inventory to a youth whose depressed mood is a major concern). 4. If the services of a Paraprofessional Support worker for skills training is needed and recommended by the treatment team, then the Therapist will provide clinical direction to the Paraprofessional support worker (PSW) as follows: a. The PSW works conjointly with the therapist to plan interventions and to develop agreements with the youth about the paraprofessional's schedule and activities. This can include the therapist's modeling the specific ways the paraprofessional should work with the youth, demonstrating skills for them to practice, etc. Concurrent work may not be more than two (2) hours a month. b. Implementing crisis and safety plans and providing crisis intervention and de-escalation. c. Working with the identified youth to support skill-building interventions being offered by the therapist which may include any of the following: i. Self-care skills (i.e. cooking, laundry, house-cleaning, personal hygiene). ii. Social skills, including communication and problem-solving in personal relationships. iii. Basic personal finances (i.e. developing a budget, balancing a checkbook; utilizing credit). iv. Emotion regulation skills, including anger control and conflict management. d. Providing support to address vocational and other transition-related issues which may include any of the following: i. Investigating fields and jobs that might be of interest. ii. Doing volunteer work in areas consistent with career goals. iii. Assessing one's own job-relevant skills and writing a resume. iv. Obtaining job applications and interviewing for jobs. v. Finding sources of needed job training, including assistance working with DOE programs, vocation rehab programs, community college programs, GED programs, etc. vi. Coaching and support to help the youth stick with challenging training and job experiences. e. Collecting detailed information about problematic behavior to help the therapist design effective interventions.
Admission Criteria	**All** the following criteria are met: 1. The youth must be at least sixteen years old. 2. Youth must be identified as needing intensive outpatient services focused on promoting growth toward independent living with in the CMP. 3. Pre-admission meeting is held to identify treatment targets to be addressed in the treatment, safety planning and realistic discharge criteria along with expectations of family/guardian involvement in the treatment process. 4. The youth adult/youth and/or family are amenable to actively working with

	program staff for the duration of the expected program period.
Authorizations	Unit = fifteen (15) minutes Pre-admission meeting authorization: Clinical Lead may authorize up to eight (8) units [two (2) hours] Therapist to attend a pre-admission meeting with the youth present for initial planning and match. Authorization for Therapist: Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. PSW authorization: The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month for up to three (3) months. Billing limits: Daily billing must not exceed sixteen (16) units [four (4) hours] per day, including combined billing for the Therapist and PSW. No billing for no shows, cancellation, or travel time. No billing for collateral contacts unless youth or caregiver is present during contact.
Overlapping Services	Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per month for a therapist to begin engaging with a youth and his/her out-of-home treatment team. IILS services provided while overlapping with any out-of-home treatment will be billed under an overlapping service authorization.
Conjoint Services	Clinical lead may authorize up to eight (8) units [two (2) hours] per month for conjoint work. When the Therapist and the PSW work conjointly with the youth and/or family, only the therapist's time will be counted toward the daily and monthly maximums and will bill as usual. The PSW time will be billed under the conjoint service authorization for sessions with therapist present and attendance at treatment team meetings.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize the Therapist for up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. The number of hours authorized each month should be determined by the needs of the youth, should meet medical necessity criteria, and should decrease as progress is made.
Continuing Stay Criteria	Threshold - The average length of IILS treatment five (5) months with most youth reaching a point of diminishing progress by the sixth (6) month. When the youth's treatment will exceed six (6) months, continued reauthorization must be preceded by a clinical review and **all** the following conditions are determined to be true: 1. The youth meets admission criteria and is actively involved in treatment interventions and treatment planning and continues to have deficits in several areas of skills necessary for independent living.

	2. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but goals of treatment have not yet been achieved. 3. The MHTP and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable, and achievable goals, objectives and discharge criteria directed toward independence. 4. The MHTP includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post service resources. 5. There is documented evidence of active family involvement in treatment as required by the treatment plan or there are active documented efforts being made to involve them unless it is documented as contraindicated. 6. There is reasonable expectation that continued treatment will remediate the symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued.
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The young person is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible. 2. The young person's documented treatment plan goals and objectives have been substantially met and can be transitioned to independence as evidenced by one (1) of the following: a. The young person reaches a level of functioning that allows for transition to independent living. b. The young person has attained the knowledge and supports necessary to sustain treatment outcomes and/or to support a successful life in the community. 3. The young person or parent/guardian is not participating in treatment or in following program rules. The non-participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3) documented attempts to address non-participation issues. 4. Youth has demonstrated minimal or no progress toward treatment goals for three (3) month period and appropriate modification of plans has been made and implemented with no significant success, suggesting the youth is not benefiting from Intensive Independent Living Skills service at this time. 5. The youth and family no longer wants to participate in this service and revokes consent with no imminent danger to self or others.
Service Exclusions	Intensive Independent Living Skills is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same time as any out-of-home service, unless the youth is expected to discharge from the service within thirty (30) days of referral. 2. Not offered at the same time as Intensive In-Home Intervention, Multisystemic Therapy, Functional Family Therapy, or Adaptive Behavioral Intervention except when the youth has a planned discharge from the service within two (2) weeks of referral. 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth. 4. No admissions that are being sought solely for convenience of child protective services housing, as an alternative to incarceration within juvenile

	justice, as an alternative to specialized schooling, or simply as respite.
Clinical Exclusions	Youth is in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program has a QMHP experienced in providing transitional services to youth with serious emotional and behavioral challenges and who is knowledgeable in evidenced-based treatments is responsible for clinical supervision, program oversight, and active guidance to staff.
2. The program is required to have a QMHP who provides twenty-four (24) hours on-call coverage, seven (7) days a week.
3. IILS Therapists must, at minimum, be an MHP with experience providing transition to independent living services to youth with serious emotional and behavioral challenges.
4. PSWs must be credentialed as a paraprofessional level 2.
5. The IILS Therapist working directly with the or youth/family may partner with a PSW or team of PSWs as needed with the recommendation of the treatment team and authorized by the Clinical Lead.
6. The PSW will work under the direct guidance of the IILS Therapist to meet the specific identified needs.
7. The ratio shall not exceed twelve (12), youth per therapist at any time with the consideration that at least two (2) of the twelve (12) youth will be stepping down from care. Staff to client ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

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-based interventions.
2. A pre-admission meeting is required to obtain youth, family, CC, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan will be developed that identifies effective youth self-calming interventions that will be incorporated into the youth's MHTP/crisis plan. The pre-admission meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.
3. The Contractor has an intake policy and procedure that includes integration of information available on the youth/family in the treatment planning to ensure appropriate and effective treatment. Program also has an established protocol for orienting the youth and family to the service.
4. A complete intake assessment is provided focusing on the young person's needs in the areas of housing, employment, education, social, financial and health/mental domains in support of acquiring independent living skills. Intake assessments may be completed within three (3) calendar days of intake by one individual or by a multidisciplinary team, but a QMHP must be involved to assure adequate integration of available clinical information into treatment planning.
5. The MHTP documents targets of treatment that are reflective of the youth's admission behaviors/symptom along with realistic goals and discharge criteria within ten (10) days of

admission as part of the initial assessment process and pre-admission meeting. The MHTP and crisis plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.

6. The discharge plan component of the MHTP will document realistic discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to support independence.
7. Intensive Independent Living Skills services are individually designed for each youth in full partnership with the family or other support system to minimize intrusion and maximize independence.
8. All services must be provided with the youth involvement. Any contact where the youth is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
9. The majority of services [eighty percent (80%) are provided face-to-face with youth and their family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
10. The Contractor has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric consultation or hospitalization. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others and requires consult with the program QMHP prior to, during or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.
11. The Contractor shall 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.
12. The Contractor has policies which govern the provision of services in natural settings and which document that it respects youth's and/or family's right to privacy and confidentiality when services are provided in these settings.
13. The Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
14. The Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
15. The Contractor must have an Intensive Independent Living Skills organizational plan that addresses the following:
    a. Description of the particular skill-building interventions, 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.
    d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual plan.
    e. Description of the qualifications of the QMHP experienced in evidenced-based treatment who supervises the treatment program and assumes clinical responsibility.
16. The Contractor must perform a Summary Annual Evaluation for youth in their care their care at the time the annual evaluation is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The MHTP is submit to the Family Guidance Center within ten (10) days of admission. Using information gathered from the referral, pre-admission meeting and initial assessment. This initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan). This documentation is required for any reauthorization of Intensive IILS.
   a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
   b. The discharge component of the MHTP will document realistic discharge criteria aligned with the youth's treatment goals/objectives, projected timeframe, and anticipated aftercare resources needed to support independence (see General Performance Standards, D4b. Discharge Planning).
2. The MHTP is updated on a quarterly basis. MHTP updates should summarize gains/achievements from the previous three (3) months and the treatment goals/objectives adjusted to reflect the youth's changing condition.
3. Progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all treatment activities These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
4. A Discharge Summary Progress Note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

Q. ADAPTIVE BEHAVIORAL INTERVENTION (ABI)

Definition	This specialized intensive outpatient service is used to provide treatment and support to youth who have co-occurring mental health needs and mild intellectual developmental disabilities (MH-DD) and their families. It is designed to enhance the family's capacity to sustain the youth in their current living environment and to prevent the need for placement outside the home due to behavioral challenges. Adaptive Behavioral Intervention (ABI) also may be used to help re-unify the family after the youth has been placed outside the home or to support the transition to a new resource family for foster youth with both developmental disabilities and behavioral difficulties. This service is family-and youth-centered; it utilizes evidence-based or evidence-informed interventions and adheres to CASSP principles. This service may be delivered in the family's home or community. Youth with MH-DD frequently require support from several child-serving agencies, and this level of care incorporates some indirect case coordination activities along with standard behavioral and therapeutic interventions to help families manage their child's complex needs. This service assists families in incorporating their own strengths and their informal support systems to help improve and maintain the youth's functioning. ABI generally will be provided by a team that includes a therapist (MHP or QMHP) and at least one Paraprofessional Support Worker (PSW).
Service Components	1. Therapy services including family- and youth-centered interventions that target identified treatment outcomes. Services are provided in the home or community at a level that is more intensive than outpatient services. Interventions may include: a. Gathering information to develop a behavioral Assessment of the youth's problematic behavior in the home or community setting. b. Developing behavioral support plans with families, based on the assessment, to target challenging behavior and develop positive coping skills. c. Working with families to implement home-based behavioral support plans. (This may include modeling/coaching and paraprofessional support). d. Individual work with youth who have internalizing problems (depression, anxiety, post-traumatic stress disorder) utilizing evidence-based therapy approaches that are adjusted as needed to accommodate the youth's developmental level. e. Family Therapy interventions to improve family communication, decrease conflict, improve relationships, etc. f. Crisis management interventions. g. Psychoeducation with family members and the youth to help them understand the youth's particular difficulties and limitations. h. Linkages to other needed supports through coordination activities and referral, including utilizing, ensuring, and facilitating access to formal and informal supports in the community and school. 2. Paraprofessional Support services to reinforce and extend the work of the therapist. Paraprofessional interventions may include: a. Collecting detailed information about problematic behavior to help the therapist complete an assessment and design effective interventions. For example, recording incidents of non-compliance during the morning routine. b. Working with the identified youth and/or care-giver to support skill-

	building interventions being offered by the therapist. For example, practicing problem-solving skills with the youth while engaging in a community activity, practicing the use of praise and selective ignoring with the caregiver during the bed-time routine. c. Providing support to transition-age youth to implement plans developed to address vocational and other transition-related issues. For example, the Paraprofessional could support the youth with obtaining job applications, preparing for a job interview, learning to use public transportation, etc. d. Providing "line of sight" supervision and working with the identified youth to support emotional regulation and acceptable behavior during community-based activities or house-hold routines. e. Modeling behavior management skills and parenting approaches for parents during daily routines in the home. f. Implementing crisis and safety plans and providing crisis intervention and de-escalation. g. Accompanying the client or caregiver in order to support their participation in important meetings/appointments or activities. 3. Active coordination of community-based services being provided for the youth. This can be done by either the therapist or the paraprofessional working with the family. Because of the complex, specialized needs of youth with MH-DD, this service includes indirect case coordination activities including: a. Taking the lead role in coordinating the work of paraprofessionals, volunteers, family members and other support people to help the family assure that the youth is making progress, that learning is occurring between settings (e.g. school staff are teaching and learning from-based staff) and that the youth is adequately supervised. b. Scheduling team meetings with all the involved agencies, and keeping various stakeholders informed about the youth. c. Investigating additional services, benefit programs, youth activities, educational resources, etc. that might be needed by the youth and assisting the family to access them. d. Attending school meetings and working with school-based providers to assure continuity with the school program. e. Arranging training for various support people around how best to work with the youth. f. Coordinating with medical providers, especially psychiatrists to assure good communication and adherence to medical regimens. 4. A MHTP that identifies targets of treatment connected to realistic goals, objectives, and discharge criteria will be developed as part of the initial assessment process and will include information from the pre-admission meeting. The treatment plan shall target challenging behavior related to a mental health need and shall not be focused primarily on the acquisition of basic adaptive skills. The plan will be evaluated and revised as necessary as treatment proceeds, and the planning process will include the youth, family/guardian and other relevant treatment team members. a. A clear plan for use of the Paraprofessional Support Worker's services is incorporated into the treatment plan.

	b. The crisis plan component of the treatment plan includes a safety plan that identifies the youth's problematic behaviors, triggers and preferred means of calming or regaining control. The safety plan is part of the treatment plan that articulates the youth's self-calming interventions consistent with treatment targets, goals and objectives. The purpose of the safety plan is to help the youth regain control and avoid escalation into crisis. c. The discharge component of the treatment plan specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, the time frame for discharge and any aftercare resources needed to transition the youth and family to a lower level of care or out of CAMHD services. 5. Monitoring of the youth/family's progress on a regular basis using reliable and valid data gathering strategies. The monitoring strategy shall be noted on the MHTP and shall take one or both of these forms: a. Frequent and repeated assessment (at least monthly) of individually determined and behaviorally observable treatment targets (e.g., monitoring the frequency and intensity of temper outbursts) and/or b. Regularly scheduled administration of reliable and valid measures that are meaningful to the youth's presenting concerns (e.g., giving the Child Behavior Checklist to monitor symptoms)
Admission Criteria	**All** the following are met: 1. The youth is between the ages of three (3) and twenty (20). 2. The youth has documented borderline, mild or moderate deficits in intellectual functioning (e.g., tested IQ less than 85; assessment from a QMHP that estimates the youth is functioning in the mild range of intellectual disability, etc.). 3. The youth is displaying behavioral and and/or emotional difficulties in the home or community (not *only* in school) and there is a reasonable likelihood that ABI services will lead to specific, observable improvements in the youth and family's functioning. 4. Pre-admission meeting is held with the youth, family/guardian, CC and other relevant treatment team members to identify: 1) targets to be addressed in the treatment and safety plan, 2) realistic discharge criteria and 3) expectations of family/guardian involvement in the treatment process. If clear goals cannot be identified at the pre-admission meeting (e.g. the family is too distressed or uncomfortable with the process), developing a workable plan becomes the primary target for the first month of this service. 5. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.
Authorizations	Unit = fifteen (15) minutes Pre-admission meeting authorizations: Clinical Lead may authorize up eight (8) units [two (2) hours] for an ABI therapist to attend a pre-admission meeting with the youth/family present for initial planning and matching.

	Authorization for Therapist: Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. Authorization for PSW: The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month for up to three (3) months. Billing limits: Daily billing must not exceed sixteen (16) units [four (4) hours] per day, including combined billing for the Therapist and PSW. No billing for no shows, cancellation, or travel time. No billing for collateral contacts unless youth or caregiver is present during contact.
Overlapping Services	Clinical Lead may authorize up to ninety-six (96) units [twenty-four (24) hours] for up to thirty (30) days for a therapist to begin engaging with a youth and his/her out-of-home treatment team. ABI services provided while overlapping with any out-of-home treatment will be billed as follows for overlapping time only:
Conjoint Work	Clinical lead may authorize up to eight (8) units [two (2) hours] per month for conjoint work. When the Therapist and the PSW work conjointly with the youth and/or family, only the therapist's time will be counted toward the daily and monthly maximums and will bill as usual. The PSW time will be billed under the conjoint service authorization for sessions with therapist present and attendance at treatment team meetings.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize as follows: Authorization for Therapist: Clinical Lead may reauthorize the Therapist for up to ninety-six (96) units [twenty-four (24) hours] per month for up to three (3) months. Authorization for PSW: The Clinical Lead may authorize additional units up to two hundred twenty-four (224) [fifty-six (56) hours]. The combined total for both the Therapist and the PSW must not exceed three hundred twenty (320) units [eighty (80) hours] per month for up to three (3) months. The number of hours authorized each month should be determined by the needs of the youth, should meet medical necessity criteria, and should decrease as progress is made. The maximum allowed hours shall not be authorized after the first three months of services except in unusual circumstances when very intensive intervention continues to be medically necessary.
Continuing Stay Criteria	Threshold – The average length of ABI treatment is eight (8) months with most youth showing diminishing progress by the sixth (6) month. When the youth's treatment will exceed six (6) months, continued reauthorization must be preceded by a clinical review and **all** the following conditions are determined to

	be true: 1. All admission criteria continue to be met. 2. The measurable treatment goals have not been met and there are regular and timely assessments and documentation of youth/family response to services. Data on progress have been presented in a visual or tabular format showing changes over time and reviewed with the family and treatment team. Timely and appropriate modifications have been made to services and plans as needed. 3. The documented MHTP and safety plan is individualized and appropriate to the individual's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria. The treatment plan has been shared with relevant team members. 4. The MHTP includes a formulated discharge plan that is directly linked to the behaviors and/or symptoms that resulted in admission and begins to identify appropriate post service resources. 5. There is documented evidence of active family involvement in treatment as required by the treatment plan or there are active documented efforts being made to involve them unless it is documented as contraindicated. 6. There is reasonable expectation that continued treatment will improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued. 7. There are documented active attempts at coordination of care with other relevant behavioral health providers when appropriate. If coordination is not successful, the reason(s) are documented.
Discharge Criteria	Youth is no longer in need of or eligible for services due to **one** (1) of the following: 1. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least disruptive manner possible. 2. Targeted symptoms and/or maladaptive behaviors have lessened to a level of severity which no longer requires this level of care as documented by attainment of goals in the MHTP; 3. The parent/guardian or youth is unable to participate in treatment. Non-participation is of such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple (at least 3) documented attempts to address the non-participation issues; 4. Youth exhibits new symptoms and/or maladaptive behaviors that cannot be addressed safely and effectively through this service as determined by the Branch Clinical Lead. 5. Youth/family has demonstrated no progress toward treatment goals and/or deterioration in functioning for at least a three (3) month period, and clinical review has determined that the youth is not benefiting from this service; or 6. The youth/family no longer wants to participate in this service and revokes consent.
Service Exclusions	ABI is not considered medically necessary and will not be authorized under the following circumstances: 1. Not offered at the same time as any out-of-home services except in cases

	where the youth has a planned discharge from out-of-home care within thirty (30) days. ABI can begin to work with the youth and family for up to thirty (30) days to aid in family reunification following out-of-home care. 2. Not offered at the same time as any other intensive outpatient services (e.g., MST, FFT, Intensive In-Home, Intensive Independent Living Skills). 3. No admissions and/or continued stays which are solely for parent/guardian convenience and not related to the care and treatment of a youth. 4. No admissions that are being sought solely for convenience of child protective services, as an alternative to incarceration within juvenile justice, as an alternative to specialized schooling, or as respite.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. Once stable, youth who otherwise meet the eligibility criteria may be referred into the program. ABI may be provided to hospitalized youth who are still stabilizing as part of a transition back to the home.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program has a QMHP who has oversight and supervision responsibilities for all staff decisions made regarding youth/family treatment.
2. ABI Therapists must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges.
3. Paraprofessional Support Worker (PSW) must be credentialed as a paraprofessional level 2.
4. The program provides a therapist with experience working with youth who have serious behavioral or emotional challenges and/or with youth who have developmental disabilities. As discussed in a later section, the program will provide additional training to assure that all therapists develop expertise in working with youth who have co-occurring MH-DD.
5. ABI Therapist working directly with the family may partner with a PSW or team of PSWs as needed with the recommendation of the treatment team and authorization by the Clinical Lead.
6. The PSW will work under the direct guidance of the Therapist to meet the specific identified needs of the youth and family.
7. The ratio shall not exceed ten (10), families per primary ABI therapist (team leader). This staff to family ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be covered.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

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 and family interventions.
2. A pre-admission meeting is required to obtain youth, family, CC, CL and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the MHTP. A safety plan developed in the CSP identifies effective youth self-calming strategies that shall be incorporated into the youth's MHTP/crisis plan. The pre-admission

meeting also facilitates the development of the youth's discharge plan, including the development of concrete, realistic, measurable discharge criteria and projected timeframe for discharge.

3. Program has an intake process that includes integration of information available regarding the youth and family into the treatment planning process to ensure appropriate and effective treatment. Program also has an established protocol for orienting the youth and family to the program.
4. ABI services are individually designed for each family, in full partnership with the family, to minimize intrusion and maximize strengths and 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.
5. ABI must be provided through a cohesive team approach and services must be flexible with the capacity to address concrete therapeutic and environmental issues in order to stabilize the crisis situation as soon as possible. Services are evidence-based, family-centered, strengths based, culturally competent, active and rehabilitative, and delivered primarily in the individual's home or other locations in the community.
6. All services must be provided with the youth and/or their caregiver's involvement. Any contact where the youth or family is not present—is NOT billable. The only exception is regularly scheduled treatment team meetings where the youth and caregiver are included members. These meetings may still happen and are billable even if the youth and family don't attend.
7. The majority of the service (80% or more) is provided face-to-face with the youth and family. The use of Telehealth technology to deliver treatment when appropriate is considered face-to-face.
8. Service delivery is preceded by a thorough assessment of the youth and their family so that an appropriate and effective treatment plan can be developed.
9. The Contractor has 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.
10. The Contractor has developed a training program, in collaboration with CAMHD, that assures professional and paraprofessional staff understand the particular needs and vulnerabilities of youth with co-occurring MH-DD.
11. The Contractor 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.
12. The Contractor has established procedures/protocols for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric consultation or hospitalization. Request for police /crisis hotline assistance are limited to situations of imminent risk or harm to self or others and requires consult with the program QMHP prior to, during or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.
13. Each Contractor has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
14. Each Contractor has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.
15. The Contractor must have an organizational plan that addresses the following:
    a. Description of the particular family centered interventions, 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/family 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.

d. Description as to how the plan for services is modified or adjusted to meet the needs specified in each youth's individual treatment plan.
e. Description of how the developmental needs of youth with intellectual disabilities are accommodated in the program model and in-service planning.

16. The Contractor shall conduct a Summary Annual Evaluation for youth in their care at the time the annual assessment is due for youth who have received at least three (3) months of services from the Contractor. See Summary Annual Evaluation performance standard.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The MHTP is submit to the Family Guidance Center within ten (10) days of admission. Using information gathered from the referral and pre-admission meeting. This initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan). This documentation is required for any reauthorization of Intensive In-Home services.
   c. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
   d. The transition/discharge component of the MHTP will document realistic discharge criteria aligned with the youth's treatment goals/objectives, projected timeframe, and anticipated aftercare supports (see General Performance Standards, D4b. Discharge Planning).
2. The MHTP is updated on a quarterly basis. MHTP updates should summarize gains/achievements from the previous three (3) months and the treatment goals/objectives adjusted to reflect the youth's changing condition.
3. Progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all treatment activities These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
4. A Discharge Summary Progress Note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

R. TRANSITIONAL SUPPORT SERVICE (TSS)

Definition	Transitional Support Service is used to help youth who have successfully completed a Transitional Family Home or Community-Based Residential treatment program make a smooth transition to their family home, DHS-provided resource home, or stepped-down treatment program. This service is provided by a clinical staff member from the out-of-home program who continues to meet with the youth and family, giving the youth access to support from a known mental health service provider as they cope with the changes involved with shifts in care. A central goal of TSS is to help the youth and family make a smooth transition to a new therapist and a new treatment plan. TSS is a time-limited, focused approach that incorporates family- and youth-centered evidence-based interventions and adheres to CASSP principles. This service may be delivered in the family's home, in the community, at the out-of-home treatment program facility, or via video conferencing/ telehealth technology. The venue for the service should be chosen based on what is preferred by the youth and family.
Service Components	1. A schedule of regular treatment sessions is planned while the youth is enrolled in the out-of-home program; and goals for these meetings are set with the youth and family as part of discharge planning from the out-of-home program. 2. Usually, the main provider for these transitional sessions will be the youth's primary therapist in the out-of-home program. 3. Interventions may include any of the following: a. Individual work with youth on maintaining gains and utilizing skills learned in out-of-home care. This can include relapse prevention and coaching by the therapist to get through stressful times. b. Work with families to set up and maintain consistent, strength-based interactions in the household, including training parents in behavior management skills, other parenting skills and working with parents on implementing home based behavioral support plans that build on successes achieved in the treatment program. c. Family Therapy interventions. d. Crisis management interventions. e. Coordinating care with the receiving program and therapist and facilitating transfer of the work to the new provider(s). 4. Development of a Mental Health Treatment Plan (MHTP) that identifies targets of treatment, goals, objectives, and discharge criteria. The planning process will include the youth, family/guardian, and other relevant treatment team members – particularly staff from the receiving step-down program.
Admission Criteria	**All** the following criteria must be met: 1. The youth has completed treatment in a CAMHD out-of-home program with at least partial success and is entering a lower level of care. 2. The youth continues to display behavioral or emotional challenges in the home/community and there is a reasonable likelihood that TSS will lead to specific observable improvements in the youth and family's functioning and/or will help make the new lower level of care more effective. 3. At least one planning meeting is held with the youth, family/guardian, CC, prospective Transitional Support Services therapist, staff of the prospective lower level of care, and other relevant treatment team members to identify

	treatment targets to be addressed by the TSS prior to discharge from out-of-home program. 4. The family/guardian(s) agree to active involvement in treatment and planning meetings, and the youth is willing to participate.
Authorizations	Unit = fifteen (15) minutes Clinical Lead may authorize up to eighty (80) units [20 hours] per month. If authorizing for Residential Stabilization Program (RSP), the Clinical Lead may authorize forty (40) units for the two (2) week transitional period. Billing limits: Billing for this service must not start until the youth is discharged from the out-of-home program and must not exceed sixteen (16) units [four (4) hours] in any one day. Services shall not be provided during the same hour(s) the youth or family is working with a therapist who is providing another intensive outpatient service such as Intensive In-Home therapy, Independent Living Skills, Adaptive Behavioral Intervention, Multisystemic Therapy or Functional Family Therapy.
Reauthorization	Clinical Lead may authorize up to eighty (80) units [20 hours] per month. Threshold - This service is transitional in nature and is not expected to last longer than 60 days.
Continuing Stay Criteria	**All** the following criteria are met as determined by clinical review: 1. All admission criteria continue to be met. 2. The documented MHTP is individualized and appropriate to the youth's changing condition with realistic, measurable and achievable goals, objectives and discharge criteria directed toward stabilization to allow treatment to continue in a less restrictive environment. The MHTP has been shared with the relevant team members. 3. There is reasonable expectation that continued treatment will enable a smooth transition to the new stepdown service provider or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued. 4. Progress in relation to specific targeted symptoms or impairments is clearly evident and can be described in objective terms, but the goals of treatment have not yet been achieved. 5. There is documented evidence of active family involvement in the treatment as required by the MHTP or there is active documented efforts being made to involve them unless contraindicated. 6. There are documented contacts for coordination of care with the step-down therapist and any other relevant behavioral health providers. If coordination is not successful, the reason(s) are documented
Discharge Criteria	Youth is no longer in need of or eligible for this service due to **one** (1) of the following criteria: 1. The youth and family have begun working well with their stepped-down service provider(s). The new provider has developed a good understanding of what was helpful to the youth/family in the out-of-home treatment and has incorporated the information into the new MHTP. 2. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the

	least disruptive manner possible. 3. Youth/family has demonstrated minimal or no progress toward treatment goals and clinical review has determined that the youth is not benefiting from this service at this time. 4. The youth or parent/guardian is not participating in treatment or is not following program rules and regulations. Non- participation is of such a degree that treatment at this level of care is rendered ineffective, despite multiple (at least 3), documented attempts to address the non-participation issues. 5. The youth/family no longer wants to participate in this service and revokes consent.
Service Exclusions	Transitional Support Services are not considered medically necessary and will not be authorized under the following conditions: 1. While youth is in HBR or Sub-Acute.
Clinical Exclusions	Youth in need of immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A QMHP experienced in evidence-based treatment and family-based interventions in most cases this will be the supervising QMHP of the out-of-home program has oversight and supervision responsibilities for all staff decisions made regarding youth/family treatment.
2. The TSS Therapist must minimally be credentialed as an MHP with experience working with youth who have serious behavioral or emotional challenges.
3. The Contracted Provider Agency is required to have a QMHP who provides twenty-four (24) hour on-call coverage seven (7) days a week.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A planning meeting prior to discharge from the out-of-home program is required to obtain youth, family, CC, Clinical Lead, step-down provider, and other relevant team members' input into symptoms/behavior that are the targets of treatment and reflected in the goals and objectives in the respective MHTPs. The meeting facilitates planning with the receiving stepped-down program provider to ensure the care is coordinated upon release from out-of-home care.
2. The Contracted Provider Agency has process for closing the youth's case in the residential program and opening it in TSS. Contractor also has an established protocol for orienting the youth and family to the TSS.
3. A MHTP that identifies targets of treatment that are reflective of the youth's behaviors/symptom on transfer to TSS and the development of realistic goals, objectives, and discharge criteria will be developed within ten (10) days of admission as part of the initial assessment process. The MHTP and crisis plan component will be evaluated and revised as necessary as treatment proceeds and will include the youth, family/guardian, CC, and Center Clinical Lead along with other relevant treatment team members.
4. As part of the treatment planning, the discharge component of the MHTP will be developed with

the family that specifies realistic indicators that transition to the step-down program is complete including projected timeframe.

5. TSS is individually designed for each youth, in full partnership with the family, to minimize intrusion and maximize strengths and independence. Services are normally more intensive at the beginning of treatment and decrease over time as the individual and/or family's relationship with the receiving treatment program develops and their strengths and coping skills increase.
6. Telehealth/video technology may be used when youth and family are on a different island than the residential program provider or when distances are otherwise prohibitive of home visits.
7. The Contracted Provider Agency has policies, which govern the provision of services in natural settings that respects youths' and/or families' right to privacy and confidentiality when services are provided in these settings.
8. The Contracted Provider Agency has established policies and procedures for handling emergency and crisis situations that describe methods for triaging youth who require psychiatric consultation or hospitalization. Request for police/crisis hotline assistance are limited to situations of imminent risk or harm to self or others and requires consult with the program QMHP prior to, during or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and document their efforts in the youth's chart.
9. The Contracted Provider Agency has policies and procedures governing the provision of outreach services, including methods for protecting the safety of staff who engage in outreach activities.
10. The Contracted Provider Agency has policies and procedures around the use of personal vehicles for outreach services and for transporting clients when necessary.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A written MHTP identifying targets of treatment with realistic goals, objectives and discharge criteria linked to the admission behavior/symptoms will be submitted to the Center with ten (10) calendar days of admission. This documentation is required for any reauthorization of TSS.
2. Progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all treatment activities These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
3. A discharge summary is submitted to the Center with ten (10) calendar days of discharge.

S. THERAPEUTIC RESPITE HOME (TRH)

Definition	Therapeutic Respite Homes provide short-term care and supervision for youth with emotional and/or behavioral challenges in a supportive environment as a planned part of their treatment. These homes provide structured relief to the youth to prevent disruptions in the regular living arrangement. The goal of Therapeutic Respite Home services is to provide rest and relief to the youth and to help the youth achieve their highest level of functioning. Therapeutic Respite Home is not provided as a stand-alone service, and there is close coordination of this service with other on-going mental health treatment services.
Service Components	1. Services are provided in a Transitional Family Home and are available twenty-four (24) hours a day, seven (7) days a week. 2. Culturally relevant recreational and social activities that support the development of interpersonal relationships and life skills through modeling and coaching. 3. Positive behavioral supports, social skills training, observation and supervision of the youth. 4. Regular communication with the youth's primary caregiver and other service providers to assure coordination of care. 5. Medication administration if needed. 6. A documented MHTP will be developed with the team to help inform the therapeutic goals and strategies utilized within TRH. Additionally, the crisis plan component shall be revised for use within the TRH.
Admission Criteria	**All** the following criteria are met: 1. The youth between the ages of three (3) and seventeen (17). 2. Youth resides in the family home or a DHS Resource Home (i.e., youth is not in a CAMHD-funded out-of-home service). 3. Youth receives a CAMHD-funded intensive in-home service. 4. The CMP identifies TRH as necessary to preserve the youth's living situation and specifies how and when the service will be utilized.
Authorizations	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the residence when the day begins. Clinical Lead may authorize up to two (2) units per month for up to three (3) months. Youth may not remain in a TRH residence for more than two (2) consecutive days without prior approval by the Clinical Services Office.
Reauthorization	Clinical Lead may reauthorize up to two (2) units per month for up to three (3) additional months. No more than twelve (12) units may be authorized in a six (6) month period without review and approval by the Clinical Services Office.
Continuing Stay Criteria	**All** admission criteria continue to be met. Service duration may not exceed six (6) months without review and approval by the Clinical Services Office.
Discharge Criteria	At least **one** (1) of the following criteria is met: 1. Youth is no longer eligible for CAMHD services. As part of discharge, the CC will help coordinate transfer to appropriate treatment services in the least

	disruptive manner possible. 2. Youth (or family) no longer wishes to participate in the service and revokes consent. 3. Youth (or family) stops participating in a CAMHD-funded intensive in-home service. 4. Youth requires a more intensive service/higher level of care.
Service Exclusions	<u>TRH is not considered medically necessary and will not be authorized under any of the following circumstances:</u> 1. Youth is actively enrolled in another CAMHD-funded out-of-home service; or 2. Use of the service (or continued stay) is solely for the convenience of the parent/guardian and not related to the mental health care and treatment of the youth.
Clinical Exclusions	1. Youth requires immediate crisis stabilization because of active suicidal, homicidal, or psychotic behavior. 2. Youth's clinical issues interfere with the safe provision of services in this level of care.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The Therapeutic Respite Home residence must be a licensed Foster Home with the Department of Human Services (DHS) prior to service initiation.
2. Contractors shall complete a Profile Form (see Appendix 4) for every home licensed. Profile Forms must be submitted to the CAMHD Utilization Management Section upon contract execution and updated quarterly.
3. Therapeutic Respite Home caregivers are required to receive at least two (2) hours a month of supervision from a QMHP or MHP. One (1) hour of the required supervision may be multi-family or group supervision.
4. Therapeutic Respite Home program staffing shall match/mirror Transitional Family Home program staffing, minimally to include a Program Director (QMHP), Therapist (MHP), Caregiver Recruiter/Trainer (MHP), and Case Manager (Para2).
5. A QMHP, with experience providing services to youth/families and knowledge of evidenced-based/best practice treatments, is responsible for overseeing the Therapeutic Respite Home program and those in care.
6. A program staff member must be available twenty-four (24) hours per day, seven (7) days a week to provide on-call coverage support for TRH caregivers.
7. The program must assign a staff member who is responsible for communicating with CCs and relevant service providers to assure TRH caregivers have current information about the youth and that treatment is coordinated across service settings.
8. Youth who are unable to attend regularly scheduled day activities (e.g., school, work) must be provided supervision and therapeutic structure by program staff.
9. Therapeutic Respite Home caregivers must be trained in the provision of short-term care for youth with emotional and/or behavioral challenges, including training on medication administration.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Service is available twenty-four (24) hours a day, seven (7) days a week.
2. The Therapeutic Respite Home will have no more than two (2) CAMHD youth in the residence without prior written approval from the CAMHD Utilization Management Section.
3. 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.
4. In addition to all DHS licensing requirements, Contractors will ensure all Therapeutic Respite Home caregivers receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Therapeutic Respite Home services; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the youth's parents/family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; and be trained in CPR and First Aid.
5. Therapeutic Respite Home caregivers shall receive at least twenty (20) hours of on-going training annually on topics related to youth with special behavioral and emotional needs. Contractors must maintain documentation of all training opportunities offered and completed.
6. The Contractor must have written policies and procedures for and provide training on medication administration inclusive of storing, securing, labeling, administering, and disposing of medications; recording medication administration and refusal; observing and reporting possible side effects; and youth-requested medication adjustments.
7. Therapeutic Respite Home caregivers shall actively engage youth in planned, structured, therapeutic activities, rooted in evidence-based treatment, throughout the day. There is a predictable and orderly routine that allows the youth to develop and enhance interpersonal skills and behaviors.
8. The Therapeutic Respite Home program must have 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 interventions.
9. The Contractor will have policies and procedures in place for preventing and managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police or Crisis Mobile Outreach assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP or on-call QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions.
10. Emergency contact information for the youth's parent(s)/guardian(s) is provided to the Therapeutic Respite Home caregivers prior to or upon admission.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Therapeutic Respite Home caregivers shall maintain a daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more.
2. Therapeutic Respite Home caregivers shall complete a daily progress note recording events or activities youth engaged in and treatment progress achieved. The respite home progress note may

be in the form of a checklist or written note. The notes shall be signed and dated by the Therapeutic Respite Home caregiver. Contractors must place attendance logs and daily progress notes in the youth's file within seven (7) calendar days.

T. TRANSITIONAL FAMILY HOME (TFH)

Definition	This service is an intensive, short-term treatment service provided in a family home setting for youth with emotional and behavioral challenges. Transitional Family Homes provide a normative, community-based environment with parental supervision, home structure, and support for youth capable of demonstrating growth in such a setting. This service provides a supportive platform for family therapy and treatment to occur with the goal of reuniting youth with their family or transitioning to another longer-term living arrangement. The youth are generally capable of attending their home school or an alternative community educational or vocational program. This service may also be beneficial for youth transitioning from a more restrictive setting as these homes offer a family-like orientation.
Service Components	1. Evidence-Based Interventions including individualized positive behavioral supports delivered in the TFH and parent management training for the youth's family of origin or caregiver. 2. Individual Therapy occurring at least one (1) time per week to address youth's specific emotional and behavioral treatment needs as indicated in the Clinical Management Plan. The role of the TFH therapist is to assist in the youth's adjustment to the TFH residence and support the youth in acquiring and mastering skills needed for a successful return to their family or identified step-down placement. Transition-aged youth will be provided opportunities to learn and enhance skills necessary to live independently in the community upon discharge. Youth will be linked to educational, vocational, health, and social resources as necessary. 3. Family Therapy occurring at least one (1) time per week with the youth and family of origin or caregiver in the identified step-down placement. The role of the TFH therapist is to support the family's adoption of successful individualized behavioral approaches used within the TFH residence by providing behavioral management and parenting education, training, and skill building opportunities. 4. Recreational Social Activities that support the development of positive interpersonal relationships and life skills through modeling and coaching. 5. Coordination with the Family Guidance Center including participation in monthly Treatment Team Meetings to monitor progress and discuss treatment strategies. Coordination with other involved service providers, including youth's school, to implement and provide supports in the TFH residence as necessary. 6. Mental Health Treatment Plan (MHTP) developed with the youth and youth's family/caregiver. 7. Planned Therapeutic Passes to allow the youth and family members to practice skills in their natural environment, maintain family connections, and prepare for reunification. 8. Transitional Support Service when clinically indicated, to facilitate a successful transition from the TFH residence to the identified step-down setting.
Admission Criteria	**All** the following criteria are met: 1. The youth is between the ages of three (3) and seventeen (17). 2. Youth is not sufficiently stable to be treated outside of a structured

	therapeutic setting as evidenced by **one** (1) of the following: a. Moderate impairment in at least three (3) domains of the youth's life (e.g., home, community, moods/emotions). b. Recent history of successful treatment in a higher level of care and needing transitional support. c. Recent history of unsuccessful treatment in a lower level of care and needing more structure and support before returning to pre-treatment environment. 3. If youth's primary problem is a disruptive behavioral disorder there must be documentation of the use of one of the available evidenced-based treatments for disruptive behavior disorders (i.e., MST, FFT) unless there is documentation of clear and compelling clinical evidence that the youth is inappropriate for one of these approaches at this time. 4. Youth's documented needs can appropriately be met in a structured and consistent family-like environment. 5. Family/guardian agree to active involvement in treatment and planning meetings. 6. Youth agrees to active involvement in treatment. 7. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the residence when the day begins. Clinical Lead may authorize up to thirty-one (31) units per month for up to three (3) months.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize up to thirty-one (31) units per month for up to three (3) additional months.
Paid Holds	Therapeutic Pass – Clinical Lead may authorize up to eight (8) units per episode of care, not to exceed three (3) units at one time. Bed Hold – Clinical Lead may authorize up to three (3) units per episode of care.
Overlapping Services	Youth may not receive a CAMHD-funded home-based service concurrent with TFH services *except* for the thirty (30) day period leading up to transition from the TFH residence to the identified step-down setting. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	Threshold - The average length of TFH treatment is six (6) months, with most youth achieving maximum improvement between four (4) to six (6) months. When the youth's length of stay will exceed six (6) months, continued reauthorization must be preceded by a clinical review and **all** of the following conditions determined to be true: 1. The youth is actively engaged in treatment and continues to meet admission criteria. 2. Progress in relation to specific treatment targets is evident and can be described in objective terms, but goals of treatment have not yet been achieved.

	3. There is reasonable expectation that the youth will continue to make progress/improve or there is reasonable evidence that the youth's condition will worsen if services are discontinued. 4. The treatment goals, objectives, and discharge plan have been reviewed and updated/adjusted to reflect the youth's changing condition. 5. There is documented evidence of active family/guardian involvement in treatment (at least weekly) or documented efforts/attempts to involve them (unless contraindicated). 6. There is documented evidence of active coordination with the Family Guidance Center and other involved service providers (as applicable) or, if coordination is not successful, the reason(s) are documented.
Discharge Criteria	Discharges are to be conducted in a thoughtful, planned manner through co-management and regular communication among the provider, Family Guidance Center, family/guardian, and other treatment team members. Discharges that are not conducted in accordance with a previously agreed upon plan devised by the team will be considered ejections. <u>The youth is no longer in need of or eligible for TFH when **any one (1)** of the following is true:</u> 1. The goals of treatment have been substantially met. 2. Targeted symptoms/behaviors have abated in severity and can be adequately managed at a less intensive level of care. 3. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent. 4. The youth (or family/guardian) is not participating in treatment or following program rules and regulations. The non-participation is of such a degree that treatment is rendered ineffective and efforts to address non-participation issues have proven unsuccessful. 5. The youth has made little-to-no progress toward treatment goals for a three (3) month period, appropriate modifications have been implemented without significant improvement, and there is no reasonable expectation that the youth will improve in this level of care nor is there evidence that the youth's condition will worsen if services are discontinued. 6. The youth exhibits new symptoms and/or maladaptive behaviors that cannot be safely and/or effectively addressed in this treatment setting. 7. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	<u>TFH is not considered medically necessary and will not be authorized under any of the following circumstances:</u> 1. Youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the parent/guardian and not related to the mental health care and treatment of the youth. 3. Use of the service (or continued stay) is solely for the convenience of another child-serving agency. 4. Use of the service is for respite.

Clinical Exclusions	1. The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior. 2. Youth's clinical issues interfere with the safe provision of services in this level of care.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The Transitional Family Home residence must be a licensed Foster Home with the Department of Human Services (DHS) prior to service initiation.
2. Contractors shall complete a Profile Form (see Appendix 4) for every home licensed. Profile Forms must be submitted to the CAMHD Utilization Management Section upon contract execution and updated quarterly.
3. Transitional Family Home caregivers are required to receive at least two (2) hours a month of supervision from a QMHP or MHP. One (1) hour of the required supervision may be multi-family or group supervision.
4. Transitional Family Home program staffing shall minimally include a Program Director (QMHP), Therapist (MHP), Caregiver Recruiter/Trainer (MHP), and Case Manager (Para2).
5. A QMHP, with experience providing services to youth/families and knowledge of evidenced-based/best practice treatments, is responsible for overseeing the Transitional Family Home program and those in care.
6. A program staff member must be available twenty-four (24) hours per day, seven (7) days a week to provide on-call coverage support for TFH caregivers.

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Services are available twenty-four (24) hours a day, seven (7) days a week.
2. The Transitional Family Home will have no more than two (2) CAMHD youth in the residence without prior written approval from the CAMHD Utilization Management Section.
3. There shall be a minimum of one (1) adult at home whenever the youth is present. The program shall ensure additional staff support as necessary to meet this requirement.
4. The program provides TFH caregivers with a written plan for providing emergency and psychiatric care prior to youth being treated in the family home.
5. The program will assist TFH caregivers in developing reasonable rules and expectations for youth taking into consideration their age and individual circumstances (see Reasonable and Prudent Parent Standard).
6. In addition to all DHS licensing requirements, Contractors will ensure all TFH caregivers receive at least twenty (20) hours of initial orientation to include: orientation to the Contractor agency; orientation to the Hawaii Child-Serving System and the role of Transitional Family Home services; understanding children and youth with emotional disturbances; providing positive behavioral support to children and adolescents; how to work as part of a treatment team; how to relate to the youth's parents/family members; a review of State laws regarding child abuse and neglect reporting, reporting criminal behavior, and threats regarding suicide and homicide; and be trained in CPR and First Aid.

7. TFH caregivers shall receive at least twenty (20) hours of on-going training annually on topics related to youth with special behavioral and emotional needs. Contractors must maintain documentation of all training opportunities offered and completed.
8. A pre-admission meeting is required to explain treatment expectations and obtain input from the youth, family/guardian, and CC about the treatment goals that will be reflected in the MHTP. An initial discharge plan should also be formulated during this meeting, including the development of concrete, realistic, measurable discharge criteria and a projected timeframe for discharge.
9. The program will have an intake process that includes introducing the youth and family/guardian to the program, review and assessment of existing documentation to integrate into the treatment plan and crisis plan within their milieu.
10. Families/guardians are actively involved and participate in team meetings, therapy sessions, and other activities. The Family/guardian(s) 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. Every effort to include parents/guardians in the treatment process must be documented and the use of Telehealth video conferencing or telephone conferencing to facilitate family therapy sessions must be utilized for families/guardians that are unable to attend in person.
11. Contractor is to follow all applicable professional practice standards and ethical guidelines.
12. A QMHP or MHP provides weekly best practice family therapy services to the family of origin/guardian of each youth in placement as well as weekly best practice treatment to each youth in the program. If the program is without a QMHP/MHP to provide therapy services, the Contractor shall ensure that there is coverage of duties via sub-contract so that the weekly services are continued.
13. The Contractor must have written policies and procedures for and provide training on medication administration inclusive of storing, securing, labeling, administering, and disposing of medications; recording medication administration and refusal; observing and reporting possible side effects; and youth-requested medication adjustments.
14. The Contractor will have written policies and procedures for providing respite opportunities to TFH caregivers and shall ensure TFH caregivers know how to request internal respite arrangements.
15. The Contractor must have written policies and procedures that ensure youth will receive regular medical and dental services. TFH caregivers must inform program staff of any health problems or changes that adversely affect the youth in TFH care.
16. The Contractor must have written policies and procedures, which specify its approach to positive behavior management and to best practice family therapy interventions. These procedures must clearly delineate methods to be used for the training and implementation of these behavioral interventions.
17. The Contractor has established policies and procedures in place for preventing and managing crises effectively and efficiently through the direct interventions of its professional staff. Included in these procedures are descriptions of methods for handling emergency and crisis situations and triaging youth who require more intensive interventions. Request for police assistance or crisis hotline assistance is limited to situations of imminent risk of harm to self or others and requires consult with the program QMHP prior to, during, or after the call for assistance. The QMHP must follow-up to ensure the crisis situation has stabilized, debrief the incident and provide triage for youth needing more intensive interventions and documents their effort in the youth's chart.
18. The Contractor must complete a Summary Annual Evaluation when requested by the Family Guidance Center if the youth has been in the service for at least three (3) months (see Summary Annual Evaluation Performance Standard).
19. Up to three (3) consecutive bed hold days may be authorized per episode of care to reserve the bed for a youth who is absent from the program for an acute admission or detainment in the Detention Home, adjudicated to the Hawaii Youth Correctional Facility or on elopement status. Youth who are discharged from the program due to acute admission, detainment, adjudication or elopement status, will be given priority and expedited readmission if admission is sought within a

thirty (30) day period from discharge. This means they shall have priority for any open bed, and a new referral packet shall not be required. (See General Performance Standards, Q1. Bed Holds).

20. Up to eight (8) therapeutic passes are permitted per episode of care for each youth in the program to assist him/her in meeting the MHTP goals as defined in the general standards. These passes must be preapproved and used for therapeutic purposes. Program staff shall maintain contact with youth/family while on pass and debrief each pass. Authorization of more than eight (8) therapeutic passes requires review and prior approval by the Clinical Services Office.
21. When clinically indicated and requested by the Family Guidance Center, the program will provide Transitional Support Services to facilitate a successful discharge from the program and engagement in the step-down service (see Transitional Support Service Performance Standard).
22. The program may request Therapeutic One-to-One Support to help stabilize a youth exhibiting increasingly challenging or unsafe behaviors (see Therapeutic One-to-One Support Performance Standard).
23. The program will continue to treat any youth that turns eighteen (18) while in treatment if they wish to continue services. However, the youth must exit the program before their nineteenth (19^{th}) birthday.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A written treatment plan identifying targets of treatment with realistic goals, objective and discharge criteria linked to the admission behavior/symptoms will be submitted to the CAMHD Center within ten (10) days of admission. This documentation is required for any reauthorization of Transitional Family Home service.
   A documented MHTP that identifies targets of treatment connected to realistic goals will be developed as part of the initial assessment process and includes information from the pre-admission meeting and CMP. The MHTP will be evaluated and revised as necessary, at least monthly as treatment proceeds and will include the youth, family/guardian and other relevant treatment team members.
   a. The crisis component of the MHTP identifies the youth's problematic behaviors, setting events, triggers and preferred means of calming or regaining control along with the steps the caregivers will take in the event the behavior escalates out of control. The crisis plan builds on available information from the youth's personal safety plan in the CSP. The crisis plan must focus on early intervention for any problematic behavior to reduce the need to take reactive steps.
   b. The discharge component of the MHTP specifies discharge criteria directly linked to behaviors/symptoms that resulted in the admission, time frame for discharge and any aftercare resources needed to transition the youth to a less restrictive level of treatment. Planning begins at the pre-admission meeting and is revised throughout treatment to ensure that any potential obstacles to discharge are recognized and addressed before anticipated discharge date.
2. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual and family therapy sessions. These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings within seventy-two (72) hours of service.
3. TFH caregivers shall maintain progress notes that provide a) daily attendance log indicating the youth's presence or absence from the home including absences of twenty-four (24) hours or more and b) provide daily progress notes as documentation of treatment progress, events or activities youth engaged in and developmental milestones achieved. These notes shall be fully dated and

signed by the TFH parent, originals of which shall be placed in the youth's file within seven (7) calendar days. These Transitional Family Home progress notes may be in the form of a checklist or written note.

4. A Discharge Summary Progress Note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

U. COMMUNITY-BASED RESIDENTIAL 3 (CBR3)

Definition	CBR3 provides round-the-clock care in a structured, therapeutic residential setting designed to deliver comprehensive treatment addressing behavioral, emotional, and family challenges that prevent the youth from fully participating in family and community life. The program is expected to deliver psychosocial, educational, and rehabilitative skill development, with a primary focus on reintegration into the family and broader community.
Service Components	1. Trauma-Informed Milieu supported by a non-coercive, evidence-based behavior management model. 2. Orderly Schedule and Normalized Routine of well-supervised therapeutic activities designed to improve behavior and general functioning, support emotional regulation, and promote the development of appropriate daily and independent living skills. 3. Intensive Individual Therapy occurring at least two (2) times per week to address youth's specific emotional and behavioral treatment needs as indicated by referral and assessment. 4. Family Therapy occurring at least one (1) time per week to support successful return to the youth's home/community. In cases where there is no family/guardian to participate in family therapy, discussions with probation officer or care coordinator to support transitioning the youth to their home/community is acceptable. 5. Group Therapy occurring at least five (5) times per week. 6. Psychiatric Services to include a comprehensive medical evaluation at intake and ongoing medication management at least one (1) time a month. 7. Substance Abuse Counseling and education as indicated by referral and assessment. 8. On-site Educational Program with instruction delivered by certified education specialists (provided by the Department of Education) tailored to the youth's educational needs or aligned with the youth's IEP goals and objectives, if applicable. 9. Prosocial Interpersonal Activities that increase empowerment and self-determination such as nature-based recreation, creative arts, and vocational training opportunities. 10. Mental Health Treatment Plan (MHTP) developed with the youth and family/guardian. 11. Coordination with the Family Guidance Center, including participation in monthly Treatment Team Meetings to monitor progress and discuss treatment strategies, as well as other involved service providers as appropriate/necessary. 12. Planned Therapeutic Passes to allow youth and family members to practice skills in their natural environment, maintain family connections, and prepare for reunification. 13. Transitional Support Service when clinically indicated, to facilitate a successful transition from the residential treatment setting to the identified step-down setting. 14. Therapeutic One-to-One Support when clinically indicated, to help stabilize escalating or unsafe behaviors and increase the likelihood of maintaining services in the current treatment setting.

Admission Criteria	**All** the following are met: 1. The youth is between the ages of twelve (12) and seventeen (17). 2. There is clinical evidence that the youth would present a risk to self or others if not in a residential treatment program as evidenced by at least one (1) of the following: a. Severe functional impairment in at least three (3) life domains (e.g., home, school, emotions). b. Expression of suicidal/homicidal ideation or occurrences of severely impulsive or aggressive behavior within the past sixty (60) days. c. Substance dependency as evidenced by cravings and/or withdrawal symptoms not so severe as to require hospitalized treatment. 3. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors. 4. An adequate trial of treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of treatment at a less restrictive level. 5. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting. 6. The youth's family/guardian agree to active involvement in treatment. 7. The youth agrees to active involvement in treatment.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the facility when the day begins. Clinical Lead may authorize up to thirty-one (31) units per month for up to three (3) months.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize up to thirty-one (31) units per month for up to three (3) additional months.
Paid Holds	Therapeutic Pass – Clinical Lead may authorize up to five (5) units per episode of care, not to exceed three (3) units at one time. Bed Hold – Clinical Lead may authorize up to three (3) units per episode of care.
Overlapping Services	Youth may not receive a CAMHD-funded home-based service concurrent with CBR3 services *except* for the thirty (30) day period leading up to transition from the CBR3 program to the identified step-down setting. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	The average length of CBR3 treatment is between three (3) to five (5) months, with most youth achieving maximum benefit/improvement by month five (5). When the youth's length of stay will exceed six (6) months, continued reauthorization must be preceded by a clinical review documented in a Case Review with **all** of the following conditions determined to be true: 1. The youth is actively engaged in treatment and continues to meet admission criteria. 2. Progress in relation to specific treatment targets is evident and can be described in objective terms, but goals of treatment have not yet been achieved.

	3. There is reasonable expectation that the youth will continue to make progress/improve or there is reasonable evidence that the youth's condition will worsen if services are discontinued. 4. The treatment goals, objectives, and discharge plan have been reviewed and updated/adjusted to reflect the youth's changing condition. 5. There is documented evidence of active family/guardian involvement in treatment (at least weekly) or documented efforts/attempts to involve them (unless contraindicated). 6. There is documented evidence of active coordination with the Family Guidance Center and other involved service providers (as applicable) or, if coordination is not successful, the reason(s) are documented.
Discharge Criteria	Discharges from the program are conducted in a thoughtful, planned manner through co-management and regular communication among the provider, center, family, and other treatment team members. Discharges from the program which are not conducted in conjunction with a previously agreed upon plan devised by the team (including the Center and family) will be considered ejections. The youth is no longer in need of or eligible for CBR3 when **any one (1)** of the following is true: 1. The goals of treatment have been substantially met. 2. Targeted symptoms/behaviors have abated in severity and can be adequately managed in a less restrictive setting. 3. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent. 4. The youth (or family/guardian) is not participating in treatment or following program rules and regulations. The non-participation is of such a degree that treatment is rendered ineffective and efforts to address non-participation issues have proven unsuccessful. 5. The youth has made little-to-no progress toward treatment goals for a three (3) month period, appropriate modifications have been implemented without significant improvement, and there is no reasonable expectation that the youth will improve in this level of care nor is there evidence that the youth's condition will worsen if services are discontinued. 6. The youth exhibits new symptoms and/or maladaptive behaviors that cannot be safely and/or effectively addressed in this treatment setting. 7. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	CBR3 is not considered medically necessary and will not be authorized under any of the following circumstances: 1. The youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the family/guardian and not related to the mental health care and treatment of the youth. 3. Use of the service (or continued stay) is solely for the convenience of another child-serving agency.
Clinical Exclusions	1. The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior.

	2. The youth's clinical issues interfere with the safe provision of services in this treatment setting.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Program staff must include:
   a. Clinical Program Director – QMPH (full time staff)
      The Clinical Program Director is responsible for the treatment program and those in its care, ensuring staff are adequately trained and the services delivered are safe, ethical, grounded in evidence/empirically supported and culturally appropriate. The Clinical Program Director must be knowledgeable of evidenced-based treatments for youth with complex emotional and behavioral needs.
   b. Medical Director – Licensed psychiatrist or psychiatric nurse practitioner (staff or consultant)
      The Medical Director is responsible for assessing and ordering all medical and medication needs as necessary, and providing ongoing consultation to staff regarding medication, diagnoses, and other clinical matters.
   c. Therapist(s) – QMPH or MHP (full time staff)
      The Therapist is responsible for providing individualized therapy, including development of the MHTP based on assessment of the youth's needs.
   d. Program Nurse – Licensed registered nurse (full time staff)
      The Program Nurse is responsible for establishing operations for administering and monitoring medications, tracking and coordinating medical needs, and training staff on medication protocols and proper procedures.
   e. Residential Specialists – Paraprofessionals Level 1 and 2 (full time and part time staff)
   f. Certified Substance Abuse Counselor (staff or contracted consultant)
      The CSAC is responsible for developing and integrating substance abuse education into the treatment program and providing individualized substance abuse counseling based on assessment of the youth's needs.
   g. Certified Education Specialists (provided by the Department of Education)
2. The program must have the means to secure services from qualified professionals and specialists (e.g., medical, psychology, behavioral analysis, occupational/physical therapy, dietetics, recreation, etc.) to meet the unique needs of each youth, either through cooperative arrangements or by utilizing the organization's own personnel.
3. All staff must be CAMHD credentialed prior to working directly with any CAMHD youth (see General Performance Standards, I. Credentialing).
4. An on-call QMHP must be available at all times to provide clinical support to staff, with the ability to arrive on-site within one (1) hour for events that merit an in-person response. The Medical Director must be available for consultation in the event of psychiatric emergencies.
5. A staff-to-youth ratio of one-to-four (1:4) must be maintained at all times with a minimum of two (2) staff on duty per shift per living unit. Staff shall always be in attendance whenever youth are present. Youth that are ill or otherwise unable to participate in the program schedule/routine must be directly supervised by a staff member.
6. The overnight shift must maintain a staff-to-youth ratio of one-to-six (1:6). Two (2) staff must be on duty per living unit with at least one (1) staff awake throughout the shift.
7. At least one (1) residential specialist will be present in the classroom to assist the DOE Certified Education Specialists with behavior management and provide necessary therapeutic redirection.

8. The program must have the capacity to adjust staffing when necessary to ensure additional staff are available during busy or stressful periods such as for one-to-one (1:1) assignments, new admissions, medical appointments, etc.
9. The program staffing schedule shall reflect an overlap in shift hours, an adequate number of on-duty and backup staff based on the needs of the milieu, an appropriate staff gender mix, and identify the shift leader.
10. The program shall have a protocol in place to ensure appropriate and qualified coverage for the Clinical Program Director and Medical Director during absences due to illness or vacation.
11. The program must facilitate ongoing training sessions to enhance staff knowledge and skills related to treatment protocols for youth in residential settings, informed by the needs of the milieu. Training topics shall include but not be limited to the core expectations specified in the General Performance Standards (see G. Training).
12. All program staff shall receive and participate in clinical supervision as described in the General Performance Standards (see H. Supervision).

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must be operational twenty-four (24) hours a day, seven (7) days a week.
2. The program shall always be staff-secure, with round-the-clock supervision of all youth physically present, in alignment with the minimum staff-to-youth ratios.
3. The program must adhere to all applicable facility licensing requirements/regulations.
4. The program and its staff must follow all applicable professional practice standards and ethical guidelines.
5. The number of CAMHD youth present in the program at any given time shall not exceed the contracted number of beds without prior written approval from the CAMHD Utilization Management Section (CBR Bed Expansion Request).
6. The living environment should be home-like with comfortable, age-appropriate furnishings, and the youth encouraged to decorate and maintain their personal spaces.
7. The program shall have an intake process that includes orienting the youth and family/guardian to the facility, reviewing program rules/guidelines, explaining treatment expectations, and completing the admission summary. Input from the youth, family/guardian, and CC will be obtained to establish treatment goals for the MHTP and formulate an initial discharge plan with concrete, realistic, measurable discharge criteria and a projected discharge timeframe.
8. The program will have a predictable and orderly daily routine with structured, therapeutically meaningful activities scheduled throughout the day, seven (7) days a week. The activities should provide safe opportunities for the youth to develop and enhance intrapersonal intelligence, social competence, and independent living skills.
9. The program will engage each youth in therapy sessions tailored to their unique therapeutic needs, focused on addressing the emotional and behavioral factors leading to admission.
10. The program will actively involve the youth's family/guardian in team meetings, therapy sessions, and other activities, providing them with opportunities to learn and practice effective strategies that can be applied at home. All efforts to include families/guardians in the treatment process must be documented. For families unable to attend in person, telehealth video conferencing or telephone conferencing should be used to facilitate family therapy sessions.
11. Each youth will receive monthly psychiatric services either through the program's Medical Director or private practitioner if the youth is under the care of a private provider.
12. The program will conduct weekly all-staff case reviews to ensure everyone is informed about each youth's treatment goals and planned interventions to promote consistency and support progress.

13. The program should be well versed in multi-agency involvement and shall have internal operational guidelines and procedures documenting how staff will interact and collaborate with CAMHD Family Guidance Centers and key system partners (e.g., DOE, CWS, etc.).
14. The program will collaborate with the DOE Certified Education Specialists to ensure the course work aligns with the youth's educational level, goals, and plans, maximizing the likelihood that credits earned during treatment will be accepted by their home school.
15. The program will participate in regularly scheduled treatment team meetings, convened by the Family Guidance Center at least monthly, to discuss treatment progress.
16. The planned use of community resources may be appropriate for transitional age youth preparing to discharge from the program but requires careful assessment of the risks and benefits as well as discussion with the Family Guidance Center prior to implementation.
17. The program will continue to treat any youth that turns eighteen (18) while in treatment if they wish to continue services. However, the youth must exit the program before their nineteenth (19^{th}) birthday.
18. The program must have written policies and procedures for medication administration and provide training on various aspects, including storing, securing, labeling, administering, and disposing of medications; documenting medication administration and refusals; observing and reporting possible side effects; and managing youth-requested medication adjustments.
19. The program shall have clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate the methods of training and implementation of positive behavioral interventions.
20. The program must have established policies and procedures for effectively and efficiently managing crises with the direct assistance of senior clinical staff. These procedures should outline methods for managing emergency situations with a focus on de-escalation, clearly define processes for debriefing crises, and establish protocols for triaging youth in need of more intensive interventions. Requests for police or crisis line assistance should be limited to situations of imminent risk of harm to self or others, and only after consulting with the on-call QMHP (see General Performance Standards, N. Risk Management).
21. The program must complete a Summary Annual Evaluation when requested by the Family Guidance Center if the youth has been in the service for at least three (3) months (see Summary Annual Evaluation Performance Standard).
22. Up to three (3) consecutive bed hold days may be authorized per episode of care to reserve a bed for a youth absent from the program due to acute admission, detainment in the Detention Home, adjudicated to the Hawaii Youth Correctional Facility, or elopement. Youth discharged from the program for these reasons will be given priority and expedited readmission if requested within thirty (30) days of discharge (see General Performance Standards, Q1. Bed Holds).
23. Each youth in the program is permitted up to five (5) therapeutic passes per episode of care. These passes must be pre-approved, used for therapeutic purposes, and require the program to maintain contact with the youth and family/guardian during the pass, as well as conduct a debrief afterward (see General Performance Standards, Q2. Therapeutic Passes).
24. The program may request Therapeutic One-to-One Support to help stabilize a youth exhibiting increasingly challenging or unsafe behaviors (see Therapeutic One-to-One Support Performance Standard).
25. When clinically indicated and requested by the Family Guidance Center, the program will provide Transitional Support Services to facilitate a successful discharge from the program and engagement in the step-down service (see Transitional Support Service Performance Standard).

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must complete and submit to the Family Guidance Center an initial MHTP within ten (10) days of the youth's admission. Using information gathered from the referral, intake process, and assessment, the initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan).
   a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
   b. The transition/discharge component of the MHTP will document realistic discharge criteria aligned with the youth's treatment goals/objectives, projected timeframe, and anticipated aftercare supports (see General Performance Standards, D4b. Discharge Planning). Decisions about discharge must be based on the achievement of significant treatment goals/objectives, rather than the successful completion of all program levels/phases.
2. One (1) shift note must be completed per shift, per day documenting activity and behavioral observations. The overnight shift note serves as the billable daily residential encounter and must be completed for each youth certifying their presence in the facility when the day started at midnight (12AM).
3. Psychiatric service notes must be completed for any medication management activities provided by the program's Medical Director.
4. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual, family, and group therapy sessions. These notes should provide a description of the interventions implemented, the youth's response, interpretation of the effectiveness/impact on treatment goals/objectives, and routine evaluation of progress on goals addressing problematic sexual behaviors.
5. The program shall update the MHTP on a quarterly basis. MHTP updates should summarize gains/achievements from the previous three (3) months and the treatment goals/objectives adjusted to reflect the youth's changing condition.
6. A Discharge Summary progress note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

V. COMMUNITY-BASED RESIDENTIAL 2 - SEXUALLY REACTIVE YOUTH (CBR2 - SRY)

Definition	CBR2-SRY provides round-the-clock care, supervision, and evidence-based treatments and best practice interventions to address the behavioral, emotional, social, and environmental needs of male youth who have a history of challenges related to sexual offending, aggression or deviance (both adjudicated and non-adjudicated offenses), that prevent the youth from taking part in family and/or community life. The CBR2-SRY program is designed for youth who pose a moderate risk to the community and whose needs can best be met in a structured program of small group living that includes educational, recreational, and occupational services. The CBR2-SRY program will provide support and assistance to the youth and their family in service of the following overarching treatment goals: 1. Promote healthy sexual values and behaviors. 2. Reduce and control deviant sexual arousal patterns. 3. Develop victim empathy and appreciate feelings of others. 4. Accept responsibility and be accountable for sexually abusive or antisocial behavior. 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 re-offending. 8. Address other behavioral or emotional problems including trauma resulting from prior physical, sexual, and/or emotional abuse.
Service Components	1. Trauma-Informed Milieu supported by an evidence-based treatment model and youth-centered approach prioritizing the treatment goals specified above. 2. Orderly Schedule and Normalized Routine of well-supervised therapeutic activities designed to improve behavior and general functioning, support emotional regulation, and promote the development of appropriate daily and independent living skills. 3. Intensive Individual Therapy occurring at least two (2) times per week to address youth's specific emotional and behavioral treatment needs as indicated in the Clinical Management Plan. 4. Family Therapy occurring at least one (1) time per week to support successful return to the youth's home/community. In cases where there is no family/guardian to participate in family therapy, discussions with probation officer or care coordinator to support transitioning the youth to their home/community is acceptable. 5. Group Therapy occurring at least five (5) times per week. 6. Psychiatric Services to include a comprehensive medical evaluation at intake and ongoing medication management at least one (1) time a month. 7. Substance Abuse Counseling and education as indicated in the Clinical Management Plan. 8. On-site Educational Program with instruction delivered by certified education specialists (provided by the Department of Education) tailored to the youth's educational needs or aligned with the youth's IEP goals and objectives, if applicable. 9. Prosocial Interpersonal Activities that increase empowerment and self-determination such as nature-based recreation, creative arts, and vocational

	training opportunities. 10. Mental Health Treatment Plan (MHTP) developed with the youth and family/guardian. 11. Coordination with the Family Guidance Center, including participation in monthly Treatment Team Meetings to monitor progress and discuss treatment strategies, as well as other involved service providers as appropriate/necessary. 12. Planned Therapeutic Passes to allow youth and family members to practice skills in their natural environment, maintain family connections, and prepare for reunification. 13. Transitional Support Service when clinically indicated, to facilitate a successful transition from the residential treatment setting to the identified step-down setting. 14. Therapeutic One-to-One Support when clinically indicated, to help stabilize escalating or unsafe behaviors and increase the likelihood of maintaining services in the current treatment setting.
Admission Criteria	**All** the following are met: 1. The youth is male between the ages of twelve (12) and seventeen (17). 2. The youth has a severe emotional and/or behavioral disorder(s). 3. The youth has a history of sexual behavior problems and has engaged in sexually deviant or aggressive behaviors with or without adjudication. 4. The youth has been identified as requiring specialized treatment and poses a moderate risk to the community (based on targeted behavioral risk assessment). 5. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors. 6. An adequate trial of treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of treatment at a less restrictive level. 7. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting. 8. The youth's family/guardian agree to active involvement in treatment. 9. The youth agrees to active involvement in treatment.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the facility when the day begins. Clinical Lead may authorize up to thirty-one (31) units per month for up to three (3) months.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize up to thirty-one (31) units per month for up to three (3) additional months.
Paid Holds	Therapeutic Pass – Clinical Lead may authorize up to five (5) units per episode of care, not to exceed three (3) units at one time. Bed Hold – Clinical Lead may authorize up to three (3) units per episode of care.

Overlapping Services	Youth may not receive a CAMHD-funded home-based service concurrent with CBR2 services *except* for the thirty (30) day period leading up to transition from the CBR2-SRY program to the identified step-down setting. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	The average length of CBR2-SRY treatment ranges between twelve (12) to fourteen (14) months. When the youth's length of stay will exceed twelve (12) months, continued reauthorization must be preceded by a clinical review documented in a Case Review with **all** of the following conditions determined to be true: 1. The youth is actively engaged in treatment and continues to meet admission criteria. 2. Progress in relation to specific treatment targets is evident and can be described in objective terms, but goals of treatment have not yet been achieved. 3. There is reasonable expectation that the youth will continue to make progress/improve or there is reasonable evidence that the youth's condition will worsen if services are discontinued. 4. The treatment goals, objectives, and discharge plan have been reviewed and updated/adjusted to reflect the youth's changing condition. 5. There is documented evidence of active family/guardian involvement in treatment (at least weekly) or documented efforts/attempts to involve them (unless contraindicated). 6. There is documented evidence of active coordination with the Family Guidance Center and other involved service providers (as applicable) or, if coordination is not successful, the reason(s) are documented.
Discharge Criteria	Discharges are to be conducted in a thoughtful, planned manner through co-management and regular communication among the provider, Family Guidance Center, family/guardian, and other treatment team members. Discharges that are not conducted in accordance with a previously agreed upon plan devised by the team will be considered ejections. The youth is no longer in need of or eligible for CBR2-SRY when **any one (1)** of the following is true: 1. The goals of treatment have been substantially met. 2. Targeted symptoms/behaviors have abated in severity and can be adequately managed in a less restrictive setting. 3. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent. 4. The youth (or family/guardian) is not participating in treatment or following program rules and regulations. The non-participation is of such a degree that treatment is rendered ineffective and efforts to address non-participation issues have proven unsuccessful. 5. The youth has made little-to-no progress toward treatment goals for a three (3) month period, appropriate modifications have been implemented without significant improvement, and there is no reasonable expectation that the youth will improve in this level of care nor is there evidence that the youth's condition will worsen if services are discontinued. 6. The youth exhibits new symptoms and/or maladaptive behaviors that cannot

	be safely and/or effectively addressed in this treatment setting. 7. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	CBR2-SRY is not considered medically necessary and <u>will not be authorized under any of the following circumstances:</u> 1. The youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the family/guardian and not related to the mental health care and treatment of the youth. 3. Use of the service (or continued stay) is solely for the convenience of another child-serving agency.
Clinical Exclusions	1. The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior. 2. The youth's clinical issues interfere with the safe provision of services in this treatment setting.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Program staff must include:
   a. Clinical Program Director – QMPH (full time staff)
      The Clinical Program Director is responsible for the treatment program and those in its care, ensuring staff are adequately trained and the services delivered are safe, ethical, grounded in evidence/empirically supported and culturally appropriate. The Clinical Program Director must be knowledgeable of evidenced-based treatment for sexualized behavior.
   b. Medical Director – Licensed psychiatrist or psychiatric nurse practitioner (staff or consultant)
      The Medical Director is responsible for comprehensively assessing each youth's medical condition, managing their medication on a regular basis, and providing ongoing consultation to staff regarding medication, diagnoses, and other clinical matters.
   c. Therapist(s) – QMPH or MHP (full time staff)
      The Therapist is responsible for providing individualized therapy, including development of the MHTP based on assessment of the youth's needs. The Therapist must have at least three (3) years of direct experience working with sexually reactive youth.
   d. Program Nurse – Licensed registered nurse (full time staff)
      The Program Nurse is responsible for establishing operations for administering and monitoring medications, tracking and coordinating medical needs, and training staff on medication protocols and proper procedures.
   e. Residential Specialists – Paraprofessionals Level 1 and 2 (full time and part time staff)
   f. Certified Substance Abuse Counselor (staff or contracted consultant)
      The CSAC is responsible for developing and integrating substance abuse education into the treatment program and providing individualized substance abuse counseling based on assessment of the youth's needs.
   g. Certified Education Specialists (provided by the Department of Education)
2. The program must have the means to secure services from qualified professionals and specialists (e.g., medical, psychology, behavioral analysis, occupational/physical therapy, dietetics, recreation,

etc.) to meet the unique needs of each youth, either through cooperative arrangements or by utilizing the organization's own personnel.
3. All staff must be CAMHD credentialed prior to working directly with any CAMHD youth (see General Performance Standards, I. Credentialing).
4. An on-call QMHP must be available at all times to provide clinical support to staff, with the ability to arrive on-site within one (1) hour for events that merit an in-person response. The Medical Director must be available for consultation in the event of psychiatric emergencies.
5. A staff-to-youth ratio of one-to-four (1:4) must be maintained at all times with a minimum of two (2) staff on duty per shift per living unit. Staff shall always be in attendance whenever youth are present. Youth that are ill or otherwise unable to participate in the program schedule/routine must be directly supervised by a staff member.
6. The overnight shift must maintain a staff-to-youth ratio of one-to-six (1:6). Two (2) staff must be on duty per living unit with at least one (1) staff awake throughout the shift.
7. At least one (1) residential specialist will be present in the classroom to assist the DOE Certified Education Specialists with behavior management and provide necessary therapeutic redirection and interventions.
8. The program must have the capacity to adjust staffing when necessary to ensure additional staff are available during busy or stressful periods such as for one-to-one (1:1) assignments, new admissions, medical appointments, etc.
9. The program staffing schedule shall reflect an overlap in shift hours, an adequate number of on-duty and backup staff based on the needs of the milieu, an appropriate staff gender mix, and identify the shift leader.
10. The program shall have a protocol in place to ensure appropriate and qualified coverage for the Clinical Program Director and Medical Director during absences due to illness or vacation.
11. All staff must be knowledgeable about the treatment of sexually reactive youth. Beyond the core training expectations specified in the General Performance Standards (see G. Training), staff shall receive specialized training covering offender characteristics, offense cycle, normal and deviant sexual development, major components of the treatment program, the role of families in treatment, staff issues such as personal reactions and beliefs, dealing with manipulation, and stress and burnout prevention.
12. The program must facilitate ongoing training sessions to enhance staff knowledge and skills related to treatment protocols for youth in residential settings. Training topics should be guided by the agency's curriculum as well as the current needs/challenges of the milieu.
13. All program staff shall receive and participate in clinical supervision as described in the General Performance Standards (see H. Supervision).

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must be operational twenty-four (24) hours a day, seven (7) days a week.
2. The program shall always be staff-secure, with round-the-clock supervision of all youth physically present, in alignment with the minimum staff-to-youth ratios.
3. The program must adhere to all applicable facility licensing requirements/regulations.
4. The program and its staff must follow all applicable professional practice standards and ethical guidelines.
5. The number of CAMHD youth present in the program at any given time shall not exceed the contracted number of beds without prior written approval from the CAMHD Utilization Management Section (CBR Bed Expansion Request).

6. The living environment should be home-like with comfortable, age-appropriate furnishings, and the youth encouraged to decorate and maintain their personal spaces.
7. The program shall maintain awareness of community safety issues and have policies, procedures, and mechanisms in place to continuously assess and effectively manage these risks.
8. The program shall have an intake process that includes orienting the youth and family/guardian to the facility, reviewing program rules/guidelines, explaining treatment expectations, and completing the admission summary. Input from the youth, family/guardian, and CC will be obtained to establish treatment goals for the MHTP and formulate an initial discharge plan with concrete, realistic, measurable discharge criteria and a projected discharge timeframe.
9. The program will have a predictable and orderly daily routine with structured, therapeutically meaningful activities scheduled throughout the day, seven (7) days a week. The activities should provide safe opportunities for the youth to develop and enhance intrapersonal intelligence, social competence, and independent living skills.
10. The program will engage each youth in therapy sessions tailored to their unique therapeutic needs, focused on addressing problematic sexual behaviors as well as associated factors (e.g., dysfunction within the social ecosystem, involvement with the juvenile justice or child welfare systems, substance use, aggressive and/or avoidant behaviors, etc.).
11. The program will actively involve the youth's family/guardian in team meetings, therapy sessions, and other activities, providing them with opportunities to learn and practice effective strategies that can be applied at home. All efforts to include families/guardians in the treatment process must be documented. For families unable to attend in person, telehealth video conferencing or telephone conferencing should be used to facilitate family therapy sessions.
12. Each youth will receive monthly psychiatric services either through the program's Medical Director or private practitioner if the youth is under the care of a private provider.
13. The program will utilize standardized, evidence-based risk assessment tools to routinely evaluate offending behavior and use assessment results to inform significant treatment decisions.
14. The program will conduct weekly all-staff case reviews to ensure everyone is informed about each youth's treatment goals and planned interventions to promote consistency and support progress.
15. The program should be well versed in multi-agency involvement and shall have internal operational guidelines and procedures documenting how staff will interact and collaborate with CAMHD Family Guidance Centers and key system partners (e.g., DOE, CWS, etc.).
16. The program will collaborate with the DOE Certified Education Specialists to ensure the course work aligns with the youth's educational level, goals, and plans, maximizing the likelihood that credits earned during treatment will be accepted by their home school.
17. The program will participate in regularly scheduled treatment team meetings, convened by the Family Guidance Center at least monthly, to discuss treatment progress.
18. The planned use of community resources may be appropriate for transitional age youth preparing to discharge from the program but requires careful assessment of the risks and benefits as well as discussion with the Family Guidance Center prior to implementation.
19. The program will continue to treat any youth that turns eighteen (18) while in treatment if they wish to continue services. However, the youth must exit the program before their nineteenth (19^{th}) birthday.
20. The program must have written policies and procedures for medication administration and provide training on various aspects, including storing, securing, labeling, administering, and disposing of medications; documenting medication administration and refusals; observing and reporting possible side effects; and managing youth-requested medication adjustments.
21. The program shall have clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate the methods of training and implementation of positive behavioral interventions.
22. The program must have established policies and procedures for effectively and efficiently managing crises with the direct assistance of senior clinical staff. These procedures should outline methods

for managing emergency situations with a focus on de-escalation, clearly define processes for debriefing crises, and establish protocols for triaging youth in need of more intensive interventions. Requests for police or crisis line assistance should be limited to situations of imminent risk of harm to self or others, and only after consulting with the on-call QMHP (see General Performance Standards, N. Risk Management).

23. The program must complete a Summary Annual Evaluation when requested by the Family Guidance Center if the youth has been in the service for at least three (3) months (see Summary Annual Evaluation Performance Standard).
24. Up to three (3) consecutive bed hold days may be authorized per episode of care to reserve a bed for a youth absent from the program due to acute admission, detainment in the Detention Home, adjudicated to the Hawaii Youth Correctional Facility, or elopement. Youth discharged from the program for these reasons will be given priority and expedited readmission if requested within thirty (30) days of discharge (see General Performance Standards, Q1. Bed Holds).
25. Each youth in the program is permitted up to five (5) therapeutic passes per episode of care. These passes must be pre-approved, used for therapeutic purposes, and require the program to maintain contact with the youth and family/guardian during the pass, as well as conduct a debrief afterward (see General Performance Standards, Q2. Therapeutic Passes).
26. The program may request Therapeutic One-to-One Support to help stabilize a youth exhibiting increasingly challenging or unsafe behaviors (see Therapeutic One-to-One Support Performance Standard).
27. When clinically indicated and requested by the Family Guidance Center, the program will provide Transitional Support Services to facilitate a successful discharge from the program and engagement in the step-down service (see Transitional Support Service Performance Standard).

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must complete and submit to the Family Guidance Center an initial MHTP within ten (10) days of the youth's admission. Using information gathered from the referral, intake process, and assessment, the initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan).
   a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
   b. The transition/discharge component of the MHTP will document realistic discharge criteria aligned with the youth's treatment goals/objectives, projected timeframe, and anticipated aftercare supports (see General Performance Standards, D4b. Discharge Planning). Decisions about discharge must be based on the achievement of significant treatment goals/objectives, rather than the successful completion of all program levels/phases.
2. One (1) shift note must be completed per shift, per day documenting activity and behavioral observations. The overnight shift note serves as the billable daily residential encounter and must be completed for each youth certifying their presence in the facility when the day started at midnight (12AM).
3. Psychiatric service notes must be completed for any medication management activities provided by the program's Medical Director.
4. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual, family, and group therapy sessions. These notes should provide a description of the

interventions implemented, the youth's response, interpretation of the effectiveness/impact on treatment goals/objectives, and routine evaluation of progress on goals addressing problematic sexual behaviors.

5. The program shall update the MHTP on a quarterly basis. MHTP updates should summarize gains/achievements from the previous three (3) months and the treatment goals/objectives adjusted to reflect the youth's changing condition.
6. A Discharge Summary progress note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

W. COMMUNITY-BASED RESIDENTIAL 2 - COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CBR2-CSEC)

Definition	CBR2-CSEC provides round-the-clock care, supervision, and evidence-based treatments and best practice interventions to address the behavioral, emotional, social, and environmental needs of female identifying and non-binary youth who have a history of sexual exploitation, and/or trauma related to sexual abuse, and/or are considered at significant risk for sexual exploitation.
Service Components	1. Trauma-Informed Milieu supported by an evidence-based treatment model and youth-centered approach, meaning the sense of safety and self-identified needs of the youth are prioritized. 2. Orderly Schedule and Normalized Routine of well-supervised therapeutic activities designed to improve behavior and general functioning, support emotional regulation, and promote the development of appropriate daily and independent living skills. 3. Intensive Individual Therapy occurring at least two (2) times per week to address youth's specific emotional and behavioral treatment needs as indicated in the Clinical Management Plan. 4. Family Therapy occurring at least one (1) time per week to support successful return to the youth's home/community. In cases where there is no family/guardian to participate in family therapy, discussions with probation officer or care coordinator to support transitioning the youth to their home/community is acceptable. 5. Group Therapy occurring at least five (5) times per week. 6. Psychiatric Services to include a comprehensive medical evaluation at intake and ongoing medication management at least one (1) time a month. 7. Substance Abuse Counseling and education as indicated in the Clinical Management Plan. 8. On-site Educational Program with instruction delivered by certified education specialists (provided by the Department of Education) tailored to the youth's educational needs or aligned with the youth's IEP goals and objectives, if applicable. 9. Prosocial Interpersonal Activities that increase empowerment and self-determination such as nature-based recreation, creative arts, and vocational training opportunities. 10. Mental Health Treatment Plan (MHTP) developed with the youth and family/guardian. 11. Coordination with the Family Guidance Center, including participation in monthly Treatment Team Meetings to monitor progress and discuss treatment strategies, as well as other involved service providers as appropriate/necessary. 12. Planned Therapeutic Passes to allow youth and family members to practice skills in their natural environment, maintain family connections, and prepare for reunification. 13. Transitional Support Service when clinically indicated, to facilitate a successful transition from the residential treatment setting to the identified step-down setting. 14. Therapeutic One-to-One Support when clinically indicated, to help stabilize escalating or unsafe behaviors and increase the likelihood of maintaining services in the current treatment setting.

Admission Criteria	**All** the following are met: 1. The youth is female identifying (or non-binary) between the ages of twelve (12) and seventeen (17). 2. The youth has a severe emotional and/or behavioral disorder(s). 3. The youth has a history of sexual exploitation, and/or trauma related to sexual abuse, and/or is considered at significant risk for sexual exploitation. 4. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors. 5. An adequate trial of treatment at a less restrictive level has been unsuccessful or there is clear and compelling documented clinical evidence that the youth is inappropriate for a trial of treatment at a less restrictive level. 6. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting. 7. The youth's family/guardian agree to active involvement in treatment. 8. The youth agrees to active involvement in treatment.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the facility when the day begins. Clinical Lead may authorize up to thirty-one (31) units per month for up to three (3) months.
Reauthorization	With evidence of continued medical necessity documented in the Case Review, Clinical Lead may reauthorize up to thirty-one (31) units per month for up to three (3) additional months.
Paid Holds	Therapeutic Pass – Clinical Lead may authorize up to five (5) units per episode of care, not to exceed three (3) units at one time. Bed Hold – Clinical Lead may authorize up to three (3) units per episode of care.
Overlapping Services	Youth may not receive a CAMHD-funded home-based service concurrent with CBR2 services *except* for the thirty (30) day period leading up to transition from the CBR2-CSEC program to the identified step-down setting. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	The average length of CBR2-CSEC treatment is six (6) months. When the youth's length of stay will exceed six (6) months, continued reauthorization must be preceded by a clinical review documented in a Case Review with **all** of the following conditions determined to be true: 1. The youth is actively engaged in treatment and continues to meet admission criteria. 2. Progress in relation to specific treatment targets is evident and can be described in objective terms, but goals of treatment have not yet been achieved. 3. There is reasonable expectation that the youth will continue to make progress/improve or there is reasonable evidence that the youth's condition will worsen if services are discontinued. 4. The treatment goals, objectives, and discharge plan have been reviewed and updated/adjusted to reflect the youth's changing condition. 5. There is documented evidence of active family/guardian involvement in

	treatment (at least weekly) or documented efforts/attempts to involve them (unless contraindicated). 6. There is documented evidence of active coordination with the Family Guidance Center and other involved service providers (as applicable) or, if coordination is not successful, the reason(s) are documented.
Discharge Criteria	Discharges are to be conducted in a thoughtful, planned manner through co-management and regular communication among the provider, Family Guidance Center, family/guardian, and other treatment team members. Discharges that are not conducted in accordance with a previously agreed upon plan devised by the team will be considered ejections. The youth is no longer in need of or eligible for CBR2-CSEC when **any one (1)** of the following is true: 1. The goals of treatment have been substantially met. 2. Targeted symptoms/behaviors have abated in severity and can be adequately managed in a less restrictive setting. 3. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent. 4. The youth (or family/guardian) is not participating in treatment or following program rules and regulations. The non-participation is of such a degree that treatment is rendered ineffective and efforts to address non-participation issues have proven unsuccessful. 5. The youth has made little-to-no progress toward treatment goals for a three (3) month period, appropriate modifications have been implemented without significant improvement, and there is no reasonable expectation that the youth will improve in this level of care nor is there evidence that the youth's condition will worsen if services are discontinued. 6. The youth exhibits new symptoms and/or maladaptive behaviors that cannot be safely and/or effectively addressed in this treatment setting. 7. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will coordinate transfer to appropriate treatment services in the least disruptive manner possible.
Service Exclusions	CBR2-CSEC is not considered medically necessary and will not be authorized under any of the following circumstances: 1. The youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the family/guardian and not related to the mental health care and treatment of the youth. 3. Use of the service (or continued stay) is solely for the convenience of another child-serving agency.
Clinical Exclusions	1. The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior. 2. The youth's clinical issues interfere with the safe provision of services in this treatment setting.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Program staff must include:
   a. Clinical Program Director – QMPH (full time staff)
      The Clinical Program Director is responsible for the treatment program and those in its care, ensuring staff are adequately trained and the services delivered are safe, ethical, grounded in evidence/empirically supported and culturally appropriate. The Clinical Program Director must be knowledgeable of evidenced-based treatment for youth who have been sexually exploited.
   b. Medical Director – Licensed psychiatrist or psychiatric nurse practitioner (staff or consultant)
      The Medical Director is responsible for comprehensively assessing each youth's medical condition, managing their medication on a regular basis, and providing ongoing consultation to staff regarding medication, diagnoses, and other clinical matters.
   c. Therapist(s) – QMPH or MHP (full time staff)
      The Therapist is responsible for providing individualized therapy, including development of the MHTP based on assessment of the youth's needs. The Therapist must have at least three (3) years of direct experience working with individuals who have been sexually exploited.
   d. Program Nurse – Licensed registered nurse (full time staff)
      The Program Nurse is responsible for establishing operations for administering and monitoring medications, tracking and coordinating medical needs, and training staff on medication protocols and proper procedures.
   e. Residential Specialists – Paraprofessionals Level 1 and 2 (full time and part time staff)
   f. Certified Substance Abuse Counselor (staff or contracted consultant)
      The CSAC is responsible for developing and integrating substance abuse education into the treatment program and providing individualized substance abuse counseling based on assessment of the youth's needs.
   g. Certified Education Specialists (provided by the Department of Education)
2. The program must have the means to secure services from qualified professionals and specialists (e.g., medical, psychology, behavioral analysis, occupational/physical therapy, dietetics, recreation, etc.) to meet the unique needs of each youth, either through cooperative arrangements or by utilizing the organization's own personnel.
3. All staff must be CAMHD credentialed prior to working directly with any CAMHD youth (see General Performance Standards, I. Credentialing).
4. An on-call QMHP must be always available to provide clinical support to staff, with the ability to arrive on-site within one (1) hour for events that merit an in-person response. The Medical Director must be available for consultation in the event of psychiatric emergencies.
5. A staff-to-youth ratio of one-to-four (1:4) must be maintained at all times with a minimum of two (2) staff on duty per shift per living unit. Staff shall always be in attendance whenever youth are present. Youth that are ill or otherwise unable to participate in the program schedule/routine must be directly supervised by a staff member.
6. The overnight shift must maintain a staff-to-youth ratio of one-to-six (1:6). Two (2) staff must be on duty per living unit with at least one (1) staff awake throughout the shift.
7. At least one (1) Residential Specialist will be present in the classroom to assist the DOE Certified Education Specialists with behavior management and provide necessary therapeutic redirection and interventions.
8. The program must have the capacity to adjust staffing when necessary to ensure additional staff are available during busy or stressful periods such as for one-to-one (1:1) assignments, new admissions, medical appointments, etc.

9. The program staffing schedule shall reflect an overlap in shift hours, an adequate number of on-duty and backup staff based on the needs of the milieu, an appropriate staff gender mix, and identify the shift leader.
10. The program shall have a protocol in place to ensure appropriate and qualified coverage for the Clinical Program Director and Medical Director during their absences due to illness or vacation.
11. All staff must be knowledgeable about the treatment of sexually exploited youth and understand the impact of trauma in their lives. Beyond the core training expectations specified in the General Performance Standards (see G. Training), staff shall receive specialized training covering trauma and its effects, lack of trust, personal safety, substance use, staff issues such as personal reactions and beliefs, dealing with manipulation, and stress and burnout prevention.
12. The program must facilitate ongoing training sessions to enhance staff knowledge and skills related to treatment protocols for youth in residential settings. Training topics should be guided by the agency's curriculum as well as the current needs/challenges of the milieu.
13. All program staff shall receive and participate in clinical supervision as described in the General Performance Standards (see H. Supervision).

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must be operational twenty-four (24) hours a day, seven (7) days a week.
2. The program shall always be staff-secure, with round-the-clock supervision of all youth physically present, in alignment with the minimum staff-to-youth ratios.
3. The program must adhere to all applicable facility licensing requirements/regulations.
4. The program and its staff must follow all applicable professional practice standards and ethical guidelines.
5. The number of CAMHD youth present in the program at any given time shall not exceed the contracted number of beds without prior written approval from the CAMHD Utilization Management Section (CBR Bed Expansion Request).
6. The living environment should be home-like with comfortable, age-appropriate furnishings, and the youth encouraged to decorate and maintain their personal spaces.
7. The program shall maintain awareness of community safety issues and have policies, procedures, and mechanisms in place to continuously assess and effectively manage these risks.
8. The program shall have an intake process that includes orienting the youth and family/guardian to the facility, reviewing program rules/guidelines, explaining treatment expectations, and completing the admission summary. Input from the youth, family/guardian, and CC will be obtained to establish treatment goals for the MHTP and formulate an initial discharge plan with concrete, realistic, measurable discharge criteria and a projected discharge timeframe.
9. The program will have a predictable and orderly daily routine with structured, therapeutically meaningful activities scheduled throughout the day, seven (7) days a week. The activities should provide safe opportunities for the youth to develop and enhance intrapersonal intelligence, social competence, and independent living skills.
10. The program will engage each youth in therapy sessions tailored to their unique therapeutic needs, focused on addressing trauma related to sexual exploitation/abuse as well as associated environmental factors (e.g., dysfunction within the social ecosystem, involvement with the juvenile justice or child welfare systems, substance use, aggressive and/or avoidant behaviors, etc.).
11. The program will actively involve the youth's family/guardian in team meetings, therapy sessions, and other activities, providing them with opportunities to learn and practice effective strategies that can be applied at home. All efforts to include families/guardians in the treatment process must be

documented. For families unable to attend in person, telehealth video conferencing or telephone conferencing should be used to facilitate family therapy sessions.

12. Each youth will receive monthly psychiatric services either through the program's Medical Director or private practitioner if the youth is under the care of a private provider.
13. The program will conduct weekly all-staff case reviews to ensure everyone is informed about each youth's treatment goals and planned interventions to promote consistency and support progress.
14. The program should be well versed in multi-agency involvement and shall have internal operational guidelines and procedures documenting how staff will interact and collaborate with CAMHD Family Guidance Centers and key system partners (e.g., DOE, CWS, etc.).
15. The program will collaborate with the DOE Certified Education Specialists to ensure the course work aligns with the youth's educational level, goals, and plans, maximizing the likelihood that credits earned during treatment will be accepted by their home school.
16. The program will participate in regularly scheduled treatment team meetings, convened by the Family Guidance Center at least monthly, to discuss treatment progress.
17. The planned use of community resources may be appropriate for transitional age youth preparing to discharge from the program but requires careful assessment of the risks and benefits as well as discussion with the Family Guidance Center prior to implementation.
18. The program will continue to treat any youth that turns eighteen (18) while in treatment if they wish to continue services. However, the youth must exit the program before their nineteenth (19^{th}) birthday.
19. The program must have written policies and procedures for medication administration and provide training on various aspects, including storing, securing, labeling, administering, and disposing of medications; documenting medication administration and refusals; observing and reporting possible side effects; and managing youth-requested medication adjustments.
20. The program shall have clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate the methods of training and implementation of positive behavioral interventions.
21. The program must have established policies and procedures for effectively and efficiently managing crises with the direct assistance of senior clinical staff. These procedures should outline methods for managing emergency situations with a focus on de-escalation, clearly define processes for debriefing crises, and establish protocols for triaging youth in need of more intensive interventions. Requests for police or crisis line assistance should be limited to situations of imminent risk of harm to self or others, and only after consulting with the on-call QMHP (see General Performance Standards, N. Risk Management).
22. The program must complete a Summary Annual Evaluation when requested by the Family Guidance Center if the youth has been in the service for at least three (3) months (see Summary Annual Evaluation Performance Standard).
23. Up to three (3) consecutive bed hold days may be authorized per episode of care to reserve a bed for a youth absent from the program due to acute admission, detainment in the Detention Home, adjudicated to the Hawaii Youth Correctional Facility, or elopement. Youth discharged from the program for these reasons will be given priority and expedited readmission if requested within thirty (30) days of discharge (see General Performance Standards, Q1. Bed Holds).
24. Each youth in the program is permitted up to five (5) therapeutic passes per episode of care. These passes must be pre-approved, used for therapeutic purposes, and require the program to maintain contact with the youth and family/guardian during the pass, as well as conduct a debrief afterward (see General Performance Standards, Q2. Therapeutic Passes).
25. The program may request Therapeutic One-to-One Support to help stabilize a youth exhibiting increasingly challenging or unsafe behaviors (see Therapeutic One-to-One Support Performance Standard).

26. When clinically indicated and requested by the Family Guidance Center, the program will provide Transitional Support Services to facilitate a successful discharge from the program and engagement in the step-down service (see Transitional Support Service Performance Standard).

Documentation
In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must complete and submit to the Family Guidance Center an initial MHTP within ten (10) days of the youth's admission. Using information gathered from the referral, intake process, and assessment, the initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan).
   a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
   b. The transition/discharge component of the MHTP will document realistic discharge criteria aligned with the youth's treatment goals/objectives, projected timeframe, and anticipated aftercare supports (see General Performance Standards, D4b. Discharge Planning). Decisions about discharge must be based on the achievement of significant treatment goals/objectives, rather than the successful completion of all program levels/phases.
2. One (1) shift note must be completed per shift, per day documenting activity and behavioral observations. The overnight shift note serves as the billable daily residential encounter and must be completed for each youth certifying their presence in the facility when the day started at midnight (12AM).
3. Psychiatric service notes must be completed for any medication management activities provided by the program's Medical Director.
4. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual, family, and group therapy sessions. These notes should provide a description of the interventions implemented, the youth's response, interpretation of the effectiveness/impact on treatment goals/objectives, and routine evaluation of progress on goals addressing problematic sexual behaviors.
5. The program shall update the MHTP on a quarterly basis. MHTP updates should summarize gains/achievements from the previous three (3) months and the treatment goals/objectives adjusted to reflect the youth's changing condition.
6. A Discharge Summary progress note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

X. RESIDENTIAL STABILIZATION PROGRAM (RSP)

Definition	RSP provides round-the-clock care in a structured, therapeutic residential setting for youth experiencing disruption in their primary living arrangement due to a recent emotional or behavioral crisis and residual behavior challenges that exceed the family's capacity to manage. The program is expected to deliver short-term, intensive case management focused on arranging post-discharge services to expedite transition to a longer-term living environment, as well as therapeutic interventions, recreational activities, brief educational support, and access to medication management
Service Components	1. Trauma-Informed Milieu supported by a non-coercive, evidence-based behavior management model. 2. Orderly Schedule and Normalized Routine of well-supervised therapeutic activities designed to improve behavior and general functioning. 3. Intensive Case Management and service coordination to facilitate collaboration with all agencies involved in the youth's care and ensure proactive discharge and treatment planning. 4. Safety and Crisis Planning to identify effective interventions for addressing the disruptive behaviors leading to admission. 5. Individual, Family, and Group Therapy as needed to address youth's specific emotional and behavioral treatment needs as indicated by referral and assessment. 6. Psychiatric Services including evaluation at admission to assess and coordinate medical and medication needs as necessary. 7. Substance Abuse Counseling and education as indicated by assessment and plan. 8. Educational Support from staff to help the youth complete assignments provided by the home school. 9. Mental Health Treatment Plan (MHTP) developed with the youth and family/guardian. 10. Transitional Support Service when clinically indicated, to facilitate a successful transition from the residential treatment setting to the identified step-down setting. 11. Therapeutic One-to-One Support when clinically indicated, to help stabilize escalating or unsafe behaviors and increase the likelihood of maintaining services in the current treatment setting.
Admission Criteria	**All** the following are met: 1. The youth is between the ages of six (6) and seventeen (17). 2. The youth's intellectual functioning is above the moderately impaired range (i.e., IQ above 70). 3. The youth has recently experienced an emotional or behavioral crisis but does not meet criteria for acute psychiatric hospitalization. 4. The youth is experiencing one (1) of the following placement disruptions: a. The youth cannot remain in the home due to behavior challenges exceeding the family's capacity to manage, and/or significant conflict with other family members. b. The youth has been placed in State custody due to abuse or neglect, and CWS is unable to secure placement in a shelter or resource home due to concerns about managing behavior challenges. c. The youth has completed treatment in a psychiatric program and is

	awaiting a planned step-down placement but cannot return home due to behavior challenges beyond the family's capacity to manage. 5. The youth's family/guardian agree to admission.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the facility when the day begins. Clinical Lead may authorize up to thirty (30) units.
Paid Holds	Therapeutic Pass – Not permitted. Bed Hold – Clinical Lead may authorize up to three (3) units per episode of care.
Overlapping Services	Youth may receive a CAMHD-funded home-based service concurrent with RSP services to maintain continuity of an active service (i.e., in place prior to admission) or in preparation for discharge from RSP. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	When the youth's length of stay will exceed thirty (30) days, reauthorization requires the review and approval of the of the RSP Advisory Board, including representatives from CAMHD, CWS, and OYS. Evidence of continued necessity must be documented in a Case Review with **all** of the following conditions determined to be true: 1. The youth's multi-agency team is actively working on developing discharge placement options, including at least weekly team meetings. 2. The youth continues to need supervision by staff skilled at behavior management but does not meet criteria for acute psychiatric hospitalization. 3. The youth and family/guardian are willing to continue with the service.
Discharge Criteria	Discharges are to be conducted in a thoughtful, planned manner through co-management and regular communication among the provider, Family Guidance Center, family/guardian, and other treatment team members. Discharges that are not conducted in accordance with a previously agreed upon plan devised by the team will be considered ejections. The youth is no longer in need of or eligible for RSP when **any one (1)** of the following is true: 1. The reason for referral/admission has been resolved or sufficiently addressed. 2. An appropriate placement and/or treatment service has been arranged and the youth can safely transition to another setting. 3. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent. 4. The youth's difficulties have intensified suggesting imminent risk of harm to self or others and the need for acute psychiatric hospitalization. 5. The youth elopes and does not return within three (3) days.
Service Exclusions	RSP is not considered medically necessary and will not be authorized under any of the following circumstances: 1. The youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the family/guardian and not related to the mental health care and treatment of the

	youth. 3. There are no identified mental health needs, and the service is being used solely for the convenience of another child-serving agency or to provide housing.
Clinical Exclusions	The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior.

Staffing Requirements
In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Program staff must include:
   a. Clinical Program Director – QMPH (full time staff)
      The Clinical Program Director is responsible for the treatment program and those in its care, ensuring staff are adequately trained and the services delivered are safe, ethical, grounded in evidence/empirically supported and culturally appropriate. The Clinical Program Director must be knowledgeable of evidenced-based treatments for youth with complex emotional and behavioral needs.
   b. Medical Director – Licensed psychiatrist or psychiatric nurse practitioner (staff or consultant)
      The Medical Director is responsible for assessing and ordering all medical and medication needs as necessary, and providing ongoing consultation to staff regarding medication, diagnoses, and other clinical matters.
   c. Therapist(s) – QMPH or MHP (full time staff)
      The Therapist is responsible for providing individualized therapy, including development of the MHTP based on assessment of the youth's needs. The Therapist must have experience providing focused, high-intensity therapy to families.
   d. Program Nurse – Licensed registered nurse (staff or contracted consultant)
      The Program Nurse is responsible for establishing operations for administering and monitoring medications, tracking and coordinating medical needs, and training staff on medication protocols and proper procedures.
   e. Residential Specialists – Paraprofessionals Level 1 and 2 (full time and part time staff)
   f. Case Manager (full time staff)
      The Case Manager is responsible for coordination of team meetings with various child-serving agencies and for working with youths' home schools to obtain school assignments.
   g. Certified Substance Abuse Counselor (staff or contracted consultant)
      The CSAC is responsible for developing and integrating substance abuse education into the treatment program and providing individualized substance abuse counseling based on assessment of the youth's needs.
2. All staff must be CAMHD credentialed prior to working directly with any CAMHD youth (see General Performance Standards, I. Credentialing).
3. An on-call QMHP must be available at all times to provide clinical support to staff, with the ability to arrive on-site within one (1) hour for events that merit an in-person response. The Medical Director must be available for consultation in the event of psychiatric emergencies.
4. A staff-to-youth ratio of one-to-four (1:4) must be maintained during day and evening shifts with a minimum of two (2) staff on duty at all times. Staff shall always be in attendance whenever youth are present. Youth that are ill or otherwise unable to participate in the program schedule/routine must be directly supervised by a staff member.
5. The overnight shift must maintain a staff-to-youth ratio of one-to-six (1:6). Two (2) staff must be on duty with at least one (1) staff awake throughout the shift.

6. The program must have the capacity to adjust staffing when necessary to ensure additional staff are available during busy or stressful periods such as for one-to-one (1:1) assignments, new admissions, medical appointments, etc.
7. The program staffing schedule shall reflect an overlap in shift hours, an adequate number of on-duty and backup staff based on the needs of the milieu, an appropriate staff gender mix, and identify the shift leader.
8. The program shall have a protocol in place to ensure appropriate and qualified coverage for the Clinical Program Director and Medical Director during absences due to illness or vacation.
9. The program must facilitate ongoing training sessions to enhance staff knowledge and skills related to treatment protocols for youth in residential settings, informed by the needs of the milieu. Training topics shall include but not be limited to the core expectations specified in the General Performance Standards (see G. Training).
10. All program staff shall receive and participate in clinical supervision as described in the General Performance Standards (see H. Supervision).

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must be operational twenty-four (24) hours a day, seven (7) days a week.
2. The program shall always be staff-secure, with round-the-clock supervision of all youth physically present, in alignment with the minimum staff-to-youth ratios.
3. The program must adhere to all applicable facility licensing requirements/regulations.
4. The program and its staff must follow all applicable professional practice standards and ethical guidelines.
5. The living environment should be home-like with comfortable, age-appropriate furnishings, and the youth encouraged to decorate and maintain their personal spaces.
6. The number of CAMHD youth present in the program at any given time shall not exceed the contracted number of beds without prior written approval from the CAMHD Utilization Management Section (CBR Bed Expansion Request).
7. The Clinical Program Director shall establish an RSP Advisory Board comprising representatives from the partnering funding agencies (i.e., CAMHD, CWS, and OYS), and convene regular meetings to assist the program with patient flow decisions.
8. The program will have a process for receiving referrals from other child-serving agencies, facilitating admissions of eligible youth, and notifying CAMHD of any youth admitted through external sources. A Clinical Services Office representative will provide authorizations for youth not actively enrolled in CAMHD services.
9. The program shall have an intake process that includes orienting the youth and family/guardian to the facility, reviewing program rules/guidelines, explaining treatment expectations, and completing a brief psychosocial assessment to guide development of the MHTP.
10. The program will convene an initial service planning and coordination team meeting within three (3) days of the youth's admission to identify post-discharge service needs and initiate arrangements for necessary supports. Ongoing service planning and coordination team meetings will occur regularly throughout the duration of the youth’s stay.
11. The program will have a predictable and orderly daily routine with structured, therapeutically meaningful activities scheduled throughout the day, seven (7) days a week. The activities should provide safe opportunities for the youth to develop and enhance interpersonal skills and pro-social behaviors.
12. The program will engage each youth in individual, family, and group therapy sessions, focused on addressing the emotional and behavioral factors leading to admission.

13. Each youth will receive psychiatric services as necessary either through the program's Medical Director or private practitioner if the youth is under the care of a private provider.
14. Special attention and effort will be dedicated to creating a personalized Safety Plan that identifies the youth's triggers and warning signs associated with the disruptive behaviors that led to admission. The plan will outline self-calming strategies to help the youth regain control and prevent escalation into a crisis.
15. The program will actively involve the youth's family/guardian in team meetings, therapy sessions, and other activities, providing them with opportunities to learn and practice effective strategies that can be applied at home. All efforts to include families/guardians in the treatment process must be documented. For families unable to attend in person, telehealth video conferencing or telephone conferencing should be used to facilitate family therapy sessions.
16. The program will work closely with the youth's home school to obtain assignments and implement an education transition plan.
17. The program must have written policies and procedures for medication administration and provide training on various aspects, including storing, securing, labeling, administering, and disposing of medications; documenting medication administration and refusals; observing and reporting possible side effects; and managing youth-requested medication adjustments.
18. The program shall have clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate the methods of training and implementation of positive behavioral interventions.
19. The program must have established policies and procedures for effectively and efficiently managing crises with the direct assistance of senior clinical staff. These procedures should outline methods for managing emergency situations with a focus on de-escalation, clearly define processes for debriefing crises, and establish protocols for triaging youth in need of more intensive interventions. Requests for police or crisis line assistance should be limited to situations of imminent risk of harm to self or others, and only after consulting with the on-call QMHP (see General Performance Standards, N. Risk Management).
20. Up to three (3) consecutive bed hold days may be authorized per episode of care to reserve a bed for a youth absent from the program due to acute admission, detainment in the Detention Home, adjudicated to the Hawaii Youth Correctional Facility, or elopement. Youth discharged from the program for these reasons will be given priority and expedited readmission if requested within thirty (30) days of discharge (see General Performance Standards, Q1. Bed Holds).
21. The program may request Therapeutic One-to-One Support to help stabilize a youth exhibiting increasingly challenging or unsafe behaviors (see Therapeutic One-to-One Support Performance Standard).
22. When clinically indicated and requested by the Family Guidance Center, the program will provide two (2) weeks of Transitional Support Services to facilitate a successful discharge from the program and engagement in the step-down service (see Transitional Support Service Performance Standard).

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must complete and submit to the Family Guidance Center an initial MHTP within ten (10) days of the youth's admission. Using information gathered from the referral, intake process, and initial service planning and coordination team meeting, the MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan).
   a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if

already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).

b. The transition/discharge component of the MHTP will document realistic discharge criteria directly linked to the admitting symptoms/behaviors, projected timeframe, and aftercare resources needed to transition the youth to a less restrictive treatment setting (see General Performance Standards, D4b. Discharge Planning).

2. One (1) shift note must be completed per shift, per day documenting activity and behavioral observations. The overnight shift note serves as the billable daily residential encounter and must be completed for each youth certifying their presence in the facility when the day started at midnight (12AM).
3. Psychiatric service notes must be completed for any medication management activities provided by the program's Medical Director.
4. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual, family, and group therapy sessions. These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
5. A Discharge Summary progress note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

Y. SUB-ACUTE RESIDENTIAL (SAR)

Definition	SAR provides intensive psychiatric intervention and round-the-clock care for youth requiring rapid stabilization of psychiatric symptoms in a secured residential setting. The program is expected to deliver a full range of psychiatric and diagnostic evaluations, medication titration, symptom stabilization, and intensive short-term treatment informed by a suite of multidisciplinary assessments.
Service Components	1. Trauma-Informed Milieu supported by an evidence-based treatment model of intensive clinical services coordinated and delivered by a multidisciplinary team under the direction of a child and adolescent psychiatrist. 2. Orderly Schedule and Normalized Routine of well-supervised therapeutic activities designed to improve behavior and general functioning. 3. Comprehensive Assessments conducted by each member of the multidisciplinary team. 4. Psychiatric Services including evaluation at admission and face-to-face meetings with the youth at least two (2) times per week to assess, monitor, and manage all psychiatric and medical needs and effectively coordinate treatment. 5. Intensive Individual Therapy occurring at least two (2) times per week to address youth's specific emotional and behavioral treatment needs as indicated by referral and assessment. 6. Family Therapy occurring at least one (1) time per week to support successful return to the youth's home/community. The family therapy will be done in a format of a well-known, generally accepted style of family therapy such as Structural Family Therapy, Strategic Family Therapy, etc. In cases where there is no family/guardian to participate in family therapy, discussions with social worker or caregiver to support transitioning the youth to their home/community is acceptable. 7. Group Therapy occurring at least five (5) times per week. 8. Psychological Testing and therapy as indicated by referral and assessment. 9. Substance Abuse Counseling and education as indicated by assessment and plan. 10. On-site Educational Program with instruction delivered by certified education specialists (provided by the Department of Education) tailored to the youth's educational needs or aligned with the youth's IEP goals and objectives, if applicable. 11. Mental Health Treatment Plan (MHTP) developed with the youth and family/guardian. 12. Coordination with the Family Guidance Center as well as other involved service providers as appropriate/necessary to monitor progress and discuss treatment strategies. 13. Therapeutic One-to-One Support when clinically indicated, to help stabilize escalating or unsafe behaviors and increase the likelihood of maintaining services in the current treatment setting.
Admission Criteria	**All** the following are met: 1. The youth is between the ages of twelve (12) and seventeen (17). 2. The youth has presented a serious risk of harm to self or others within the past thirty (30) days as evidenced by any of the following: a. Serious risk for self-injury, with an inability to guarantee safety, as

	manifested by any of the following: i. Recent, serious suicide attempt with continued risk as demonstrated by poor impulse control or an inability to plan reliably for safety. ii. Recent or chronic suicidal ideation with intent, realistic plan, and/or available means. iii. Recent self-injurious behavior. iv. Recent verbalization or behavior indicating high risk for severe injury to self. v. Recent running or treatment avoidant behaviors presenting high risk for harm or injury to self. vi. Hallucinations, bizarre or delusional behavior, or intoxication resulting in danger to self. b. Serious risk of injury to others as manifested by any of the following: i. Active plan, means, and intent to inflict serious injury to others. ii. Recent assaultive behaviors that indicate a high risk for recurrence and serious injury to others. iii. Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to others. iv. Hallucinations, bizarre or delusional behavior, or intoxication resulting in danger to others. 3. The youth requires intensive, coordinated, multidisciplinary psychiatric intervention within a secured residential therapeutic milieu. 4. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated. 5. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting. 6. The youth's family/guardian agree to active involvement in treatment. 7. The youth agrees to active involvement in treatment.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the facility when the day begins. Clinical Lead may authorize up to fifteen (15) units.
Reauthorization	Reauthorization must be preceded by a treatment team meeting clearly documenting continued medical necessity and status review of admitting symptoms/behaviors. Clinical Lead may reauthorize up to fifteen (15) additional units.
Overlapping Services	Youth may receive a CAMHD-funded home-based service concurrent with SAR services to maintain continuity of an active service (i.e., in place prior to admission) or in preparation for discharge from SAR. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	When the youth's length of stay will exceed sixty (60) days, continued reauthorization requires the review and approval of the CAMHD Medical Director (or designee). Evidence of continued medical necessity must be documented in a Case Review

	with **all** of the following conditions determined to be true: 1. The youth is actively engaged in treatment. 2. The youth's condition has not improved or has worsened as evidenced by any of the following: a. Admitting symptoms/behaviors continue despite treatment efforts and/or modifications to the treatment plan, indicating the need for further evaluation and/or implementation of alternative approaches. b. New or previously unrecognized symptoms/behaviors have emerged that are significant enough that the youth still meets criteria for admission. c. The youth demonstrates regression or an unexpected adverse response to treatment efforts. 3. There is reasonable expectation that continued treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued. 4. The treatment goals, objectives, and discharge plan have been reviewed and updated/adjusted to reflect the youth's changing condition. 5. There is documented evidence of active family/guardian involvement in treatment (at least weekly) or documented efforts/attempts to involve them (unless contraindicated). 6. There is documented evidence of active coordination with the Family Guidance Center and other involved service providers (as applicable) or, if coordination is not successful, the reason(s) are documented.
Discharge Criteria	Discharges are to be conducted in a thoughtful, planned manner through co-management and regular communication among the provider, Family Guidance Center, family/guardian, and other treatment team members. Discharges that are not conducted in accordance with a previously agreed upon plan devised by the team will be considered ejections. The youth is no longer in need of or eligible for SAR when **any one (1)** of the following is true: 1. The youth no longer presents a serious risk of harm to self or others. 2. Admitting symptoms/behaviors have stabilized sufficiently and can be adequately managed in a less restrictive setting. 3. Medication is titrated and there is no longer a need for daily psychiatric/nursing oversight. 4. The goals of treatment have been substantially met. 5. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent (must not present a serious risk of harm to self or others). 6. The youth (or family/guardian) is not participating in treatment or following program rules and regulations. The non-participation is of such a degree that treatment is rendered ineffective and efforts to address non-participation issues have proven unsuccessful. 7. The youth requires acute psychiatric hospitalization. 8. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will coordinate transfer to appropriate treatment services in the least disruptive manner possible.

Service Exclusions	SAR is not considered medically necessary and will not be authorized under any of the following circumstances: 1. The youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the family/guardian and not related to the mental health care and treatment of the youth. 3. Use of the service (or continued stay) is solely for the convenience of another child-serving agency.
Clinical Exclusions	The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior.

Staffing Requirements

In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards, these requirements will take precedence.

1. Program staff must include:
   a. Medical Director – Licensed, board-certified child and adolescent psychiatrist (full time staff)
      The Medical Director is responsible for the entire SAR program and those in its care, ensuring staff are adequately trained and the services delivered are safe, ethical, grounded in evidence/empirically supported and medically appropriate.
   b. Program Director – Licensed psychologist or other QMPH (full time staff)
      The Program Director is responsible for the therapy program including training and supervision of the therapists. The Program Director must be knowledgeable of evidenced-based treatments for psychiatric disorders.
   c. Therapist(s) – QMPH or MHP (full time staff)
      The Therapist is responsible for providing individualized therapy, including development of the MHTP based on assessment of the youth's needs. The Therapist must have experience providing focused, high-intensity therapy to families.
   d. Program Nurse – Licensed registered nurse (full time staff)
      The Program Nurse is responsible for establishing operations for administering and monitoring medications, tracking and coordinating medical needs, and training staff on medication protocols and proper procedures.
   e. Residential Specialists – Paraprofessionals Level 1 and 2 (full time and part time staff)
   f. Certified Education Specialists (provided by the Department of Education)
2. The program must have the means to secure services from qualified professionals and specialists (e.g., medical, psychology, behavioral analysis, occupational/physical therapy, dietetics, recreation, etc.) to meet the unique needs of each youth, either through cooperative arrangements or by utilizing the organization's own personnel.
3. All staff must be CAMHD credentialed prior to working directly with any CAMHD youth (see General Performance Standards, I. Credentialing).
4. A child and adolescent psychiatrist must be available at all times to provide psychiatric coverage and guidance in the event of psychiatric emergencies.
5. A staff-to-youth ratio of one-to-four (1:4) must be maintained during day and evening shifts with a minimum of two (2) staff on duty at all times.
6. The overnight shift must maintain a staff-to-youth ratio of one-to-six (1:6). Two (2) staff must be on duty with at least one (1) staff awake throughout the shift.
7. Staff must be assigned only to the SAR program schedule (i.e., may not simultaneously cover other units).

8. At least one (1) residential specialist will be present in the classroom to assist the DOE Certified Education Specialists with behavior management and provide necessary therapeutic redirection.
9. The program must have the capacity to expand staffing when necessary to ensure additional staff are available during busy or stressful periods (e.g., higher-than-usual acuity, influx of new admissions, etc.).
10. The program shall have a protocol in place to ensure appropriate and qualified coverage for the Medical Director and Program Director during absences due to illness or vacation.
11. All staff must have an understanding of and ability to assess psychiatric symptoms, medication issues, and behaviors in order to identify situations requiring additional staff assistance.
12. The program must facilitate ongoing training sessions to enhance staff knowledge and skills related to treatment protocols for youth in residential settings, informed by the needs of the milieu. Training topics shall include but not be limited to the core expectations specified in the General Performance Standards (see G. Training).
13. All program staff shall receive and participate in clinical supervision as described in the General Performance Standards (see H. Supervision).

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must operate within a secure residential facility.
2. The program must adhere to all applicable facility licensing requirements/regulations.
3. The program must be operational twenty-four (24) hours a day, seven (7) days a week.
4. The program shall always be staff-secure, with round-the-clock supervision of all youth physically present, in alignment with the minimum staff-to-youth ratios.
5. The program and its staff must follow all applicable professional practice standards and ethical guidelines.
6. The program shall have an intake process that includes orienting the youth and family/guardian to the facility, reviewing program rules/guidelines, explaining treatment expectations, and completing the admission summary. Input from the youth, family/guardian, and CC will be obtained to establish treatment goals for the MHTP and formulate an initial discharge plan with concrete, realistic, measurable discharge criteria and a projected discharge timeframe.
7. Comprehensive assessments shall be conducted by each member of the multidisciplinary team within forty-eight (48) hours of the youth's admission. These assessments should include consideration of evidence-based treatment options, DSM-5 diagnoses, identify youth, family, community strengths/resources, and provide multi-modal treatment recommendations that address the specific bio-psycho-social factors contributing to admission and those that can be effectively targeted to facilitate transition to a less restrictive level of care. The assessments must provide a comprehensive evaluation of the youth's developmental milestones and trajectory; current and past family/systems and contextual influences; performance in school, work, or other social roles; social interactions and peer relationships; substance use/abuse, summary of prior psychiatric hospitalizations, medication trials, and other mental health or psychosocial interventions with an evaluation of their effectiveness or shortcomings.
8. Psychological testing will be completed when necessary to guide differential diagnosis of a mental health disorder.
9. The program will have a predictable and orderly daily routine with structured, therapeutically meaningful activities scheduled throughout the day, seven (7) days a week. If providing gender-specific programming, the program is expected to place youth in the group consistent with their gender identity. For youth who do not identify as any gender or who identify as gender fluid, non-binary, or another gender minority group, the program is expected to consult with the youth,

family/guardian, and treatment team to determine placement that best fits the youth's identity and treatment needs.
10. The program will engage each youth in therapy sessions tailored to their unique therapeutic needs, focused on addressing the factors leading to admission and other areas of focus identified through assessments.
11. Each youth will receive face-to-face psychiatric services at least two (2) times per week. Routine assessments are performed by the psychiatrist to effectively coordinate all treatment, manage medication trials and/or adjustments, minimize serious medication side effects, and provide medical management of all psychiatric and medical problems.
12. The program will actively involve the youth's family/guardian in team meetings, therapy sessions, and other activities, providing them with opportunities to learn and practice effective strategies that can be applied at home. All efforts to include families/guardians in the treatment process must be documented. For families unable to attend in person, telehealth video conferencing or telephone conferencing should be used to facilitate family therapy sessions.
13. Weekly all-clinical-staff case discussions will occur to review the status of each youth's treatment progress and disposition plan. The Medical Director, Program Director, Program Nurse, and Therapist(s) must participate in weekly case discussions to ensure key program staff are aware of adjustments and plans.
14. The program will participate in scheduled treatment team meetings with the Family Guidance Center at least once per authorization period to discuss treatment progress and transition plans. All reauthorizations for continued stay must be preceded by a treatment team meeting. The program may not unilaterally make discharge recommendations or eject youth who meet continuing stay criteria.
15. The program shall have clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate the methods of training and implementation of positive behavioral interventions.
16. The program must have established policies and procedures for effectively and efficiently managing crises with the direct assistance of senior clinical and medical staff. These procedures should include methods for handling emergency situations, debriefing crises, and triaging youth requiring more intensive interventions (see General Performance Standards, N. Risk Management).
17. The program shall establish policies, procedures, and practices to manage threats of harm to self or others prioritizing de-escalation and nonrestrictive behavioral interventions. Restrictive control measures may be implemented as a secondary response, when necessary, under the direction of a child and adolescent psychiatrist. Any use of restrictive behavior management techniques must comply with The Joint Commission's Restraint and Seclusion Requirements (CTS.05.05.01).
18. While bed hold and therapeutic pass authorizations are not permitted, youth are allowed planned therapeutic visits and outings with family members, but these outings are not allowed to be overnight visits.
19. The program may request Therapeutic One-to-One Support to help stabilize a youth exhibiting increasingly challenging or unsafe behaviors (see Therapeutic One-to-One Support Performance Standard).

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A written admission summary outlining the presenting problem, initial diagnosis, mental status, preliminary recommendations, and any further assessments/testing needed must be provided to the Family Guidance Center within five (5) days of admission.

2. The program must complete and submit to the Family Guidance Center an initial MHTP within ten (10) days of the youth's admission. Using information gathered from the referral, intake process, and admission summary, the initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan).
    a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).
    b. The transition/discharge component of the MHTP will document realistic discharge criteria directly linked to the admitting symptoms/behaviors, projected timeframe, and aftercare resources needed to transition the youth to a less restrictive treatment setting (see General Performance Standards, D4b. Discharge Planning).
3. One (1) shift note must be completed per shift, per day documenting routine medical and behavioral observations. The overnight shift note serves as the billable daily residential encounter and must be completed for each youth certifying their presence in the facility when the day started at midnight (12AM).
4. Psychiatric service notes must be completed documenting the psychiatrist's face-to-face meetings with the youth. Minimally, these notes should include a review of systems, mental status examination, medical decision-making rationale, and plan.
5. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual, family, and group therapy sessions. These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
6. The program is required to update the MHTP on a monthly basis. The treatment goals, objectives, and discharge plan shall be adjusted to reflect the youth's changing condition.
7. A Discharge Summary progress note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note).

Z. HOSPITAL-BASED RESIDENTIAL (HBR)

Definition	HBR provides intensive psychiatric intervention and round-the-clock nursing care for youth requiring rapid stabilization of psychiatric symptoms in a secured inpatient setting. The program is expected to deliver a full range of psychiatric, diagnostic, and medical evaluations, medication titration, symptom stabilization, and intensive short-term treatment informed by a suite of multidisciplinary assessments. This service is most appropriate for youth who require close psychiatric oversight for medication titration, or those that may require emergency psychiatric interventions (seclusion/restraint) due to a risk of harm to self or others.
Service Components	1. Trauma-Informed Milieu supported by an evidence-based treatment model of intensive clinical services coordinated and delivered by a multidisciplinary team under the direction of a child and adolescent psychiatrist. 2. Orderly Schedule and Normalized Routine of well-supervised therapeutic activities designed to improve behavior and general functioning. 3. Comprehensive Assessments conducted by each member of the multidisciplinary team. 4. Psychiatric Services including evaluation at admission and face-to-face meetings with the youth at least two (2) times per week to assess, monitor, and manage all psychiatric and medical needs and effectively coordinate treatment. 5. Intensive Individual Therapy occurring at least two (2) times per week to address youth's specific emotional and behavioral treatment needs as indicated by referral and assessment. 6. Family Therapy occurring at least one (1) time per week to support successful return to the youth's home/community. The family therapy will be done in a format of a well-known, generally accepted style of family therapy such as Structural Family Therapy, Strategic Family Therapy, etc. In cases where there is no family/guardian to participate in family therapy, discussions with social worker or caregiver to support transitioning the youth to their home/community is acceptable. 7. Group Therapy occurring at least five (5) times per week. 8. Psychological Testing and therapy as indicated by referral and assessment. 9. Substance Abuse Counseling and education as indicated by assessment and plan. 10. On-site Educational Program with instruction delivered by certified education specialists (provided by the Department of Education) tailored to the youth's educational needs or aligned with the youth's IEP goals and objectives, if applicable. 11. Mental Health Treatment Plan (MHTP) developed with the youth and family/guardian. 12. Coordination with the Family Guidance Center as well as other involved service providers as appropriate/necessary to monitor progress and discuss treatment strategies.
Admission Criteria	**All** the following are met: 1. The youth is not older than age seventeen (17). 2. The youth has presented a serious risk of harm to self or others within the past thirty (30) days as evidenced by any of the following: a. Serious risk for self-injury, with an inability to guarantee safety, as

	manifested by any of the following: i. Recent, serious suicide attempt with continued risk as demonstrated by poor impulse control or an inability to plan reliably for safety. ii. Recent or chronic suicidal ideation with intent, realistic plan, and/or available means. iii. Recent self-injurious behavior. iv. Recent verbalization or behavior indicating high risk for severe injury to self. v. Hallucinations, bizarre or delusional behavior, or intoxication resulting in danger to self. b. Serious risk of injury to others as manifested by any of the following: i. Active plan, means, and intent to inflict serious injury to others. ii. Recent assaultive behaviors that indicate a high risk for recurrence and serious injury to others. iii. Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to others. iv. Hallucinations, bizarre or delusional behavior, or intoxication resulting in danger to others. 3. The youth requires intensive, coordinated, multidisciplinary psychiatric intervention within a secured inpatient therapeutic milieu. 4. The youth is able to participate in and benefit from the milieu and there is reasonable expectation that treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are not initiated. 5. The CMP identifies problem areas and treatment strategies to be addressed within this treatment setting. 6. The youth's family/guardian agree to active involvement in treatment. 7. The youth agrees to active involvement in treatment.
Initial Authorization	Unit = one (1) day – a "billable day" begins at midnight (12AM); youth must be present in the facility when the day begins. Clinical Lead may authorize up to fifteen (15) units.
Reauthorization	Reauthorization must be preceded by a treatment team meeting clearly documenting continued medical necessity and status review of admitting symptoms/behaviors. Clinical Lead may reauthorize up to fifteen (15) additional units.
Overlapping Services	Youth may receive a CAMHD-funded home-based service concurrent with HBR services to maintain continuity of an active service (i.e., in place prior to admission) or in preparation for discharge from HBR. Overlapping service duration may not exceed thirty (30) days without review and approval by the Clinical Services Office.
Continuing Stay Criteria	When the youth's length of stay will exceed thirty (30) days, continued reauthorization requires the review and approval of the CAMHD Medical Director (or designee). Reauthorization must be submitted by the Clinical Lead to the CAMHD Medical Director (or designee) at least three (3) days, but not more than seven (7) days, before the end date of the prior authorization. Evidence of continued medical necessity must be documented in a Case

	Review with **all** of the following conditions determined to be true: 1. The youth is actively engaged in treatment. 2. The youth's condition has not improved or has worsened as evidenced by any of the following: a. Admitting symptoms/behaviors continue despite treatment efforts and/or modifications to the treatment plan, indicating the need for further evaluation and/or implementation of alternative approaches. b. New or previously unrecognized symptoms/behaviors have emerged that are significant enough that the youth still meets criteria for admission. c. The youth demonstrates regression or an unexpected adverse response to treatment efforts. 3. There is reasonable expectation that continued treatment will remediate symptoms and/or improve behaviors or there is reasonable evidence that the youth will decompensate or experience relapse if services are discontinued. 4. The treatment goals, objectives, and discharge plan have been reviewed and updated/adjusted to reflect the youth's changing condition. 5. There is documented evidence of active family/guardian involvement in treatment (at least weekly) or documented efforts/attempts to involve them (unless contraindicated). 6. There is documented evidence of active coordination with the Family Guidance Center and other involved service providers as (as applicable) or, if coordination is not successful, the reason(s) are documented.
Discharge Criteria	Discharges are to be conducted in a thoughtful, planned manner through co-management and regular communication among the provider, Family Guidance Center, family/guardian, and other treatment team members. Discharges that are not conducted in accordance with a previously agreed upon plan devised by the team will be considered ejections. The youth is no longer in need of or eligible for HBR when **any one (1)** of the following is true: 1. The youth no longer presents a serious risk of harm to self or others. 2. Admitting symptoms/behaviors have stabilized sufficiently and can be adequately managed in a less restrictive setting. 3. Medication is titrated and there is no longer a need for daily psychiatric/nursing oversight. 4. The goals of treatment have been substantially met. 5. The youth (or family/guardian) no longer wishes to participate in treatment and revokes consent (must not present a serious risk of harm to self or others). 6. The youth (or family/guardian) is not participating in treatment or following program rules and regulations. The non-participation is of such a degree that treatment is rendered ineffective and efforts to address non-participation issues have proven unsuccessful. 7. The youth requires acute psychiatric hospitalization. 8. The youth is no longer eligible for CAMHD services. As part of discharge, the CC will coordinate transfer to appropriate treatment services in the least disruptive manner possible.

Service Exclusions	HBR is not considered medically necessary and will not be authorized under any of the following circumstances: 1. The youth is actively enrolled in another CAMHD-funded out-of-home service. 2. Use of the service (or continued stay) is solely for the convenience of the family/guardian and not related to the mental health care and treatment of the youth. 3. Use of the service (or continued stay) is solely for the convenience of another child-serving agency.
Clinical Exclusions	The youth requires acute psychiatric hospitalization because of active suicidal, homicidal, or psychotic behavior.

Staffing Requirements
In addition to the staffing requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. Program staff must include:
   a. Medical Director – Licensed, board-certified child and adolescent psychiatrist (full time staff)
      The Medical Director is responsible for the entire HBR program and those in its care, ensuring staff are adequately trained and the services delivered are safe, ethical, grounded in evidence/empirically supported and medically appropriate.
   b. Program Director – QMPH (full time staff)
      The Program Director is responsible for the therapy program including training and supervision of the therapists. The Program Director must be knowledgeable of evidenced-based treatments for psychiatric disorders.
   c. Therapist(s) – QMPH or MHP (full time staff)
      The Therapist is responsible for providing individualized therapy, including development of the MHTP based on assessment of the youth's needs. The Therapist must have experience providing focused, high-intensity therapy to families.
   d. Program Nurse – Licensed registered nurse (full time staff)
      The Program Nurse is responsible for the team of nursing staff, including training and supervision.
   e. Residential Specialists – Paraprofessionals Level 1 and 2 (full time and part time staff)
   f. Certified Substance Abuse Counselor (full time staff)
      The CSAC is responsible for developing and integrating substance abuse education into the treatment program and providing individualized substance abuse counseling based on assessment of the youth's needs.
   g. Licensed Psychologist (staff or contracted consultant)
   h. Occupational and Recreational Therapist(s) (staff or contracted consultants)
   i. Certified Education Specialists (provided by the Department of Education)
2. The program must have the means to secure services from qualified professionals and specialists (e.g., medical, behavioral analysis, dietetics, etc.) to meet the unique needs of each youth, either through cooperative arrangements or by utilizing the organization's own personnel.
3. All staff must be CAMHD credentialed prior to working directly with any CAMHD youth (see General Performance Standards, I. Credentialing).
4. A child and adolescent psychiatrist must be available at all times to provide psychiatric coverage and guidance in the event of psychiatric emergencies.
5. A staff-to-youth ratio of one-to-four (1:4) must be maintained during day and evening shifts with a minimum of two (2) staff on duty at all times.

6. The overnight shift must maintain a staff-to-youth ratio of one-to-six (1:6) with a minimum of two (2) staff on duty at all times.
7. At least one (1) registered nurse must be on duty per shift.
8. Primary nursing staff and residential specialists must be assigned only to the HBR program schedule (i.e., may not simultaneously cover other units).
9. At least one (1) residential specialist will be present in the classroom to assist the DOE Certified Education Specialists with behavior management and provide necessary therapeutic redirection.
10. The program must have the capacity to expand staffing when necessary to ensure additional staff are available during busy or stressful periods (e.g., higher-than-usual acuity, influx of new admissions, etc.).
11. The program shall have a protocol in place to ensure appropriate and qualified coverage for the Medical Director and Program Director during absences due to illness or vacation.
12. All staff must have an understanding of and ability to assess psychiatric symptoms, medication issues, and behaviors in order to identify situations requiring additional staff assistance.
13. The program must facilitate ongoing training sessions to enhance staff knowledge and skills related to treatment protocols for youth in residential settings, informed by the needs of the milieu. Training topics shall include but not be limited to the core expectations specified in the General Performance Standards (see G. Training).
14. All program staff shall receive and participate in clinical supervision as described in the General Performance Standards (see H. Supervision).

Clinical Operations

In addition to the clinical operation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. The program must operate within a secure unit of a licensed accredited hospital.
2. The program must adhere to all applicable facility licensing requirements/regulations.
3. The program must be operational twenty-four (24) hours a day, seven (7) days a week.
4. The program shall always be staff-secure, with round-the-clock supervision of all youth physically present, in alignment with the minimum staff-to-youth ratios.
5. The program and its staff must follow all applicable professional practice standards and ethical guidelines.
6. The program shall have an intake process that includes orienting the youth and family/guardian to the facility, reviewing program rules/guidelines, explaining treatment expectations, and completing the admission summary. Input from the youth, family/guardian, and CC will be obtained to establish treatment goals for the MHTP and formulate an initial discharge plan with concrete, realistic, measurable discharge criteria and a projected discharge timeframe.
7. Comprehensive assessments shall be conducted by each member of the multidisciplinary team within forty-eight (48) hours of the youth's admission. These assessments should include consideration of evidence-based treatment options, DSM-5 diagnoses, identify youth, family, community strengths/resources, and provide multi-modal treatment recommendations that address the specific bio-psycho-social factors contributing to admission and those that can be effectively targeted to facilitate transition to a less restrictive level of care. The assessments must provide a comprehensive evaluation of the youth's developmental milestones and trajectory; current and past family/systems and contextual influences; performance in school, work, or other social roles; social interactions and peer relationships; substance use/abuse, summary of prior psychiatric hospitalizations, medication trials, and other mental health or psychosocial interventions with an evaluation of their effectiveness or shortcomings.
8. Psychological testing will be completed when necessary to guide differential diagnosis of a mental health disorder.

9. The program will have a predictable and orderly daily routine with structured, therapeutically meaningful activities scheduled throughout the day, seven (7) days a week.
10. The program will engage each youth in therapy sessions tailored to their unique therapeutic needs, focused on addressing the factors leading to admission and other areas of focus identified through assessments.
11. Each youth will receive face-to-face psychiatric services at least two (2) times per week.
12. The program will actively involve the youth's family/guardian in team meetings, therapy sessions, and other activities, providing them with opportunities to learn and practice effective strategies that can be applied at home. All efforts to include families/guardians in the treatment process must be documented. For families unable to attend in person, telehealth video conferencing or telephone conferencing should be used to facilitate family therapy sessions.
13. Weekly all-clinical-staff case discussions will occur to review the status of each youth's treatment progress and disposition plan. The Medical Director, Program Director, Program Nurse, and Therapist(s) must participate in weekly case discussions to ensure key program staff are aware of adjustments and plans.
14. The program will participate in scheduled treatment team meetings with the Family Guidance Center at least once per authorization period to discuss treatment progress and transition plans. All reauthorizations for continued stay must be preceded by a treatment team meeting.
15. The program shall have clear procedures for training, which specify its approach to positive behavior supports. These procedures must clearly delineate the methods of training and implementation of positive behavioral interventions.
16. The program must have established policies and procedures for effectively and efficiently managing crises with the direct assistance of senior clinical and medical staff. These procedures should include methods for handling emergency situations, debriefing crises, and triaging youth requiring more intensive interventions (see General Performance Standards, N. Risk Management).
17. The program shall establish policies, procedures, and practices to manage threats of harm to self or others prioritizing de-escalation and nonrestrictive behavioral interventions. Restrictive control measures may be implemented as a secondary response, when necessary, under the direction of a child and adolescent psychiatrist. Any use of restrictive behavior management techniques must comply with The Joint Commission's Restraint and Seclusion Requirements (CTS.05.05.01).
18. While bed hold and therapeutic pass authorizations are not permitted, youth are allowed planned therapeutic visits and outings with family members, but these outings are not allowed to be overnight visits.

Documentation

In addition to the documentation requirements specified in the General Performance Standards, the requirements below must also be followed. If the expectations listed here differ from those in the General Performance Standards these requirements will take precedence.

1. A written admission summary outlining the presenting problem, initial diagnosis, mental status, preliminary recommendations, and any further assessments/testing needed must be provided to the Family Guidance Center within five (5) days of admission.
2. The program must complete and submit to the Family Guidance Center an initial MHTP within ten (10) days of the youth's admission. Using information gathered from the referral, intake process, and admission summary, the initial MHTP shall identify individualized and measurable treatment goals/objectives linked with evidence-based interventions (see General Performance Standards, D4. Mental Health Treatment Plan).
    a. The crisis prevention and intervention component of the MHTP will be created (or reviewed, if already established) in collaboration with the youth and shared with their family/guardian (see General Performance Standards, D4a. Crisis Prevention and Intervention Planning).

   b. The transition/discharge component of the MHTP will document realistic discharge criteria directly linked to the admitting symptoms/behaviors, projected timeframe, and aftercare resources needed to transition the youth to a less restrictive treatment setting (see General Performance Standards, D4b. Discharge Planning).
3. One (1) shift note must be completed by nursing staff per shift, per day documenting routine medical and behavioral observations. The overnight shift note serves as the billable daily residential encounter and must be completed for each youth certifying their presence in the facility when the day started at midnight (12AM).
4. Psychiatric service notes must be completed documenting the psychiatrist's face-to-face meetings with the youth. Minimally, these notes should include a review of systems, mental status examination, medical decision-making rationale, and plan.
5. Clinical progress notes must be completed in the manner specified in the General Performance Standards (see K. Maintenance of Service Records) for all primary treatment activities including individual, family, and group therapy sessions. These notes should provide a description of the interventions implemented, the youth's response, and interpretation of the effectiveness/impact on treatment goals/objectives in the form of Treatment Target Progress Ratings.
6. The program is required to update the MHTP monthly. The treatment goals, objectives, and discharge plan shall be adjusted to reflect the youth's changing condition.
7. A Discharge Summary progress note must be completed within ten (10) days of the youth's discharge (see General Performance Standards, D4c. Discharge Summary Progress Note). If hospital procedures prevent this timeline from being met, at a minimum the program must have written discharge follow-up orders which include the youth's diagnosis at discharge, statement of status at discharge and any recommended follow-up treatment including medications and follow-up appointments which is given to the family/guardian at discharge and sent to the youth's Family Guidance Center.

SECTION III:

APPENDIX

Appendix Documents

▪ CAMHD INDEPENDENT PSYCHIATRIST CONSULTATION FORM

Please fill in and submit this form prior to conducting an independent evaluation. Fax it to the Clinical Services Office at 733-9875. CAMHD will fax its approval or disapproval within three (3) business days of the receipt of this form.

Agency Name: _____ Date: _____

Agency Contact: _____ Phone: _____ Fax: _____

Name of Proposed Independent Psychiatrist: _____

Please indicate the qualifications of the psychiatrist as follows:

Yes	No	Psychiatrist licensed as MD or DO in the State of Hawaii.
Yes	No	Current expertise in the Level of Care being disputed (both the level of care and the level of care proposed)
Describe:		
Yes	No	Experience and formal training in Child and Adolescent Psychiatry (prefer psychiatrist boarded in Child Psychiatry)
Describe:		
Yes	No	Does the proposed psychiatrist work for your agency as employee or as a consultant?
Yes	No	Is the psychiatrist employed by the Family Guidance Center providing care coordination for the youth involved?

CAMHD Clinical Director Review:

Agree: Do Not Agree:

Reason:

Signature: Date:

Competency Assessment for Paraprofessionals in Residential Programs

Instructions: The primary supervisor should complete these ratings based on her/his direct observations of the Paraprofessional worker and input from other supervisors/clinical leaders. Checking any description that fits the individual well. Any endorsement of a description in the "deficient" column should lead to the development of a supervision plan to address that area inclusive on of training.

1. Knowledge of Individualized Treatment Plan		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Does not know the youth's mutually agreed upon goal ☐ May know general issues that youth is dealing with but nothing specific. ☐ Has different goals than identified in the plan.	☐ Knows the youth's primary mutually agreed upon goal in general terms. ☐ Has general ideas on how to support the youth in reaching this goal.	☐ Knows the youth's specific mutually agreed upon goal in solvable and/or measureable terms. ☐ Can articulate specific methods to support this goal. ☐ Has discussed this youth's goals and support strategies with clinician.
2. Trauma Informed Care		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Uses consequences or threats of consequences as initial response to problem behaviors. ☐ Responds in a negatively emotionally charged manner. ☐ Feels betrayed by youth who break rules.	☐ Able to establish trust and demonstrates advocacy with youth s/he works with. ☐ Encourages youth's voice regarding goals, daily activities, coping, recreation, education, etc. ☐ Demonstrates consistency with youth and promotes consistency amongst staff.	☐ Employs specific trauma-informed principles such as increasing predictability in the environment; reducing known triggers; using validation; increasing a sense of personal control; establishing a sense of safety etc. ☐ Has an understanding of how trauma is exhibited in different youth.
3. Strength-based Intervention		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Views relapses as failures of treatment, program or youth. ☐ Attempts to teach and enforce while youth is dysregulated. ☐ Engages in power struggles. ☐ When youth are in crisis or	☐ Welcomes visiting families as a valuable resource to the youth. ☐ Responds to youth in an encouraging and non-judgmental manner. ☐ Is working to more regularly incorporate crisis prevention techniques in job	☐ Uses specific Motivational Interviewing techniques. ☐ Uses functional strengths identified by team to promote health. ☐ Looks for what is being communicated by youth in problematic behaviors.

experiencing emotional dysregulation, does not attempt to de-escalate youth before resorting to hands-on redirection or restraints.	performance.	☐ Communicates with clinician and family (when appropriate) on progress being made in milieu. ☐ Utilizes de-escalation techniques regularly before resorting to hands-on re-direction/restraints.
4. Therapeutic Knowledge Base		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Pathologizes or moralizes all problematic behaviors. ☐ Does not see a difference between adolescents and adults. ☐ Does not incorporate trainings, techniques or new knowledge to improve job performance or understanding of youth.	☐ Views some defiance as developmentally appropriate behavior. ☐ Is aware of developmental trauma and trauma informed care. ☐ Sometimes incorporates new training and techniques to improve job performance and increase understanding of population served.	☐ Has an understanding of differences in the treatment needs of male and female youth. ☐ Can articulate some of the risk factors that make the youth we serve vulnerable. ☐ Can articulate some of the protective factors that we support in the youth we serve. ☐ Has a basic understanding of child and adolescent development. ☐ Regularly incorporates new training and techniques to improve job performance and expand understanding of youth.
5. Professional Behavior		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Overly rigid boundary that prevents engagement with youth and family. ☐ Has interactions with youth or family members outside of work hours or regarding non-programmatic matters. ☐ Treats youth as one would treat a peer. ☐ Youth interacts with particular staff as though	☐ Does not communicate with the youth or family outside of work hours or for non-programmatic matters. ☐ Does not disclose personal information that is not already public, not relevant nor unresolved. ☐ Speaks respectfully to youth and family. ☐ Regularly attends supervision	☐ Is capable of appropriate use of self-disclosure to engage and facilitate progress with youth in a manner that does not blur professional boundaries or place youth or family in a vulnerable position. ☐ Discusses the limits of the relationship with the youth and family when a boundary is challenged.

they were a peer. ☐ Discusses other youth or other staff issues with youth. ☐ Staff behavior has been interpreted as demeaning, inciting or intimidating by youth. ☐ Regularly misses supervision sessions. ☐ Takes professional advice/constructive criticism as a personal attack.	and meetings. ☐ Incorporates constructive criticism into improved performance.	☐ Seeks out supervision, clarification and consultation.
6. Programmatic Knowledge		
Deficient (0)	Satisfactory (1)	Proficient (2)
☐ Does not know or follow policies and procedures.	☐ Understands and adheres to policies and procedures (most notably for crisis responses).	☐ Is viewed as a leader and is often sought after for accurate programmatic information. ☐ Contributes to programmatic development (procedural, operational, therapeutic activities, educational etc.)

Agency Name:

State Training Proportion of Total Trng. Cost [%]

CONTRACTED AGENCY QUARTERLY TRAINING REPORT (TRAINER & TRAINEE COSTS)

Staff Name (Last, First)	Position Title		Professional Degree (Ph.D., MSW, etc)		Social Security or Position ID#			
Training Title/Topic and a Brief Description:	Trng. Purpose Categ*****	Training Dates	Training Modality*	Training Hours	Hourly Trng Cost**	Salary Cost***	Other Costs****	Total Trng. Cost
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
Total Training Hours/Cost for Staff				0		$ -	$ -	$ -

Staff Name (Last, First)	Position Title		Professional Degree (Ph.D., MSW, etc.)		Social Security or Position ID#			
Training Title/Topic and a Brief Description:	Trng. Purpose Categ*****	Training Dates	Training Modality*	Training Hours	Hourly Trng Cost**	Salary Cost***	Other Costs****	Total Trng. Cost
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
						$ -		$ -
Total Training Hours/Cost for Staff				0		$ -	$ -	$ -

INSTRUCTION: 1)Read Attachment before filling out form;

2) Use this form to list all training attended or conducted by staff. **IV-E Training Form 05**

Transitional Family Home Profile Form

1. Agency Name:
2. Agency Contact Name & Number: Date:
3. Foster Family Name:
4. Transitional Family geographic location:
5. Transitional Family preference or exclusions for youth (if any including age, gender, diagnosis, etc):
6. Transitional Family length of experience as TFH:
7. Transitional Family current number, age and sex of foster youth:
8. Transitional Family current number, age and sex of biological youth:
9. Transitional Family, maximum number of foster youth willing to take:
10. Transitional Family strengths:
11. Transitional Family weaknesses:

Comments:

Caregiver Skills Menu

Caregiver name:

W	D		W	D	
		Giving Praise			Providing incentives to my child
		Giving Rewards			Expectations and monitoring
		Setting limits & giving consequences			Learning to really hear what my child is saying
		Teach problem solving			Improve my communication skills
		Manage my own anger			Depression management (for self)
		Managing my own stress			Identifying what is already working
		Help my child calm down			Responding to depression (of youth)
		Develop routines (meals, homework etc.)			Supporting my anxious child
		Practicing and supporting therapeutic interventions given to youth			Using family meetings to maintain order, consistency and clear expectations
		Supporting school achievement			Conflict resolution skills
		Learning about the thinking-feeling-doing triangle			Learning about parenting organizations and resources
		Learning about youth organizations and resources			How to promote family members supporting each other
		What to do when my child runs away			What to do when my child threatens suicide
		What to do when my child threatens me or a family members			Understanding my child's crisis plan
		Developing family goals			Find a non-caregiver reliable adult support for youth
		Other:			

W=want to learn
D=Did it!

Life Skill Menu

Building Relationships Skills

W	D		W	D	
		Knowing when I can trust someone			Accepting help
		Getting close and staying close			Difficulty sharing about myself "letting people in"
		Helping/supporting others			Supporting yourself
		Expressing gratitude			Giving compliments
		Making new friends or contacts			Able to talk story
		Understanding how others feel			Identifying a non-parent adult support (i.e. Uncle/Aunty, coach, kumu, clergy etc.)
		Accepting "no" as an answer			Accepting compliments
		Handling rejection			Being anxious or nervousness around people
		Knowing when someone is taking advantage of you			managing romantic or sexual feelings
		Other:			

Managing Joint Decisions & Managing Interpersonal Conflict

W	D		W	D	
		Dealing someone else's different opinion			Accepting disappointment
		Deciding on how much to self-sacrifice			Thinking out-of-the-box for interpersonal problems
		Recognizing and choosing reasonable solutions			Problem solving
		Negotiating			Asserting yourself
		Picking your battles			Forgiving others
		Other:			

W=want to learn
D=Did it!

Dealing with frustration and unfavorable events

W	D		W	D	
		Handling frustration			Handling one's own mistakes and failures
		Feeling appropriate fear in a dangerous situation			Telling whether a situation is dangerous
		Feeling appropriate guilt when you've done wrong			Tolerating one's own feelings or thoughts
		Handling thoughts or impulses that I shouldn't do			Dealing with second person's getting something that one wants for oneself
		Suicidal thoughts			Thoughts of self-harm
		Dealing with being apart from a loved one			Other:

Celebrating good things, feeling pleasure, leisure time

W	D		W	D	
		Accepting approval, compliments and positive attention			Enjoying exploration, discovery and the unknown
		Feeling pleasure from doing kind, loving acts			Feeling gratitude
		Celebrating and feeling the blessing of luck			Playing, being silly, carefree
		Rewarding oneself for one's own accomplishments			Finding constructive use of time
		Relaxing			Enjoying humor
		Other:			

W=want to learn
D=Did it!

Developing the capacity for delayed gratification

W	D		W	D	
		Denying myself something I want right now			Following rules, obeying
		Persisting on tasks even when discouraged			Maintaining healthy habits (smoking, drugs etc.)
		Being honest and dependable			Developing skills that bring approval from people (work, school, recreation)
		Saving instead of spending			Concentration and attending
		Working towards a long-term goal			Understanding "deliberate" practice
		Tracking your own progress and hard work			Scheduling and prioritizing meaningful activities and healthy habits
		Other:			

Cognitive processing through words, symbols and images

W	D		W	D	
		Using words to understand the world			Recognizing and talking about your feelings
		Correctly seeing how other people feel			Deciding how much control you have over different events
		Decision making; defining a problem, gathering info, generating options, predicting and evaluating consequences, making choices			Thinking before acting
		Organizing and planning			Realistically looking at your own skills and abilities
		Seeing the skills and character of others			Being able to use imagination as a tool
		Identifying problem thoughts			Changing problem thoughts
		Re-thinking the meaning of past events			Other:

W=want to learn
D=Did it!

Transition Shopping List

Education

W	D		W	D	
		Obtain High School Diploma			Complete Personal Statement
		Apply for College			Search For Scholarship
		Complete Financial Aid Forms			Complete/Submit Scholarship App.
		Enter Another Educational/Cert. Program			Go On A Campus Tour
		Other:			

Employment

W	D		W	D	
		Find A Job			Learn Basic Computer Skills
		Write A Resume; Complete Job Appl.			Learn How To Read A Paycheck Stub
		Learn To Read A Job Ad			Get A Social Security Card
		Get A State Of Hawaii ID			Get An Official Birth Certificate
		Open a Checking/Savings Account			Learn About Building Credit & Savings

Living Situation

W	D		W	D	
		Learn About Tenant And Landlord Rights			Learn How To Cook Five Good Meals
		Understand A Lease Agreement			Learn About Nutrition and Diet
		Learn How To Do Your Own Laundry			Learn How To Use A Stove, Oven, etc.
		Learn How To Clean A Kitchen/Bathroom			Find An Affordable Safe Place To Live
		Other:			

Life skills:

W	D		W	D	
		Get A Driver's Permit			Get Medical Insurance
		Get A Driver's License			Get Auto Insurance
		Balance My Checkbook			Understand My Medications
		Learn How To Shop For The Best Deals			Learn How To Protect Myself From ID Theft
		Learn The Local Bus System			Find 5 New Ways To Have Fun
		Learn How To Manage Stress			Find A Workout System That I Enjoy
		Understand Birth Control And STDs			Gain or Lose _____ lbs.
		Make New Friends			Volunteer In The Community
		Find A Good Doctor You Can Visit			Learn How To file Taxes
		Find A Good Counselor You Can Visit			Find A Good Dentist You can Visit

W=Want to Do It
D=Did it!