

# Program Standards for Children's Residential Treatment

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The standards are grouped into four main categories. Smaller workgroups were formed to research best practice in each category and develop draft standards and measures. Members met for many hours to review and revise drafts and incorporate suggestions made by the larger workgroup membership.

Drafts of the Program Standards were distributed to a host of individuals and member organizations for review. Their comments and suggestions strengthened the final product.

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## Background

Most residential programs in Maine were developed before 2003 in response to needs expressed by the three state agencies that work with children (Department of Health and Human Services Child Welfare Services, Children's Behavioral Health Services and the Office of Substance Abuse; Department of Education and the Department of Corrections). Providers worked with each state agency separately to develop programs that met the needs of the particular population they served. There were unwritten agreements that slots would be held for the agency that provided the start-up cost, resulting in waiting lists and uneven admission practices. As a result, a confusing system was developed. The state therefore lacked a consistent array of services that were easily accessible by those families who needed them and there were no common practice expectations other than the minimal requirements mandated by state licensing standards.

Over the last four years, residential services in Maine have undergone dramatic changes. State agencies that use children's residential services have moved rapidly towards a family-centered paradigm that focuses on developing necessary services to safely keep a child in a family setting and in their home community. This has resulted in a shift toward providing an array of intensive community-based services to support children and families and prevent out-of-home care whenever possible. Subsequently, this paradigm shift has resulted in a 35% reduction in the use of residential treatment beds. In response, providers have re-examined their program designs and shifted services to become better aligned with the current needs. Although use of residential care has substantially decreased, the Office of Child and Family Services recognizes that it continues to be an important part of a treatment continuum. Residential treatment is currently utilized as a targeted, intensive, shorter-term treatment intervention that actively includes the child and family as integral members of the team.

In 2005, a group known as the Interdepartmental Resource Review (IRR) was organized to respond to provider requests to redesign their services. This group, composed of staff from five State child-serving agencies, meets monthly to review proposed redesigns and make recommendations to the directors of the various State agencies. Over the last two and half years, the IRR has reviewed 57 distinct proposals from 43 different providers. Over half of the residential programs in Maine have redesigned their programs to deliver more intensive, short term mental health treatment that focuses on the child and his/her family.

During the summer of 2005, the 122<sup>nd</sup> Maine Legislature, Health and Human Services (HHS) Committee directed the Department of Health and Human Services to convene workgroups that would provide recommendations regarding children's service system reforms. The HHS Committee stipulated that reforms should address, at a minimum, service delivery structures, financing of these services, quality assurance, and quality improvement strategies. Subsequently, the Children's Services Reform Steering Committee was convened to review the changing landscape of children's services in Maine. One workgroup, established under the Steering committee to address residential care, was the Reforming Residential Services Workgroup. This workgroup developed a set of recommendations which were included in the Maine Children's Services Reform

Report, published in January 2006. One of the many recommendations was to develop family-centered residential standards. This document is intended to fulfill that recommendation and provide standards for consistent quality of children's residential treatment throughout the State.

## Introduction

The first rule of health treatment is to do no harm. The next core value of the Office of Child and Family Services (OCFS) is that services be provided to children in the most appropriate and least restrictive setting, preferably in the child's home and community. OCFS also affirms that there are times when a child's needs can most appropriately be addressed in a residential treatment setting. OCFS believes that when a child is placed in a residential setting, family-centered collaborative team planning and decision-making must remain the essential components in an inclusive process for children and families.

The standards included herein were developed based on values identified by OCFS as well as the following purpose statement created by the Reforming Residential Services Workgroup which reads in part:

*Residential treatment is a part of Maine's continuum of care and should be utilized when: directed by the child and family team; there are presenting challenges that the family acknowledges they cannot handle and sufficient community cannot remedy; and when the child and family team has routinely reviewed the service needs and determined that the residential placement meets specific needs.*

Residential treatment is a resource to families and should be viewed as an intervention, not a placement. It is part of a community-based continuum of care. The primary goal should be to prepare the child and family, as quickly as possible, for the child's return to home and the community.

The Office of Child and Family Services believes that the following guiding principles for Systems of Care should be utilized in all service areas:

- Families are full participants in service planning
- Services and supports are family-centered
- There is access to comprehensive services for children, including social, emotional, and educational
- Services should be provided in the least restrictive and normative environment
- Early identification and intervention is promoted
- Case management provides service coordination to meet changing needs of families and children
- Children with emotional disturbances are served in a manner sensitive to cultural needs and differences

*Reference: Building Systems of Care A Primer. Author: Sheila A. Pires (2002)*

## Purpose and Role of Program Standards

OCFS believes it is vital for children's residential treatment programs in Maine to operate with the highest possible quality. In keeping with a systems of care philosophy, OCFS recognizes that special components of treatment and certain services may require additional requisites or guidelines to fulfill the unique service needs of the children for which OCFS seeks service. Therefore, in addition to the requirements of licensing and regulation, OCFS established these *Children's Residential Program Standards* ("*Program Standards*") as expectations of the programs from which they purchase services through contract or agreement.

These *Program Standards* will apply to all licensed Children's Residential Mental Health Programs. They do not replace the state licensing regulation requirements for Children's Residential Treatment, nor are they meant to certify or accredit residential treatment programs. These standards reflect desired practices in working with children and families. Their purpose is intended to achieve statewide consistency in the development and application of residential treatment services and to help parents and guardians, as well as those running residential programs, understand what quality residential treatment looks like. The goal of developing these standards is to assure that high quality family-centered treatment services are provided using evidenced-based or best practice methods. They will provide measurable outcomes of current services, highlight areas of strength and help agencies focus their attention on areas to improve. Children's Crisis Programs are not covered by these standards.

OCFS plans to work in close partnership with the DHHS Division of Licensing and Regulatory Services (DLRS) in the implementation and ongoing review of these standards. The goal will be to reduce administrative burdens on providers by coordinating efforts in the oversight and review of both licensing and program standards.

These *Program Standards* were initially developed and reviewed by a committee comprised of representatives from: contracted service providers and member associations; regional office staff representing Children's Behavioral Health and Child Welfare; staff from the OCFS Central Office, and staff from the Muskie School of Public Service/ University of Southern Maine. The basis of these practice standards are the experiences of the committee members, current literature and feedback from consumers, service providers and staff. The standards will be subject to ongoing review and revision to ensure quality residential services are provided to Maine's children and their families.

## Categories of Program Standards

The following program requirements have been determined to be the essential components of quality care for children, youth and families receiving residential treatment services. They are grouped into four main categories:

- Mental Health Treatment Standards
- Family-Centered Practice Standards
- Behavioral Support and Management Standards
- Treatment and Discharge Planning Standards

These categories were selected based on wide-ranging discussions that examined various levels of standards including:

1. *Structural*- Daily services providers would be expected to deliver, staff-to-child ratios, staff qualifications, use of recreational funds
2. *Process*- Treatment models, family-centered programming, amount and duration of treatment
3. *Outcomes*- Measures that would be monitored across all types of programs

In addition to the proposed levels, the committee members identified additional issues that they wanted to see addressed in standards. These were eventually grouped into broader categories and cross-referenced with standards in Licensing to eliminate duplication. The committee ultimately recommended that educational issues continue to be monitored by the IEP process and Department of Education policies. They also came to consensus that standards related to creation of a normalized living environment should remain within Licensing Standards. The final four categories as determined above are not meant to be an exhaustive list but rather a starting point for reviewing program practices.

The following sections outline in detail the standards in each of these categories.

## Section 1: Mental Health Treatment Standards

### **Purpose:**

It is the goal of the OCFS that all children and adolescents receive services in the least restrictive, most normalized and stable environment that is clinically appropriate. The treatment setting should be, whenever possible, in the family's local community. However, at times children and adolescents present with complex behavioral health issues that are serious or unsafe enough to necessitate treatment in a residential setting. When the complexity of the child's clinical conditions and their developmental needs require residential treatment, it is expected that they receive intensive, temporary, high quality behavioral healthcare commensurate with their psychosocial needs.

Treatment of children and adolescents with severe emotional disturbance requires specialized knowledge and skill in the field of child and adolescent mental health. Currently there are few evidenced-based or best practice models for residential treatment as most models currently used were tested in outpatient settings. It is the expectation that clinical care and treatment should be provided by qualified staff, be well-coordinated, demonstrate continuous quality improvement practices and base length of stay on the clinical needs of the child and family. The residential program will be responsible for researching outpatient evidenced-based practice to determine which parts of the models would be most effective for the children and youth they serve.

Residential staff should actively work to ensure that partnerships are preserved with other child serving systems and coordinated with community-based resources throughout the child's stay in residential care. Residential staff need to ensure that families are provided with ongoing resources and support. Families must be supported and empowered as equal partners in all aspects of decision making, joint treatment and discharge planning. Family treatment is a critical element to successful outcomes and, as such, family involvement and participation should remain at the center of the child's treatment. All

treatment services should be provided in a manner that ensures children and families receive comprehensive, culturally competent treatment.

## Mental Health Treatment Standards (MHT)

**MHT Standard 1: Clinical Staff Qualifications:** Clinical services will be delivered by appropriately trained and licensed mental health professionals.

- 1) A Children's Residential Provider (CRP) must employ or have an agreement with one or more licensed professionals, in order to deliver individual and family treatment. All CRP clinical staff must retain one of following licenses: LCPC, LCPC-Conditional, LCSW, CSW-IP, LMSW Conditional Clinical, LMFT, LMFT Conditional, APRN-PMH-NP, APRN-PMH-CNS, psychiatrist, or licensed clinical psychologist. Therapists with conditional licenses must maintain appropriate supervision.
  - a) **Outcome Measure:** The CRP must maintain a copy of the all clinicians' current licenses and will make them available upon request.
  - b) **Outcome Measure:** The CRP must maintain a record of the number of hours of face to face individual and family treatment delivered by the clinical staff.
- 2) A CRP must employ or have an agreement with one or more off-site licensed psychologists or psychological examiners. All psychological testing will be performed by a licensed psychologist or licensed psychological examiner.
  - a) **Outcome Measures:** The CRP must maintain a copy of all psychologist or psychological examiner current licenses and will make them available upon request.
- 3) A CRP will employ or have an agreement with one or more licensed medical professionals to prescribe psychotropic medication. It is preferable that the licensed medical professional be either a child and adolescent psychiatrist or a behavioral/developmental pediatrician. The licensed medical professional must complete at least 8 hours of continuing education credits every 2 years in the area of child and adolescent pharmacology. Licensed medical professionals who have not completed a residency in child/adolescent psychiatry must be supervised quarterly by a child and adolescent psychiatrist or a behavioral/developmental pediatrician.
  - a) **Outcome Measure:** The CRP will maintain a copy of the medical professional's license, continuing education credits and supervision. This information will be available upon request

**MHT Standard 2: Coordination of Clinical Services:** On-site mental health treatment, psychological testing and medication management is preferable to off-site treatment, in order to enhance collaboration, team functioning and information sharing. When off-site treatment is necessary due to the specialized clinical needs or unavailability of staff, it is the CRP's responsibly to ensure coordination of care. Off-site treatment is generally discouraged because of the difficulty with full and complete communication and lack of comprehensive integration into the multidisciplinary team and milieu

- 1) When individual or family therapy is provided off-site, the CRP will ensure that the therapist is informed about the child's current level of functioning within the residential and school setting. The CRP will communicate information related to other significant issues/stressors the child is experiencing related to other residents in the program or staff. The therapist, with the child's and guardian's permission, will keep the CRP informed of the issues being worked on in treatment. This communication will take place pre and post each therapy session. The off-site therapist will participate in all residential treatment planning to ensure that family and milieu issues are addressed as well as the child's issues.
  - a) **Outcome Measure:** The CRP will maintain documentation of all collaboration with off-site therapist. In the case where the therapist does not have an agreement with the CRP, (cases in which the child and family chose to maintain treatment with a pre-existing therapist) or in the case where the therapist or the child decline to inform the agency of issues being worked on in treatment, the CRP will maintain documentation of coordination of services with the off-site provider.
  
- 2) When a specialized assessment (psychological evaluation, psychosexual assessment, etc) is provided off-site, the CRP will ensure that the evaluator is informed about the child's current level of functioning within the residential and school setting. The evaluator will provide a written report of the results and recommendations to the CRP that will be inclusive of relevant milieu issues and family concerns/issues.
  - a) **Outcome Measure:** The CRP will maintain documentation of all communication between the evaluator and the program. In the case where the evaluator does not have an agreement with the CRP, (cases in which the child and family chose to continue with a prior evaluator) the CRP will maintain documentation of coordination of services with the off-site provider. The CRP will maintain a copy of the written report in the child's file.
  
- 3) When medication management is provided off-site, the CRP will ensure that the licensed medical professional is informed about the child's current level of functioning within the residential and school setting. The physician shall be made aware of any disruptions or disturbances in the milieu (staff or client) that might effect the child's functioning. The licensed medical professional, with the child's and guardian's permission, shall inform the CRP staff, the family/guardian, and child/youth about any medications prescribed, the child's diagnosis which the medication is intended to treat, medication treatment goals and any possible side effects. The licensed medical professional will inform the program when to contact the physician and steps to take in an emergency. The licensed medical professional will provide medical notes for the child's residential records.
  - a) **Outcome Measure:** The CRP will maintain documentation of collaboration with the licensed medical professional. There shall be documentation of: a) consent to treatment regarding all medications; b) description of measurable treatment goals of medications; c) how progress will be assessed by child, family/guardian, and staff; d) list of side effects and how to respond to any that may occur. In the case where the licensed medical professional does not have an agreement with the CRP, (cases in which the child and family chose to maintain medication

management with a preexisting doctor), the CRP will maintain documentation of attempts to coordinate services with the off-site provider.

**MHT Standard 3: Models of Treatment:** The CRP will determine which mental health treatment model has the strongest evidence of effectiveness for the problems experienced by the clients it serves. The CRP will ensure that the model is an integral part of the agency's service delivery. An agency may utilize more than one model of treatment based on each child's clinical presentation.

- 1) The CRP will have a process for determining which treatment models have the strongest research supporting the effectiveness of treating a child's presenting problem, diagnosis and/or clinical presentation. For whichever treatment interventions are chosen, the agency will have a process for implementation of the model with the highest degree of fidelity feasible.
  - a) **Outcome Measure:** The CRP will maintain documentation of the steps it took in choosing a method of treatment and delivery of the treatment with the highest fidelity feasible.

**MHT Standard 4: Measurement of Effectiveness:** The CRP will measure the effectiveness of the services it provides to clients and use this information to continuously improve its mental health services.

- 1) The CRP will measure the clinical status of each child upon admission, at least every three months and at discharge using a State approved clinical outcome measure. The CRP will document whether the child was discharged to a lower, similar or higher level of care. Classification of the level of restriction of various placement settings will be available from OCFS.
  - a) **Outcome Measure:** The CRP will collect, maintain and analyze data on the child's clinical functioning and level of care in order to determine the effectiveness of the mental health services delivered. This data and analysis will be made available upon request.
- 2) The CRP will develop a continuous quality improvement plan that uses its own outcome data, as well as information from State agencies, to improve its services.

**MHT Standard 5: Length of Stay:** A child's length of stay in residential care will be determined primarily by the clinical needs of the child for out of home care, and should be kept to as short as time as possible.

- 1) The CRP will maintain an internal utilization review process to ensure that the length of stay for each child is justified by the clinical need.
  - a) **Outcome Measure:** The CRP will collect, maintain and analyze length of stay data. This information will be made available upon request.

## Section 2: Family-Centered Practice Standards

### **Purpose:**

Modern day residential treatment is no longer a separation from one's family. Given that the child or adolescent will return to a family and community, it is imperative to include and support family members as extensively as possible from the beginning of the admissions process through discharge, transition and aftercare. When a child is placed in an out-of-home setting, it is a time to redouble efforts in working with the family as parents are the most important resources in a child's life and must be given the necessary support to fulfill that role.

Family-centered practice approaches include some fundamental touchstones including allowing families, rather than professionals, to identify needs. Families should be full partners in all aspects of their child's treatment. Families have the right to decide what is in the best interest of their family unit and residential treatment staff should assist and encourage families to be actively and meaningful involved in all aspects of their child's care. Residential treatment staff should engage in empowerment practices that "*de-emphasize the family's responsibility for causing problems, focus on helping families acquire the skills necessary to solve problems, meet needs, and attain desired goals. Empowerment practices assume that families are competent or have the capacity to become competent*" (Well & Fuller, 2000). Staff in a supportive residential environment acknowledge a parent's strengths, abilities and accomplishments. They notice what parents do right and encourage more of that behavior. They recognize stressful circumstances (such as past trauma, poverty, parental mental health challenges, single parenthood and distressed marriages) and assist parents in developing the necessary supports to overcome these circumstances.

Residential providers need to work with the child and family team to continually pursue effective levels of engagement with families which include extended family members and natural/informal supports. *In some situations, a child may not be returning to his/her family of origin or may not have an identified family to return to. Residential providers must work with the child and family team to assist these children/youth in developing ties to their community, non-family resources upon which they can depend for assistance and connections with caregivers that can meet their relationship needs.* (AZ Department of Health Services, 2005)

## Family-Centered Practice Standards (FCP)

**FCP Standard 1: Family-Centered Policy:** The CRP will maintain clear policies on family involvement and will encourage families to take an active part in the child's treatment plan and daily life in the program.

- 1) The CRP will develop policies and practices that assure family involvement in all aspects of the program from the day of admission and going forward throughout treatment. Policies will clearly spell out the family's right to visitation and expectations of the family regarding participation in treatment. The policy should also clearly define exceptions when family involvement is limited by state action or detrimental to a child, and how those determinations will be made.
  - a) **Outcome Measure:** The agency will have a family-centered policy and maintain records documenting training of all staff in the policy. The policy will be available upon request.
  
- 2) The CRP will provide parent supports and treatment interventions including psycho-educational, preventive and supportive services as indicated by assessments. The focus will be on enhancing the parents' coping mechanisms and providing them with the tools to move towards self-sufficiency, through involvement in normal parenting activities such as cleaning rooms, cooking meals, doing homework, or participating in development of positive and negative consequences of behavior. The program will encourage parental involvement and provide ongoing opportunities for parent to engage within the daily life activities of the child.
  - a) **Outcome Measure:** Documentation of parental presence and participation in treatment and typical daily parenting activities shall be maintained in the child's record. The CRP shall track the frequency and type of parental involvement across all admissions to assist in the agency's continuous quality improvement plan.
  
- 3) As much as possible, siblings will be included in the family-centered treatment, visitation and the daily life of the child unless a determination has been made that it would be contraindicated as defined in FCP 1. Emphasis should also be placed on maintaining frequent sibling contact through phone contact, letter writing and e-mail.
  - a) **Outcome Measure:** Documentation of sibling visits, shared activities, and participation in treatment shall be maintained in the child's record. The agency shall track the frequency and type of all sibling involvement to assist in the agency's continuous quality improvement plan.
  
- 4) Visits to a child's home and community shall be a main focus of the treatment. It presents the opportunity for the child and family to practice and refine skills learned in the CRP. Family and home visits will be on an individualized schedule and part of the treatment plan. The family and child will be provided with a written schedule for

home visits. The treatment plan will reflect the goals and skills for the child and family to work on during visits. Family and home visits should be used as an opportunity for the family to practice skills learned in treatment.

- a) **Outcome Measure:** Documentation of the progress and challenges during visits as well as any modification of the family's involvement shall be maintained in the child's record.

**FCP Standard 2: Family-Centered Treatment Plans:** The CRP will design and deliver treatment that addresses the child and family's assessed strengths, needs and identified barriers to achieving permanency

- 1) Planning must operate within a family-centered practice framework, valuing the importance of the family and demonstrating a strong respect for the inherent strength, importance and capabilities of family members in all phases including the assessment process, setting and prioritization of treatment goals, ongoing care and discharge planning. Families will be integral in deciding on how to measure realistic treatment progress, develop and refine appropriate interventions.
  - a) **Outcome Measure:** Interviews or surveys of family members by state agency staff during licensing and other site reviews confirms they feel planning process is family-centered
- 2) The family and the CRP will jointly develop measurable family treatment goals that are strengths-based, developmentally appropriate, attainable and culturally competent. The child and family must play an integral part in developing the treatment plan to ensure a successful course of treatment and discharge. Strategies to address any potential barriers to discharge should be clearly defined in the treatment plan and written in the everyday language of the child and family.
  - a) **Outcome Measure:** Each child and family will receive a written copy of the treatment plan, with clearly identifiable, realistic and measurable goals. The CRP will maintain documentation that the written plan was developed with, reviewed and approved by the family. Documentation of parental presence and participation in the treatment and typical daily parenting activities shall be maintained in the child's record. The CRP shall notify the involved state agencies staff weekly if parents do not participate. This documentation will be made available upon request.

**FCP Standard 3: Evaluation:** The CRP will develop a process to solicit feedback from families, children, youth and other stakeholders. The agency will use this information as part of its continuous quality improvement plan.

- 1) The CRP will solicit feedback from families, children, youth and stakeholders using a standardized instrument developed in partnership with State agencies. The instrument shall measure functional progress, family functioning, and child and family satisfaction. Information shall be collected at discharge from the program and six months post discharge.

- a) **Outcome Measure:** The agency will maintain records of parental feedback during treatment, at discharge and six months post discharge.
- 2) The CRP will have an established grievance and conflict resolution process for families who have questions or concerns about their child's care.
  - a) **Outcome Measure:** The program will have documentation of their policy and will maintain a complete list of all grievances or uses of the conflict resolution process. This information will be made available upon request.
- 3) The CRP will utilize the information gathered from family/stakeholder feedback and the grievance/conflict resolution process as part of their continuous quality improvement plan.

## **Section 3: Behavioral Support and Management Standards**

### **Purpose:**

Each child is entitled to be treated with dignity while in a culture that promotes healing and provides them the support they need to manage their own behavior. It is expected that each child who is a recipient of residential services resides in an environment in which he or she is valued, respected and well cared for. OCFS endorses national best practice standards which encourage adults working with children to set clear expectations and limits, develop regular routines, encourage cooperation and problem solving, and use a full range of positive interventions before using more intrusive interventions such as physical restraint. Interventions with children which are designed to modify their behavior should be respectful, developmentally appropriate, related to the issue at hand, flexibly applied and designed to help the child master age and developmentally appropriate skills.

All residential programs should practice positive behavior support strategies. Positive behavior support is a systems approach to establish the social culture and behavioral supports needed for all children to achieve social and behavioral success. It is based on respect, dignity and offering choices, *as appropriate to the child's age and developmental level*. Positive behavior support helps children develop effective strategies for getting their needs met and helps reduce behavior problems. See Appendix A for information on the components of positive behavior support.

The effective use of prevention strategies can help children and adolescents master the difficult developmental skills of coping with internal distress and external conflict. Each child or adolescent should have a behavioral plan that includes strategies to that encourage the use of adaptive and pro-social behaviors with the goal of preventing aggressive behavior and de-escalating behavior before it becomes necessary to use more

restrictive measures. When prevention strategies are ineffective and a child or adolescent is in danger of hurting themselves or others, approved behavioral intervention procedures will be utilized to maintain health and safety. Each behavioral intervention must be thoroughly documented and reported to the child's guardian in accordance with the standards below. Each incident should be viewed as an opportunity to explore new methods to support the child or adolescent in managing his or her future behavior. The child or adolescent should have a debriefing discussion that allows him/her to process and understand what happened including reviewing the events that triggered the incident and discussing alternative strategies to avoid similar incidents.

Anger management and stress reduction techniques are important components of prevention in residential programs and should be a component of a psycho-education program for children and adolescents. Behavioral/safety plans should include a review of triggers, warning signs, repetitive behaviors, response to interventions, and prior restraint events that are associated with aggressive acts. Staff should take into consideration cultural factors, cognitive limitations, neurological deficits, learning disabilities and medical issues that may influence the triggers and expression of aggression by children and adolescents in residential programs. All residential care providers must comply with the discipline and restraint requirements contained in the Maine Children's Residential Program licensing requirements.

Programs must provide ongoing training to maintain highly qualified staff. Training should assist staff in identifying situations in which children and adolescents are likely to lose self-control and examine positive ways to gain self-control. Training should include updated information about creating a supportive environment, prevention techniques including behavioral skill development, redirection, de-escalation, proper use of restraint, de-briefing and documentation.

## Behavioral Support and Management (BSM)

**BSM Standard – 1 Policy:** Residential agencies shall maintain clear Behavioral Support and Management policies and assure that all staff are trained and knowledgeable in the policies and their implementation.

- 1) Each child’s treatment plan shall include a behavioral plan that includes preventative and de-escalation strategies. All behavioral plans shall be based on an assessment by a qualified clinician as defined in MHT Standard 1. Monitoring, review and adjustment of behavioral plans will not be limited to a quarterly basis. Plans will be adapted on an ongoing basis and as needs dictate.
  - a) **Outcome Measure:** A review of treatment plans at the CRP shall include the child’s behavioral plan 100% of the time.
  
- 2) The CRP prohibits the use of mechanical restraints, chemical restraints, and locked seclusion. Use of medication in a time of increased psychosis or aggression is not considered chemical restraint, but appropriate use of medication, as long as the goal is increased self control and not physical immobilization. Administration of PRN medication requires prescription by a licensed medical professional prior to administration. Any plan for the use of PRN medication must be clearly documented in the treatment plan and all incidents must be recorded
  - a) **Outcome Measure:** The CRP’s behavioral support and management policies will be available upon request. The agency will maintain records documenting training of all staff in the agency’s policy. The agency will document each use of PRN medication in the child’s record.
  
- 3) Behavioral intervention shall never be used as punishment, a form of discipline or compliance or for the convenience of staff.
  - a) **Outcome Measure:** A review of the CRP treatment plans will indicate that the appropriate use of behavioral interventions 100% of the time.

**BSM Standard – 2 Consequences:** The use of consequences is an invaluable tool in assisting a child with the management of her or her own behavior. Positive consequences are inherently preferable over negative consequences. They should be employed whenever possible to incentivize pro-social behavior.

- 1) When negative consequences are administered, they will be related to the inappropriate behavior demonstrated by the child. Consequences shall be appropriate for the child’s age/developmental level and timely (preferably immediately following the inappropriate behavior). The use of consequences shall be coordinated closely with those responsible for supervision of the child in other settings (parents/guardians, foster parents, school, and respite providers). Any consequences

that the parent's are expected to follow during visitation or home visits should be realistic and shall take into considerations the family's skills and home environment.

- a) **Outcome Measure:** Documentation of the use of positive and negative consequences shall be included in individual client records. Documentation of debriefing with parents and others who supervise the child will include information about use of positive and negative consequences and an assessment of their effectiveness.
- 2) The agency will provide written guidelines in the use of positive and negative consequences for staff and clients. Guidelines will include the steps a child can take to appeal a negative consequence. Consequences must be individualized. A group should not be given a consequence for the actions of an individual. The agency prohibits the use of the following as consequences:
    - Denial/disruption of contact, visits or phone calls with family members or legal guardians
    - Denial/disruption of contact, visits or phone calls with State agency staff, lawyers, or guardian ad litem
    - Denial/disruption of contact with therapist
  - a) **Outcome Measure:** The agency policy and guidelines on the use of consequences will be available on request

**BSM Standard 3:** Isolation – Separating a child from the milieu can be a useful tool in reducing excessive stimuli and helping a child to regain control of his or her behavior

- 1) The agency will provide written guidelines to the staff and clients on the appropriate use of isolation. Guidelines will include the steps the staff are required to follow.
  - a) **Outcome Measure:** The agency's policy and written guidelines on the use of isolation will be available upon request
- 2) A child can be led involuntarily to an isolation area. The door may never be locked or barred. The child must be monitored continuously. The child must be given clear choices of behaviors that can lead to re-engagement in the milieu.

*The use of "self time-out" or "life space" is not considered isolation as long as the child voluntarily separates him or herself from the milieu to a quiet non-stressful area. Isolation/safe rooms may be used for this purpose, but the child cannot be denied exit from the room.*

  - a) **Outcome Measure:** All incidents of isolation will be documented in the child's file. In addition the agency will keep a log of all involuntary isolations. This log will be available upon request.

**BSM Standard 4:** Physical restraint is utilized only to maintain client health and safety in situations when less restrictive methods have been ineffective.

- 1) Passive physical restraints are permitted only in children's licensed mental health residential programs. All residential staff shall be trained in the use of an approved physical restraint method. Untrained staff or peers are prohibited from the use of restraint. At no time may restraint be used as punishment, a form of discipline or compliance or for the convenience of staff.
  - a) **Outcome Measure:** The agency policy on the use of restraint and documentation of all staff training shall be available upon request
  
- 2) If physical restraint is continuous for more than 30 minutes, the provider staff must call the clinician in charge for a review. The provider may continue restraint until the clinician is able to access the situation. The clinician will immediately conduct an assessment to determine if the child should be placed in a higher level of care or what other steps should be taken.
  - a) **Outcome Measure:** All use of restraint will be documented in the child's file. Any calls the clinician in charge will be documented in the child's file.

**BSM Standard 5:** The use of restraint shall be clearly documented and all parties will be informed of the incident. The CRP will strive to find methods to reduce the use of restraint and improve client treatment.

- 1) State agency staff and the child's legal guardian shall be informed within one business day of any use of physical restraint. The agency must fill out and submit the Behavioral Intervention Form mandated by OCFS and fax it to the state caseworker, or other state official involved in the case. For children with no state involvement, the form must be sent to the legal guardian. The agency will document the following:
  - An assessment of the precipitating cause or reason for the physical restraint.
  - Documentation of the methods used, including the length/duration of the intervention
  - An explanation of the less restrictive interventions tried prior to the behavioral intervention and why such measures were not successful
  - An assessment of the impact/effectiveness of the treatment plan and how it may need to be modified to prevent the use of behavioral interventions in the future
  - The names of the staff involved and the supervisor who authorized the physical restraint
  
- 2) The child must be given a chance to process all physical restraints. This should be done as soon as the child is calm enough and willing to engage in a discussion. This processing becomes a part of treatment as it allows an understanding of what happened, triggers and possible alternative responses by staff and the child
  - a) **Outcome Measure:** Clinical records must indicate documentation of discussion with the child and staff, regarding why the restraint took place, and what he/she can do in the future to avoid the situation.
  
- 3) For any physical restraint that: 1) is more than 30 continuous minutes, 2) requires medical treatment for the child or staff or 3) occurs three times within an hour, the

provider shall schedule a debriefing to review the behavioral intervention by the next business day. State agency staff and the child's legal guardian shall be informed of the meeting and given the option to attend.

- a) **Outcome Measure:** Documentation in the child's record will indicate that the debriefing occurred and will identify the antecedent behaviors that led to the intervention. Alternative responses by staff and the youth shall be integrated into the modified treatment plan
- 4) On an annual basis the agency shall produce a report documenting the use of isolation and physical restraint. The report will include data on total use of these methods, trends in the use of these methods, areas of concern and plans for improvement.
- a) **Outcome Measure:** This report will be made available to Division of Licensing staff, state agency staff and legal guardians.

## Section 4: Treatment and Discharge Planning Standards

### Purpose:

Essential to family-centered practice is that “staff and families work together in relationships based on equality and respect” (Family Resource Coalition of America, 1996). As this relates to the development of treatment and discharge plans, ownership of the plans must be shared with the individual and family receiving services.

The 2003 President’s New Freedom Commission on Mental Health report stated:

*Nearly every consumer of mental health services who testified before or submitted public comments to the Commission expressed the need to fully participate in his or her plan for recovery. In the case of children with serious emotional disturbances, their parents and guardians strongly echoed this sentiment. Consumers and families told the Commission that having hope and the opportunity to regain control of their lives was vital to their recovery.*

The report goes on to recommend a joint planning and development process in which providers and families develop customized treatment plans in full partnership.

*Consumer needs and preferences should drive the type and mix of services provided, and should take into account the developmental, gender, linguistic, or cultural aspects of providing and receiving services. Providers should develop these customized plans in full partnership with consumers, while understanding changes in individual needs across the lifespan and the obligation to review treatment plans regularly.*

In Maine, the Office of Child and Family Services recognizes the essential role that child and family teams play and expects that all treatment and discharge planning be driven by the child and family team. The team is a group of people selected by the family that includes natural and community supports and any public or private child serving agencies that are or may need to be involved. This includes but may not be limited to: Parents and/or legal guardian, child/child, informal familial supports, DHHS caseworker,

community case manager, representatives of the placing agency, residential providers and educational staff.

As the child and family team is dynamic, it expands to incorporate members from the residential program. Team members will need to communicate what has worked in previous planning for the child and family and work with the residential staff to integrate significant family strengths and culture into the day-to-day treatment of the child. It is expected that this team will meet on an ongoing basis to identify strengths, needs, goals and family-driven outcomes that will guide the treatment and discharge plans.

Children and youth will be actively engaged and included in the planning process. Information needs to be shared in age-appropriate terms with special consideration and sensitivity being placed on preparing them for the transition process. The team will identify ways to support and maintain connections with provider staff, peers, school personnel and other community members that were made during the child/adolescent's out-of-home placement.

Planning with families should make every effort to mobilize both informal and formal resources in support of families. Informal/natural supports include identification of the child and family's personal resources including their specific skills, capacities or attributes. In addition, other natural supports include extended family members, friends, neighbors, co-workers and community resources such as clubs, sports teams and faith-based organizations. The residential staff should work as a part of the team in exploring these resources for families.

Efforts at preparing children and family members for an active role in treatment planning may also be necessary. Some families are not sure what a treatment plan is, how the process is organized, and the role they should play. Some may feel intimidated by the process so the provider's role should include aspects of coaching, facilitating and mentoring. Residential providers must work to build a partnership and help in the creation of an individualized plan.

Individualized treatment plans guide the staff on a daily basis and treatment goals should be reviewed each week. They are living documents that need to be modified regularly and utilize goals and objectives that are Specific, Measurable, Attainable, Realistic and Time limited (SMART). Treatment and discharge planning should be focused on eliminating barriers so that a child or adolescent can live successfully with his/her family. It must be recognized that the primary reason for admission need not be fully resolved before a child can successfully transition back home and that the most appropriate setting for long term therapeutic work is the environment in which the child will be living and functioning.

For children receiving residential treatment, it is imperative to address how we can increase the chances of a positive outcome. Research studies have shown that one consistent factor focuses on discharge planning/aftercare. Specifically, communication and coordination between the residential provider, family, school, and community based service providers is paramount to positive outcomes. Treatment team planning will need to address family readiness and the specific supports needed to ensure placement stability and success. Discharge planning should be approached in a careful manner, providing ample time for the family to make adjustments to the impending discharge and sufficient planning for setting up the necessary services and /or supports in the home/receiving community. On those occasions when a placement opportunity necessitates a rapid planning process, the team should respond accordingly and demonstrate flexibility in developing supports for the child and family

## Treatment and Discharge Planning Standards (TDP)

**TDP Standard 1: Individualized Treatment Plans:** Treatment plans shall be primarily focused on the skills necessary to function safely in the child's home and community. Treatment plans must be individualized and comprehensive. They must include information related to discharge needs and crisis situations. Plans must be jointly developed with the child/child, family members and other stakeholders. Treatment plans should be developed based on the SMART model: Specific, Measurable, Attainable, Realistic and Time limited.

- 1) The treatment plan shall be developed by the treatment team and based on a comprehensive assessment of the child by a licensed clinician. The plan must be individualized and include specific target symptoms/behaviors to be addressed. The plan must be based on the child's current level of functioning. The plan must clearly identify who is responsible to implement specific goals and objectives.
- 2) Adolescents in residential services age 14 and older have the right to be as fully and actively involved, as is developmentally appropriate and possible, in the development or revision of his/her treatment plan. Exclusion of an adolescent, age 14 or over, based on incapacity, developmental or mental issues requires the approval of the adolescent's guardian. The rationale for the exclusion must be documented in the treatment plan. Involvement of child under age 14 in the development of the treatment plan will be encouraged whenever developmentally appropriate .
- 3) The parent, guardian or familiar resource for a child in residential services must be fully and actively involved in the development or revision of the child's treatment and discharge plans given time and location constraints. Since the goal of placement is the return to a family setting, the CRP should make every effort to accommodate the family involvement. The CRP shall make a good faith effort to provide a seven day notice of any treatment planning meeting to the parents, guardians or familiar resources. An exception may be made if an emergency meeting is held to change the plan following a significant event.
  - a) **Outcome Measure:** The child and family must be provided with a written copy of the treatment plan. Treatment plans will be made available to appropriate state personnel upon request. The plan should be written in the everyday language of the consumer. The CRP must maintain documentation of the child and family involvement in the development of the treatment plan. Approved state personnel shall be provided copies of all treatment plans upon request. The CRP will document in the treatment plan if a family declines to be involved or if there are legal barriers to the family's involvement.

**TDP Standard 2:** Treatment plans shall follow the timelines established in the Rights of Recipients of Mental Health Services

- 1) Treatment plans shall be developed within 72 hours of admission to a CRP. Whenever possible, or at the request of a state agency, an Initial plan will be developed prior to admission. Treatment plans shall be developed within 20 working days from admission. A plan shall be considered completed based on the signature date of the majority of the participants on the treatment team. In the unlikely event that the timelines cannot be met, the record should clearly document the reasons for the delay.
  - a) **Outcome Measure:** The provider will have a clear policy on the development of treatment plans. The policy will list the level of staff who are responsible for coordinating the planning meeting and writing the plan. A log of expected and actual completion dates of all treatment plans will be maintained by the provider. The following will be monitored:
    - i) Average number of days from admission to treatment planning meetings
    - ii) Percentage of initial treatment plans completed on time
    - iii) Average number of days to the development of the treatment plan
    - iv) Percentage of treatment plans completed on time
    - v) Parent/guardian and child involvement in the treatment planning process

**TDP Standard 3: Crisis Planning:** The treatment plan will include Crisis/Safety plans for all children admitted to a CRP. Whenever possible, the plan will allow for adaptation to various settings, such as home, school or the community. The plan should include use of natural and community supports whenever possible.

- 1) Initial crisis/safety plans shall be developed within 24 hours of admission to a CRP. A more individualized plan will be developed within seven days of admission and will be used across all settings. The initial crisis plan should focus on how to handle any crises that develop in the facility. The child and family/guardian should be actively involved in the development of this plan. The plan should focus on assuring the safety of the child and others during family and home visits. The CRP will review the plan with the family before any home visits. Prior to discharge, a crisis/safety plan will be developed by the team that will build upon the crisis/safety plans utilized during home visits.
  - a) **Outcome Measure:** The CRP will have a clear policy on the development of crisis/safety plans, listing the staff responsible for coordinating the planning meeting and writing the plan. A copy of the crisis/safety plan shall be maintained in the child's record. The CRP will document that the crisis/safety plan is reviewed before home visits. A log of expected and actual completion dates of all crisis/safety plans will be maintained the provider.
- 2) Law enforcement should be utilized only for serious criminal behavior and/or significant safety concerns. It is expected that law enforcement will not be called to respond to behavior that is indicative of the child's focal behavior goals.

- a) **Outcome Measure:** The CRP will maintain a written individual crisis plan that clearly indicates when and how the police/law enforcement will be called to respond to the client's behavior. When a client has current DOC involvement, the CRP will meet with the JCCO or other responsible party to establish clear guidelines for the involvement of law enforcement.
- b) The CRP must have a clear process for decision making concerning the use law enforcement. The plan shall include a process by which approval is made by the agency clinical or executive director prior to law enforcement being contacted.

**TDP Standard 4: Review of Treatment Plan:** Each CRP will establish a policy and review schedule regarding treatment plans

- 1) The treatment plan shall be reviewed at least every 90 days, unless a more frequent review is clinical indicated. The plan will include information regarding discharge.
- 2) If treatment goals extend beyond 90 days, the child's record shall indicate what changes to the methodology have been made and how the delivery of services has been revised. If neither the methodology of the services delivery has been changed, the clinical record must document the rational for the continuation.
  - a) **Outcome Measure:** Approved state personnel shall be provided copies of all treatment plans upon request.

**TDP Standard 5: Discharge Plans:** All children admitted to a CRP will have a discharge plan developed at the time of admission that is part of the treatment plan. This individualized discharge planning continues throughout treatment with an emphasis on planning for transitions. Discharges can occur without full resolution of the presenting problems. A child can be successfully transitioned home/to a community-based setting as soon as he/she can be safely treated on an outpatient basis

- 1) The parent, guardian or familiar resource for a child in residential services must be fully and actively involved in the development or revision of the child's discharge plan. Since the goal of placement is the return to a family setting, the CRP should make every effort to accommodate family involvement.
- 2) Adolescents in residential services age 14 and older have the right to be fully and actively involved in the development or revision of his/her discharge plan. Information will be shared in age-appropriate terms. Special consideration and sensitivity will be placed on preparing them for the transition and identifying ways to support and maintain connections that were made during their out-of-home placement with residential staff, peers, school personnel and other community members. Exclusion of an adolescent, age 14 or over, based on incapacity, developmental or mental issues requires the approval of a licensed clinician and the approval of the child's guardian. The rational for the exclusion must be documented in the treatment plan.

- 3) Involvement of child under age 14 in the development of the discharge plan will be encouraged whenever developmentally appropriate. Information will be shared in age appropriate terms. Special consideration and sensitivity will be placed on preparing them for the transition and identifying ways to support and maintain connections that were made during their out-of-home placement with provider staff, peers, school personnel and other community members.
- 4) The discharge plan shall be developed by the treatment team and based on a thorough assessment of the child by a licensed clinician. The plan must be individualized for each child and must be based on the child's current level of functioning.
- 5) The discharge plan will have clear, time-limited measurable objectives including strategies and techniques that can be used by parents to allow the child to return safely to the community. Plans must clearly identify who is responsible to implement specific goals and objectives. Plans will be reality-based and address needs in the most practical way possible. Plans will focus on reintegration through outreach efforts, skills strengthening, practicing and preparation.
- 6) When faced with a precipitous or unplanned discharge, the CRP and other team members are expected to continue to work with all parties to ensure the child's and family's safety and ongoing treatment.
- 7) The CRP will document justification in the medical record when a child is ready for discharge but remains in the program due to lack of a discharge placement.

**a) Outcome Measure:** The child and family must be provided with a written copy of the discharge plan. Discharge plans will be made available to appropriate state personnel upon request. The plan should be written in the everyday language of the child/youth and include strategies and techniques that can be used by parents when the child/youth returns to the community.

## Appendix A

### The Components of Positive Behavioral Support

- 1. Supportive environment:** A supportive environment ensures children get their needs met when they use socially acceptable behaviors. It reduces a child's need to use problem behaviors to obtain an adult response. Treatment in a supportive environment:
  - 1) Acknowledge the child's abilities and accomplishments;
  - 2) Notice what the child does right and encourage more of that behavior;
  - 3) Balance predictability and consistency with an ability to respond quickly to changes in the child's life and behavior; and
  - 4) Recognize stressful circumstances (such as poor sleep, hunger, illness, parental visits, or court dates) and make reasonable adjustments in expectations for the child.
  
- 2. Skill development:** Adults can increase behavioral control skills in children by:
  - 1) Explaining what is expected;
  - 2) Redirecting ineffective behavior;
  - 3) Offering choices;
  - 4) Modeling how to negotiate and problem solve;
  - 5) Supporting the child's efforts to effectively control her own behavior;
  - 6) Being aware of and managing their own responses to challenging behaviors;
  - 7) Providing a daily structure which supports the child's need for consistency;
  - 8) Developing a list of response options and matching the intensity of the adult response to the seriousness of the child's behavior;
  - 9) Giving consequences for unacceptable behavior;
  - 10) Encouraging each child to be appropriately involved in school and community activities; and
  - 11) Making sure each child has opportunities to form significant, positive friendships and family relationships.
  
- 3. Health care:** Prompt assessment and treatment of any ongoing or suspected medical condition allows adults to better understand what behaviors can reasonably be expected of a child. Adults ensure appropriate health care by:
  - 1) Acting on concerns they have about a child's health;
  - 2) Obtaining a yearly well-child exam and dental exam;
  - 3) Keeping all scheduled medical and therapeutic appointments;
  - 4) Educating themselves about the nature of the child's illness or condition and its expected effects on the child's behavior;
  - 5) Following the instructions of the doctor or pharmacist;
  - 6) Educating themselves about prescribed medications and possible side effects; and
  - 7) Sharing medical and prescription information with other caregivers, including respite providers.

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