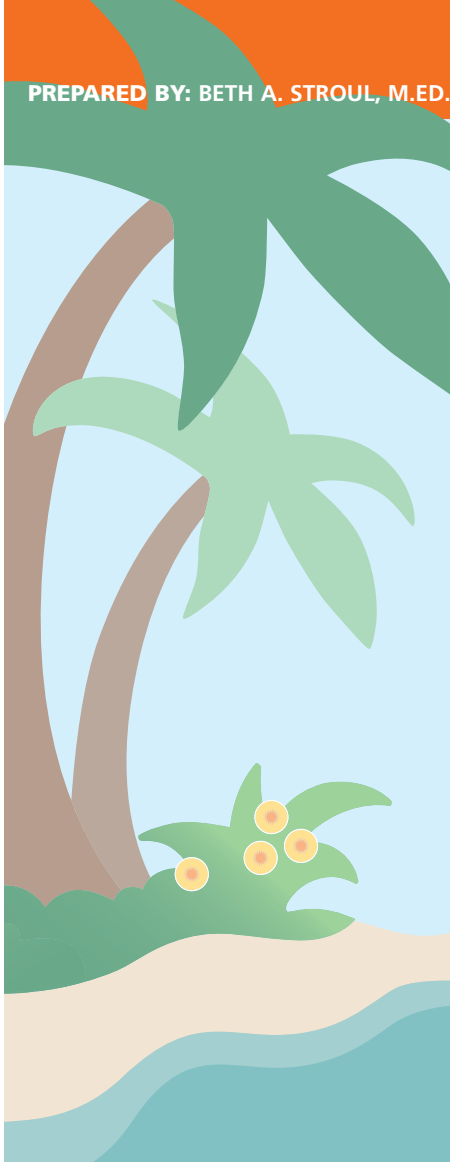


Building Bridges Between Residential and Nonresidential Services in Systems of Care

SUMMARY OF THE SPECIAL FORUM HELD AT THE
2006 GEORGETOWN UNIVERSITY TRAINING INSTITUTES

ORLANDO, FLORIDA • JULY 2006

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Introduction

A series of Special Forums were held at the Georgetown University Training Institutes in July 2006 to provide opportunities for dialogue about critical issues in order to contribute to the development of future policy and technical assistance. The Special Forums were designed as interactive discussions about communities and populations with unique service needs, requiring specialized planning and service delivery approaches within systems of care. Specifically, the goals of the Special Forums were to:

- Summarize issues and challenges related to each topic
- Identify effective service delivery strategies for local systems of care
- Develop recommendations for policy and technical assistance that will support communities in implementing these effective service delivery strategies

Each Special Forum began with brief framing presentations summarizing issues and challenges related to the topic and offering examples of effective service delivery strategies. The remainder of the forum consisted of facilitated discussion among forum participants focusing on recommendations for services, financing, policy, advocacy, information development and dissemination, and training and technical assistance. The Special Forums were tape recorded and transcribed, and additional input was collected from participants through worksheets completed at the conclusion of each forum. These materials were used to prepare a paper summarizing the issues and recommendations resulting from each Special Forum.

This paper presents the issues and recommendations from the Special Forum on Bridging the Gap Between Residential and Nonresidential Services in Systems of Care. Presenters included:

- Gary Blau, Ph.D., *Chief, Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD*
- Dan Embree, M.Ed., *Director, The Dawn Project, Choices, Inc., Indianapolis, IN*
- Robert Lieberman, *Executive Director, Southern Oregon Adolescent Study and Treatment Center, Grants Pass, OR*

Issues and Strategies

Building Bridges Summit

Gary Blau noted that there is a history of tension and, in some ways, adversarial relationships between residential treatment providers and those involved in community-based systems of care. Some of the tension can be

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traced to the original legislation for the federal program to develop systems of care (the Comprehensive Community Mental Health Services for Children and their Families Program), which specified that these funds could not be used to pay for residential services. As systems of care developed, there has been a focus and goal to shift dollars from deep-end residential services to more home and community-based services. This has not changed. Additionally, state and community agencies were challenged by the number of children who were being placed in residential treatment settings, both in state and out of state. Many of these placements were far away, creating problems and barriers for families. All of this contributed to the growing tensions.

Blau related that when he became Chief of the Child, Adolescent and Family Branch of the federal Center for Mental Health Services, he initiated a dialogue with residential treatment centers, community service providers, families, and youth to engage them in the process of creating more comprehensive systems of care. Initially, at a meeting of the American Association of Children's Residential Centers and the National Association for Children's Behavioral Health, he characterized residential treatment centers as "fortresses" that created fortress-sized walls between themselves and communities and between themselves and family members. He further talked about the coercive and punitive interventions used in some facilities, as well as the lack of nurturing and family-focused environments, and challenged the centers to think of ways in which they could become more family friendly and change the way they serve children and families. The discussion proved provocative

for some and inspirational for others and opened a dialogue with national leaders in this organization. Subsequently, similar dialogues were held with leaders of the Alliance for Children and Families and the Child Welfare League of America, all of which represent numerous residential treatment facilities.

These meetings and discussions led to the establishment of a work group with representation from these organizations and others representing residential treatment providers along with system of care leaders. This group planned and held a summit in June, 2006 in Omaha, Nebraska, entitled, "Building Bridges Between Residential and Community-Based Service Delivery Providers, Families, and Youth." The purpose of the summit was to:

- Establish defined areas of consensus related to values, philosophies, services and outcomes.
- Develop a joint statement about the importance of creating a comprehensive service array for children, youth and families, inclusive of residential and out-of-home treatment settings as part of the entire range of services.
- Identify best practices in linking and integrating residential and home and community-based services.
- Set the stage for strengthening relationships and promoting consensus building.
- Create action steps for the future.

Participants from across the country were identified to participate, including residential and home and community-based service providers, family and youth leaders, national and state policy makers, system of care council members, tribal

representatives, and representatives of national associations related to children's mental health and residential care. With financial support from The Annie E. Casey Foundation and other foundations, the summit brought together about 70 individuals with disparate views to address the difficult issues of how to integrate residential services into systems of care for those youth needing this level of care, how to help residential treatment centers shift their practice model to the system of care philosophy, and how to bring the expertise of residential treatment centers to a wider array of service delivery options for children and their families. The forum allowed discussion of some of the complex challenges involved in changing service delivery approaches, including financing, training, learning a new philosophy of care, adopting new practice models, and others. Additionally, families and youth shared their experiences in residential treatment settings, emphasizing that though there are issues about money and staff, this is about their lives and their experiences; the care provided to children and their families should be the most important consideration.

The summit resulted in a Joint Resolution which establishes core values that were agreed upon by summit participants-family-driven and youth-guided care; cultural and linguistic competence; clinical excellence and quality standards; accessibility and community involvement; transition planning and services; effective workforce development; and assessment, evaluation and continuous quality improvement. The Joint Resolution details principles and practices in each of these areas. For example, principles specify that facilities should strive to provide continuity

and support for effective transitions and incorporate a “whatever-it-takes” attitude. Visitation with families is a right, not a privilege, and should be used neither as punishment nor reinforcement. Blau emphasized that the principles contain powerful messages for improving services to children and families across all services in a continuum of care. The Joint Resolution is included at the end of this summary.

Service Delivery Strategies

Dan Embree directs the Dawn Project in Indianapolis, Indiana, which is one of the programs of Choices, Inc. Choices manages the care for people involved in one or more public systems and currently operates in three states—Indiana, Ohio, and Maryland. He participated in the summit representing a system of care and brought with him a residential provider that has partnered with Choices and the community to provide services in a different way. Choices manages all aspects of the care of youth in its service population, and, as coordinators of care, takes over full responsibility for that care wherever youth are. They are responsible for fiscal and clinical aspects of care, whether it is community-based, residential, or any sort of placement. Children served by Choices have a child and family team to plan and coordinate services. However, historically, when a child had a residential treatment episode, the process would be disrupted and the child “went behind these walls and fell off into the abyss.” When the child was discharged, Choices would start the process again. In response, efforts were directed at trying to gain control of this and have a seamless service delivery process with the child and family teams maintaining control of

the planning process while the child was in residential treatment.

Embree noted that the lessons learned by Wraparound Milwaukee, shown on Table 1, about integrating residential treatment are similar to the lessons learned by the Dawn Project of Choices:

- Residential treatment is part of the continuum in systems of care.
- Residential treatment should be short-term, anywhere from 30 to 90 days.
- Targeted behavioral and mental health needs should be the focus of residential treatment.
- Care planning should remain with the child and family team and not switch to a different

team that just focuses on the residential treatment.

- Family involvement should be supported and families should be drivers of the plan, and youth should have the opportunity to guide the plan.
- The outcomes for the residential treatment stay should be very clear and time-limited.
- Residential treatment centers should provide a broader continuum of care.

Bob Lieberman directs the Southern Oregon Adolescent Study and Treatment Center, a multi-service agency which has psychiatric residential treatment as its original service. It is a community-based residential program and has only

TABLE 1

Best Approaches in Working with Residential Treatment Centers and Other Institutional Providers in a System of Care: Lessons Learned by Wraparound Milwaukee
<ul style="list-style-type: none"> • Residential treatment should usually be kept short-term (30-90 days) and focus on meeting those immediate behavioral and mental health needs that cannot be met in the community • Care planning resides with the child and family team and the residential treatment center joins the team—RTC care becomes one of many strategies used by the team to achieve community care plan objectives • Parents, care takers, and siblings are encouraged and supported to participate in treatment and care planning for youth while in RTC • Families are given a choice of residential treatment options and facilities • Clear time-limited measurable objectives are developed for the child while in residential treatment with clear goal of how strategies and techniques can be used by parents when child returns to the community • A crisis safety plan is developed for each child and residential center helps parents in understanding how to anticipate and respond to potential future crisis situations • Residential centers develop a continuum of care of services and supports for the child in the community such as <ul style="list-style-type: none"> – Group homes or treatment foster care – Mentors and crisis intervention and short-term respite or crisis care in the RTC – In-home family therapy or other behavioral supports available in the home – Independent living and supervised apartments for youth transitioning to adulthood • Discharge to community occurs when the immediate identified needs are met—long term treatment needs can be met in the community

served children from the local community, with few exceptions, since opening in 1977. He also has been the President of the American Association of Children's Residential Centers (AACRC) and now serves as its Public Policy Chair. He commented on what was done in AACRC and in Oregon to try to link residential and community services.

Lieberman described pilot projects undertaken in Oregon whereby residential facilities were able to enter into relationships with mental health organizations (MHOs), which are the entities that manage mental health care under the managed care system in that state. Residential facilities, which had feared draconian revenue cuts if they moved into the managed care environment, entered these contracts with a "hold harmless" provision, allowing them to invoke the right to be held harmless to total revenue for a period of years. According to Lieberman, the pilot projects had variable results, depending on the residential provider, the MHO, and the agreement between them. However, the Southern Oregon Adolescent Study and Treatment Center developed an effective relationship with the managed care organization, and was able to link residential and community services, shorten residential length of stay, and send staff out to follow the children and support them in the community post-discharge with in-home and other kinds of services. The results included better outcomes as measured by several functional outcome scales. In addition, as an organization, the Southern Oregon Adolescent Study and Treatment Center learned how to become more flexible, how to work with children and families differently, and how to respond to emerging situations

without saying, "Well, that doesn't fit the set of criteria that we have for admission or how we work with kids." They were able to redesign services to further link residential and community services as Oregon has moved into a fully managed care model for children's mental health.

Lieberman explained that change also was supported by the work of the American Association of Children's Residential Centers. Starting at their annual conference in 1999 and since then, the AACRC has been exploring how its members can better respond to emerging systems of care. The AACRC recognized that the system of care vision and approach, and the progress in adopting this framework nationwide, were competing and inarguable philosophically. However, the "residential world" felt as if it were on the outside. "People would say nobody wants to see residential anywhere." Part of what residential providers felt was needed was some critical self examination, which has been a painful process of going back and re-examining what could be done differently. AACRC examined the history of residential treatment and found that they had seen themselves, and the rest of the system had seen them, as the "failure option," the placement of last resort, where youth were sent when they could not be helped anywhere else. Lieberman stated: "The CFR-42 rules for placement in a psychiatric residential setting specify that no other services work; a deficit area and diagnosis for the youth are needed in order to get access to payment. The system labeled residential centers as the failure option, and so did residential centers themselves—they began to collude in the idea that they are needed to help those youth that nobody else can help. 'Their parents

can't help them. The system can't help them. Nobody else can help them. We are so desperately needed. Nobody else can deal with these youth, and, therefore, we're here to heal them, and we feel bad for whatever may happen when they leave us, because the system is not going to pick them up.' This attitude is not very healthy. Further, data show that youth get better while they are in residential treatment, but gains often are not maintained after they leave. Data were not supporting the belief system of residential treatment providers, and they began thinking that they needed to redefine their role in conjunction with community systems of care."

AARC made a commitment that every annual conference would devote significant attention to systems of care and linking residential services to systems of care. Lieberman emphasized that, from the organization's perspective, it is critical to move residential out of a placement model into an intervention model. "If residential becomes an intervention, what is the purpose of the intervention? If we are designing care plans through child and family teams, then what is the specific treatment purpose of a youth being in a residential treatment setting? And once a youth enters a residential setting, how can this be done in a way that the family maintains, asserts, or resumes their role as the parents of the child? And how do you handle children with no available family, for example, the large cohort of children in the child welfare system for whom the family is not immediately available. Who can we find who is like family and how can we help normalize the circumstance for the child as much as possible?"

Recommendations

Service Delivery

- *Ensure that children receive services, including residential treatment, appropriate to their individual needs*—Youth should receive residential services according to their needs. Though residential services should primarily be short term, some youth may need longer-term residential stays. One participant shared that he had two different short-term residential stays, both of which ended in relapse and having to return to a residential treatment center. He also was in an unregulated, therapeutic boarding school in Massachusetts for 15 years, and credited that experience with saving his life. The danger is in categorizing services for everyone versus individualizing care to each child or adolescent. One cannot make the 30 to 90 day guideline be “one size fits all.” Child and family teams should be used to make decisions about individualized services.
- *Include residential treatment providers as system of care partners*—Residential services should be seen as part of a complete continuum of services. These services should be integrated with other services in systems of care and should not be eliminated as an option.
- *Use child and family teams to guide service delivery*—Child and family teams should continue to oversee care, monitor progress, and revise the plan of care even if a child is in a residential treatment setting. This ensures continuity across different treatment settings and levels of care.
- *Provide family-driven, youth-guided services in residential settings*—Care in residential treatment centers should be family focused and youth centered.
- *Provide alternatives to large institutional settings*—When residential care is needed, services should be provided to the extent possible in more normalized settings, such as treatment foster homes or therapeutic group homes rather than in large institutions.
- *Provide specialized residential treatment services for youth with highly complex needs*—Specialized residential services should be available for youth with dangerous behaviors, such as fire setting, that are not responsive to intensive, nonresidential service approaches.
- *Provide mobile crisis services* to avert the need for inpatient and residential treatment.

Financing

- *Develop financing strategies to redeploy funding from out-of-home placements to home and community-based services*—Financing strategies should include redeployment of resources from deep-end residential services to home and community-based approaches. Dollars saved by shortening or averting residential stays should be reinvested into the community system of care to create new capacity and to serve additional children.
- *Develop fiscal incentives for residential treatment centers that develop alternatives to out-of-home placement and that shorten their lengths of stay*—Grants and other fiscal incentives should be provided to residential treatment centers to support their transition to a broader service array and new roles for residential treatment.
- *Provide funding to residential treatment providers to support the transition to a broader service array*—Support for this type of transition can be in many forms. One state provided rate relief for a brief period of time. For example, if beds were closed, the state increased the bed rate for a period of time for the remaining beds to provide support during this transitional time.
- *Advocate coverage of a broad array of home and community-based services by private insurers*—Families with private insurance are in the “gray zone.” They have children with significant and complex mental health needs, and, often, the only way they can access services that are covered by their insurance is in residential treatment centers. While they may want their children to receive intensive services in the community, these typically are not covered by insurance and are not available to families with private coverage; only medication or limited outpatient therapy is covered. Efforts are needed to partner with businesses that self insure and private insurers to provide information that will help them to realize the benefits of restructuring their mental health benefits package.
- *Work with Centers for Medicare and Medicaid Services (CMS) to include wraparound approaches and other flexible services* provided within systems of care as reimbursable under Medicaid.

Recommendations

Policy and Advocacy

- *Develop uniform national standards for care in residential therapeutic settings*—Such standards should address treatment, length of stay, family involvement, cultural competence, quality monitoring, outcome measurement, and others.
 - *Develop a standard “report card” that rates both residential and community providers on key elements of the system of care philosophy and service delivery.*
 - *Require that all residential treatment facilities be licensed and regulated.*
 - *Encourage state mental health agencies to adopt the Joint Resolution.*
 - *Hold a continuing series of summit meetings to address better integrating residential treatment into systems of care and new roles for residential treatment centers*—The disconnect between residential and nonresidential services should not be perpetuated. Additionally, it should be recognized that residential treatment can be community-based and should be part of a system of care. The focus on residential versus community services should not be perpetuated.
 - *Implement policies that require providing home and community-based alternatives prior to approving admission to residential treatment settings.*
 - *Implement enhanced quality oversight processes in residential treatment centers and other therapeutic residential settings.*
 - *Use oversight by purchasers and national organizations to shift residential treatment centers to shorter-term, more focused practice models and new roles in systems of care*—Some facilities seem “married” to a 9-12 month program of residential treatment. Purchasers of care must strongly adhere to the principle of oversight and management to move to a shorter-term approach. For example, the Dawn Project created a residential treatment committee that reviews the youngsters’ care and delivery every 30 days. State and communities that purchase services should provide this type of oversight. National organizations can support this shift by working with their membership to assist them in redesigning their service approaches.
- Providers who do not change with new directions in service delivery ultimately will not receive any business from purchasers of services. One must ask, “Why is a residential treatment center on its own deciding how long the youth is going to be there?” That is the old model; the new model involves sitting around the table with the child and family team to determine what the child really needs. Sometimes that might be more than 90 days, and often it might be fewer. It is a fundamental shift in who makes the decision—decision making authority should be with a team of people that includes the child, the family, and the involved providers.
- *Support the Alliance for the Safe Therapeutic and Appropriate Use of Residential Treatment (ASTART) in its efforts to address unlicensed and unregulated residential placements*—ASTART is a group that includes mental health providers, as well as other child advocates, child serving professionals, and youth and family members who came together to try to respond to another dimension of the residential care phenomenon that has been occurring for the last 15 years. These are placements that are often referred to as therapeutic boarding schools, wilderness programs, and others. Concerns have been raised in the public media and in numerous reports that consistently seem to indicate that youth are having experiences that do not correspond with either system of care values and principles or the traditional standards of care within residential facilities. ASTART is a grassroots effort with a website and a phone number. Calls have come from youth or parents who have had experiences with programs or who are desperately trying to figure out how to identify an appropriate program. Calls also have come from professionals in organizations comprised of licensed and regulated residential facilities seeking a way to respond to reports of the sub-standard and sometimes abusive care in these other programs. It is important to become aware of what is occurring and to recognize that many families are paying out of pocket for these services. These families are not registering in the system of care “radar screen” and are not registering in the more formal residential treatment center community because they are choosing these other options.
 - *Advocate for legislation prohibiting unlicensed, unregulated residential treatment facilities for children.*

Recommendations

- *Use the Joint Resolution strategically to assist states, communities, and providers to shift to new approaches to services*—The Joint Resolution can help states, communities, and providers to make policy shifts.
- *Create incentives to shift provider agencies and systems from residentially-based to home and community-based*—Contractual, financial, and other incentives should be implemented to help residential providers shift their approach, addressing their fear of going out of business. Even the most ardent defenders of residential treatment acknowledge that the system is out of balance in that there are too many beds relative to the availability of wraparound and other kinds of community-based services and supports. Systems need to shift. “Though the theme of the summit was building bridges, we also have to build roads.” We have to build roads so that residential programs can move from where they are to where we and the children and families need them to be, which is moving away from so many beds and toward community-based services, children systems of care, and wraparound services. As we build these roads, we must remember that these are nonprofit organizations and small businesses, and the first rule of organizational behavior for any organization is to ensure the survival of the organization. So it is important to help them understand that just because some of the residential beds close, it does not necessarily mean they are going to go out of business. Perhaps they can close 50 residential beds, 100 residential beds, and create 100 wraparound slots and move the whole organization in a different direction with programs and services that kids really need. We will always need some residential beds, but residential services will be much more short-term, more focused on crises when a child is in an acute situation, or used when the child or the family need some respite. The residential beds that we are going to need in the future will have to be linked with the community-based and wraparound services. They shouldn’t be separate; they should be very much tied together. If we want to move this field, we need to find a way to help those residential programs see that there is life after residential instead of what they fear, that they’ll go out of business.
- *Include youth on licensing teams for residential programs*—Abuses can occur even in licensed and regulated facilities. One state is planning to include youth on the licensing teams who can connect with residents and bring a unique viewpoint to the oversight process.
- *Redefine the role of residential treatment within systems of care*—The contribution of residential treatment in systems of care needs to be redefined.
- *Engage other child serving systems in agreeing to the principles in the Joint Resolution*—Until other child serving systems buy into the guiding principles outlined in the Joint Resolution, it will be difficult to make significant changes as they frequently are the purchasers of these services. There are often conflicting goals and approaches among system partners.
- *Include families and youth on the advisory boards of residential treatment facilities*—Families and youth who have experienced residential treatment should be involved on policy and advisory bodies of residential treatment facilities and should be involved in reviewing and monitoring the quality and effectiveness of services.
- *Develop policies to set standards for the use of restraint and seclusion in residential and hospital settings.*
- *Require residential treatment providers to include families in planning and delivering services*—Contracts, monitoring protocols, and other mechanisms should be used to require residential treatment providers to fully involve families in service delivery.

Information Development and Dissemination

- *Develop and disseminate specific information on strategies residential treatment centers have used successfully to reduce lengths of stay.*
- *Document and disseminate information about how residential services have been redefined and re-engineered*—As states and communities are shifting to a home and community-based approach, residential services are being redefined and re-engineered to better link with systems of care and to fulfill specific, expanded roles within service systems. These experiences should be documented and disseminated to assist other states, communities, and residential providers to make this transition in an incremental change process. This may help to

Recommendations

allay the fears of residential providers about going out of business and not being able to fulfill their mission. Contracting and other regulatory processes can encourage residential treatment providers to redefine how they help children and families and how they go about doing the work. This is referred to as “reengineering” rather than “it’s old fashioned residential or bust.” This type of assistance acknowledges that there is likely going to be a reduction in residential treatment services, but does not necessarily mean that the specific provider organization is not going to be able to fulfill its mission in the community. In the Indianapolis’ community and the Dawn Project, the focus of the discussion has not been on the number of beds, but rather on how to provide the best care in the best way and on working with residential treatment centers to redesign the way that they provide the care.

- *Form coalitions of residential treatment providers who have shifted or are shifting their business from residential services to community-based services*—Much can be learned from the experience of residential providers who have shifted their practice from primarily residential to a broader array of services. Their experience should be documented and used to provide guidance and technical assistance to other providers in making this transition. Residential providers who have done this report that it “hurts” for several years, and then provider agencies find that business is better and outcomes are improved.
- *Collect and disseminate data to forecast changing needs for residential treatment beds*—As states and communities roll out systems of care and wraparound services, there is little data available to predict the resulting impact on residential treatment centers and the closure of beds. A “forecasting model” would be helpful to guide state efforts in decreasing need for residential treatment or therapeutic group home services as a range of other home and community-based services are developed. This would help states and communities to project the number of beds they may need on the future and enable them to “protect” some beds as they transition.
- *Develop resources and tip sheets for parents to consider before placing their children in unlicensed facilities.*

- *Provide information to judges, probation officers, child welfare, and juvenile justice administrators and other who tend to rely too heavily on residential treatment.*
- *Conduct research on the effectiveness of residential treatment.*
- *Conduct research on the effectiveness of systems of care and wraparound service approaches.*

Training and Technical Assistance

- *Develop a curriculum and training program on residential treatment that has successfully integrated family and youth driven practice*—This type of training will help providers to understand and operationalize what it means to be family driven and youth guided and how this translates into practice changes in residential treatment facilities.
- *Use training and technical assistance strategies to shift the culture and practice model to a targeted, short-term approach*—Training and technical assistance are needed to shift residential treatment providers to a more short-term treatment approach directed at specific treatment goals and outcomes.
- *Provide training to residential treatment providers on the system of care philosophy and approach*—National organizations, conferences, and other mechanisms should be used to provide training to residential treatment providers on the system of care values, principles, and approach to service delivery.
- *Provide technical assistance to residential treatment providers on how to develop home and community-based alternatives to out-of-home care*—Technical assistance on grant writing, developing new service capacity, etc. should be provided to help residential treatment providers re-engineer their services.
- *Provide training and technical assistance to residential treatment providers on evidence-based practices*—Residential treatment providers should receive training and technical assistance on evidence-based therapeutic approaches, alternatives to restraint and seclusion, and others.
- *Provide training and technical assistance on family search and engagement services* to residential treatment providers, child welfare, and system of care staff to help them find family and natural supports for youth as they transition from residential settings.

**BUILDING BRIDGES BETWEEN RESIDENTIAL AND COMMUNITY BASED
SERVICE DELIVERY PROVIDERS, FAMILIES AND YOUTH
JOINT RESOLUTION TO ADVANCE A STATEMENT OF SHARED CORE PRINCIPLES**

September 15, 2006

JOINT RESOLUTION TO ADVANCE A STATEMENT OF SHARED CORE PRINCIPLES

Whereas,
Children, youth and families should live a full life, where they experience love, joy, learning, health, hope, safety and growth, and are able to reach their full potential as healthy, functioning, contributing members of their families and communities;

Whereas,
Children, youth and families should have access to a flexible, well coordinated and comprehensive array of appropriate and individualized mental health services that includes promotion and prevention, early identification, home and community-based services and supports, crisis intervention services and services that include settings that provide in-home and out-of-home 24-hour treatment;

Whereas,
Children and youth who have mental health needs and their families are often also served by one or more other child serving systems, including child welfare, social services, substance abuse, juvenile justice, education, health and developmental disabilities; and

Whereas,
There is a sense of urgency to transform and improve mental health service delivery because children, youth and families currently in the system deserve to have their mental health needs addressed now.

Be it therefore now resolved that the undersigned agree to establish a partnership and a commitment to a core set of principles. Further, we agree to follow these principles and practices in our work and daily lives, and to promote them in our activities.

Specifically, we agree to:

Core Values

1. Demonstrate, in word and deed, the utmost respect for children, youth and families and one another, and create environments that value cultural differences, self examination, listening and learning from each other.

2. Embrace the concept of family driven and youth guided care so that youth and families are integral partners and have a primary decision making role in service delivery decisions and agency functioning, including having roles of significance on agency boards and committees.
3. Ensure that funding approaches and policies and practices do not create incentives or lead to families having to relinquish custody of their child to obtain mental health services.
4. Espouse a model for 24-hour out-of-home treatment that is multi-service, takes a holistic view of each child, youth and family, incorporates physical health, spiritual health, educational and vocational pursuits, social engagement and emotional health, and creates and insures access to a comprehensive and flexible array of affordable services and supports.
5. Commit to developing or enhancing home and community-based services that are flexible and responsive, that serve to decrease the need for 24-hour out-of-home treatment settings, and that facilitate the transition from such 24-hour treatment to more integrated home and community-based service delivery and service settings as appropriate to meet the needs of individual children, youth, families and communities.
6. Recognize the value of relationship based approaches that incorporate the primacy of family and community relationships and utilize them in all aspects of care.

Family Driven and Youth Guided

7. Create and advance a philosophy that the commitment to a child, youth and family is on-going, does not allow for a premature discharge, strives to provide continuity, supports transitions, promotes individualized and culturally competent service delivery and goals, eliminates blame and supports the strengths of each family member, and incorporates a “whatever it takes” and “never give up” attitude to providing help and support.
8. Ensure that children, youth and families feel safe and nurtured and have a sense of belonging, and that children and youth have a developmentally appropriate role in their care and in creating rules,

regulations and policies that govern their living environments.

9. Ensure that sibling bonds are maintained and that assistance to siblings is incorporated into treatment and support plans as indicated.
10. Commit to finding ways to ensure that children and youth grow up in families. If a youth requires treatment in a 24-hour out-of-home treatment setting, it should be understood that placement occurs only for as short a period of time as is necessary, and is appropriate to meet the clinical needs of the child and family.
11. For however long the youth is placed in a 24-hour out-of-home treatment setting it is understood that this placement represents a young person's home away from home, and that there is a need to create a home-like environment in which activities are "normalized," and family members are viewed as partners, not visitors, having open access to the out-of-home setting.
12. Ensure that families receive whatever services and supports they identify as necessary to provide for the well-being of their child.

Cultural and Linguistic Competence

13. Embrace the importance of cultural competence in all aspects of service delivery and in all treatment settings as integral to the promotion of positive outcomes for children, youth and their families.
14. Develop plans and implement services that value culture, spirituality and religion, and provide opportunities for children, youth and families to incorporate and use their native language and indigenous healing practices in the course of their treatment.
15. Develop strategies to reduce the over-representation of children of color in both restrictive and non-restrictive settings, and the disparity of outcomes.

Clinical Excellence and Quality Standards

16. Achieve and maintain clinical excellence by providing the highest possible quality of care that is trauma informed, uses the latest research evidence, and employs continuous quality improvement practices that use relevant data and feedback to improve services.
17. Determine which individualized service approaches and treatment settings are most appropriate for children, youth and families, and for how long they should be implemented.

18. Develop behavior support and teaching techniques that are strengths-based (e.g., behavioral and emotional support interventions versus behavioral management interventions), strive to eliminate coercion and coercive interventions (e.g., seclusion, restraint and aversive practices), promote self-regulation and self-monitoring, foster critical thinking and personal responsibility, and that are able to be generalized into less restrictive, family and community environments.
19. In keeping with family driven and youth guided principles, basic rights, including visits between families and children, should not be denied or restricted for punitive purposes at any point in the treatment process.
20. Use only medications that are clinically appropriate and medically managed according to an individualized treatment plan.
21. Ensure that all treatment services are licensed and regulated by appropriate agencies, and that monitoring is performed by well-trained individuals (including families and professionals) whose values are consistent with the principles articulated in this resolution.
22. Hold all providers and systems accountable for actions and outcomes.

Accessibility and Community Involvement

23. Provide services to children and youth within close proximity to their families and home community, or if a child must be in a 24-hour out-of-home treatment setting that is not in close proximity to his or her family and home community, implement strategies to ensure that the child's relationship with their family is maintained and strengthened.
24. Participate in the local community and with other child serving agencies to improve coordination of services and supports, facilitate access to schools and recreational opportunities, and promote linkages with other supports that foster healthy child development and growth.

Transition Planning and Services (Between Settings and from Youth to Adulthood)

25. Ensure that transitions to and from 24-hour out-of-home treatment are addressed as a component of the service model, including both the preparation for treatment and coordination and follow-up with post-discharge treatment.

26. Provide access to high quality standards-based education, ensure that life skills practice and training are required in all service delivery models, make certain that education/vocation services are a core component of the services offered, and work to make sure that skills can be generalized in the home and community.
27. Provide coordination and assistance as a young person transitions to adulthood, including responsibility for linkages with adult systems if needed and follow-up post discharge, including access to services such as housing, supported employment, vocational rehabilitation and life skills training.
28. Improve competitive employment outcomes by providing the structure and support necessary to build a strong vocational foundation, including systematic instruction and training of essential workplace skills, information about career options and employment alternatives and opportunities to develop social, civic and leadership skills.

Effective Workforce Development

29. Strive for a workforce that is competent, well compensated and reflects the diversity of the population being served; ensure that the workforce receives regular, on-going training, mentoring, coaching, and frequently scheduled and competency-based supervision sessions and evaluations, and that practice reflects the principles of family driven, youth guided care.
30. Engage family members and youth who have experience as consumers of mental health services, as trainers for the workforce and providers of care, and invite family members, youth and family advocacy organizations to participate in on-going training for program, agency and facility staff.

Assessment, Evaluation and Continuous Quality Improvement

31. Develop universal outcomes that measure the effectiveness of services for the child and family, including outcomes related to improved school attendance and performance, sustained improvement in emotional and behavioral functioning, reduced time in out-of home care, reduction of arrest rates and use of detention centers, and reduction of suicide related behaviors.
32. Obtain and provide the highest quality assessments and use the results to drive services so that

meaningful individualized plans for every child, youth and family are developed and implemented; ensure that these plans are strengths-based and culturally competent, and address resource availability and access so as to avoid unrealistic expectations and additional burdens on the family.

33. Promote the development and use of sound, clinically appropriate and effective evidence-based practices or practice-based evidence that are methodologically and/or clinically demonstrated to yield effective and positive clinical outcomes in keeping with the principles of family driven and youth guided care; actively promulgate the development and integration of these effective evidence-based practices and practice-based evidence into all aspects of comprehensive care to enhance clinical practices, supports and services.
34. Conduct research and evaluation, including follow-up and post discharge data collection, to determine effectiveness of services on relevant outcomes such as success in education and work settings, recidivism in mental health and other child serving systems, sustained success in the community, social connectedness and quality of life for the child and other family members.

In addressing the principles espoused in this Joint Resolution, the undersigned recognize the fiscal complexities and realities in providing services. Therefore, we agree to:

35. Commit to working together to identify resources that support the goals, values and principles in this statement, including strategies to support flexible funds and waivers for home and community-based services (e.g., in-home supports services, respite care, mentorship).
36. Commit to creating balance and coordination in funding and capacity between and across home and community-based services and 24-hour out-of-home treatment that reflects the importance of having a comprehensive, linked and flexible array of services and supports and strives to ensure that there are sufficient resources in the community and across systems to support all necessary and appropriate placements while facilitating timely discharge.
37. Create incentives for developing more short and long term home and community services and supports that creatively rebalance, reallocate, realign, reengineer and ultimately reinvest in services to allow for youth and family choice.

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