



DIVISION OF
PREVENTION AND
BEHAVIORAL HEALTH
SERVICES

TREATMENT PROVIDER
MANUAL

2016

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1 INTRODUCTION

Welcome to the Delaware Department of Services for Children, Youth, and Their Families' (DSCYF) Division of Prevention and Behavioral Health Services (DPBHS). This manual is intended to provide general information, guidelines, policies and procedures for agencies partnering with DPBHS to deliver prevention and behavioral health services to children. We thank you for your commitment to providing the highest quality of care and support available to serve these families and are eager to work in close partnership with you!

All are encouraged to contact DPBHS directly should additional questions arise. Each Provider will be connected with a Program Administrator with whom you can reach out to for assistance and support. DPBHS also encourage, new and existing, providers to visit the Providers' page on the DPBHS website for additional resources, information and DPBHS contact information:

- <http://kids.delaware.gov/>

DPBHS provides a robust statewide continuum of behavioral health prevention, early intervention, and treatment services for children, youth and their families. DPBHS has positioned resources in elementary and middle schools throughout Delaware. DPBHS provides licensed psychologists in our Department's secure and non-secure detention facilities, offers support and provides services for early education facilities and families with very young children and works closely with community partners to ensure the needs of children and their families involved with DPBHS are effectively addressed as quickly and efficiently as possible.

Our Mission - To develop and support a family-driven, youth-guided, trauma-informed prevention and behavioral health system of care.

Our Vision - Resilient children and families living in supportive communities.

Guiding Principles:

- Comprehensive service array to meet individual child and family needs;
- Individualized service planning;
- Least restrictive, most normative setting which is clinically appropriate;
- Families should be full participants in all aspects of the planning and delivery of service;
- Intensive care management to ensure coordination and integration of services;
- Early identification and intervention for children is critical;
- Smooth transitions to adult services at age 18;
- Rights of children and their families should be protected; and
- Effective advocacy for children and their families should be promoted.

For definitions of terms and acronyms used in this manual please refer to Appendix 2.

2 PROVIDER NETWORK

DPBHS provides a coordinated network of community-based services and supports that are child/youth-guided and family-driven to produce individualized, evidence-based, culturally and linguistically competent services that improve outcomes for children and their families.

This manual is a supplement to the Department of Services for Children, Youth and Their Families (DSCYF) Operating Guidelines for Service Providers, which sets forth the minimum standards expected for DSCYF providers. DSCYF Operating Guidelines can be found online at:

- http://kids.delaware.gov/pbhs/pbhs_providers_mhsa.shtml

These documents specify performance standards and expectations for DSCYF and DPBHS Providers. These are in addition to but not in lieu of other certifications, licensures, and State or Federal requirements. If appropriate, providers shall reference Office of Child Care Licensing (OCCL), Delaware, and/or Division of Substance Abuse and Mental Health (DSAMH) regulations and standards.

Partnership and Collaboration

DPBHS has recently undergone many changes to strengthen our behavioral health system. DPBHS collaborates with community partners and treatment providers to deliver the best services possible for children and their families. DPBHS has a holistic approach to better manage and coordinate the care of our families.

DPBHS appreciates the importance of family participation and commitment to the care of the children and youth that enter our services. Family choice, family voice, family support and participation are essential components of care. DPBHS creates partnerships which value the input of service providers, community resources and support and most importantly, the families, to develop a plan of care to successfully attend to the issues and challenges faced by the children and families we serve.

Treatment delivered by DPBHS' Network Providers will be:

- Youth-guided;
- Family-driven;
- Individualized and community based;
- Culturally and linguistically competent; and
- Evidenced based (or supported by best practice standards).

DPBHS realizes children achieve more successful outcomes when interventions occur early, participants function as a team and value the contributions of all the people and resources that touch a child and family's life.

Provider Contracts and Agreements

In order to provide a continuum of behavioral health services, DPBHS contracts with a network of individuals and agencies qualified to prescribe and render services under the provision of DPBHS. The network includes licensed psychiatrists, psychologists, social workers, master's prepared clinicians and other behavioral health professionals, as well as agencies to ensure numerous clinical and cultural specialties are represented to serve individuals.

In accordance with Delaware Code Title 29 Section 6981, DSCYF purchases professional services in excess of the established current annual expenditure threshold, using a competitive bidding process. In order to join the Provider Network, one must bid to provide a service once a Request for Proposals (RFP) has been announced. To receive automatic notification of bid opportunities go to the State of Delaware's Bid Solicitation Directory and follow the instructions to register for bid notifications at:

- <http://bids.delaware.gov/>

Medicaid

Health care services are provided to the majority of Medicaid clients through Delaware's Diamond State Health Plan (DSHP) managed care program. The managed care package includes behavioral health benefit of 30 units of outpatient services. DPBHS provides coverage of services outside of DSHP's managed care package. Instructions for how MCO providers can access supplementary funding for their outpatient clients is on the DPBHS website:

- http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml

All licensed mental health providers must be paneled with Medicaid. Licensed staff refers to any licensed practitioner of the healing arts who is licensed in the State of Delaware to diagnose and treat behavioral health and/or substance abuse issues acting within the scope of all applicable state laws and their professional licenses. Within the State of Delaware, those licensed by the Delaware Division of Professional Regulation are as follows:

- Licensed Psychologists;
- Licensed Clinical Social Workers (LCSWs);
- Licensed Professional Counselors (LPCMHs);
- Licensed Marriage and Family Therapists (LMFTs);
- Licensed Chemical Dependency Professionals (LCDP);
- Advanced Practice Registered Nurses; and
- Physician (MD or DO).

DPBHS providers are required to enroll with Delaware Medical Assistance Program (DMAP). Please refer to the following website for information on how to apply to the respective panels for the Medicaid Managed Care organizations, or to obtain information about applying for Medicaid:

- <http://www.dmap.state.de.us/home/index.html>

Accreditation

DPBHS maintains accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) under Business and Services Management Network Standards. CARF accreditation demonstrates DPBHS' commitment to continually enhance the quality of services and programs with a focus on the satisfaction of the persons served.

DPBHS seeks to collaborate with providers who demonstrate a commitment to quality and excellence in service delivery and are accredited by one of the following national accrediting bodies:

- The Joint Commission (TJC);
- Council on Accreditation (COA);
- Commission on Accreditation of Rehabilitation Facilities (CARF); and
- Community Health Accreditation Program (CHAP).

Providers without accreditation status must meet DPBHS clinical standards outlined in this Manual and the Commission on Accreditation of Rehabilitation Facilities (CARF) standards for unaccredited providers under the Business and Services Management Network. The 2015-2016 CARF standards are:

- All providers who are active with DPBHS and have an annual contract of \$350,000 or more must have their own independent accreditation;
- Providers who have contracts ranging from \$35,000.00 to \$349,999.00: must obtain independent accreditation within 3 years of the initiation of the contract, whichever is later, and will be treated as unaccredited providers by DPBHS and CARF and subject to compliance with CARF survey requirements as an unaccredited provider; and
- New unaccredited providers who have an annual contract of \$350,000 or more will be required to demonstrate a plan to have their own independent accreditation within three years of start-up. They will be treated as unaccredited providers by DPBHS and CARF and subject to compliance with CARF survey requirements as an unaccredited provider until such time as they obtain their individual accreditation.

Accreditation, license(s) and licensure certificate(s) must be prominently displayed at each organizational site. Changes in accreditation status must be brought to the attention of both DPBHS Program Administration and Quality Improvement contacts within 24 hours. DPBHS Quality Improvement should be provided with any corrective action or performance improvement plans upon submission to or receipt from the accrediting body.

3 PROVIDER QUALIFICATION & REQUIREMENTS

Agencies must meet any applicable federal and state regulations, and the agencies and their staff must maintain and keep current the appropriate professional and business licenses and/or certifications.

Delaware state regulation and policy define general standards for all providers that contract with DSCYF. Provider should refer to the DSCYF Provider Operating Manual and Delaware's Office of Budget and Management for additional provider/contractor guidelines.

- <http://gss.omb.delaware.gov/>

Business License(s) - In order to provide services within the State of Delaware, providers must have a Delaware Business License. For non-profit entities, please review Delaware business licensure website for possible exemption.

You can apply for a Delaware business license online through the Division of Revenue:

- <https://onestop.delaware.gov/osbrpublic/Home.jsp>

Professional License(s) – All providers, agencies and individuals, partnering with DPBHS must be properly licensed and/or certified professionally, in accordance with federal and state laws in which state they are located. For more information visit:

- <http://dpr.delaware.gov/>

Insurance – proof of commercial liability, motor vehicle and all other insurance coverage as applicable, must be available at all times, and any changes in status must be brought to the attention of DBPHS within 24 hours.

DSAMH License – the Provider shall maintain licensure in good standing with Division of Substance Abuse and Mental (DSAMH), if applicable.

- <http://dhss.delaware.gov/dhss/dsamh/>

Criminal Background Checks and Child Protection Registry Checks

All contractors and their employees with direct access to DPBHS clients are required to pass a Criminal Background Check completed by Delaware State Police and a Child Abuse Registry check by DSCYF.

More information on Criminal Background Checks can be found in Delaware Code: Title 31 Chapter 3 Subchapter I section 309 at:

- <http://delcode.delaware.gov/title31/c003/sc01/index.shtml>

More information on Child Protection Registry checks can be found in Delaware Code – Title 11 Chapter 85 Subchapter V Section 8563 at:

- <http://delcode.delaware.gov/title11/c085/sc05/index.shtml>

Maintenance of Agency/Provider Records and Documentation

Personnel Practices and Staff Credentialing - The provider will have and implement written policies and procedures for personnel management which will include but not necessarily be limited to:

- Job descriptions for each position outlining the minimum education, training and experience required to perform each function. These job descriptions must specify education and experience in child-related programs/activities;
- Documentation that primary verification of education, training, past employment history, professional license and/or certification, etc. is completed prior to the hire;
- Annual performance plans and reviews;
- Processes for disciplinary actions and termination and documentation that staff are informed of these processes; and
- Processes for tracking participation of staff in training and other professional development opportunities.

Personnel File/Records

Criminal History and Child Protection Registry – Documentation of a completed Delaware State Police background check and Child Protection Registry’s approval letter must be present in the employees personnel file on site.

Human Resource Form – All staff with direct, regular access to children and/or providing treatment services or supervising staff providing the services, shall submit a Human Resource Form to DPBHS Program Administration Unit via fax, mail or email. If employment status changes or if updated information is available, the Human Resource Form must be resubmitted within 10 business days.

Notification of staff change within 48 hours must be made if:

- Termination of employment for cause involving performance in program for use of drugs or alcohol, or whose records and/or conduct may negatively affect fiscal and/or program audits;
- Arrest for any reason;
- Loss of driver’s license if staff are required to transport clients;
- Accusation of abuse or neglect of staff’s children or those in the care of the program; or
- Loss of professional license or certification.

Credentialing

DPBHS is committed to meeting the highest standards in quality consumer care. It is therefore expected that all DPBHS employees and network providers will possess appropriate education, skills, and training to fulfill their job responsibilities in a competent manner.

Supervision

Unlicensed staff members are required to participate in weekly supervision with a licensed behavioral health professional. Supervision will be documented in the Supervision Log which will be available for review by DPBHS upon request. The Supervision Log should contain the name of the employee receiving supervision and list the date, length and time of the supervisory session as well as the number of cases discussed. The licensed behavioral health professional must sign off to document this supervisory session occurred as reported. The licensed behavioral health professional assumes clinical responsibility for employees under their supervision.

The licensed behavioral health professional providing supervision to the unlicensed staff is also required to sign off on assessments, treatment plans, progress notes and discharge summaries completed by unlicensed staff under their supervision.

For Substance Abuse services: If the licensed professional providing oversight of the agency is not a Licensed Chemical Dependency Professional and is not a Certified Alcohol and Drug Counselor (CADC), a CADC must be available to supervise all staff that are uncertified in this area. A CADC's signature is accepted on initial assessments and treatment plans for Substance Abuse services.

Risk Management

Risk Management System - The provider will have an overall risk management system as well as procedures for developing individual client risk management plans which include procedures for assuring client safety.

After-Hours Clinical Emergencies - The provider will have 24-hour, 7 day/week on-call coverage for active clients. Services performed by on-call coverage are subject to the same clinical standards as those of the contracted provider.

The provider will give active clients and families clear written directions for how to reach the provider in an after-hours emergency. In substance abuse programs, this will also include information for caretakers that they have been informed about the signs of overdose as it applies to each child's pattern of substance abuse and instructions for obtaining medical help in this emergency. The provider will document that the child has been given this information with a signed form that will be filed in the clinical record.

For all community-based providers, recorded telephone messages shall include the DPBHS crisis number(s).

If the provider has a client who displays deteriorating symptoms and the providers suspects the child may go into crisis during periods when the client is not receiving direct services, the provider shall:



- Establish a written safety plan with the client and family including contact numbers for people the client and family have identified as supportive to them (someone they are comfortable reaching out to in times of crisis; these identified parties should be aware they are identified on the child's safety plan) along with the 24 hours DPBHS Crisis Hotline Number;
- Provide the child and family of the provider's crisis procedures;
- Provide reasonable and sufficient hours of operation, including 24-hour availability of information, referral and treatment for emergency conditions;
- With parental consent, provide for the notification of the appropriate DPBHS Crisis Services about the child, current clinical status, and instructions for how to reach the provider if a crisis occurs; and
- If a child is active with DPBHS Crisis Services, work with them to reach disposition of child in crisis.

Critical Incidents

All DSCYF providers are required to follow the procedures as listed in the DSCYF Operating Guidelines. These procedures are further articulated in the DPBHS Incident Reporting Policy and Procedure along with the required forms on the DPBHS website:

- http://kids.delaware.gov/pbhs/pbhs_providers_forms.shtml.

Written reports are to be faxed to the DPBHS Quality Improvement Unit at E-Fax 1-302-661-7270 or send secure email to DSCYF_DPBHS_QI@state.de.us

Alleged Child Abuse - For any allegation of child abuse:

- If the DPBHS provider delivers services in Delaware - The Provider recognizes that its employees and therapists are mandated reporters as specified in Title 16, Delaware Code, Chapter 9, Paragraphs 901-909. The provider shall assure that its entire staff who provide services under this Contract are trained in DFS reporting procedures. When a provider's employee or agent knows of or reasonably suspects child abuse or neglect, including any such incident within the agency, or receives information regarding suspected abuse from the client, then he/she shall make an oral report to the Delaware Child Abuse Report Line by calling 1-800-292-9582. Within 72 hours of the oral report, a completed Child Abuse Reporting Form shall be sent to the appropriate regional office of the Division of Family Services;
- For further information about professional responsibility with regard to abuse and neglect, consult <http://kids.delaware.gov/information/cai.shtml> to read "The Professional's Guide to Reporting Abuse and Neglect." The Division of Professional Regulation, <http://dpr.delaware.gov/> also contains relevant information;
- If the provider does not deliver services in Delaware - The provider shall adhere to the guidelines for critical incident reporting set forth in the DPBHS policy. Additionally, the provider shall follow the legal requirements for reporting child abuse and neglect in the



State in which services are provided. A copy of this report must be forwarded to the DPBHS Quality Improvement Unit via Fax 1-302-661-7270 or send secure email to DSCYF_DPBHS_QI@state.de.us

Environment and Milieu

Smoking - Smoking is not permitted by any minor in any state operated or funded facility or program. Smoking by adults will be permitted only in designated areas which are away from space used in common for therapeutic and living activities and recreation as well as being out of sight of the children. Under no circumstances will the purchase of tobacco products by minors be directly or indirectly supported by program personnel.

Hazardous Materials - If applicable to the treatment setting, the provider will establish and maintain a program to safely control and dispose of hazardous or potentially infectious materials and waste.

Medication - The provider will have policies and procedures for prescribing, transporting, dispensing, administering and/or ordering medications, as applicable. These policies and procedures will address, at minimum, procurement, storage, control and documentation thereof of all medication in accordance with rules and regulations of the State Board of Pharmacy, the State Board of Nursing, Delacare and other authorizing agencies as applicable.

Behavior Management/Seclusion/Restraint - (Only for hospital, residential and related day treatment programs which are licensed and/or accredited.) These providers will have policies and procedures in place for the safe and appropriate use of restrictive behavior management techniques such as seclusion and restraint. See section 16 of this manual for additional information.

Handicap Accessibility – providers are required to develop procedures to accommodate child/youth or family with disabilities.

Emergency Preparedness

The provider will have and implement a written plan for natural and man-made emergencies, including but not limited to fire, weather emergencies, criminal and/or terroristic acts. Fire safety plan will comply with the National Fire Protection Association Life Safety Code. It will also comply with the DSCYF Operating Guidelines regarding client safety. At minimum, these procedures will list evacuation and shelter-in-place/lockdown procedures as appropriate to the level of care.

- Drills for evacuation procedures will be documented as having occurred, at minimum, once per year on every shift at every location, as applicable to the level of care.
- Drills for lock-down/shelter-in- place will be documented as having occurred, at minimum, once per year on every shift, at every location, as applicable to the level of care.



- Table-top exercises involving all pertinent staff may replace in vivo drills if they are appropriate to the level of care.
- Documentation for drills will include at minimum, date, time, purpose, participants, outcome summary, and lessons learned, if applicable.

Audits and Monitoring

All DPBHS providers are subject to routine review and/or audit by authorized representatives of DSCYF. Reviews may include but not be limited to: desk audits of available data on utilization and outcome, accreditation and licensure status, complaints, incident reporting and deliverable submissions, etc. DPBHS also conducts on-site monitoring surveys to evaluate client safety, appropriateness of services and compliance with DSCYF and DPBHS standards. By contract, providers agree to allow the authorized representatives access to all requested financial/fiscal and clinical/medical records and documentation, as appropriate. Audit proceedings should not be construed as an indication of any wrongdoing on the part of the provider. Rather, an audit should be looked upon as ongoing and necessary to ensure quality service delivery within State and Federal regulations.

DPBHS supports providers in maintaining compliance with CARF standards and Federal and State regulations, and utilizes audits to identify areas of improvement and to determine the accuracy and propriety of provider billing, compliance with Program policy and procedures, quality of care, and utilization of services.

Documentation in the clinical record must support the code being billed. Services shall not be rendered without a valid authorization for that service type or level, except in exigent circumstances. Should an audit reveal incorrect payments were made, or that the provider's records do not support the payments that were made, the provider shall make appropriate restitution. Audits may be conducted by the Quality Improvement Unit, Billing Unit, Program Administrators, or by the Unit which oversees contracts.

While DPBHS works with Providers to ensure compliance and the highest level of integrity in service delivery, Providers are subject to administrative sanctions. DPBHS may seek to exclude any provider whom it determines for fraudulent activities or crime whenever the federal authority directs such action. Medicaid fraud legislation exists which allows for various penalties due to infractions committed by providers. Should a provider be found to be non-compliant, DPBHS has a duty to report to the appropriate governing body, including Medicaid.

Administrative Sanctions

Administrative sanctions may be imposed against any provider who does not meet the State and Federal guidelines, regulations and laws, DSCYF/DPBHS quality or contract standards, or otherwise demonstrates concerning, significant or repeated deficiencies.

Administrative sanction refers to any administrative action applied by DPBHS, and is designed to improve practices or ensure compliance with the DPBHS policies and procedures, or State/Federal statutes, and regulations.

DPBHS may impose sanctions against a contracted service provider, if DPBHS finds that the provider:

- Is not complying with policy or rules and regulations, or with the terms and conditions prescribed in the provider contract;
- Has submitted a false or fraudulent application for provider enrollment status;
- Is not properly licensed or qualified, or that the provider's professional license, certificate or other authorization has not been renewed or has been revoked, suspended or terminated;
- Failed to comply with DPBHS supervision requirements;
- Has failed to correct any deficiencies in its delivery of service or billing practices after having received written notice of these deficiencies from DPBHS;
- Has presented any false or fraudulent claim for services;
- Has failed to repay or make arrangements for the repayment of any identified overpayment or erroneous payment;
- Has failed to keep or make available for review, audit, or copying any information or records to substantiate payment of claims for service provision;
- Has failed to comply with any Federal, State or DPBHS policy or procedure to ensure the effective delivery of quality services to DPBHS children; and/or
- Has engaged in or enabled unlawful, unethical conduct.

DPBHS may impose various levels of administrative sanctions, including the following:

- Give warning through written notice or consultation;
- Require education in program policies and billing procedures;
- Place claims on manual review before payment is made;
- Suspend or withhold payments;
- Recover money improperly or erroneously paid either by crediting against future billings or by requiring direct payment;
- Refer to the State licensing authority for review;
- Refer for review by appropriate professional organizations;
- Refer to Attorney General's Fraud Control Unit for fraud investigation;
- Suspend certification and participation in the Provider Network;
- Cancellation of Provider's Contract with DSCYF; and/or
- Refuse to allow participation in the Provider Network.

Sanction Levels

Level I – Written Warning, Program Improvement Plan (PIP) – examples include but are not limited to: poor client documentation, consistent billing errors, personnel files, lack of documentation, isolated failure to report;

Level II- Corrective Action Plan (CAP), refer to professional organization – examples include but are not limited to: licensing or ethics violations, fraudulent billing, and frequent IR reporting errors;

Level III- Suspension of services, restrictive plus CAP – examples include but are not limited to: severity and risk of violation, failure to report critical incidents, isolated abuse of child; and

Level IV-Termination of services – examples include but are not limited to: willful and wanton behavior, not addressing previously identified issues, blatant fraudulent activities, flaws in the administrative oversight of the program creating risk for all the children being served.

Performance Improvement

DPBHS is committed to the provision of safe appropriate services that facilitate positive behavioral change and positive outcomes for children, youth and their families. Providers will use a continuous performance improvement process that will achieve these outcomes.

The provider will have and implement a written performance and quality improvement plan which establishes a process for ongoing monitoring and evaluation of the quality and effectiveness of treatment and client safety. The plan and resulting process will assure that there is clinical oversight of services provided by all staff.

Where licensed staff are otherwise operating without clinical supervision, there will be a process by which the quality of their work is reviewed. This may be through peer-review, QI Committee review, etc.

In agencies/programs that have non-licensed staff providing services, the process and frequency of the supervision of these staff by a licensed professional will be included in the plan. This plan and related procedures will start with data/information. Design and implementation of improvements will be tracked and data will be gathered to assess whether the improvements achieved the desired outcomes. Where appropriate, the provider will collaborate with DPBHS in their performance planning and evaluation process

Outcome Measurement - DPBHS conducts empirical measurement of client outcomes both at the individual client level and at the systems level.

Client Progress Reviews - The CFCC's initiate client Progress Reviews to evaluate client progress periodically throughout treatment and at discharge. Providers will insure that staff is reasonably available for these reviews and that accurate and complete information as to progress in treatment is provided.

Pre and Post-Measurement and Data Submission - The provider will cooperate with DPBHS in administering reasonable pre- and post-treatment outcome measurement instruments, and report on requests for data on approved DPBHS forms or systems

4 ETHICS AND PROFESSIONAL BOUNDARIES

Respect Physical, Mental and Emotional Boundaries

A boundary is how far people can go with comfort in a relationship. It is suggested boundaries be established in the first session, review and discuss ground rules and expectations.

- Physical: Respecting the individual's space and include the act of touching
- Mental: beliefs, thoughts, decisions and choices
- Emotional: refers to self-esteem and feelings

Professional Code of Ethics

Each professional discipline defines its Code of Ethics. Please refer to the most recent version of the Code of Ethics by which you are bound. Below are some of the online resources available for professionals (this is not an exhaustive list):

- <http://www.apa.org/ethics/code/>
- <https://www.socialworkers.org/pubs/code/default.asp>
- <https://www.counseling.org/resources/aca-code-of-ethics.pdf>
- <http://www.psychiatry.org/psychiatrists/practice/ethics>
- <http://dpr.delaware.gov/>
- <https://www.decortboard.org/ethics>

Guiding Principles of Ethical Behavior

Ethical principles can be used to work through an ethical dilemma. All principles are considered equal with no one holding greater weight or importance than another.

Respect for People's Rights and Dignity (Autonomy)

Behavioral Health Professionals respect all clients and their right to privacy, confidentiality and self-determination. Clients are free to choose their own direction and have the ability to make choices free from the constraints of others (APA, 2010). An individual is to be aware of the choice taken and the effect/ consequences it has on others. Limitations to client autonomy apply to those clients who are currently unable to understand the repercussions of their action – for example children and mental health patients (Corey, Corey, & Callanan, 2007; Welfel, 1998).

Beneficence and Non-maleficence

Behavioral Health Professionals seek to safeguard clients and do no harm. Behavioral Health Professionals judgments and actions may affect the lives of other, thus be careful not to misuse their influence and avoid the use of interventions that could or have the potential to harm clients. Behavioral Health Professionals must be aware of the impact of their own physical and mental

health on their ability to help others. The Behavioral Health Professional is expected to do the best for the client and if unable to assist, to offer alternatives as appropriate. (APA, 2010; Corey et al., 2007; Welfel, 1998).

Justice

Behavioral Health Professionals will act in a non-discriminatory, fair and just manner to individuals or groups. It is expected that Behavioral Health Professionals will have the ability to acknowledge inequity and apply intervention to suit. (APA, 2010; Welfel, 1998).

Fidelity and Responsibility

Relationships of trust are established between the Behavioral Health Professional and their client. The interests of the client are placed before those of the Behavioral Health Professional even if such loyalty (towards the client) is inconvenient or uncomfortable. A client needs to be able to trust that the words and actions of the Behavioral Health Professional are truthful and reliable. (APA, 2010; Welfel, 1998).

Integrity

Accuracy, honesty and truthfulness are evident in the practice of behavioral health treatment. Behavioral Health Professionals are obligated and responsible to refrain from activities such as fraud, theft, or intentional misrepresentation and avoid unwise or unclear commitments (APA, 2010).

Steps in the Ethical Decision Making Process in Appendix 3 or visit the link below for guidance:

- [http://psyc.csustan.edu/kbaker/3790/ethical%20decision%20making%20\(Corey%20et%20al\).pdf](http://psyc.csustan.edu/kbaker/3790/ethical%20decision%20making%20(Corey%20et%20al).pdf)

5 FAMILY CHOICE

DPBHS appreciates the time and effort a family takes to make sure their child/youth receives proper behavioral health care. Family engagement in the child's care maximizes the benefits received from treatment. When the family is engaged the child/youth is more likely to succeed and experience more positive outcomes from the treatment than a child/youth without an engaged family (Kuhlthau & et al., 2010).

A family might ask, "Why is it so important that I make the decisions and not just let the professionals?" The answer is simple. The family serves as the expert in having first-hand knowledge concerning their child. The family can offer their expertise and perspectives regarding the child/youth's behavior across multiple settings, such as school, home, and in the community. The family can also provide valuable input and feedback that provides specific information such as when the child/youth's behaviors occur, certain environmental triggers, and the emotional, behavioral manifestations, and so much more. It is pivotal to remember that the information

provided by the family is essential to designing an effective treatment plan for the child/youth and family. The information and expertise provided by the family cannot be duplicated by a professional. As the child/youth enters and continues in treatment, the family is empowered to remain engaged throughout the process to ensure their expertise informs the child/youth's treatment.

DPBHS is fully committed to the value of family involvement thus families must be included in all decisions regarding the planning and provision of behavioral health services for their children. DPBHS makes every effort to ensure DPBHS services meet the physical, cultural and linguistic needs of the children and families served. If a provider is unable to offer services in the children or family's first language, DPBHS will arrange for translation services to be available for the children and family through its State contracts.

6 CLIENT ELIGIBILITY

DPBHS provides mental health and substance use services to children under age 18, who have Medicaid, or who are without insurance coverage, who are residents of the State of Delaware and meet medical necessity for behavioral health services. DPBHS Eligibility policy can be found at:

- <http://kids.delaware.gov/pbhs/pbhs.shtml>

DPBHS Eligibility for Non-Residents of the State of Delaware - Crisis services and short-term emergency hospitalization may be provided to non-resident children under the age of 18 who are in Delaware and whose behaviors present imminent danger to self or others due to behavioral health disorders. DPBHS reserves the right to seek reimbursement for services provided to non-Delaware residents.

MCO Referral - If you are a MCO Provider seeking DPBHS services for your client:

- For extended outpatient benefits (beyond the 30-unit MCO limit) – please submit a referral to DPBHS' Central Intake Office. Referral form can be found at:
 - http://kids.delaware.gov/pbhs/pbhs_providers_forms.shtml
- For a more intensive services submit a Mental Health and Substance Abuse Referral to DPBHS Central Intake Office.

7 ACCESS

The Intake and Acute Care units are responsible for screening referrals and determining eligibility of child/youth and families referred for DPBHS services. These units conduct all initial and concurrent reviews of acute inpatient care and makes determinations regarding the appropriate level of service intensity a child/youth and their family may require.



Three paths through which a child/youth and their family may be admitted to DPBHS treatment services:

- Outpatient Services - Parents/caretakers may call any of the DPBHS mental health or substance use outpatient providers listed in the DPBHS information brochure and on the DPBHS Website. These providers will assess clinical and financial eligibility and assist child/youth and their families to obtain appropriate care. Brochures are available on the DPBHS Website.
- Central Intake - For non-emergency situations where a child is in need of a higher level of care above outpatient, a referral may be made to DPBHS's central intake office; and
- Acute Care/Crisis Services - Child Priority Response is a DPBHS services that offers 24-hour, 7 day a week crisis response for children or adolescents who are exhibiting behaviors that pose a serious and immediate danger to oneself or others due to emotional disturbance, substance abuse or mental illness (e.g., suicidal attempts or threats, command hallucinations, aggressive behavior, etc.). This service also responds to children in crisis who may have experienced recent and severe trauma (e.g. witness to a suicide, murder, etc.).

Referral

Referrals may come from a variety of sources such as a child/youth's current behavioral health provider, a school counselor, a physician, or the family has self-referred to DPBHS. If you need additional information on making a referral call 1-800-722-7710. **If the child/youth is in a behavioral crisis and could cause self-harm or harm someone else call the Crisis Service Hotline 1-800-969-HELP (4357).** Regardless of the origin of the referral, DPBHS uses the information and completes the intake process.

Process

Once DPBHS receives a completed referral with the required documentation (and any other relevant information), it will be reviewed for eligibility. If the information received is incomplete, the referral agent will be contacted and informed of what is needed in order to process the referral. If the required information is not received within 10 business days, referrals will be closed. If the information is received within 30 days of the initial date the referral was received the referral will be processed. After 30 days, a new referral will need to be completed for processing. If the referral packet is complete it will be processed within 2 business days.

Next Steps

If there is an immediate need for services, the Acute Care Unit will authorize services through Child Priority Response.

If a child/youth and family are determined to be eligible for a greater level of service intensity with higher care coordination, the case may be assigned to the Child and Family Care Coordination Team (CFCC) and provided with a Care Coordinator. The Care Coordinator will assist the

child/youth and family in the selection of service(s) and provider(s) based on the family's needs and preferences. The Care Coordinator will provide the child/youth and family with any additional information regarding service expectations so they can make an informed decision.

8 LEVEL OF SERVICE DETERMINATION

The Intake/Acute Care Units and Child and Family Care Coordination Team use established DPBHS clinical criteria, clinical instruments, standardized assessments along with child/youth and family input and referral information provided to assist in determining the child/youth's eligibility for services, level of service need, and care coordination support across the DPBHS service continuum. Clinical necessity criteria are available in Appendix 4. A summary of the clinical instruments and standardized assessment are provided below:

Clinical Instruments

Child and Adolescent Service Intensity Instrument (CASII)

The CASII is a standardized instrument that assists in a determination of the appropriate level of services needed by a child or adolescent and his or her family (AACAP, 2015). The CASII assesses the service intensity needs of children and adolescents presenting with psychiatric, substance use, psychosocial and/or developmental concerns. It incorporates holistic information on the child, within the context of his/her family and social ecology, assessing across six key dimensions: Risk of Harm, Functional Status, Co-Occurrence, Recovery Environment-Stress/ Recovery Environment-Support, Resiliency and/or Response to Services, and Involvement in Services.

The CASII is developmentally informed and compatible with the System of Care approach -- embracing individualized service planning, offering child and family teams, and providing a broad service array. CASII recognizes use of home and community based services and natural supports as part of the "medical necessity" and treatment implementation equation.

CASII is applicable to children living in the community with their parents or extended family, and to children in foster care, and institutional settings. The CASII is culturally informed, and supports active participation by child and family during assessment and thereafter. The CASII can be used at all stages of intervention and is designed for use in all child-serving systems (behavioral health, physical health, education, child welfare, juvenile justice, etc.) to facilitate integrated attention to the child's needs. It promotes effective communication between providers and systems and informs clinicians' engagement with the child, family, and community.

- http://www.aacap.org/aacap/Member_Resources/Practice_Information/CASII.aspx

American Society of Addiction Medicine (ASAM)

ASAM Criteria is a national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. ASAM criteria has become the most widely used and comprehensive

set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions. ASAM's criteria are required in over 30 states.

ASAM's treatment criteria creates comprehensive and individualized treatment plans. Treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

- <http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria>

Standardized Assessments

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure

The tool assesses mental health domains that are important across psychiatric diagnoses. It is intended to help clinicians identify additional areas of inquiry that may have significant impact on the child's treatment and prognosis. The measure may also be used to track changes in the child's symptom presentation over time (APA, 2013). This will replace the EPSDT form.

The information gathered using the tool will be used in conjunction with the other information provided in a higher level of care referral to determine eligibility.

- <http://www.psychiatry.org/psychiatrists/practice/dsm/dsm-5/online-assessment-measures>

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS was developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices. The CANS is meaningful to an individual child and family. The way the CANS works is that each item suggests different pathways for service planning.

For information on using the CANS as a multi-purpose tool, please use the following link:

- <https://praedfoundation.org>

Assessment for Residential Treatment (ART) Committee

The ART Committee was created to review out-of-state and in-state RTC referrals by using a standardized instrument (the CASII) and a standardized format (the ART Referral Checklist). The ART Committee reviews RTC referrals to match the needs of child and families with the most appropriate level of service intensity and natural supports.

ART Committee goals include:

- Assuring inter-rater reliable use of the CASII instrument;



- Using a standardized method of case presentation;
- Developing collaborative case consultation to address areas of risk and need with the most appropriate level of service intensity and natural supports;
- Consistent level of care decision-making across clinical service teams; and
- A uniform, collaborative approach to support Child and Family Care Coordination in explaining level of service intensity decisions to families and other stakeholders.

ART Committee process:

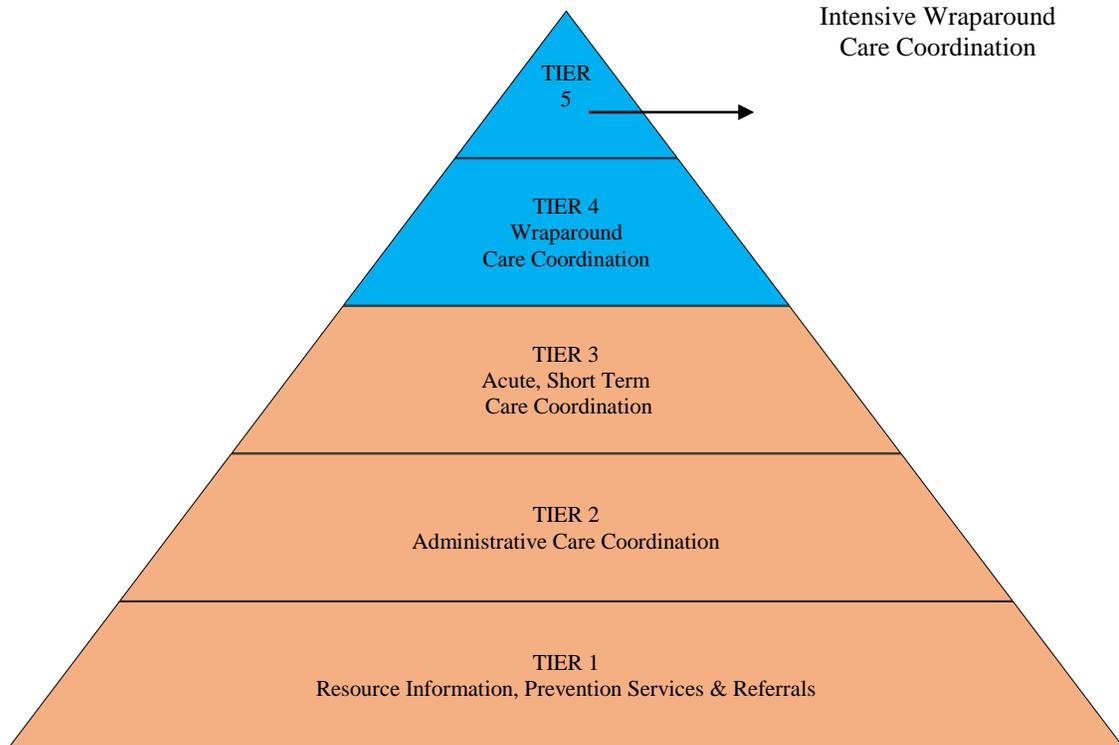
- The ART Committee meets once per week;
- The ART Committee members are not required to attend every meeting and should determine their attendance based upon their work priorities;
- Team Leaders may rotate into the ART schedule to improve their reliable use of the CASII instrument and to gain experience with case consultation and collaborative problem-solving; and
- ART limits reviews to new RTC referrals and review of boarders.

9 CARE COORDINATION

Care coordination is provided for a child/youth and their family to support the family's success in navigating systems to ensure needs are met and promote self-sufficiency of the family. Care coordinators assist families in obtaining, coordinating and engaging in services across systems, as well as provide linkage to community-based services. Care coordinators partner with families and providers to promote continuity of care. Care coordination is a critical component of DPBHS's service continuum for children/youth and families at-risk because it provides a bridge across



multiple systems that serve children and families. DPBHS offers a five tiered care coordination model:





Tier Level	Focus of Tier	Care Coordination intensity	Frequency of Contact	Eligibility Criteria
Tier 1: <i>Resource Information, Prevention, and Referral</i>	The child-youth and their family are looking for information on community based low level services. They are connected to community resources through referrals given and are able to effectively access these resources on their own or with minimal guidance and support.	Level of Care Coordination: This is a single service intervention (incoming phone call) where resources are provided verbally on the phone call and/or provided via mail, email, and/or fax.	Only through incoming call with no follow up	Single service need for intervention; looking for low level/non intensive community based resources
Tier 2: <i>Administrative Care Coordination</i>	A child-youth and their family are in need of administrative support to access services that meet PBH eligibility and do not require tier 3 or 4 care coordination.	Administrative management and coordination of community services.	Contact with providers based on utilization review criteria.	PBH service eligibility and does not meet criteria for tier 3 and 4.
Tier 3: <i>Acute Short Term Care Coordination</i>	Child-Youth and their family are in need of brief intervention and crisis stabilization. Following stabilization an assessment will be completed to determine the most appropriate LOC and/or Care Coordination for continuation of services.	There is communication and coordination with current and aftercare providers and with family as needed.	Utilization reviews as well as contact with providers and/or families is 1 or more times per week.	Admission into crisis bed, crisis intervention, or inpatient hospital.
Tier 4: <i>Wraparound Care Coordination</i>	A child-youth and their family are in active need for community-based services and supports to promote and maintain stability in the home, school or community.	Care coordination services involve a child-youth and family driven team process, based on wraparound principles and processes. A child-youth and family may have multiple needs for services and support or may not have achieved success of goals in Tiers 1 – 2.	Care coordination contact with child-youth and family occurs every two weeks. Child-youth and family team (CFT) mtgs. Occur every two months.	DPBHS Eligibility Criteria, CANS, Standardized Instruments (CASII Dimensions/ASAM Criteria), Cultural and Linguistic Factors and other considerations.
Tier 5: <i>Intensive Wraparound Care Coordination</i>	A child-youth and their family are in need of intensive community-based services to establish and maintain stability in the home, school or community with a focus on the reduction of crisis and risk for residential treatment.	Care coordination services are delivered consistent with High Fidelity Wraparound principles with emphasis on integrating the child-youth into the community and building the family's natural and social support networks.	Care coordination contact with child-youth and family occurs once a week. Child-youth and family team (CFT) mtgs. Occur at least once per month.	DPBHS Eligibility Criteria, CANS, Standardized Instruments (CASII Dimensions/ASAM Criteria), Cultural and Linguistic Factors and other considerations.

Care Coordination support is provided on all Tiers. When a child/youth and family have been determined to need a greater level of service intensity and/or Care Coordination support, they will be assigned to a Child and Family Care Coordination Team (CFCC) for support. Tier 4 (Wraparound Care Coordination) and Tier 5 (Intensive Wraparound Care Coordination) represent higher levels of service and/or Care Coordination need. The primary focus of Tier 4 is for children/youth and families in active need for community-based services and supports to promote and maintain stability in the home, school or community. The primary focus of Tier 5 involves the reduction of crisis and risk for children/youth for residential treatment.

DPBHS's Child and Family Care Coordination Team (CFCC) is comprised of a licensed Team Leader, Psychiatric Social Worker, Clinical Services Care Coordinator and Families Services Assistant. The Clinical Services Care Coordinator serves as the primary person responsible for coordinating care for the child/youth and family. Care Coordination activities support System of Care (SOC) values and principles and wraparound processes to include the following:

Family Voice and Choice – Team Based- Natural Supports – Collaboration – Community Based – Cultural/Linguistic Competence – Individualized – Strengths Based – Persistence – Outcome Based

- CFCC responsibilities may include:
 - Client and Family Support:
 - Information and referral to community services;
 - Case-specific consultation to parents, educators, and medical and social service providers in home and agency settings;
 - Training in public benefits and local systems of care.
 - Assist the child/youth and family to coordinate medical, social and educational systems;
 - Identify the changing needs of their child/youth and family;
 - Understand the full range of available public benefits;
 - Identify community resources to assist them;
 - Gain access to specific programs and services;
 - Become more effective advocates;
 - Connect with other families who face similar challenges; and
 - Plan for greater self-sufficiency and community integration.

10 PREVENTION

DPBHS provides an array of Prevention services in which all children and families are able to participate. Prevention services are directed towards promoting health and wellness and to prevent: child abuse and neglect, dependency, juvenile delinquency, truancy, tobacco/drug/alcohol use, domestic violence and other risky behaviors.

Children and families are not required to be active with DPBHS treatment services to benefit from Prevention Services. Connecting children and families with Prevention services, programs and resources is an expectation of DPBHS providers.

The Prevention Resource Center (PRC) holds a collection of psycho-educational materials includes books, research and science-based curriculums, videos and DVDs that are available for loan. In addition, the Resource Center distributes informational brochures and pamphlets to the public that focus on substance abuse, violence, child abuse and neglect prevention as well as other related issues, such as, mental health and juvenile justice issues. Orders can be placed by fax, e-mail, online catalog or phone. Please call 302-892-6440 for more information or obtain an online order form at:

- http://kids.delaware.gov/pdfsFillSave/pbh_ResourceCenterOrderForm_2013_fs.pdf

11 CONTRACTED TREATMENT SERVICES

Below is a brief overview of DPBHS' service continuum. DPBHS has developed a continuum of services to accommodate the children and families that are served. Providers offer services statewide with extended hours to make services available for those with varying needs. Appendix 4 provides additional information including a complete service description and clinical necessity.

Outpatient Services, Mental Health

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns, from behavior problems, relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the child is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the child's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change. Length of stay will vary based on the individual's needs.

Outpatient Services, Substance Abuse

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns, from substance use, behavior problems, and relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the child is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the child's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources

as appropriate as the client's needs change. Length of stay will vary based on the individual's needs.

Therapeutic Support for Families (TSF)

Therapeutic Support for Families provides psycho-educational, therapeutic and supportive services for parents/ caregivers and child who are participating in treatment services from the Division of Prevention and Behavioral Health Services. TSF services are delivered in conjunction with other medically necessary treatment services. TSF goals will be included in the child and family's treatment plan and will include the projected frequency and length of service along with the specific interventions and activities (with purpose) to be incorporated in the attainment of these goals. TSF services will provide parent education and skill building services for identified caregivers and child and therapeutic intervention and support for child and families as they strive to achieve treatment success.

TSF services may be provided individually or in family and/or group settings. TSF services are tailored to meet the unique needs of the child and family. Often these services will be required during specific times of day (such as in the morning, evening or bedtime) so availability of resources must allow for services to be provided at the times identified by the caregiver. Structured outings and activities should be scheduled which include both the child and caregivers, allowing them to demonstrate acquisition of skills and practice applying these skills in real life situations with support and coaching from the TSF, as appropriate. These services are delivered by trained, skilled paraprofessionals. Length of stay will vary based on the individual's needs.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence based outpatient service. It has been empirically validated for adults and the emerging literature shows great promise for treating adolescents. This has been an effective treatment for a variety of conditions such as borderline personality disorder, depression, post-traumatic stress disorder (PTSD), substance abuse, self-injurious behaviors and eating disorders. Treatment is used to aid adolescents in managing problem behaviors (self-harm, self-injury, suicidal planning, gestures, actions, impulsive decision making, and avoidance) used maladaptive to manage stressful life situations. Treatment includes 24/7 phone coaching, 2 group sessions per week, individual, family and parent groups. Average length of stay is 6 to 12 months.

Multi-Systemic Therapy (MST)

Multi-Systemic Therapy (MST) is a home-based intensive family and community-based treatment that addresses multiple aspects of serious conduct related behavior in adolescents. MST typically targets chronic, aggressive youth who are at high risk of out-of-home placement. MST recognizes that many "systems" (family, schools, neighborhood/community, and peers) play a critical role in a youth's world and impacts their behavior. Each system requires attention when effective change is needed to improve the quality of life for youth and their families.



MST strives to promote behavior changes in the youth's natural environment, using the strengths of each system to facilitate change. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change. Interventions promote responsible behavior among family members and are present-focused, action-oriented and developmentally appropriate. In addition, the interventions target specific, well-defined problems and are designed to require daily or weekly effort by family members. They incorporate strategies that promote treatment generalization and long-term maintenance of therapeutic change. Service is available 24/7 (on call system). Average length of stay is 3 to 5 months with an average of 2-4 hours pf direct service per week.

Family Based Mental Health Services (FBMHS)

The Family Based Mental Health Services are designed to service children between 3 and 17 years of age and living with their parents, guardians, or caretakers and have a serious mental illness or emotional disturbance. These children are also at risk for out-of-home placement into residential treatment facilities, psychiatric hospitals or foster placements due their symptomatic behaviors and/or the dysfunction of the family system that contributes to the behaviors. Family Based Mental Health Services (FBMHS) are able to treat these children and adolescents in their homes, communities and schools thus allowing the youth to remain in the home.

FBMHS is a team delivered service rendered in home, community and school settings. It is designed to integrate mental health treatment, the family, family support services, the surrounding system, and casework so that families may continue to care for their children and adolescents with a serious mental illness or emotional disturbance in their home. These children and adolescents experience depression, anxiety, chronic acting out behaviors, aggression, social, coping and skill deficits, drug and alcohol abuse, and school truancy. These children are frequently described as "hard to manage" by their parents. Often times, their personality traits and their parents' management skills are frequently in conflict with each other which lead to a youth/family's involvement with multiple systems. Services are available 24 hours per day and 7 days a week via on call therapist from the FBMHS program. Average length of stay is 32 weeks.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for, or who manifest, antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in or outpatient settings and at times of transition, from a residential placement.

FFT incorporates specific intervention phases which include engagement, motivation, assessment, behavior change and generalization. FFT is designed to improve within-family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior. Parenting skills, youth compliance, and the complete range of behaviors (cognitive, emotional, and behavioral) domains are targeted for change based on the specific risk and protective factor profile of each family. FFT provides approximately 2.5-3 hours of service weekly which includes face to face and collateral contact, travel, case planning. Average length of stay is 3 to 4 months.

Day Treatment, Mental Health

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for children or adolescents with moderate to severe behavioral health disorders who are unable to fulfill the functional requirements without this level of intensive service.

The program is available as clinically appropriate and is open approximately 250 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the youth's natural environment. Average length of stay is 1 to 3 months.

Day Treatment, Substance Abuse

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate treatment for children or adolescents with moderate to severe behavioral health disorders who are unable to fulfill the functional requirements without this level of intensive service.

The program is available as clinically appropriate and is open approximately 250 days per year and provides no less than 5 hours of direct service per day. Activities are also provided in afternoons and/or evenings to assure that working parents are able to participate in treatment. Activities occur both on-site at the program and in the youth's natural environment. Average length of stay is 1 to 3 months.

Partial Hospital Program (PHP)

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable fulfill the functional requirements of his developmental stage without this level of intensive service. Average length of stay is 1 to 2 weeks.

Inpatient Hospital

Inpatient treatment services provide an out-of-home, twenty-four hour psychiatric treatment milieu under the direction of a physician. Within the medical context of an inpatient facility, clients can be safely evaluated, medications can be prescribed and monitored, and treatment interventions can

be intensively implemented. Inpatient treatment services represent the most restrictive and intensive intervention available within the DPBHS continuum of services. Average length of stay is 3 to 10 days.

Residential Treatment, Mental Health

Residential Treatment Center (RTC) service provides a 24 hour, supervised, residential living arrangement with intensive psychiatric services for children and adolescents with Mental Health and Substance Abuse disorders that impair their ability to be successful in community settings. Youth requiring RTC services are diagnosed with varying Mental Health disorders and may present with as a risk to themselves or others, require intense supervision, have difficulty self-regulating their behaviors and have not been successful in the less intensive treatment services.

Services will be delivered in a trauma informed environment in conjunction with other evidence based practices. The focus of treatment is to resolve the primary presenting problems that necessitated the youth's need for this type of structured residential treatment service. Average length of stay is 3 to 5 months.

Residential Treatment, Substance Abuse

The Joint Commission accredited residential treatment services purchased under this Contract comprise one element of the continuum of mental health treatment services provided by the DEPARTMENT'S DPBHS for children and adolescents. Services at this level are characterized by the provision of a 24-hour residential living environment, which is deliberately designed to create a structured therapeutic milieu, and which forms the basic foundation around which clinical treatment services are organized and integrated. Within the residential treatment level of the DPBHS continuum, programs and services are differentiated along several key dimensions:

- The restrictiveness of the milieu, in terms of both the physical characteristics of the environment and its proximity to the community;
- The nature and extent of clinical resources deployed in support of the milieu;
- The ratios of child care staff-to-clients, and the nature and extent of client supervision and care provided; and
- The extent to which educational services are provided within the program, versus reliance upon the public school system.

Length of stay will vary based on the individual's needs.

Residential Transition Service

Residential Transition Services (RTS) are ancillary services provided in preparation for a child's return home from a residential facility and continue, with the same provider, after the child has transitioned back to the home. Services are designed to work with the family and child prior to discharge. The service will identify natural and community supports and plan for these resources to be utilized to promote positive transitions home. Average length of stay is 3 to 4 months.

Transition Bed Service (TBS)

Transitional Bed Service (TBS) services provide supervised, supported care, including overnight, for youth with emotional disturbance or behavioral health issues. Transition Support Service may provide: short-term stabilization; a safe, structured environment for youth awaiting placement. Youth utilizing these services must be active with DPBHS and the use of the service must support a positive transition to an appropriate longer-term service or placement; Occasional periods of overnight care for youth who are active with the provider's Residential Transition Service. The use of this service can significantly reduce stress in the family, enhance the family's ability to keep their child/youth at home in the community, and prevent or delay the use of more restrictive behavioral health services for the child. The use of a Transition Support Services may be planned in advance or be offered as an option in emergent situations; and should **not** to be used in lieu of a crisis bed, inpatient care or residential treatment. These beds are not designed to provide 1:1 supervision and should not be considered for youth requiring this level of observation. Average length of stay is 1 to 3 days.

Crisis Response and Intervention

Crisis staff receive crisis calls directly from the published crisis number and respond in-person to crises as appropriate. Crisis response begins with the first face-to-face contact response with a youth experiencing a mental health emergency involving up to three contacts (face to face interactions) within a 72 hour period. Crisis intervention services continue for up to four weeks. Crisis services are community based (home, school) intensive (an unlimited number of contacts per week, with 24-hour availability), short term therapeutic intervention to assist the child and their family to improve coping mechanisms, identify and address the issues that precipitated the crisis, and plan in conjunction with DPBHS for further treatment if necessary. Average length of stay is 2 to 4 weeks.

Crisis Bed

Crisis beds provide a temporary supervised setting which provide safety, supervision and treatment and for a child in a crisis situation. Average length of stay is 1 to 3 days.

12 AUTHORIZATION PROCESS

Service Admission Form

DPBHS will notify the named agency's business contact to verify that service for a child and family has been authorized. DPBHS and will provide an authorization number for use in the billing process. Written notice of this authorization will be provided.

The Provider must call the identified CFCC within 24 hours (or the next working day) to notify DPBHS of the child and family's acceptance of service from the provider (Failure to advise DPBHS of the acceptance of service may result in the lack of or delay payment to the provider)

Retroactivity - Retroactive authorization and/or payment will not be made. Providers are responsible to submit appropriate documentation within sufficient time-frames for the authorization process to be completed. DPBHS has no obligation to reimburse unauthorized services.

Accredited Hospitals - The initial authorization for accredited hospitals is contingent on the provider's timely submission of a provider Certificate of Need on the approved DPBHS form. Please refer to the Schedule of Deliverables in this Manual.

Authorization of Continued Treatment - If treatment is to continue beyond the authorization period, a Progress Review must be conducted between the provider and the CFCC.

Progress Review - Prior to the end of the authorization period, the provider will communicate with CFCC or its contracted proxy in order to conduct a progress review. The review typically involves review of required deliverables which the provider is expected to submit in a timely fashion. NOTE: Active provider participation is essential to assure all data necessary to evaluate client's progress and enable timely reauthorization or for service discharge planning.

Re-authorization - The CFCC member will give verbal, faxed or email notification of re-authorization within two business days and re-authorization will be confirmed by DPBHS. DPBHS has no obligation to reimburse unauthorized services.

13 TREATMENT PROTOCOL

Written information for children and families is provided upon admission. Providers will meet with children and families to discuss their rights and responsibilities, procedures and expectations. Providers will have a system for documenting child and family receipt of such information (e.g. progress note, signatures, etc.). This information will include, but not necessarily be limited to, the following:

- General service orientation
 - Provider complaint/grievance procedures
 - Emergency procedures
 - Prevention resources information
- Consent to Treat
- Client Rights and Responsibilities
- Confidentiality
- Additional information for Clinical Record

Consent to Treat

The provider will have written policies and procedures to assure that no minor will be treated without documentation of informed written consent to treat, signed by at least one parent or a person

having legal authority to consent to treatment and witnessed by a representative of the provider. This consent must be renewed after one year. In certain cases, consent to treat may be signed by someone other than the parent or legal guardian.

If a child is prescribed psychotropic medication, the provider shall ensure that written informed consent is obtained from the parent, legal guardian or other individual with legal authority to make such decisions, prior to the implementation of the medication treatment. At a minimum, such informed consent shall indicate the drug and dosage, likely benefits, potential risks and side effects of the prescribed medication. Such informed consent shall also inform, to the extent permitted by law, the child, their parents, legal guardians and other individuals with legal authority to give such consent, of their right to refuse specific medication or treatment procedures (see applicable Delacare Requirements for Residential Child Care Facilities, § 213; Delacare Requirements for Day Treatment Programs 215(e); 16 Del. C. 5161(b) (3), (5)); DFS policies # 3045, 3046, 3047).

Delaware's Relative Caregiver statute allows relative caregivers to consent to lawful medical treatment for minors if the relative caregiver is in possession of a valid affidavit of establishment of power to consent to medical treatment. For further information please see: <http://www.dhss.delaware.gov/dhss/dsaapd/intergen.html>.

In mental health emergencies when a minor is exhibiting behaviors of such severity that failure to provide an immediate mental status examination and follow-up would result in imminent harm to the child, evaluations may be performed by the DPBHS Crisis Services without initial written parental consent, if reasonable efforts have been documented to contact parents, legal guardians or other legally authorized caregivers. All follow-up treatment provided by crisis services must be with the appropriate signed consent-to-treat.

A representative of the Division of Family Services (DFS) may sign consent to treat in all levels of DPBHS services with the exception of psychiatric hospital and/or the provision of psychotropic medication, if the child is in the custody of DFS, the parent cannot be contacted or reached and reasonable effort has been documented to notify the parent, legal guardian or legally authorized caregiver that the child has been admitted to those services.

Consent to Treat for Youth age 14 and older

In accordance to 16 Delaware Code § 2210, Chapter 22 "Substance Abuse Treatment Act", voluntary treatment for substance abuse, youth ages 14 and older may sign consent for treatment for alcohol or drug addiction without parental consent, for all levels of care excluding Residential Treatment Services for Substance Abuse. DPBHS highly recommends that every effort be made to work with such a youth to involve parents, legal guardian or legally authorized caregiver as soon as possible in the treatment process. If parents sign consent to treat, it is not required that the youth do so, although involving them in the consent process would be desirable.

DPBHS strongly believes that family participation is an essential component of successful treatment for children and youth, and family involvement is encouraged across all levels of service within the DPBHS service continuum. Parental consent is absolutely necessary for some services, as the primary mode of treatment is family-centered. For DPBHS Care Coordination Services (Administrative, Acute, Non-Intensive or Intensive) services, DPBHS requires parental consent for youth 14 years and older, in addition to the consent of the participating youth. DPBHS's contracted community providers will develop their own policies and procedures around consent for treatment of youth 14-18 years of age in accordance with 16 Del. C. §5003 (below):

§ 5003 Voluntary admission procedure:

Voluntary outpatient treatment — A person between 14 and 18 years of age, who is in need of mental health treatment, may request voluntary outpatient treatment from a licensed treatment facility or community provider. If the individual in need of treatment is a minor under 14 years of age, a parent, legal custodian, or legal guardian shall make the request for voluntary outpatient mental health treatment and give written consent for treatment.

- a. If a minor is 14 years of age or over, then either the minor, or a parent, legal custodian, or legal guardian may give written consent to a treatment facility or community provider for voluntary, outpatient treatment.
- b. Consent so given by a minor 14 years of age or over shall, notwithstanding the minor's minority, be valid and fully effective for all purposes and shall be binding upon such minor, the minor's parents, custodian, and legal guardian as effectively as if the minor were of full legal age at the time of giving such written consent. The consent of no other person or court shall be necessary for the treatment rendered such minor.
- c. A minor's consent is not necessary when a parent, legal custodian, or legal guardian of an individual less than 18 years of age provides consent to voluntary outpatient mental health treatment on behalf of the minor.
- d. A minor, including those age 14 and older, may not abrogate consent provided by a parent, legal custodian, or legal guardian on the minor's behalf. Nor may a parent, legal custodian, or legal guardian abrogate consent given by a minor age 14 and older on his or her own behalf.
- e. This section does not authorize a minor to receive psychotropic drugs without the consent of the minor's parent, legal custodian, or legal guardian. Only a parent, legal guardian, or legal custodian may provide consent for the administration of such medication.

Client Rights and Responsibilities

The Provider will have policies and procedures addressing clients' rights and responsibilities. These policies will conform to the DPBHS policy on rights and responsibilities. Documentation that the client has been informed of these rights in a language they can understand will be contained in the clinical record.

DPBHS will make available to providers copies of the DPBHS Child/Family Handbook. The provider will maintain copies at sites where individuals are served so that they are accessible upon request.

Confidentiality

The provider will have written policies and procedures to assure that staff comply with state and federal laws and with appropriate professional practice regarding the handling of confidential client information, including release of information. These policies and procedures will specify the condition under which client information will be disclosed and the procedures for releasing such information. All DPBHS providers will follow DSCYF (No. 205) and DPBHS (CS002) and will be in compliance with HIPAA 45 CFR. Policies on confidentiality are available on the Department and Division web sites. Releases will be time-limited for periods not to exceed one year and have specific beginning and ending dates.

Any child/youth who remains in services beyond 12 months is required to have all required consents resigned.

Substance Abuse - Written policies and procedures shall specify how confidentiality relates to the individuals receiving substance abuse treatment. All statements of confidentiality, releases and client rights must include reference to the Federal confidentiality standards cited in 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records and will also be in compliance with HIPAA 45 CFR.

Additional Documentation for the Clinical Record

Providers will include any applicable seclusion/restraint procedures.

Non-Residential substance abuse treatment providers will inform primary caretakers about the potential dangers and signs of alcohol and/or drug overdose and how to obtain medical treatment.

For crisis services, providers will review with children and families, and provide a copy of the DPBHS Child/Family Entering Care Handbook for that level of service. The signed form indicating the child has received this document must be contained in the record.

If a child is open for more than one year in any outpatient service treatment episode, documentation that he/she has been re-informed of her/his rights and responsibilities (e.g. HIPPA, consents), the complaint procedure and emergency procedures must appear in the record.

Integrated Interpretive Assessment Summary (Admission Summary)

An integrated interpretive summary is a narrative synthesis of the data gathered from the Initial Assessment (section VI.C above), and from collateral information obtained from schools and other sources such as the DPBHS Service Admission Form (SAF). It covers physical, psychological,

psychiatric, social and spiritual domains. It is used to facilitate the identification of individual treatment requirements, strengths, and risks currently presented by the child/youth. The integrated assessment is used to develop appropriate treatment interventions. This summary will be contained in the client record.

For routine outpatient services, this document must be included in the clinical record within five working days after the third session.

For crisis services, because of the short length of stay, one summary for admission and discharge may be completed. If the child continues to receive crisis services without a break in services for longer than 60 days, an admission summary should be completed.

Initial Diagnostic Evaluation

Mental health providers will use the DPBHS Assessment form. (See DPBHS Provider Page website for the most updated form).

Providers with Electronic Medical Records Systems may request exception to the use of standardized forms by contacting their program administrator and ensuring that their records contain the required content.

When assessments indicate exposure to abuse or trauma, the provider will complete a UCLA and, if indicated, make a DFS abuse report as warranted and/or mandated by law

Upon completion of the UCLA, if a client has multiple (more than 1) symptom in two domains, the CSM team should be advised. If appropriate, the therapist shall provide TF-CBT or discuss with the CSM team how to best manage the child's needs.

Therapists providing TF-CBT, are responsible to provide to the CSM team the pre & post UCLA score with the Discharge Summary.

Comprehensive Treatment Plan

Mental health providers will complete a Comprehensive Treatment Plan. This document will be consistent with the level of care and will be consistent with the areas of need identified in the CASII. The treatment plan is developed with the child and family, it is written in the child and family's words (quotes) and includes their signatures. The treatment plan also requires signatures of the primary therapist, the unlicensed therapist's supervisor when applicable, and the psychiatrist as indicated.

As appropriate for the level of care, the treatment plan will be reviewed and revised whenever new goals and objectives are added; or when identified goals or objectives are accomplished; or no less often than every 90 days. If goals are added to the treatment plan or other significant changes are

made, it is necessary for the provider to add pages to the plan or to write a new plan, depending on the agency format for this purpose. Significant treatment plan changes will be communicated with the DPBHS CFCC as a part of the progress review, such as:

- Treatment plans must be updates when a client changes level of care;
- Specific behaviors targeted for change;
- The community activities in which the child will be engaged to change these behaviors. (There must be a relationship between the target behaviors and the activities. For example, a child whose problems involve relationship problems with peers should be engaged in social activities in which he/she can practice positive peer interaction.); and
- Frequency of community activities to be provided.

When a client moves through levels of care within one agency, the agency will need to submit a revised treatment plan for the new level of care within 10 days.

Crisis Services Plan for Safety

The purpose of crisis services treatment plan is to mobilize the family's helping network, both informal and professional, in order to minimize risk while decisions are made about next steps for treatment. This is to be completed before the end of the first crisis session. At minimum a crisis treatment plan (Plan for Safety) will include:

- Risk factors as determined from the initial assessment, how they will be monitored and by whom;
- Realistic and detailed plan for the safety of the client and/or the community if applicable;
- Specification of the persons responsible for implementing each part of the plan;
- Specification of the number of treatment sessions to be provided within the crisis period;
- Criteria for discharge from crisis service;
- DSM IV 5-Axis Diagnosis; and
- Signature of primary therapist, licensed supervisor, parent and child.

Progress Notes

A progress note is required to document, in the client's record, all direct and indirect services by a Behavioral Health Professional. There must be a corresponding progress note for every claim for service. At a minimum, progress notes must include:

- Client identifier;
- Date;
- Time;
- Location of service;
- Session attendees (if group note, other client names/initial are not used);
- Content Information:
 - Progress notes for direct services shall be written in an acceptable format, which may include: Data, Assessment, Plan (DAP), Subjective Data, Objective Data,



Assessment, Plan (SOAP) or Goal, Intervention, Response, Plan (GIRP). Please see Appendix 5 for samples of these formats;

- If a particular Evidence Based Practice or treatment modality is being utilized, that should be included in the note;
 - Session content must be linked to goal on the client's treatment plan and/or other clinical intervention as appropriate; and
 - Changes in presenting problems, medications, treatment plan revisions, results of relevant screenings or tests, change in diagnosis, etc should be documented in the progress note.
- Legible signature and credentials of the Behavioral Health Professional conducting the session must be present for each note. It is suggested that the Behavioral Health Professional type or print their name and credentials below their signature line. Sessions conducted by an unlicensed Behavioral Health Professional must also be reviewed and co-signed by a licensed mental health professional. Notes must be reviewed within one week of the service claim date.

Progress notes must be in chronological order in the client's record. If sessions are being provided simultaneously, a note for each session must be present in the record in order for a claim to be made.

Progress notes for indirect services are not required to follow the format above but date, time, length of contact, participants and signatures are required.

The progress notes should "stand on its own" by supporting the clinical necessity for the service, identifying the clear link to the client's objectives and goals of treatment. The progress note must support the code being billed.

Progress notes are part of the client's clinical record and may be requested at any time.

The client/family/ Behavioral Health Professional should not be referred to by name in the progress note. "Mother", "father", "sibling" or "client" shall be used to refer to the child and family members. The Behavioral Health Professional should be referred to as "this writer" or "this therapist/clinician/Behavioral Health Professional" in the progress note.

When using an abbreviation, a reference for what that abbreviation represents must be provided in each note or appear on the list of acceptable abbreviations which is found in Appendix 2. For example, when referring to a "MT" in a note, the writer must spell out Mobile Therapist (MT) and include the abbreviation to be used throughout the remainder of the progress notes the first time the reference is used in a particular note.



If an error is made on a handwritten document or progress note, a single line is to be used to cross through it so the mistake is still legible. The word “error” is to be written and the person crossing out the wording in the document must initial next to the word “error”. No white out is to be used in the client’s record.

If there is any unused space on an unused portion of a line or page of the progress note in a client record, the writer must “x” out or write a line across any unused space so the record cannot be altered.

Progress notes should be completed and filed within 48 hours of the service provided. Progress notes must be complete and legible to be considered as appropriate documentation of the delivery of service.

Discharge

Discharge planning begins at admission and all treatment provided should be goal driven towards treatment success. Discharge is a process which continually assesses the child and family needs. This planning process involves the team including: the child, family, provider, DPBHS and any informal or community supports as identified by the family. Discharges cannot be made independently. Members of the team should be included in the discussion and planning process to change level of service or provider. Providers and DPBHS will support the child’s transition to new services or service providers. DPBHS has no obligation to reimburse unauthorized services.

Within 7-days of discharge, the provider will complete the DPBHS Discharge Summary, a copy of which will be retained in the clinical record. The Discharge Summary will be submitted to DPBHS as indicated in Appendix 6 of this Manual, and will be made available to subsequent treatment providers upon request and appropriate signed release.

Providers of routine outpatient services will send a Discharge Form to DPBHS within 18 days of the last direct face-to-face contact. If a child stops attending sessions and the therapist wishes to follow up to try to re-engage the child and family, this must be done within the 18-day timeframe. DPBHS clients may not simply be administratively discharged without follow-up attempts being documented. Notification of this discharge is done through the Outpatient Discharge Form available on the DPBHS website.

Where applicable, the care coordinator, in conjunction with the provider, will plan for transition to adult services and the CFCC will document efforts to implement this plan.

Agencies are not expected to complete an updated assessment or admission summary for the new level of care nor are they expected to complete a discharge summary for the previous level of care.

If the child/youth is on medication at the time of discharge, the provider shall ensure that a record of all current medications is given, including dosage and administration instructions. The documents shall be made available at the time of discharge to the parent or legal guardian, DPBHS and appropriate receiving agencies and personnel.

Transfer Instruction Sheet will be completed upon discharge and a copy will be kept for the provider record, a copy will be given to the family, and with appropriate consent, a copy will be provided to the new provider.

Document Submission

Each provider will send copies of child-specific clinical reports to DPBHS. These may include, but are not limited to safety plans, admission summaries, treatment plans, transfer instruction sheet, and discharge summaries. See the schedule of clinical documentation deliverables that follow for specific requirements.

The required clinical reports will be sent or faxed to the DPBHS Records Technician 302-622-4470.

14 COMPLAINTS & APPEALS

Complaints about DPBHS

The DPBHS complaint policy ensures an accessible and fair process for resolving the concerns of providers and child, their parents, relative caregivers, guardians, custodians, or their authorized representatives. It is the intent of DPBHS to resolve concerns without the use of formal processes where possible. However, if a concern cannot be resolved to the satisfaction of the aggrieved individual or entity, they may file a complaint with the appropriate DPBHS Manager of Quality Improvement.

- Step #1
Complaint is presented to the Coordinator. If your issue is not settled, go to Step #2.
- Step #2
Complaint is presented to the Team Leader. If your issue is not settled, go to Step #3.
- Step #3
Complaint is presented to the Regional Psychologist for the county in which they live. For New Castle County the Regional Psychologist may be contacted at (302-781-6145) and for Kent and Sussex counties you may call the Regional Psychologist at (302-526-5619). If your issue is not settled, go to Step #4.
- Step #4
Complaint is presented to the Director of the Child and Family Care Coordination Unit at (302 633-2611). If your issue is not settled, contact the DPBHS Quality Improvement Manager (302-683-8569). An Independent Review Panel is selected to consider your



complaint. See the DPBHS website below for policy and procedure or ask your Care Coordinator for a copy. <http://www.kids.delaware.gov>

Complaints about DPBHS Providers

Family or child complaints about DPBHS service providers should always be addressed first to the service provider. If a DPBHS staff member is notified of a complaint about a provider, the DPBHS staff will direct the aggrieved individual to the appropriate person at the provider organization. If assigned, the care coordinator may support to the family when addressing their concern with the provider. If the family and provider are unable to resolve the complaint, the care coordinator may inform their Team Leader for assistance. The Team Leader may notify the assigned Program Administrator to address the complaint with the provider as appropriate.

- Step #1
Complaint is presented to the Treatment Provider. The care coordinator will support the child and family if requested. If the issue is not settled, go to Step #2.
- Step #2
Complaint is presented to DPBHS Child and Family Care Coordination Team Leader. If the issue is not settled here, go to Step #3.
- Step #3
Complaint is presented to DPBHS Quality Improvement Manager (302) 633-2738 who will notify the Program Administrator assigned to the Provider.

If at any point child or families are concerned about any issue other than those listed above for appeals, they may go directly to the Manager of Quality Improvement at (302) 633-2738. However, we recommend that efforts be made to resolve the concern at the lowest level first.

Clients with Medicaid may also appeal directly to the Medicaid office if their concern is with the level of care that has been authorized. Custodians may appeal to the DHSS Medicaid Office by calling the Health Benefits Manager at 1(800)996-9969, Medicaid Customer Service at 1(800)372-2002 or ask for the Fair Hearing Officer at (302)577-4900. Custodians may write to: DSS Fair Hearing Officer, 1901 N. DuPont Highway, PO Box 906-Lewis Building, New Castle, DE 19720. See the PBHS website for policy and procedure or ask your coordinator for a copy.

15 REIMBURSEMENT

Payment Methodology

For Current Procedural Terminology (CPT) codes, Physicians, Psychiatrists and licensed psychologists are reimbursed at 98% of the Medicare rate. All other licensed Behavioral Health Professionals are reimbursed at 75% of the Medicare rate. DPBHS uses Optum's *Current Procedural Coding Expert* as a reference.

For Healthcare Common Procedure Coding System (HCPCS) codes, rates were developed using a cost model methodology. Factors considered in the development include: billable hours, travel, client absentee rate, supervision and training, documentation, phone contact/unbillable case management, and employee compensation. DPBHS uses *HCPCS Level II and Behavioral Health Services* as a reference.

For current DPBHS approved codes and applicable rates please visit:
http://kids.delaware.gov/pbhs/pbhs_providers_billing.shtml

DPBHS makes every effort to process bills and authorize reimbursement so that payment may be obtained in less than the thirty days stipulated in the contracts. If, however, the Provider submits bills which are inaccurate, illegible, are for unauthorized services, have calculation errors or are otherwise problematic, DPBHS will not accept responsibility for delayed and/or reduced payments.

Providers must submit bills within 6 months of the date of service. Any claim or bill submitted outside of that timeframe will not be paid unless the provider can demonstrate proof of timely submission.

In the case of electronic billing, providers will be unable to enter any claim which is not authorized. Reimbursement is contingent upon receipt of all contract deliverables due at the time invoices are submitted.

Claim Addresses and Telephone Numbers

Billing Unit Manager Kimberly Scully
302-892-6433

Claim submission address Delaware Department of Services for Children, Youth and Their
Families
Attn: DPBHS Billing Unit
1825 Faulkland Road
Wilmington, DE 19805

Secure Fax Number 302-622-4475

Acceptable claim and bill submission formats

1. Secure Email - Providers can email their claims or bills to their billing representative, as long as their submission is encrypted via use of secure email.
2. Secure Fax - Providers can send their claims or bills to our secure fax number. Please put Attention Billing Unit on the fax cover sheet. 302-622-4475
3. Mail - Providers can mail their claims or bills to the attention of the Billing Unit at the Delaware Department of Services for Children, Youth and Their Families, 1825 Faulkland Road Wilmington, DE 19805



4. In Person - Providers can bring bills to the Administration Building for the Department of Services for Children, Youth & Their Families at the address listed above. **However, due to increased security measures in the building, you must use the external phone to gain access the building. Please have the receptionist call to your billing representative to drop off the bills. Visitors may not walk throughout the building without a DSCYF employee present.**

Please note if claims and bills are not submitted to this address, DSCYF and DPBHS can make no guarantee that payment will be received in a timely fashion and could delay the processing and payment of the claims and/or bills will be returned to the sender.

DPBHS Billing Representatives:

Adriane Crisden	302-892-6464
Eartha Hopkins	302-633-2570
Vacant	302-892-6418

Receiving and Screening Claims

When claims are received by a billing representative within DPBHS, they are then screened for missing information. Only “clean claim(s)” will be processed for payment. A clean claim is defined as a claim that can be processed without obtaining the “**required information**” listed below. An incomplete claim is a claim or a bill that lacks the “**required information**” listed below. As such, that claim will be returned to the provider with a Return to Provider (RTP) letter. The claim will NOT be entered into the claims processing system. The provider will have to enter the missing information using the Re-Submission Form and resubmit the claim.

Required information

- Billing Month
- Provider Name
- Service type
- Client Full Name (First Name, Middle Name, and Last Name)
- Authorization Number
- Service Date(s)
- Units of Code
- Unit cost as specified in executed contract (not your usual and customary rates)
- Client Date of Birth
- Service Type (i.e., RTC, IP, OP,) CPT code or HCPCS code
- Admission date
- Billing activity date from
- Billing activity date to



Billing Summary

A billing summary form **MUST** accompany all monthly bills specifying the type of service authorized, number of children seen per month and a total amount of the claims submitted. The billing total on this form must equal the total of the claims being submitted.

Processing of Claims

Once a claim or bill has passed the screening as a “clean claim”, it is sent for processing. One of the following actions will happen:

Payment- The provider will be reimbursed for payment based on contractual specifications.

Denial- The claim or bill is denied payment because it does not meet program criteria and contractual specifications. Next, the provider will receive an exception report that details the reason(s) why the claim was denied in whole or part. It is the provider’s responsibility to follow up with the required information, fix any errors that may have resulted in the denial, and resubmit the bill. The re-submitted bill must be re-submitted using the re-submission forms. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Partial payment- Only a portion of the bill can be paid. Full payment cannot be made because the information supplied indicates the claim or bill does not meet program criteria or contractual specifications. Next, the provider will receive an exception report that details the reason(s) why the claim was denied in whole or part. It is the provider’s responsibility to follow up with the required information, fix any errors that may have resulted in the denial, and resubmit the bill. The bill must be re-submitted within **the identified timely claim submission guidelines**.

Exception Reasons for denial or partial payment

- Service date not authorized
 - Admission
 - Discharge
 - Authorization expired
 - End fund date expired
- Duplicate claim submission; previously paid
- Error in total amount billed
- Not authorized for that service
- Agency not authorized for that service
- Billed at incorrect rate
- Not a DPBHS client
- Service authorization gap

Electronic Billing- electronic direct submission providers can request to have direct bill processing access to our billing payment system. Any provider who is considering electronic billing must



have a minimum of three months of “clean” bills before considering electronic bill submission. DPBHS reserves the right to:

1. Revoke electronic bill submission if a provider demonstrates an inability to accurately submit electronic billing after several training(s) and information has been provided; and
2. Deny a providers request to start electronic billing.

Basic Requirements

- Ask and receive approval from your Program Administrator
- Contact your DPBHS Billing Representative
- Provider must have direct deposit set-up
- Provider must identify only 2 users within their agency to enter claims
 - One (1) user is the primary billing person and the second person is the back-up
- Both users must sign into the system at least once per month or the account will be suspended for inactivity and eventually deleted
- Complete three forms and one training

Timely Claim Submission Requirements

DPBHS requires that bills and claims must be submitted within Six (6) months of the original date of service. Bills and claims submitted after this time frame may be denied. This may include resubmitted claims.

Coordination of Benefits/Secondary Claims Submission

- DPBHS is typically the payer of last resort.
- In accordance with DPBHS policy #PBHS-CS001 *Service Eligibility*, if a child is hospitalized this Division does not function as a secondary payer for the purpose of funding insurance co-payment for the privately insured, with the following exceptions
 - If a child is hospitalized in a DPBHS designated psychiatric hospital on a voluntary basis, or is hospitalized on an emergency basis with DPBHS authorization and the hospital is unsuccessful in obtaining reimbursement for the private insurance, then DPBHS may reimburse the Provider up to the allowable contract rate for up to **72 hours**.
 - If a child has both private insurance and Medicaid, the private insurer is the primary payer and Medicaid is the secondary payer. However, if the child is treated by a participating Medicaid provider, then the parent, legal guardian or other legally liable individual is not responsible for any co-pay amount and by federal regulation, private providers may not bill payments for the amount. In such a situation, Medicaid providers who have a contact with DPBHS may be reimbursed up to the Medicaid rate in cases pre-authorized by DPBHS. If the provider and Medicaid recipient wish to utilize any applicable Medicaid coverage to pay costs after the primary insurance has paid allowable charges, the provider must obtain DPBHS authorization for the service prior to the initiation of the

service, in addition to any other authorizations which may be required by other payers.

- DPBHS will pay the difference between the primary insurance payment and the DPBHS allowable amount. This is calculated by taking the DPBHS rate by the number of units serviced and subtracting the primary insurance payment amount.
- Providers cannot bill clients or their families for a covered service or missed appointment (i.e., “no show” billing) and cannot balance bill clients or families.
- If the primary insurance carrier denies the claim as a non-covered service, DPBHS may consider the service for primary benefits.

Please note, it is the provider’s responsibility, to obtain the primary insurance carrier’s explanation of benefits (EOB) or the remittance advice for services rendered to clients that have other insurance coverage, in addition to DPBHS. Providers must bill and obtain an Explanation of Benefits (EOB) from any other insurance or source of health care coverage prior to billing DPBHS. The primary carriers’ EOB or remittance advice **MUST** accompany any secondary claims submitted to DPBHS for payment. A detailed explanation of how the claim was paid or denied should be included if not evident from the primary carrier’s EOB or remittance advice. This information is essential for DPBHS Coordination of Benefits. The information must be calculated and present on each individual claim, as outlined below:

- Line 1 -DPBHS Rate x number of units
- Line 2 - Primary Payer amount paid
- Line 3 - Amount request from DPBHS

The EOB and claim must be submitted within 6 months from the date of the service. Claims will be denied if they are not submitted without an EOB, or if the other insurance carriers’ requirements are not met.

Resubmitting Claims vs. Reconsideration

Providers have 6 months from the date of service to correct and resubmit claims or bills that received an exception report with the “required information”. Thus, the provider is re-submitting a claim or bill with the information we require that was missing from the bill or claim. A “reconsideration” is the process a provider uses when he/she has a dispute with the payment of a claim. Reconsideration is the DPBHS billing appeal process.

Resubmission- A claim originally denied because of missing documentation, incorrect coding, etc., that is now being resubmitted with the required information

Reconsideration- A request for the review of a claim that a provider believes was paid incorrectly or denied because of processing errors. Please see the Appeal process for detailed information for reconsideration

A resubmission must be on the resubmission form.

Claim Inquiries

DPBHS billing unit accepts telephone, written, and e-mailed inquiries from providers concerning claim or billing issues as long as all forms of communication are in compliance with HIPAA standards and maintain appropriate confidentiality.

Time intervals

For CPT and HCPCS codes there are specified units and time intervals built into the actual description of these codes. For a detailed list of the codes by service level, please refer to the approved CPT & HCPCS codes on the PBHS website:

- http://kids.delaware.gov/pbhs/pbhs_providers_billing.shtml.

Billing Monitoring and Documentation

DPBHS monitors provider billing on an annual basis. DPBHS requires each claim or bill submitted for payment have documentation to verify the claim. Thus, DPBHS requires the progress note to include the following items for billing documentation only (for clinical expectations, please refer to the treatment services sections of the Provider Manual):

- Date(s) of service delivery;
- Client Name;
- Subservice Type/CPT or HCPCS codes billed;
- Start time;
- End time; and
- Number of units billed.

Flex Funding

Providers may access Flex Funding to cover other expenses necessary to provide services within a system of care framework. Flex funds may be used for:

1. Reimbursement for psychotropic medication. The CONTRACTOR will document that there is no other available resource for the purchase and that the agency psychiatrist has prescribed and continues to monitor its use;
2. Material reinforcements for clients as they achieve treatment plan goals; and
3. Community-Based Activities: Purchase of club memberships for clients and other activities.

Additionally, for flex fund reimbursement, DPBHS requires that documentation will be in the client chart. DPBHS requires the documentation for flex funds to have:

- Date(s) of service delivery;
- Client Name;
- Subservice Type;
- Start time;
- End time;



- Number of units billed; and
- Name of DPBHS representative who authorized/approved flex fund expenditure.

Please note, each individual client sub-service is considered a claim. Each claim **MUST** have documentation to support its existence on the date billed for the number of units billed to DPBHS. It is also the expectation of DPBHS that ALL required documentation be in the client chart within 72 hours of the service provided.

Urine Drug Screens

For Substance Abuse services including drug screens as a subservice, please use the assigned HCPCS codes. Drug screens will be reimbursed as the standard rate or at cost with proper supporting documentation.

Please note that without proper documentation, a claim cannot be verified; as a result, the money paid for that claim must be returned. Returning the money paid for these claims resolves only the overpayment. It does not impact any other investigation relating to the particular claims identified, nor will it impact any resulting civil, criminal or administrative action undertaken.

For any provider that is currently operating under a program-funded or cost-reimbursable contract, please be sure to have supporting documentation for the services you bill in your cost reimbursable/program funded contacts. Thus, during an audit you should be able to provide documentation that corresponds with each expense line in your contractual “budget form”, for each bill that was submitted to DPBHS for reimbursement.

Provider Claim or Bill Appeal Process

A provider may submit a claim for reconsideration. This claim reconsideration must be submitted within 30 days after the initial denial is received. The first step in disputing a claim payment or decision is to contact their billing representative. Generally the billing representative can resolve the billing dispute within 5-7 business days.

Level 1 Appeal

If the provider is not satisfied with the reconsideration decision made by the billing representative, they must file a Written Level 1 Appeal to the Billing Manager. Please submit this appeal using the Level 1 Appeal Form. Please send this appeal within 30 days of the initial denial from the billing representative. Send the form and any supporting documentation to:

Delaware Department of Services for Children, Youth and Their Families
Attention: Billing Manager
1825 Faulkland Road
Wilmington, DE 19805

DPBHS will notify providers of the Level 1 decision in writing within 30 days of receipt of the appeal, unless we request additional information. If we need additional information we will send the Level 1 Appeal decision within 30 days of receipt of the additional requested information. If the Level 1 Appeal decision is in the providers' favor, we will recalculate and reprocess the claim or bill affected by the decision. If the Level 1 Appeal decision upholds DPBHS's original position, the provider can appeal to Level 2.

Level 2 Appeal

If the provider is not satisfied with the Level 1 Appeal decision, they must file a Written Level 2 Appeal to the Manager of Provider Services. Please submit this appeal using the Level 2 Appeal Form. Please send this appeal within 30 days of the Level 1 Appeal denial letter. Send the form and any supporting documentation to:

Delaware Department of Services for Children, Youth and Their Families
Attention: Manager of Provider Services
1825 Faulkland Road
Wilmington, DE 19805

DPBHS will notify providers of the Level 2 decision in writing within 30 days of receipt of the appeal, unless we request additional information. If we need additional information, we will send the Level 2 Appeal decision within 30 days of receipt of the additional requested information. If the Level 2 Appeal decision is in the providers' favor, we will recalculate and reprocess the claim or bill. The decision of the Level 2 Appeal is the final decision.

Provider Errors and Notification to DPBHS

If a provider realizes that they have submitted a bill for payment in error, they must contact the Billing Manager **as soon as they have become aware**. These errors include incorrect; units, dates, sub service or clients etc. The provider is required to use the "Submitted in Error" form. The provider may also be required to return payment to DPBHS for the claim or billing error. The two payback options would be recoupment through future claims and documented by exception report, or through direct check made payable to The State of Delaware and in the memo line, the client's initial and date of service that was billed in error. For multiple errors and multiple dates billed in error, a letter must accompany the check to specify what the check covers (which clients, which dates of service, etc.).

Fiscal Year End Close Out

At the end of each fiscal year (June) our fiscal department *closes down*. This means they cannot process payments until the fiscal system *opens back* up in mid to late July. DPBHS will notify providers in advance by e-mail and at the provider forums. It is the provider's responsibility to adhere to the dates and requirements to ensure proper and timely payment during this period. Please be advised no advance payment can be made for future claims.

Submission of Hardcopy Billing

Cost-reimbursable Contracts and State Operated Programs - day treatment, residential treatment, crisis intervention, and crisis bed.

Activity logs and/or calendar logs must be submitted monthly directly to the DPBHS Data Unit no later than the 15th of the next month.

Line item bills from cost-reimbursable programs will be submitted monthly and contain at minimum:

- Annual contracted budget by line-item with total.
- Current-month expenditures by line-item with total.
- Total billed to date by line item with total.
- Clinical services will be reported per day utilizing the approved CPT and HCPCS codes showing the reimbursement rate as \$0.

Unit Cost Contracts

Community-Based - Bills will be submitted with the below information and accompanied by a standard Billing Summary Sheet at the face of each package of client billing forms. All information must be completed (e.g., dates of authorization, diagnosis).

All Other Unit-Cost Contracts - At minimum, bills must contain:

- Client name;
- Client date of birth;
- Admission date;
- Each date billed in that month on which units of service were provided and for which the unit cost is being charged, along with a subtotal for each client;
- Provider of the service (primary therapist);
- Dates of authorization and the authorization number;
- DSM-5 diagnosis; and
- Cover sheet with total being billed for the program/service level.

Bills for each service must be submitted separately

Submission of Electronic Billing - Please refer to the DPBHS Electronic Billing Procedure for detailed instructions on how to use electronic billing. Providers must be trained prior to participation in electronic billing. Contact DPBHS at (302) 892-6433 to inquire about the training.

All providers must also complete any billing/activity data entry by entering their data into FACTS no later than 4:30 PM on the tenth working day of the month following the close of the month being billed. Bills not entered by 4:30 PM on the tenth working day of the month will be submitted in the next month's bill.

Providers do not have to submit a hardcopy bill if participating in electronic billing.

Direct Deposit - DSCYF offers direct deposit for vendor checks. To find out more about the direct deposit option or to enroll call the DPBHS Fiscal Agent at 302-892-4533.

Electronic payment benefits cited include quicker receipt of payment, elimination of lost checks in the US mail service and time saved on payment questions.

16 SECLUSION AND RESTRAINT PHILOSOPHY STATEMENT¹

The Division of Prevention and Behavioral Health Services (DPBHS) is committed to the effective implementation of trauma-informed care across its continuum of services for children and youth. Trauma-informed care requires that we first acknowledge the overwhelming stress and trauma so common in the lives of children and families we treat. Trauma-informed care is an approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as all aspects of organizational function.²

Safety—physical, emotional, and psychological—are critically important in supporting recovery from trauma. Treatment programs seek to provide safe, comfortable, and nurturing environments where children and youth can work through issues and develop new skills. Yet, some interventions such as restraint and seclusion may have the unintended consequence of triggering traumatic memories or re-traumatizing the child or youth.

Some individuals enter the behavioral health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless and fearful. Many enter the system involuntarily. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death. “A trauma-informed mindset assumes that: ‘bad behavior’ is a result of unmet needs; in fact there is ‘no such thing as a bad child’; children and youth are doing the best they can; and if they are not doing well, there is a reason related to how well they are able to think about and process their immediate circumstances”.³

DPBHS is committed to the continued prohibition against seclusion and reduction in the use of restraint in its facilities and programs. This goal is consistent with a mental health system that treats people with dignity, respect and mutuality, protects their rights, provides the best care possible, and supports them in their recovery. DPBHS understands that achieving this goal may require changes in the culture of the clinical environment and the ways in which the physical milieu environment is managed.

DEFINITIONS:

Restraint: Any manual method, physical intervention, or equipment that immobilizes the ability of a patient to move his or her arms, legs, body or head freely. In addition, a pre-authorized drug intervention can be administered to deescalate behaviors while or before restraints.

Seclusion: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevent from leaving. Seclusion does NOT include confinement on a locked unit where the patient is with others.

DPBHS recognizes that many individuals who have been recipients of mental health services consider restraint and seclusion abusive, violent and unnecessary. For more than 35 years, the consumer/survivor movement has continuously voiced its opposition to restraint and seclusion in documents, forums and protests. This movement has consistently championed the development of gentle, voluntary, empowering and holistic alternatives.

To accomplish the goal of eliminating the use of restraint and seclusion in its facilities and programs, DPBHS endorses and promotes a public health model that values input from patients, families, staff and advocates, and that emphasizes:

- *Primary Prevention:* preventing the need for restraint or seclusion;
- *Secondary Prevention:* early intervention which focuses on the use of creative, least restrictive alternatives, tailored to the individual, thereby reducing the need for restraint or seclusion; and
- *Tertiary Prevention:* reversing or preventing negative consequences when, in an emergency, restraint or seclusion cannot be avoided.
-

Furthermore, the public health model uses feedback from each stage to inform and improve subsequent actions. This is a strength-based, patient-driven approach that focuses on enhancing self-esteem, thereby promoting each individual's goals toward recovery. DPBHS strongly believes this approach is essential in establishing a culture that is proactive, responsive and collaborative, rather than reactive. Comprehensive training, education, modeling, mentoring, supervision and ample support mechanisms foster a therapeutic and healing environment for patients and a supportive environment for staff.

Such a therapeutic and healing environment must take into account the experiences of the clients, families and staff. Staff must be given opportunities to increase their empathy for and awareness of the client's and family's subjective and objective experience, including that of mental illness and the physical and emotional impact of restraint and seclusion.

Post Debriefing- Debriefing following the use of a restraint or seclusion is important to further reduction of these events. The patient and staff participate in debriefing sessions following the episode. The debriefing occurs as soon as possible, if appropriate, but no longer than 24 hours after the event.

DPBHS recognizes that in an emergency situation where less restrictive alternatives have failed, the judicious and humane use of restraint may be necessary to prevent the imminent risk of harm. In these instances, staff must use these interventions for the least amount of time and in the least restrictive way, taking into consideration the patient's history, preferences and cultural perspective. Intensive de-briefing is expected to promote greater understanding of the potential causes of the child's/youth's behavior, as well as to identify alternative supportive responses in the future.

DPBHS is committed to the continuous evaluation of restraint and seclusion data, and to the ongoing use of targeted performance improvement initiatives. These actions will reinforce the prevention model, improve practice, lead to better outcomes and support the goal of eliminating the use of restraint except for rare circumstances of imminent serious harm in DPBHS facilities and programs.

¹DPBHS gratefully acknowledges that most of this Philosophy Statement was taken from the Seclusion and Restraint Philosophy Statement of the Commonwealth of Massachusetts/Department of Mental Health, September 18, 2007.

²Redefining Residential: Trauma-informed Care in Residential Treatment (Adopted December, 2010). American Association of Children's Residential Centers. Milwaukee, WI.

³American Association of Children's Residential Centers.

17 FEEDBACK AND SUGGESTIONS

This Manual is updated regularly as requirements are added or changed. DPBHS welcomes feedback and suggestions for improvement from providers and the public at large. Please direct any questions or comments to:

Mental Health Program Administrator II
1825 Faulkland Road
Wilmington, DE 19805
(302) 633-2600

NOTE:

Any references to DSCYF and DPBHS policies and procedures, and/or forms for various purposes can be found on the DSCYF Website. <http://kids.delaware.gov/>

Necessary Forms, e.g. Billing, Outpatient Forms, Standardized Forms, Human Resources Forms can be found on the DPBHS website in the special section for providers. http://www.kids.delaware.gov/pbhs/pbhs_providers.shtml



18 Reference List

American Psychological Association. (2010). *Ethical principles of psychologist and code of conduct*. Washington, DC: Author.

Corey, G., Corey, M.S., & Callahan, P. (2007) *Issues and ethics in the helping professions* (7th ed.). Belmont, CA: Brooks/Cole/Thomson Learning.

Kuhithau, K., Bloom, S. Van Cleave, J., Knapp, A., Romm, D., Kiatka, K., Homer, C., Newacheck, P., & Perrin, J. (2011). Evidence for family-centered care for children with special health care needs: a systemic review. *Academy of Pediatrics, 11*(2), 136-143.

Welfel, E. R. (2010). *Ethics in counseling and psychotherapy*. Independence, KY: Cengage Learning.



Appendix 1 – Eligibility Policy

CS 001	DPBHS SERVICE ELIGIBILITY		
Authored by:	DPBHS Leadership Team	Title:	
Approved by:	Susan Cczyk, M.Ed., C.R.C.	Title: Division Director	
Signature:	<i>Susan A Cczyk 4/5/16</i>	Revisions: 12/19/99; 11/19/03; 8/31/05; 11/29/06; 11/1/07; 12/17/08; 8/10/10, 7/11/11; 4/18/12; 4/15/13, 4/17/14; 9/8/15	Originated: 5/1/97

PURPOSE: To define eligibility criteria for services provided by the Division of Prevention and Behavioral Health Services ("DPBHS"), State of Delaware.

DEFINITIONS: Applicable definitions are given in the appendix to DPBHS Policy Development and Revision of Policies."

POLICY: Consistent with statutory authority (16 Del C. chapter 90), agreement with the State Medicaid Office under the Medicaid waiver, DPBHS hereby establishes eligibility criteria for mental health and substance abuse services for children and youth who are served by DPBHS. Eligibility for service is established when criteria 1, 2, 3, and 4 below are all met or when criteria 5 is met.

1. Age: Children and youth are eligible:
 - A. Up to Age 18 - Children and youth are eligible for services until their 18th birthday.
 - B. Over age 18 - For those youth active with DFS or DYRS and over the age of 18 and less than 19 years of age, DPBHS may provide consultation, monitoring, and or diagnostic services.
2. Residence: Delaware residents are eligible for services.
3. Medical Necessity: Medical necessity is established by the application of DPBHS "Level of Care Criteria." These criteria are available on the DPBHS website.
4. Categorical Eligibility:
 - A. Insurance and Medicaid Benefits: DPBHS services are intended as a primary resource for those who have
 - 1) Medicaid benefits, and who require more than the basic Medicaid 30-hour annual outpatient benefit; or
 - 2) Uninsured, or
 - 3) Exhausted all applicable private insurance mental health or substance abuse benefits. The absence of a specific level of care or specific provider in a mental health insurance package is not sufficient grounds for categorical eligibility.
 - B. Co-Insurance: DPBHS does not function as a secondary payor for the purpose of funding insurance co- payment or deductibles for the privately insured. There are two exceptions:
 - 1) If a youth is hospitalized in a DPBHS designated psychiatric hospital on an involuntary basis, or is hospitalized on an emergency basis with DPBHS authorization, and the hospital is unsuccessful in obtaining reimbursement for the private insurance, then DPBHS may reimburse the Provider up to the allowable Contract rate for up to 72 hours.
 - 2) If a youth has both private insurance and Medicaid, the private insurer is the primary payor and Medicaid is the secondary payor. However if the youth is



treated by a participating Medicaid provider, then the parent, legal guardian or other legally liable individual is not responsible for any copay amount and, by federal regulation, private providers may not bill parents for that amount. In such a situation, Medicaid providers who have a contract with DPBHS may be reimbursed up to the Medicaid rate in cases pre-authorized by DPBHS. If the provider and Medicaid recipient wish to utilize any applicable Medicaid coverage to pay costs after the primary insurance has paid allowable charges, the provider must obtain DPBHS authorization upon exhaustion of private insurance for the service, in addition to any other authorizations which may be required by other payers.

- C. DPBHS does not provide services that substitute for services which are the responsibility of another agency. However, for clients meeting eligibility requirements for DPBHS services, and who also qualify for services from other state agencies, divisions within state agencies, school districts, physical/medical health care services, and/or other services, DPBHS will provide medically necessary mental health and substance abuse services arranged in concert with other involved agencies. For example, when eligibility criteria are met and the child has a moderate to severe mental health disorder that is not explained by an underlying developmental disorder, PBHS may authorize or co-fund medically necessary care in concert with the education system and/or the Division of Developmental Disabilities Services. Also, DPBHS may provide or co-fund mental health and substance abuse treatment for children and youth active with another DSCYF division when the child meets PBHS eligibility criteria.
- 5. Mental Health Crises - Crisis services may be provided to children and youth meeting criteria A or B. below.
 - A. DPBHS crisis services and short-term emergency hospitalizations may be provided to non-resident youth under the age of 18 years of age who are in the State of Delaware and are at imminent danger to self or others arising from mental health or substance abuse disorders . DPBHS reserves the right to seek reimbursement for services provided to non-Delaware residents.
 - B. The DPBHS crisis service also may be utilized by privately insured persons if they meet criteria 1, 2, and 3 above for initial crisis response (excluding crisis bed) intervention, but subsequent treatment is the responsibility of the insurance carrier unless the youth otherwise meets eligibility criteria and is admitted to DPBHS services.

APPLICATION:

- A. The application of this policy in a particular circumstance may be appealed by the affected parent or guardian, custodian or other legal caregiver if the parent is unavailable. (See also DPBHS Appeals Policy).
 - 1) Providers and advocates may assist children and families with an appeal under this policy.
 - 2) Families will be advised of their appeal rights whenever a client is determined to be ineligible for DPBHS services under this policy.

When DFS or DYRS has legal custody, staff in disagreement with DPBHS decisions should use the DSCYF case dispute resolution procedures instead of the appeal procedures.

- B. DPBHS staff may request a review by the Division Director if application of the policy would yield a result substantially contrary to the combined interests of the State and the client. The decision of the Director will be documented in writing and signed by the Director, and kept on file by the DPBHS Quality Improvement unit.

Appendix 2 – Acronyms and Definitions

Term	Acronym	Definition
Behavioral Health Disorder		Mental health and/or substance use disorders.
Boarder		A client who no longer meets clinical necessity for the service they are receiving
Building Bridges Initiative	BBI	Building Bridges Initiative
Child Priority Response	CPR	Includes a 24-hour crisis hot line, community & school crisis intervention, and short-term crisis stabilization.
Child and Family Care Coordination Team	CFCC	Provides care coordination for DPBHS eligible child/youth and their families who are receiving DPBHS services.
Department	DSCYF	Department of Services for Children, Youth and Their Families
Diamond State Health Plan	DSHP	Delaware’s Medicaid Managed Care Program
Division of Prevention and Behavioral Health Services	DPBHS	DPBHS provides a statewide continuum of prevention services, early intervention services, and mental health and substance abuse (behavioral health) treatment programs for children and youth in Delaware
Division of Substance Abuse and Mental Health	DSAMH	Serves the adult population in need of publically funded behavioral health services in Delaware. DSAMH licenses SUD providers contracted with DPBHS.
Early and Periodic Screening, Diagnostic, and Treatment	EPSDT	Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Mental health is included under the EPSDT benefit.
Evidence Based Practices	EBP	Practices that integrate the best available research, clinical expertise and client



		preference for which there is evidence showing they improve client outcomes.
Fee for Service		A system in health care by which particular services are paid for individually rather than provided as part of a comprehensive plan
Licensed Behavioral Health Practitioner	LBHP	Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor of Mental Health, Licensed Chemical Dependency Professional
Medical / Clinical Necessity		Justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care
Residential Treatment Center	RTC	Provides a 24 hour, supervised, residential living arrangement with intensive psychiatric services for youth with behavioral health disorders that impair their ability to be successful in community settings
Substance Used Disorder	SUD	Term used by the American Psychiatric Association to officially define both substance addiction and clinically significant substance abuse
Telemedicine		Services rendered using interactive telecommunication equipment

Appendix 3 – Steps in the Ethical Decision-Making Process¹

Here are a few key points regarding ethical decisions.

- Responsible practice requires that you:
 - base your actions on informed, sound, and responsible judgment
 - consult with colleagues or seek supervision
 - keep your knowledge and skills current
 - engage in a continual process of self-examination
 - remain open
- In making ethical decisions, as much as possible and when appropriate, include your client in this ethical decision-making process.
- Clients need enough information about the therapeutic process to be able to make informed choices.
 - The informed consent process begins with the intake interview and continues for the duration of the therapeutic relationship.
 - The aim is to involve clients in a collaborative partnership.
- The key is to make ethical decisions *with* clients, not simply for them. Get clients actively involved in the process to the extent possible and appropriate. Respecting the autonomy of your clients implies that you do not decide for clients, nor do you foster dependent attitudes and behaviors.

Eight Steps in Making Ethical Decisions

Ethical decision making should be a collaborative process between client and counselor, rather than a counselor making decisions for the client. Below are the steps, with suggested questions, to assist you in thinking through an ethical dilemma. This is one of several decision-making models which can be utilized. The steps taken may not always follow the same order shown and steps may be repeated several times in the process.

1. Identify the problem or dilemma.
 - Does a problem or dilemma actually exist?
 - Is this an ethical, legal, moral, professional, or clinical problem?
 - Is it a combination of more than one of these?
 - How can you know the nature of the problem?
 - Would you consult at this early stage as you are identifying the problem?
 - How might you begin the process of consultation with your client about the nature of the problem?
2. Identify the potential issues involved.
 - How might you best evaluate the rights, responsibilities, and welfare of all those involved and those who are affected by the decision, including your own welfare as a practitioner?
 - How can you best promote your client's independence and self-determination?



- What actions have the least chance of bringing harm to your client?
 - What decision will best safeguard the client's welfare?
 - How can you create a trusting and collaborative climate where your clients can find their own answers?
 - What principles can you use in prioritizing the potential issues involved in this situation?
 - Are there any ways to encourage the client to participate in identifying and determining potential ethical issues?
3. Review the relevant ethical codes.
- What guidance can you find on the specific problem under review by consulting with the professional codes?
 - Are your values in agreement with the specific ethical code in question?
 - How clear and specific are the codes on the specific area under consideration?
 - Are the codes consistent with applicable state laws?
4. Know the applicable laws and regulations.
- Are there any laws or regulations that have a bearing on the situation under consideration?
 - What are the specific and relevant state and federal laws that apply to the ethical dilemma?
 - What are the rules, regulations, and policies of the agency or institution where you work?
5. Obtain consultation.
- Do you know where to go to obtain consultation with professionals who are knowledgeable about ethical issues?
 - Assuming that you will consult with a colleague or a supervisor, what would you expect from this consultation?
 - What kinds of questions do you want to ask of those with whom you consult?
 - With whom do you seek consultation? Do you consult only with those who share your orientation, or do you look for consultants with different perspectives?
 - How can you use the consultation process as an opportunity to test the justification of a course of action you are inclined to take?
 - What kinds of information do you document when you consult?
 - When you do make use of a consultation process, do you inform your client about this? Are there any ways you might include the client in this consultation process?
6. Consider possible and probable courses of action.
- What are some ways that you can brainstorm many possible courses of action?
 - Do you have a systematic method for analyzing ethical obligations and possible courses of action?
 - Are you willing to involve your client in the discussion of the various courses of action?



- What might you document pertaining to discussions with your client about probable courses of action?
7. Enumerate the consequences of various decisions.
- How can you best evaluate the potential consequences of each course of action, before implementing a particular action plan?
 - Are you willing to involve your client in the discussion of the implications of each course of action for the client?
 - What ethical principles can you use as a framework for evaluating the consequences of a given course of action?
 - Examine the consequences of various decisions for your client, for you as counselor, and for the profession in general.
8. Decide on what appears to be the best course of action.
- After carefully considering all the information you have gathered, how do you know what seems to be the best action to take?
 - Do you solicit the input of your client in making this decision at this phase?
 - Once you have formulated a plan of action, do you ask for feedback from a colleague or supervisor?
 - Once the course of action has been implemented, what are some ways that you might evaluate the course of action?
 - Are you willing to follow up to determine the outcomes and see if further action is necessary?
-

¹Adapted from Corey, G., Corey, M, & Haynes, R. (1998). Student workbook for Ethics in Action. Pacific Grove, CA: Brooks/Cole.



Appendix 4 – Service Descriptions and Clinical Necessity Criteria

Outpatient Services, Mental Health

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns, from behavior problems, relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the youth is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the youth's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change.

Providers of Outpatient Therapy will embrace the System of Care (SOC) core principles, which include: Practice is Individualized; Services are Appropriate in Type and Duration; Care is Child-Centered, Youth-Guided and Family-Focused; Care is Community-Based; Care is Culturally Competent; Care is Seamless, within and across Systems; and Teams Develop and Manage Care.

Goals of Outpatient Therapy, Mental Health:

- Resolve concrete problems that impact the youth's daily living;
- Reduce symptoms resulting from thoughts, feelings, interpersonal disturbances, and /or experiences;
- Improve family and peer relationships;
- Strengthen coping skills;
- Manage emotions and behavior;
- Educate youth and families on the youth's diagnosis and symptomatology; and
- Identify and utilize formal and informal supports.

Service Components may include:

- **Assessment.** Continuous assessment of client and family needs is expected and adjustments to treatment approach, planning, duration and frequency shall reflect the client and family's changing needs.
- **Treatment planning.** This will occur in complete collaboration with the youth, family and other formal/informal supports identified. Youth/families will be active participants in establishing and prioritizing treatment goals.
- Individual, family and group therapy. Intensity and frequency of Outpatient Therapy will be based on the youth/family clinical needs. Most often sessions will occur at least once per week but more or less frequent sessions will be provided based on the individual's clinical need as determined by the Therapist and Care Coordination Team.
- **Crisis intervention and planning.** This includes development of safety plans with all youth and families entering services. The provider will establish a process for responding to after hour calls or emergencies. This process will be defined in agency policy and will be shared with DPBHS and all youth and families upon admission to this service.
- **Case management.** Case management is an element of Outpatient Therapy and should be coordinated with the DPBHS CSM and/or other agencies and supports involved with the youth and family.



- **Advocacy and education.** Outpatient Therapy providers will advocate on behalf of the clients and families in service and provide them education on varying topics, such as available community resources, medication side effects and compliance, symptoms and diagnosis, etc.

Anticipated Length of Stay (LOS): LOS will vary based on clinical necessity which will be routinely assessed.

PROVIDER QUALIFICATIONS

- At a minimum, Outpatient therapists will possess a Master's or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. It is expected that individuals who do not possess a license are in the process of obtaining required clinical supervision hours toward their professional licensure;
- Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid;
- Unlicensed therapists must participate in weekly clinical supervision provided by a licensed mental health professional. Documentation of weekly supervision is required and will be presented to DPBHS upon request;
- Therapist training and certifications will be documented and presented to DPBHS upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.;
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients;
- Possess a valid drivers' license;
- Be properly insured to provide contracted services;
- Pass a criminal background check as required in the contract; and
- Comply with additional requirements as stated in the DPBHS Provider Manual.

Outpatient therapy providers will possess the following skills and abilities:

1. Knowledge of major psychotropic medications and side effects and ability to convey this information to children and families;
2. Utilize crisis intervention skills with individuals/families in crisis;
3. Counseling skills and experience in providing individual, family and group therapy;
4. Develop and implement individualized treatment plans based on clinical experience and knowledge and revise the treatment plan in accordance with client/family's changing needs;
5. Knowledge of psycho diagnostics and ability to accurately diagnose utilizing the DSM 5.
6. Demonstrate ability to maintain knowledge of current trends in the field;
7. Utilize evidence based and best practice approaches to treatment;
8. Performs timely utilization reviews and obtains proper authorization to insure continued services;
9. Engage and counsel significant others (identified by the youth), as appropriate, to assist them in understanding, coping with, and supporting clients;
10. Knowledge of family systems and their impact on mental health within the family;
11. Skill in working with a variety of cultures;



12. Complete clinical documentation in a timely manner;
13. Be aware of community referral sources and refer when necessary;
14. Secure client information per HIPAA standards; and
15. Willingness to collaborate treatment and client care with other service providers and informal supports as identified by the youth/family and DPBHS as appropriate.

ADMISSION CRITERIA - *The youth must meet all criteria below to be admitted to this level of service:*

1. Youth ages birth-17 who meet DPBHS eligibility criteria for services;
2. The youth's parent/guardian/custodian provides voluntarily consent to treatment;
3. The CASII and/or other relevant information indicate that the youth's condition requires a coordinated course of treatment, consisting of psychotherapeutic services and, if clinically indicated, psychiatric services, to maximize functioning;
4. The youth presents with symptomatology consistent with an ICD 10 / DSM 5 diagnosis that requires a therapeutic intervention at this level of intensity;
5. The youth's symptoms interfere with the youth's ability to function in at least one area; and
6. There is an expectation that the youth has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA – *All criteria below are necessary for continuing treatment at this level of service:*

1. The CASII and other relevant information indicate that the youth continues to need the Outpatient level of care;
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care and does not require a more intensive level of care and no less intensive level of care would be appropriate;
3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated; and
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - *Any of the following criteria is sufficient for discharge from this level of service:*

1. The youth and family have reasonably met and sustained a majority of the treatment goals and are equipped to adequately manage symptoms;
2. The CASII and other relevant information indicate that the youth no longer needs the outpatient level of care;
3. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care;
4. Individuals have a history of noncompliance with treatment, and specific efforts to engage the youth and family have been well documented in the youth's clinical record.



5. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment; and
6. The youth meets criteria for a more intensive level of care.

EXCLUSION CRITERIA- *Any of the following is sufficient for exclusion from this level of service:*

1. The youth does not meet DPBHS eligibility criteria;
2. The CASII and other relevant information indicate that the youth's treatment needs are not consistent with an outpatient intensity of service, as they need a more intensive therapeutic service;
3. The youth's parent/guardian/custodian does not voluntarily consent to treatment;
4. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment; and
5. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.



Outpatient Services, Substance Abuse

Outpatient therapy is an individualized treatment which provides services in the least restrictive environment possible (office, home or community settings) to address a wide variety of concerns, from substance use, behavior problems, and relational conflicts to mood issues like depression or anxiety. Presenting problems and symptoms are the focus of treatment, with discharge when the youth is stable and treatment goals have been reasonably achieved. Outpatient therapy is intended to restore and enhance the youth's capacity to find solutions, identify and utilize available resources. Family members and/or other caregivers are encouraged to participate in these services. Outpatient therapy providers will continually assess client needs and make referrals to community resources as appropriate as the client's needs change.

Providers of Outpatient Therapy will embrace the System of Care (SOC) core principles, which include: Practice is Individualized; Services are Appropriate in Type and Duration; Care is Child-Centered, Youth-Guided and Family-Focused; Care is Community-Based; Care is Culturally Competent; Care is Seamless, within and across Systems; and Teams Develop and Manage Care.

Goals of Outpatient Therapy, Substance Abuse:

- Resolve concrete problems that impact the youth's daily living;
- Reduce symptoms resulting from thoughts, feelings, interpersonal disturbances, and /or experiences;
- Reduce frequency of substance use;
- Improve family and peer relationships;
- Strengthen coping skills;
- Manage emotions and behavior;
- Educate youth and families on the youth's diagnosis and symptomatology; and
- Identify and utilize formal and informal supports.

Service Components may include:

- **Assessment.** Continuous assessment of client and family needs is expected and adjustments to treatment approach, planning, duration and frequency shall reflect the client and family's changing needs.



- **Treatment planning.** This will occur in complete collaboration with the youth, family and other formal/informal supports identified. Youth/families will be active participants in establishing and prioritizing treatment goals.
- **Individual, family and group therapy.** Intensity and frequency of Outpatient Therapy will be based on the youth/family clinical needs. Most often sessions will occur at least once per week but more or less frequent sessions will be provided based on the individual's clinical need as determined by the Therapist and Care Coordination Team.
- **Crisis intervention and planning.** This includes development of safety plans with all youth and families entering services. The provider will establish a process for responding to after hour calls or emergencies. This process will be defined in agency policy and will be shared with DPBHS and all youth and families upon admission to this service.
- **Case management.** Case management is an element of Outpatient Therapy and should be coordinated with the DPBHS CSM and/or other agencies and supports involved with the youth and family.
- **Advocacy and education.** Outpatient Therapy providers will advocate on behalf of the clients and families in service and provide them education on varying topics, such as available community resources, medication side effects and compliance, symptoms and diagnosis, etc.

Anticipated Length of Stay: Actual LOS will vary based on clinical necessity which will be routinely assessed.

PROVIDER QUALIFICATIONS

- At a minimum, Outpatient therapists will be a Certified Alcohol and other Drug Abuse Counselor (CADC), or possess a Master's or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT), Licensed Psychologist or a Licensed Chemical Dependency Professional (LCDP). It is expected that individuals who are not certified and do not possess a license are in the process of obtaining required clinical supervision hours toward their professional licensure and/or certification.
- Providers will be enrolled with Delaware Medicaid and Licensed Mental Health Professionals will be paneled with the Delaware Medicaid MCO's.
- Providers of Outpatient Therapy, SA must have either a CADC or LCDP available on staff to provide supervision and to sign assessments and treatment plans of substance using youth.
- Unlicensed therapists must participate in weekly clinical supervision provided by a CADC, Licensed Mental Health Professional or a Licensed Chemical Dependency Professional. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
- Therapist training and certifications will be documented and presented to DPBHS upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients.
- Possess a valid drivers' license.



- Be properly insured to provide contracted services.
- Pass a criminal background check as required in the contract.
- Comply with additional requirements as stated in the DPBHS Provider Manual.

Outpatient therapy providers will possess the following skills and abilities:

1. Knowledge of major psychotropic medications and side effects and ability to convey this information to children and families.
2. Utilize crisis intervention skills with individuals/families in crisis.
3. Counseling skills and experience in providing individual, family and group therapy.
4. Develop and implement individualized treatment plans based on clinical experience and knowledge and revise the treatment plan in accordance with client/family's changing needs.
5. Knowledge of psycho diagnostics and ability to accurately diagnose utilizing the DSM 5.
6. Demonstrate ability to maintain knowledge of current trends in the field.
7. Utilize evidence based and best practice approaches to treatment.
8. Performs timely utilization reviews and obtains proper authorization to insure continued services.
9. Engage and counsel significant others (identified by the youth), as appropriate, to assist them in understanding, coping with, and supporting clients.
10. Knowledge of family systems and their impact on mental health within the family.
11. Skill in working with a variety of cultures.
12. Complete clinical documentation in a timely manner.
13. Be aware of community referral sources and refer when necessary.
14. Secure client information per HIPAA standards.
15. Willingness to collaborate treatment and client care with other service providers and informal supports as identified by the youth/family and DPBHS as appropriate.

ADMISSION CRITERIA - *The youth must meet all criteria below to be admitted to this level of service:*

1. Youth ages birth-17 who meet DPBHS eligibility criteria for services.
2. The youth's parent/guardian/custodian provides voluntarily consent to treatment. Youth 14 years of age and older may consent to Outpatient Therapy, SA without signed consent from a parent/guardian/custodian.
3. The ASAM/CASII and/or other relevant information indicate that the youth's condition requires a coordinated course of treatment, consisting of psychotherapeutic services and, if clinically indicated, psychiatric services, to maximize functioning.
4. The youth presents with symptomatology consistent with an ICD 10/DSM 5 diagnosis that requires a therapeutic intervention at this level of intensity.
5. The youth's symptoms interfere with the youth's ability to function in at least one area.
6. There is an expectation that the youth has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA – *All criteria below are necessary for continuing treatment at this level of service:*

1. The ASAM/CASII and other relevant information indicate that the youth continues to need the Outpatient level of care.



2. The severity of the behavioral disturbance continues to meet the criteria for this level of care and does not require a more intensive level of care and no less intensive level of care would be appropriate.
3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated.
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - Any of the following criteria is sufficient for discharge from this level of service:

1. The youth and family have reasonably met and sustained a majority of the treatment goals and are equipped to adequately manage symptoms;
2. The ASAM/CASII and other relevant information indicate that the youth no longer needs the outpatient level of care;
3. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care;
4. Individuals have a history of noncompliance with treatment, and specific efforts to engage the youth and family have been well documented in the youth's clinical record;
5. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment; and
6. The youth meets criteria for a more intensive level of care.

EXCLUSION CRITERIA- Any of the following is sufficient for exclusion from this level of service:

1. The youth does not meet DPBHS eligibility criteria.
2. The ASAM/CASII and other relevant information indicate that the youth's treatment needs are not consistent with an outpatient intensity of service, as they need a more intensive therapeutic service.
3. The youth (14 years and older) and/or parent/guardian/custodian does not voluntarily consent to treatment.
4. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.
5. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.



Therapeutic Support for Families (TSF)

Therapeutic Support for Families provides psycho-educational, therapeutic and supportive services for parents/ caregivers and youth who are participating in treatment services from the Division of Prevention and Behavioral Health Services. TSF services are delivered in conjunction with other medically necessary treatment services. TSF goals will be included in the youth and family's treatment plan and will include the projected frequency and length of service along with the specific interventions and activities (with purpose) to be incorporated in the attainment of these goals. TSF services will provide parent education and skill building services for identified caregivers and youth and therapeutic intervention and support for youth and families as they strive to achieve treatment success.

TSF services may be provided individually or in family and/or group settings. TSF services are tailored to meet the unique needs of the youth and family. Often these services will be required during specific times of day (such as in the morning, evening or bedtime) so availability of resources must allow for services to be provided at the times identified by the caregiver. Structured outings and activities should be scheduled which include both the youth and caregivers, allowing them to demonstrate acquisition of skills and practice applying these skills in real life situations with support and coaching from the TSF, as appropriate. These services are delivered by trained, skilled paraprofessionals.

Goals of Therapeutic Support for Families:

- Children will remain in their homes with caregivers, reducing out of home placements.
- Caregivers will build and maintain positive relationships with their children.
- Caregivers will gain knowledge and strengthen parenting practices, allowing them to successfully manage challenging behaviors and situations.
- Caregivers will build confidence in their parenting abilities and be provided support when challenges occur.
- Ability to identify precursors and triggers that result in impairment.
- Youth will develop effective and meaningful ways to manage their behaviors and appropriately express their emotions.
- Development of creative approaches to strengthen, achieve and practice proper use of coping and social skills in natural settings to promote positive peer and family relationships.
- Assist caregiver/family in preparation for a youth's return home and provide added support during periods of transition.
- Model positive skills and pro-social behaviors.
- Identify and connect caregivers with needed resources. This may include referring them for their own mental health or substance abuse treatment, assistance with meeting the family's basic needs (such as food closets, clothing resources, utility assistance) and aiding them in strengthening their own natural support network (connecting them with support groups, community resources, churches, etc).

Components:

Length of Stay: LOS will vary by case. Projected time limitations will be specified for each goal in the treatment plan and continuation of service must be justified by clinical need.



PROVIDER QUALIFICATIONS:

- Bachelor degree or higher in social work, psychology or a related human services field. Applicants with associates degrees and a minimum of 2 years of relevant work experience may be considered. Weekly supervision by a licensed mental health professional is required.
- Availability to provide services during daytime, evening and weekend hours as agreed upon by the CONTRACTOR and family.
- Possess a valid State of Delaware drivers' license and an active/adequate automobile insurance policy. Documentation must be maintained in the employee's personnel file.
- Pass a criminal background check.
- Complete the following trainings within the first year of employment:
 -
 - Mandatory Reporting - Abuse and neglect
 - Risk management and safety planning;
 - Field safety;
 - Trauma informed care;
 - Family engagement;
 - Ethics/ Maintaining Professional Behavior and Boundaries
 - Domestic violence; and
 - Child development (basics)

** Trainings provided by the CONTRACTOR must meet DPBHS requirements for content and documentation.

Providers of Therapeutic Support for Families will possess the following skills and abilities:

- Strong communication skills (verbal, writing, reading).
- Understanding of child development.
- Knowledge and practice of positive parenting techniques.
- Ability to build rapport, connect and create trusting relationships with others.
- Capacity to teach and/or model positive behavior, techniques and skills.
- Effective stress management, de-escalation and crisis intervention practices.
- General behavior intervention techniques and ability to adequately assess youth/caregiver needs.
- Knowledge of available community resources and ability to access resources.
- Knowledge/practice of financial and household management.
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ADMISSION CRITERIA – *The youth must meet all criteria below*

1. Youth meets DPBHS eligibility criteria.
2. The ASAM/CASII and/or other relevant information indicate that the youth/family's condition requires a coordinated course of treatment to maximize functioning.
3. The youth presents with symptomatology consistent with an ICD10 / DSM 5 diagnosis and/or a behavioral and emotional disturbance that requires a therapeutic intervention at this level of intensity.
4. Youth and family are actively participating in a DPBHS treatment service.
5. The symptoms interfere with the youth/family's ability to function in at least one area.
6. There is an expectation that the youth/family has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.



CONTINUED STAY CRITERIA – *All criteria below are necessary for continuing treatment at this level of service:*

1. The ASAM/CASII and/or other relevant information indicate that the youth./family continues to need this level of service
2. The severity of the behavioral disturbance continues to meet the criteria for this level of service and does not require a more intensive level of service and no less intensive level of service would be appropriate.
3. Progress in relation to specific symptom or impairments is clearly evident and can be described in objective terms. Some goals of treatment have not yet been achieved and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated.
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA- *Any of the following criteria is sufficient for discharge from this level of service:*

1. The youth and family have reasonably met and sustained a majority of the treatment goals.
2. The ASAM/CASII and/or other relevant information indicate that the youth/family no longer needs this level of service.
3. The family is able to effectively manage any recurring problems.
4. The youth/family is making reasonable improvements in identified treatment goals. The youth/caregiver is able to demonstrate acquisition of skills.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the provider to overcome barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is the you and family have not benefited from the treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. Individuals have a history of noncompliance with treatment and specific efforts to engage the youth/family have been well documented in the clinical record.
7. Youth/family withdraw consent for treatment.
8. Youth meets criteria for a more or less intensive level of service.

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EXCLUSION CRITERIA – *Any of the following is sufficient for exclusion from this level of service:*

1. The youth does not meet DPBHS eligibility criteria.
2. The youth has a sole diagnosis of Autism Spectrum Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 diagnosis.
3. The youth has a sole diagnosis of Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or the symptoms/behaviors consistent with a DSM 5 diagnosis.
4. The ASAM/CASII and/or other relevant information indicate that the youth/family's treatment needs are not consistent with this level of service.
5. The youth and/or caregiver do not voluntarily consent to treatment.
6. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.



Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT) is an evidence based outpatient service. It has been empirically validated for adults and the emerging literature shows great promise for treating adolescents. Dialectical Behavior Therapy was developed by Linehan (1993) and Associates. This has been an effective treatment for a variety of conditions such as borderline personality disorder, depression, post-traumatic stress disorder (PTSD), substance abuse, self-injurious behaviors and eating disorders. Treatment is used to aid adolescents in managing problem behaviors (self-harm, self-injury, suicidal planning, gestures, actions, impulsive decision making, and avoidance) used maladaptive to manage stressful life situations.

A comprehensive DBT program consists of the following core components:

- Skills training groups
- Individual therapy
- Parent Group
- Phone coaching
- Consultation team

The overall purpose of DBT is to help the youth create a life worth living goal. What makes a life worth living varies from client to client. While individual's goals will differ, all clients have in common the task of bringing problem behaviors, especially behaviors that are life threatening, under control. Once identified, these behaviors can be targeted for positive change. Youth use self-monitoring via diary cards to keep daily records of emotions, urges, and behaviors. In individual therapy and group sessions, participants learn and practice skills to aid in managing emotions, urges, and behaviors tracked on diary cards. Group consists of three modules total. Each module has core mindfulness taught as both a general technique and applied skill in three categories: Distress Tolerance (how to tolerate emotional pain in difficult situations, not change it), Interpersonal Effectiveness (how to ask for what you want and say no while maintaining self-respect and relationships with others) and Emotion Regulation (how to change emotions that you want to change). These skills will aid in the process of decreasing self-judgment, self-criticism and increase self-validation and acceptance while working on change.

DBT is divided into four stages of treatment. Stages are defined by the severity of the client's behaviors, and therapists work with their clients to reach the goals of each stage in their progress toward having a life that they experience as worth living.

1. In Stage 1, the client is suffering as life is currently being lived and their behavior is out of control: they may be experiencing suicidal ideation, engage in self-harming, self-injury, or self-destructive behaviors, and/or be abusing substances. When clients first start DBT treatment, they often describe their experience of their mental illness as "being in hell." The goal of Stage 1 is for the client to move from being out of control to achieving behavioral control.
2. In Stage 2, they're living a life of quiet desperation: their behavior is under control but they continue to suffer, often due to past trauma and invalidation. Their emotional experience is inhibited. The goal of Stage 2 is to help the client move from a state of quiet desperation to one of full emotional experiencing. This is the stage in which post-traumatic stress disorder (PTSD) would be treated as well as secondary targets.



3. In Stage 3, the goal is to learn to live an ordinary life and problem solve relationship conflict, dissatisfaction, career goals, etc. This work can happen in therapy or sometimes without therapy.
4. In Stage 4, the goal is to find happiness, completeness, and connection. Linehan has posited a Stage 4 specifically for those clients for whom a life of ordinary happiness and unhappiness fails to meet a further goal of spiritual fulfillment or a sense of connectedness of a greater whole. In this stage, the goal of treatment is for the client to move from a sense of incompleteness towards a life that involves an ongoing capacity for experiences of joy and freedom.

A full time outpatient therapist can maintain a maximum case load of 15 hours of DBT treatment on their case load. These hours include groups and individuals. Adolescent DBT treatment consists of a one hour individual session per a week, a two hours of group therapy sessions per week, family sessions as indicated, and monthly parent group. Phone coaching, which does not involve face-to-face occurrences, are available 24 hours per day, including weekends and holidays. If face to face intervention is needed during a phone coaching call the local mental health emergency hotline or the local emergency room will be utilized.

Length of Stay: Average of 12 months. One round of DBT comprehensive treatments lasts six months. Most participants complete two 6 months rounds of treatment. A third round of individual only treatment can be offered by the consultation team. The average length of stay is one year.

Due to the variability in learning abilities there are exceptions in order to provide the most effective treatment for the youth. For example, a fourth round of individual only has been offered to aid the client in moving through stage 3 because their processing and comprehension requires repetition outside of the average length of stay. Or, some client cannot tolerate going directly into group and will receive skills training on an individual basis. The goal would be for them to complete a round and transition into the group setting and complete up to two rounds of group skills training.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

Safety/Risk Management Events

- Allegations of abuse, cutting, suicidal attempts, hospitalization, frequency and type of impulsive and destructive behaviors, and police involvement/assistance are tracked via a risk management system and quality improvement strategies are considered during team and management meetings.
- Staff clinical competence is ensured through monitoring at regular intervals by the quality improvement and human resources team through a fidelity audit annually; this is done internally. At least one video a year is reviewed by the clinical director for each staff.

Outcome Monitoring of Client Care

Outcomes of care are monitored at admissions, three months, six months, nine months, and 12 months. If youth is in the program longer than one year monitoring continues at three month intervals. Every youth and guardian/parent will complete a Child Behavior Check List (CBCL) every three months. Additional globalized and specialized assessments are utilized per the youth's needs. Data is analyzed annually.



BILLING

DBT is a comprehensive service at the outpatient level. Youth with only medical assistance shall not bill for other behavioral health services while in DBT, with the exception of psychiatric evaluation and medication management. Only with the care manager's approval and authorization youth may receive other behavioral health services in addition to DBT. An approved list of applicable codes is attached.

Youth with primary commercial insurance may opt to seek ancillary services in addition to DBT. For example, movement therapy, art therapy and family therapy. DBT therapist will collaborate when participation is warranted or necessary.

PROVIDER QUALIFICATIONS:

- A minimum of a Master's degree in psychology, social work, or other human service field is required. The degree held must come from an educational program at a regionally accredited institution of higher education.
- Therapists must be a State of Delaware licensed, independent mental health practitioner with an unrestricted license in order to provide DBT therapy. Conditional licenses/certificates that require supervision to work as a mental health professional are not acceptable.
- Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid MCO's.
- Therapists will have a minimum of 2 years of experience working in a therapeutic setting.
- Therapists will participate in 6-8 month comprehensive training and achieve a passing score of 80% or above on a final exam, or have completed comprehensive training in DBT and provide certificates of training, proof of pedigree and references, or complete the exam scoring 80% or better.
- Therapist pedigree letter and or proof of training will be documented and presented to DPBHS upon request. This includes the credentialing results performed by the provider.
- Psychiatric services will be provided by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
- Possess a valid drivers' license.
- Be properly insured to provide contracted services.
- Pass a criminal background check as required in the contract.
- Comply with additional requirements as stated in the DPBHS Provider Manual.

ADMISSION CRITERIA: *The youth must meet all criteria below to be admitted to this level of service:*

1. Youth is between the ages of 13-17 years of age and meets DPBHS eligibility criteria. Some 11 and 12 years old may qualify and this will be assessed per an individual basis at the interview process and with consultation team review.
2. Youth must pass the pretreatment interview that last, on average, between 3 to 4 sessions.
3. Youth and family are willing to commit to attendance requirements of DBT treatment.
4. The CASII and other relevant information indicate that the youth needs the DBT level of care.



5. The youth manifests behavioral symptoms consistent with the diagnostic criteria for Borderline Personality Disorder (BPD) in ICD 10/ DSM5; meeting at least 5 out of the 9 criteria. Youth are not required to have a BPD diagnosis. These symptoms can manifest as multiple problems in multiple areas of life functioning.
6. Have mental health needs that cannot be met with other available community-based services or that need services provided concurrently with other community-based services.
7. Be at risk of **one** of the following, as recorded in the client's record:
 - a. A need for a higher level of care, such as hospitalization or partial hospitalization
 - b. Intentional self-harm (suicidal and non-suicidal) or risky impulsive behavior or be currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the client has managed to not act on them.
 - c. A mental health crisis
 - d. Decompensation of mental health
8. Understand and be cognitively capable of participating in DBT
9. Be able and willing to follow program policies and rules assuring the safety of self and others

CONTINUED STAY CRITERIA: *All of the following criteria are necessary for continuing treatment at this level of service:*

1. The CASII and other relevant information indicate that the youth continues to need the DBT level of care.
2. Be actively participating and engaged in the DBT program, its treatment components and its guidelines in accordance with treatment team expectations
3. Have made demonstrable progress as measured against the client's baseline level of functioning before the DBT intervention. Examples of demonstrable progress include:
 - a. Decreased self-destructive behaviors
 - b. Decreased acute psychiatric symptoms with increased functioning in activities of daily living
 - c. Objective signs of increased effective engagement
 - d. Reduced number of acute care services, such as emergency department (ED) visits, crisis services and hospital admissions
 - e. Application of skills learned in DBT to life situations
 - f. Continue to make progress toward goals but have not fully demonstrated an internalized ability to self-manage and use learned skills effectively
 - g. Be actively working toward discharge, including concrete planning for transition and discharge
 - h. Have a continued need for treatment as indicated in the above criteria and by ongoing documented evidence in the recipient's record

DISCHARGE CRITERIA: *Any of the following criteria is sufficient for discharge from this level of service:*

1. The client's individual treatment plan goals and objectives have been met, or the client no longer meets continuing-stay criteria.
2. The client's thought, mood, behavior or perception has improved to a level for which a lesser level of service is indicated.
3. The client chooses to discontinue treatment.



4. The provider concludes from the ongoing clinical assessment that the client no longer meets admission criteria or that another treatment modality would be more effective.
5. A client who is unable to maintain adherence to the treatment regimen can be considered for discharge after conflict resolution steps are exhausted.

EXCLUSION CRITERIA: *Any of the following is sufficient for exclusion from this level of service:*

1. Client is 10 years of age or younger.
2. Client behaviorally does not meet at least 5 out of the 9 diagnostic criteria for Borderline Personality Disorder, regardless if they have the diagnosis.
3. Client/family does not consent for treatment.
4. Client's Intellectual Developmental Disorder impairs their ability to participate in DBT.
5. Client/family is unable or unwilling to make an attendance commitment.
6. Client is unwilling to make an elimination agreement to take suicide, self-harm, and self-injury off the table.

Family Based Mental Health Services (FBMHS)

The Family Based Mental Health Services are designed to service children between 3 and 17 years of age and living with their parents, guardians, or caretakers and have a serious mental illness or emotional disturbance. These children are also at risk for out-of-home placement into residential treatment facilities, psychiatric hospitals or foster placements due their symptomatic behaviors and/or the dysfunction of the family system that contributes to the behaviors. Family Based Mental Health Services (FBMHS) are able to treat these children and adolescents in their homes, communities and schools thus allowing the youth to remain in the home. Services are available 24 hours per day and 7 days a week via on call therapist from the FBMHS program.

FBMHS is a team delivered service rendered in home, community and school settings. It is designed to integrate mental health treatment, the family, family support services, the surrounding system, and casework so that families may continue to care for their children and adolescents with a serious mental illness or emotional disturbance in their home. These children and adolescents experience depression, anxiety, chronic acting out behaviors, aggression, social, coping and skill deficits, drug and alcohol abuse, and school truancy. These children are frequently described as “hard to manage” by their parents. Often times, their personality traits and their parents’ management skills are frequently in conflict with each other which lead to a youth/family’s involvement with multiple systems.

Children and adolescents referred for FBMHS may experience multiple challenges which make it hard for them to be successful in school, home, have positive relationship in the community, accomplish age defined developmental and emotional goals, and social and academic achievements. Additionally the parent, guardian, caretaker may experience their own challenges in decision-making, problem-solving, regulating emotions and maintaining attachment with their child and functioning as the executive. Caregivers feel overwhelmed by parenting responsibilities and may feel as though they have “failed as a parent.”

FBMHS treatment is driven by the Ecosystemic Structural Family Therapy model (ESFT) that incorporates the use of the emotional relational process between the therapist and family and within the family system isomorphically. The goal is to block negative family patterns of



behaviors and forge new family patterns. Behavioral principles aid in driving the shaping and development of new behaviors in the family system. Individual, family, parents, couples, sibling and community approaches are integrated to address identified needs through the model. The treatment planning process is strength based, youth specific and focused on the achievement of individual and family goals in order to maintain the family together in the community. Family systems therapy, parent skills training and sibling counseling are mutually supportive of each other in facilitating family stability, healing and behavioral improvement.

Components of FBMHS:

- **Treatment Planning:** FBMHS team develops the treatment plan in active collaboration with parents and client creating specific goals and objectives to be worked on during the course of the program. Thereafter treatment planning occurs monthly.
- **Family Therapy:** Occurs in the home and is conducted by two master level clinicians. The FB team typically provides family therapy at least one time a week depending on family-client needs and availability to meet with the FB team. On average a session lasts 2.5 to 3 hours (which may include travel time). During family therapy the therapeutic system is constructed, a meaningful focus for treatment is agreed upon, key growth promoting interpersonal experiences are facilitated by the FB team, and the changes are solidified and extended.
- **Individual Therapy:** Supports the family therapy process. It may be provided to the authorized youth or any family member in support of strengthening the family system and well-being of the authorized youth. Therapy may be provided by either FBMHS team member in accordance with the skill set of the particular therapist, and the input of the clinical supervisor. The frequency and focus of individual therapy is unique to each family and is determined collaboratively by the family and FB team. Individual therapy works to strengths the individual members of the family system to promote new family patterns. Interventions may include evidenced-based therapy, psycho-education, coaching, person-centered therapy and skills training approaches. These are offered in the home, school or community.
- **Sibling Therapy:** Sibling therapy is subordinate to family therapy in terms of overall service provided and is consistent with and supports the progress towards family therapy goals. Sibling interventions may be team or individual delivered. Either team member may provide sibling interventions. Counseling can include directive social skills work, interactive counseling, modeling and sibling ordeals or homework to be practiced during the week.
- **Parenting/Couples Therapy:** FBMHS recognized the ‘client-family’ as the treatment focus. Within this concept there is a place for working with the guardian/parent-couple to:
 - Help identify problems and barriers to a stronger co-parenting alliance and increased executive functioning so that they can increase attachment in the family system and emotional regulation.
 - Discover ways in which to use the strengths of the guardian/spousal relationships to support the wellbeing of the youth and family.
 - Accept adjustments to guardian/spousal relationship that will support wellbeing of youth and family.
 - Locate and access professional marriage counseling if problems and FB team expertise are beyond the scope of the first three.



- FBMHS staffs are not trained marriage counselors. However, they can identify family systems, spousal dyad barriers, and ‘deadlocked’ communication patterns that contribute to the core negative patterns in the family system being addressed by the FBMHS.
- Interventions are grounded in an emotional relational process and may include evidenced-based therapy, psycho-education, coaching, person-centered therapy and skills training approaches to increase consistency in parenting intervention.
- **Interagency Team Meeting:** Are held at the beginning and end of treatment, and as needed throughout treatment to strengthen the ecosystem surrounding the family. Members of the meeting include the team, the client, and the family, in addition to other systems or supportive community members who are involved (school, CYS, JPO, neighbor, religious leaders, extended family, etc.). The purpose of these meetings is to strengthen the family by teaching them how to turn to others and advocate for their needs, and more specifically the needs of their child.
- **Case Management:** FBMHS provides necessary case management (CM) to link the client-family to resources in the community. The purpose is to gain improvements in client-family needs in the community-region in which the client-family live. Resources start with meeting the basic safety, sustenance and shelter requirements for stable life, based on the Maslow need hierarchy. It is also community based in terms of tapping into the natural support systems of communities. Specific aspects of CM include:
 - Basic services (food, clothing, shelter) support
 - Recreation support
 - Spiritual support
 - Healthcare support
 - Educational support
 - Social skills support
 - Vocational skills support
- **Skills Training:** Skills training are an integral part of FBMHS and is applied in the family system and all subsystems based on the skills deficits and needs of the particular family. Skill categories proceed from Maslow’s hierarchy of needs and may include discussing with and teaching:
 - Parents to manage basic financial and material needs of the family.
 - Parents to identify and obtain means of family and self-support.
 - Parents to understand misbehavior as an attempt to get their needs met.
 - Parents to address youth’s psychological needs of belonging and competency.
 - Parents to intervene effectively
 - Children to identify behavioral antecedents and new behavioral responses.
- **School consultation:** The FBMHS team maintains contact with all relevant members of the interagency team, which the school is a part of, to discuss necessary matters of treatment support the youth in school. The FBMHS team may:
 - Provides observation and treatment to the child in the school
 - Provide supportive mental health services for crises when requested by school officials
 - Provides consultation or suggestion requested through the interagency team process.
- **Community Integration:** Parents and guardians are encouraged to determine their children’s interest and learn how to be involved as a family in their community. FB staff help the parents to weigh the pros and cons for their decisions, but ultimately the clients



must make their own decisions as to what is worthwhile for their children based on feedback from the team. The following are suggested for discussion:

- Art
- Boy/girl Scouts
- Music enrichment program
- Recreational activities
- Physical fitness
- Other services – medication management, physical health etc.
- **Crisis Management:** Crisis management is addressed in the FB treatment plan which includes a crisis plan that is proactive and individualized for each client-family in a collaborative manner with the team. All relevant emergency and crisis phone numbers are provided to the client-family. After hours (5pm-9am M-F and weekends) crisis and mental health emergencies are handled by on-call FB staff member. The client-family is given the on-call phone number at the start of FBMHS. The goal of the on-call response is to help caregivers to move through crisis and have the process of change develop in order to resolve the symptomatic situations in their homes and communities rather than contact police and seek hospitalization for the youth.

Goals of Family Based Mental Health Service:

- Prevent psychiatric hospitalization for children and adolescents enrolled in the program.
- Prevent out of home placements for children and adolescents enrolled in the program.
 - Maintain children and adolescents with emotional and mental health problems within intact families and enable family members to continue as active participants in their local communities.
 - Offer therapeutic contact needed that is best tailored to meet the needs of individual members of families.
 - Provide a mental health service that is an alternative to traditional outpatient service allowing families more opportunities to participate in designing interventions that best meet their family's needs.
 - Offer expertise in developing transitional services to families to better enable them to obtain community supportive services after discharge from FBMHS
 - Foster safe, structured home environments through parent training, support and consultation during times of crisis while maintaining increased sense of personal achievement and family connectedness.
 - Utilization of multi learning approaches to promote personal connectedness, effectiveness, accountability, motivation and safety in the delivery of services.
 - Promote physical wellbeing, emotional stability and skills development in children, adolescents and families.

Each FBMHS team may carry a maximum of 8 clients and families at a time and is required to have a minimum of 1 face-to-face family contact per week. Contacts are regularly scheduled as well as emergency based. FBMHS are available 24 hours a day, 7 days a week via an on-call system. After hours responses by phone and in-person are a key component of this service.

Length of Stay: 32 weeks



MONITORING AND ASSESSMENT OF SERVICE DELIVERY

- The Center will collect and report outcome information through the various collaborative development and integrated mechanisms in place to monitor outcomes (incident data base, Performance Improvement Plan, program scorecard, quality QM audits, compliance audits, and supervision). Outcome variables include:
 - Length of Stay – discharge planning starts upon admission. FBMHS may be approved for up to 8 months. Additional time may be requested and approved after review by the State HMO.
 - Discharge placement based on level of care. Services are identified and in place at time of discharge along with an overlap in services to support a smooth transition of services.
 - The FBMHS Director follows the course of treatment for each client-family in weekly supervision and along with the FBMHS team determines response to treatment.
 - Monitoring of outcomes of care using the Modified Family Assessment of Functioning (MFAF) at admissions and discharge.
 - Client/family satisfaction surveys: Feedback will be elicited from children/adolescents, family members, caregivers, and agencies. Data will be used to drive the performance improvement process at the Center and when identified at the program level.

BILLING

Family Based Mental Health Service is a comprehensive service. FBMHS shall not be billed with other behavioral health services with the exception of psychiatric evaluation and medication management. An approved list of applicable codes is attached

PROVIDER QUALIFICATIONS:

1. FBMHS therapists will possess a Master's or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. Licensed Mental Health providers will be enrolled and paneled with Delaware Medicaid MCO's.
2. FBMHS therapists will participate in a 3-year core training program in Ecosystemic Structural Family Therapy (ESFT) provided by the Philadelphia Child and Family Therapy Training Center (PCFTTC). All FBMHS staff must enroll in this program and complete the required clinical and didactic learning experience yearly. The model is essentially a relational and experiential family systems approach to promoting change within families and symptomatic children. Upon completion of the core program individuals must pass both a Philadelphia Child Family Therapy Training Center (PCFTTC) competency evaluation and State exam.
3. The FBMHS supervisor will be a Licensed Mental Health Professional and is responsible for providing weekly team supervision of all teams/staff. The FBMHS supervisor works closely with the Philadelphia Child Family Therapy Training Center (PCFTTC) and staff to effectively teach and supervise the ESFT model through team, group and in-home supervision utilizing videos of sessions as teaching tools.



Documentation of supervision is required and will be presented to DPBHS upon request.

4. Therapist training and certifications will be documented and presented to DPBHS upon request. This documentation of reported degrees includes by accredited universities and certifications to deliver evidence based practices, etc.
5. Psychiatric services will be provided by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
6. Possess a valid drivers' license.
7. Be properly insured to provide contracted services.
8. Pass a criminal background check as required in the contract.
9. Comply with additional requirements as stated in the DPBHS Provider Manual.

ADMISSION CRITERIA - *The youth must meet all criteria below*

1. Youth ages 3-17 who meet DPBHS eligibility criteria for FBMHS services.
2. The youth's parent/guardian/custodian provides voluntarily consent to treatment.
3. The CASII and/or other relevant information indicate that the youth's condition requires service at this level of intensity.
4. The youth presents with symptomatology consistent with an ICD 10/ DSM 5 Diagnosis and/or ICD 10 Diagnosis where a behavioral or emotional disturbance places the youth at risk of out-of-home placement.
5. The symptoms interfere with the youth's ability to function in at least one area.
6. There is an expectation that the youth has the capacity to make progress toward treatment goals, or treatment is necessary to maintain the current level of functioning.

CONTINUED STAY CRITERIA — *All criteria below are necessary for continuing treatment at this level of service:*

1. The CASII and other relevant information indicate that the youth continues to need FBMHS level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care and does not require a more intensive level of care and no less intensive level of care would be appropriate.
3. Progress in relation to specific symptoms or impairments is clearly evident and can be described in objective terms. However, some goals of treatment have not yet been achieved; and adjustments to the treatment plan are indicated to address the lack of progress and efforts to transfer to alternative services are documented when indicated.
4. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - Any of the following criteria is sufficient for discharge from this level of care:

1. The youth and family have reasonably met and sustained a majority of the treatment goals.
2. The CASII and other relevant information indicate that the youth no longer needs the outpatient level of care.
3. The family is able to effectively manage any recurring problems.



4. The youth is making reasonable improvements in identified treatment goals. The therapists and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the FB team and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. Individuals have a history of noncompliance with treatment, and specific efforts to engage the youth and family have been well documented in the youth's clinical record.
7. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment.
8. The youth meets criteria for a more intensive level of care.

EXCLUSION CRITERIA- *Any of the following is sufficient for exclusion from this level of care:*

1. The youth does not meet DPBHS eligibility criteria.
2. The CASII and other relevant information indicate that the youth's treatment needs are not consistent with this intensity of service, as they need a more or less intensive therapeutic service.
3. The youth's parent/guardian/custodian does not voluntarily consent to treatment.
4. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment.
5. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring ICD 10 Diagnosis, or symptoms/ behaviors consistent with an ICD 10 Diagnosis.

Functional Family Therapy (FFT)

Functional Family Therapy (FFT) is a short-term, family-focused, community-based treatment for youth who are either "at risk" for, or who manifest, antisocial behavioral problems such as conduct disorder, oppositional defiant disorder, disruptive behavior disorder, violent acting-out and substance abuse disorders. Co-morbid behavioral or emotional problems, such as anxiety or depression, may also exist as well as family problems, such as communication and conflict issues. FFT has been applied to a wide range of families with at-risk, pre-adolescent and adolescent youth in various multi-ethnic, multicultural contexts. Interventions are conducted at home, in school, in or outpatient settings and at times of transition, from a residential placement.

FFT incorporates specific intervention phases which include engagement, motivation, assessment, behavior change and generalization. Each phase includes a description of goals, requisite therapist characteristics and techniques. FFT interventions consist of direct contact with the family in person or by phone. FFT is designed to improve within-family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior. Parenting skills, youth compliance, and the complete range of behaviors (cognitive, emotional, and behavioral) domains are targeted for change based on the specific risk and protective factor profile of each family.

The FFT intervention consists of five major components which include: Pretreatment, Engagements phase, Motivation phase, Relational assessment phase, Behavioral change phase



and Generalization phase. The family self-reports as they move from one phase to another. These reports are used to track progress.

Goals of FFT include the following:

- Engage and motivate the youth and family to change by decreasing the intense negativity often characteristic of these families. Work to motivate families and youth who (at the outset) may not be motivated or may not believe that they can change.
- Reduce the personal, societal and economic devastation that results from the continuation or exacerbation of the various disruptive behavioral challenges of the youth.
- Reduce and eliminate problem behaviors and family relational patterns that put the family and youth at risk. Develop individualized behavior change plans that focus on improving parenting skills, family communication, conflict resolution and problem solving skills.
- Generalize positive changes across problem situations by increasing the family's capacity to adequately utilize community resources.

Full-time clinicians will maintain an average caseload of 12 "active" cases at any given time and spend an average of 2.5 – 3 hours per family per week for face to face contact, collateral services, travel, case planning and documentation. FFT therapists will participate in in school meetings and court appearances as requested. FFT Supervisors may supervise up to 8 FFT therapists.

Length of Stay: An average of 12 sessions over a 3-4 month period.

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

The provider will assess and monitor the delivery of the FFT service via the use of CSS. This is an online data base which has been originated by FFT, LLC. The type of data collected by the CSS includes:

- Assessment of risk and protective factors (Risk and Protective Factors Assessment)
- Relationship assessments (this is embedded in the progress notes)
- Individual functioning (pre- and post-intervention) (OQ-45.2)
- Functioning within the context of assessments (pre-and post-intervention) YOQ2.01 and YOQ SR
- Assessments of family and therapist agreement (Family Self Report)
- Fidelity Ratings (Weekly adherence ratings – by national consultant in Year One and by site supervisor in Year Two and beyond)
- FFT global therapist rating
- Completion rates (CDD closed case summary)
- Drop-out rates (CSS closed case summary)
- Time of drop-out rates (CSS closed case summary or case review report)
- Outcome data (family and therapist perspective) at time of discharge (TOM, COM-A and COM-P)

Each therapist receives a log on and password for the CSS for referencing their own clients only. The provider will receive an administrator/evaluator log on and password. The FFT national

consultant will also have access to the data from the CSS. Additional information can be found at www.fftinc.com.

BILLING

FFT is a comprehensive service. FFT will typically not be billed in conjunction with other behavioral health services with the exception of psychiatric evaluation and medication management. An approved list of applicable codes is attached.

PROVIDER QUALIFICATIONS

1. At a minimum, FFT therapists will possess a Master's or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist.
2. Unlicensed therapists must participate in weekly clinical supervision provided by a licensed mental health professional. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
3. The Providing agency must be certified as a provider of FFT. The primary goal of the FFT implementation and certification process is the successful replication of the FFT program as well as its long-term viability at individual community sites. The FFT Site Certification is a 3-phase process which includes: Clinical Training (includes training, site visits, ongoing telephone supervision and externship), Supervision Training (development of competent on-site FFT supervision) and participation in the Practice Research Network (partnering relationships to assure ongoing model fidelity, impacting issues of staff development, interagency linking, and program expansion).

ADMISSION CRITERIA - *The youth must meet 1, 2 and 3 and at least ONE from 4 through 9.*

1. The youth is between the ages of 11 and 17 (Special consideration may be given to 10 year olds) and meets DPBHS eligibility criteria.
2. The CASII and other relevant information indicate that the youth qualifies for FFT treatment.
3. The youth manifests behavioral symptoms consistent with an ICD 10 / DSM 5 diagnosis that requires FFT intervention (e.g., Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS, Substance Abuse Disorders, etc.);
 - OR
 - The youth is "at risk" for developing antisocial behaviors consistent with a diagnosis such as Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS or Substance Abuse Disorders.

The youth meets any ONE of the following:

4. The youth manifests delinquent or antisocial behaviors which may include any of the following:
 - a. The youth is physically aggressive at home, at school or in the community.
 - b. The youth manifests verbal aggression which may include verbal threats of harm to others.



5. The youth is at imminent risk of out-of-home placement due to his/her behavioral problems.
6. The youth is adjudicated.
7. The youth is a chronic or violent juvenile offender.
8. The youth manifests substance abuse issues in the context of the behavioral problems.
9. The youth is transitioning from a residential placement and his/her behavioral challenges threaten the success of the transition.

CONTINUED STAY CRITERIA - *All of the following criteria are necessary for continuing treatment at this level of care:*

1. The CASII and other relevant information indicate that the youth continues to need the FFT level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care.
3. The youth's treatment does not require a more intensive level of care and no less intensive level of care would be appropriate.
4. A comprehensive treatment plan has been developed, implemented and updated with realistic goals and objectives clearly stated. The treatment plan is based on the youth's clinical condition, his/her response to treatment and the strengths of the family.
5. Individualized services are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.
6. Progress in treatment is clearly evident in objective terms but goals of treatment have not yet been fully achieved. In addition, adjustments in the treatment plan are evident to address any lack of progress.
7. The family is actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment.
8. When clinically necessary, appropriate psychopharmacological treatment has been initiated.
9. There is documented evidence of active, individualized discharge planning.

DISCHARGE CRITERIA - *Any of the following criteria is sufficient for discharge from this level of care:*

1. The youth and family have reasonably met and sustained a majority of the overarching treatment goals.
2. The CASII and other relevant information indicate that the youth no longer needs the FFT level of care.
3. The youth's behavioral problems have improved and the family is able to effectively manage any recurring problems.
4. The youth and the family have functioned reasonably well for at least three (3) to four (4) weeks. The youth is making reasonable educational/vocational efforts. The youth is involved with pro-social peers and is not involved with (or is minimally involved with) problem peers. The therapists and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapists and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth



- and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. The youth and/or the parent withdraw consent for treatment.
 7. The youth meets criteria for a more (or less) intensive level of care.

EXCLUSION CRITERIA- *Any of the following is sufficient for exclusion from this level of care:*

1. The youth's parent/guardian/custodian does not voluntarily consent to treatment.
2. There is no identifiable primary caregiver to participate in treatment despite efforts to locate extended family, adult friends and other potential surrogate caregivers.
3. The youth can be safely maintained and effectively treated in a less intensive level of care.
4. The CASII and other relevant information indicate that the youth needs a more (or less) intensive level of care.
5. The youth is actively psychotic or at imminent risk of causing serious harm to self or others, potentially indicating a need for psychiatric hospitalization and stabilization.
6. The youth is experiencing problems that are primarily psychiatric rather than behavioral.
7. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.
8. The youth does not have the cognitive capacity to utilize therapy or have a parent without such capacity.
9. The youth's sole diagnosis is substance abuse, and the emotional or behavioral disturbances appear to be mainly correlated with substance use, either intoxication or acute withdrawal effects of substances being used.
10. The youth is a juvenile sex offender who does not manifest other delinquent or antisocial behaviors.
11. The youth is living independently, or in serial foster care or in a long term residential treatment setting

Multi-Systemic Therapy (MST)

Multi-Systemic Therapy (MST) is a home-based intensive family and community-based treatment that addresses multiple aspects of serious conduct related behavior in adolescents. MST typically targets chronic, aggressive youth who are at high risk of out-of-home placement. MST recognizes that many "systems" (family, schools, neighborhood/community, and peers) play a critical role in a youth's world and impacts their behavior. Each system requires attention when effective change is needed to improve the quality of life for youth and their families.

MST strives to promote behavior changes in the youth's natural environment, using the strengths of each system to facilitate change. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change. Interventions promote responsible behavior among family members and are present-focused, action-oriented and developmentally appropriate. In addition, the interventions target specific, well-defined problems and are designed to require daily or weekly effort by family members. They incorporate strategies that promote treatment generalization and long-term maintenance of therapeutic change.

Goals of MST include the following:

- Decrease psychiatric symptoms;



- Decrease substance use;
- Increase caregivers' parenting skills and increase resources necessary to help them independently address difficulties that arise;
- Improve functioning by empowering youth to cope with family, peer, school and neighborhood problems;
- Reduce the use of out-of-home placements (e.g., incarceration, residential treatment, hospitalization); and
- Strengthen family relations and improve family functioning.

MST incorporates empirically-based treatments insofar as they exist. MST programs include cognitive behavioral approaches, behavior therapies, behavioral management parent training, pragmatic family therapies, and certain pharmacological interventions that have a reasonable evidence base.

MST is designed to overcome barriers to service, to increase family retention in treatment, to allow for the provision of intensive services (i.e., therapists have low caseloads of 4-6 families each), and to enhance the maintenance of successful behavior changes. MST intervention is available to youth and families 24 hours a day, 7 days a week via an on-call system that is staffed by MST team members. The average client receives 2-4 hours of direct service per week. Length of Service: 3-5 months

MONITORING AND ASSESSMENT OF SERVICE DELIVERY

The licensing agreement and contracts between MST Services, the network partner and the provider include monitoring activities to ensure fidelity to the MST model, as described below. Adherence to the model is monitored through the administration of two measures:

Therapist Adherence Measure-revised (TAM-R)
Supervisor Adherence Measure (SAM)

The online database also collects case-specific information, including the percentage of cases successfully completing MST and whether specific instrumental and ultimate outcomes have been achieved at discharge. The provider will ensure that the MST program collects TAM-R and SAM, as required by the model, and that this data is entered into the online database in a timely fashion.

Every 6 months, a program implementation review is completed by the system supervisor and MST clinical supervisor for each team. This review includes completion of a program review form, a narrative summary of the program's strengths and weaknesses and recommendations. This review is used to monitor the team's fidelity to the model and troubleshoot problem areas.

BILLING

MST is a comprehensive service. MST will typically not be billed in conjunction with other behavioral health services with the exception of psychiatric evaluation and medication management. An approved list of applicable codes is attached.



PROVIDER QUALIFICATIONS:

- MST therapists must possess a Master's degree and receive weekly supervision from a Doctoral or Masters level mental health professional.
- Therapist must attend 5 day MST training on the theory and techniques of the treatment model. Training is provided by The MST Institute (MSTI). All registrants of the training must be part of a licensed MST team or organization.
- MST therapists must be full-time employees assigned solely to the MST program.
- Integrity is supported and reinforced through weekly consultation with an MST expert/consultant.
- Provider must be recognized as a licensed MST team. Licensure indicates an agreement to implement the Multi-Systemic Therapy (MST) model with full fidelity in order to achieve positive outcomes for youth and families. This is accomplished by complying with all of the policies and procedures in the MST Manuals in connection with the training of staff in licensed MST programs. It also indicates an agreement to ensure that all of its employees involved with the MST System are competent and fully trained in the use of the MST System. *Licensure signifies that the Organization has complied with the above standards and has met the required criteria in the following areas: Quality Assurance data collection, program drift monitoring data collection, contract status and payment status.*
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- **ADMISSION CRITERIA** – *The youth must meet 1,2 and 3 and at least ONE from 4 through 8.*
 1. The youth is between the ages of 12 and 17.
 2. The CASII and other relevant information indicate that the youth needs MST treatment.
 3. The youth manifests behavioral symptoms consistent with an ICD 10 / DSM 5 diagnosis that requires MST intervention (e.g. Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavioral Disorder NOS, etc.).

The youth meets any **ONE** of the following:

4. The youth manifests delinquent or antisocial behaviors which may include any of the following:
 - a. The youth is physically aggressive at home, at school or in the community.
 - b. The youth manifests verbal aggression which may include verbal threats of harm to others.
5. The youth is at imminent risk of out-of-home placement due to the delinquent or antisocial behaviors.
6. The youth is adjudicated.
7. The youth is a chronic or violent juvenile offender.
8. The youth manifests substance abuse issues in the context of the delinquent or antisocial behavior problems.

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CONTINUED STAY CRITERIA - *All of the following criteria are necessary for continuing treatment at this level of care:*

1. The CASII and other relevant information indicate that the youth continues to need the MST level of care.
2. The severity of the behavioral disturbance continues to meet the criteria for this level of care.



3. The youth's treatment does not require a more intensive level of care and no less intensive level of care would be appropriate.
4. A comprehensive treatment plan has been developed, implemented and updated with realistic goals and objectives clearly stated. The treatment plan is based on the youth's clinical condition, his/her response to treatment and the strengths of the family.
5. Individualized services are tailored to achieve optimal results in a time efficient manner and are consistent with sound clinical practice.
6. Progress in treatment is clearly evident in objective terms but goals of treatment have not yet been fully achieved. In addition, adjustments in the treatment plan are evident to address any lack of progress.
7. The family is actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment.
8. When clinically necessary, appropriate psychopharmacological treatment has been initiated.
9. There is documented evidence of active, individualized discharge planning.

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DISCHARGE CRITERIA - *Any of the following criteria is sufficient for discharge from this level of care:*

1. The youth and family have met and sustained a majority of the overarching treatment goals.
2. The CASII and other relevant information indicate that the youth no longer needs the MST level of care.
3. The youth's behavioral problems have improved and the family is able to effectively manage any recurring problems.
4. The youth and the family have functioned reasonably well for at least three (3) to four (4) weeks. The youth is making reasonable educational/vocational efforts. The youth is involved with pro-social peers and is not involved with (or is minimally involved with) problem peers. The therapist and supervisor believe that the caregivers have the knowledge, skills, resources and support needed to handle subsequent problems.
5. Few of the overarching goals have been met. Despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. That is, the youth and family have not benefited from treatment despite documented efforts to engage and there is no reasonable expectation of progress at this level of care.
6. The youth and/or the parent withdraw consent for treatment and there is no court order requiring such treatment.
7. The youth meets criteria for a more (or less) intensive level of care.

• **EXCLUSION CRITERIA:** *Any of the following is sufficient for exclusion from this level of care:*

1. The youth and/or parent/guardian/custodian does not voluntarily consent to treatment.
2. There is no identifiable primary caregiver to participate in treatment despite efforts to locate all extended family, adult friends and other potential surrogate caregivers.
3. The CASII and other relevant information indicate that the youth needs a more (or less) intensive level of care.
4. The youth is at imminent risk of causing serious harm to self or others, potentially indicating a need for psychiatric hospitalization and stabilization.



5. The youth is actively psychotic or in need of crisis psychiatric hospitalization or stabilization.
6. The youth has been diagnosed with schizophrenia.
7. The youth is experiencing problems that are primarily psychiatric rather than behavioral.
8. The youth has been diagnosed with a sole diagnosis of Autism Spectrum Disorder or an Intellectual Developmental Disorder and there is no co-occurring DSM 5 diagnosis or symptoms/behaviors consistent with a DSM 5 Diagnosis.
9. The youth's level of cognitive ability does not allow him/her to benefit from the MST therapeutic interventions.
10. The youth's sole diagnosis is Substance Abuse, and the emotional or behavioral disturbances appear to be mainly correlated with substance use, either intoxication or acute withdrawal effects of substances being used.
11. The youth is a juvenile sex offender who does not manifest other delinquent or antisocial behaviors.
12. The youth is living in a long term residential treatment setting.
13. The youth can be safely maintained and effectively treated in a less intensive level of care.

Crisis Intervention Clinical Necessity Criteria

Crisis intervention is immediate action taken to evaluate, stabilize, and intervene in critical or emergency situations that appear to involve mental health concerns. The goals are to address issues which precipitated the crisis, provide intensive short-term intervention, and identify and provide transition to any necessary follow on services.

Primary considerations:

- I. There are mental health concerns, which require an immediate evaluation and intervention.
- II. There is no apparent condition or injury requiring immediate medical attention.

Crisis Bed Clinical Necessity Criteria

A crisis bed is a substitute care setting that may be utilized for a period of up to 72 hours, when such substitute care will facilitate effective implementation of crisis intervention services.

Primary Considerations:

- I. A crisis bed should not be used when other appropriate resources, e.g., extended family, are available to provide support and care.
- II. The child would be at increased risk for hospitalization or other 24 hour care if the crisis bed is not utilized.

Day Treatment, Mental Health and Substance Abuse **Service Description**

Day Treatment Services offer person-centered, culturally and linguistically appropriate, comprehensive, coordinated and structured treatment service and activities. Day treatment services are available a minimum of 4 days per week and up to 7 days per week, providing a minimum of 3 hours of treatment per day. Daily treatment includes no less than 2 hours of individual, group or family therapy and 1 hour of psycho-education or other therapies as appropriate. Services may be delivered during day time hours, after school, in the evening or on weekends. Psychiatric services will be available as a component of Day Treatment.

Day Treatment services are clinical in nature and youth participating in Day Treatment must meet clinical necessity for this service. Day Treatment is time-limited and specific interventions and individualized goals will be clearly documented in the youth's individualized treatment plan.

Day treatment services are designed to be short term with the goal of returning students to their home school as quickly as possible. Evidence that the Day Treatment provider and the youth's school are in continuous, close collaboration in preparation for the youth's transition back to school will be documented in the youth's clinical record. Youth safety is always considered prior to transitioning youth back to their natural school environment. Day Treatment Services will, in collaboration with the youth, family and school, develop a school transition plan and the service is expected to remain active during the youth's return to school, providing adequate support for the youth to ensure a successful transition.

Day treatment capacity and staffing requirements must be in compliance with OCCL standards.

The goals of Day Treatment include the following:

- Support the youth's successful transition back to their home school setting.
- Provide a short-term, time-limited step-down for youth transitioning out of an inpatient or residential treatment setting.
- Minimize the need for higher intensity services (ie. Residential and Inpatient Hospitalization).
- Enhance self-awareness and improve the youth's ability to develop and maintain healthy relationships.

18.1.1.1.1 Recommended Duration of Service: Average length of service should be 2-8 weeks. Authorization will be no more than 90 days.

Service Components:

Individual Therapy: All clients of day treatment, mental health services will be seen for a minimum of 2 individual sessions per week. Individual sessions may occur more frequently as clinically appropriate. Therapy is conducted by a Masters level or Licensed Therapist or a CADC for Substance Use services with a focus on the presenting problems identified on the youth's treatment plan. A progress note for this service must be present in the client's record.

Family Therapy: Clients with active and available caregivers will participate in a minimum of one family session per week. “Family” sessions may include the youth’s biological family (immediate and/or extended), foster family, residential rehabilitation clinical staff, Division of Family Services for youth in custody of the State, other people the client identifies as “family” and who play a supportive role in the youth’s life. Family therapy is conducted by a Masters level or Licensed Therapist or a CADC for Substance Use services with a focus on the presenting problems identified on the youth’s treatment plan. A progress note for this service must be present in the client’s record.

Group Therapy: Group therapy is conducted by a Masters level or Licensed Therapist, or a CADC for Substance Use services, with a focus on the presenting problems identified on the youth’s treatment plan. A progress note for each Group Therapy session must be present in the client’s record.

Psychiatry: Each client will be provided no less than monthly on-site psychiatric services for a minimum of 15 minutes for medication monitoring. New clients will be evaluated by a psychiatrist within 72 hours of admission to the program.

Psycho-education: Clients will participate in Psycho-education as appropriate. Psycho-education is provided by unlicensed staff and are relevant to the client’s treatment as stated on the youth’s treatment plan. A minimum of 4 hours per week of psycho-education will be provided for each client. A progress note for this service must be present in the client’s record.

Psychosocial Rehabilitation (PSR): Clients participating in day treatment services will receive supervision by staff which will comply with OCCL regulations. These services may be provided by individuals with a minimum of a High School Diploma (or equivalent) and be at least 21 years of age.

Transition Support: Day Treatment Service providers will ensure youth are properly transitioned back to their home school settings. Services will be available to support the child and school staff in managing client’s behaviors and addressing emotional challenges as the youth engages in the transition. Documentation of these services must be present in the client’s record. Transition services may be delivered by a Masters level or Licensed therapist, CADC for Substance Use services, Educational staff or Bachelor level staff as appropriate.

Education: Clients who attend Day Treatment Services may have access to educational support services which will be provided by or coordinated with the youth’s home school.

PROVIDER QUALIFICATIONS

- All Day Treatment staff must:
 - Be at least 21 years of age.
 - Possess a high school diploma (or equivalent) at a minimum.
 - Possess a valid drivers’ license.
 - Pass a criminal background in compliance with DSCYF standards.



- At a minimum, day treatment therapists will possess a Master's or Doctoral degree in psychology, social work, or other human service field. The degree held must qualify for licensure as one of the following in the State of Delaware: Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor of Mental Health (LPCMH), Licensed Marriage and Family Therapist (LMFT) or Licensed Psychologist. It is expected that individuals who do not possess a license are in the process of obtaining required supervised clinical hours toward their professional licensure.
- For Substance Use Day Treatment, a LCDP or CADC is qualified to provide counseling services.
- Providers will be enrolled with Delaware Medicaid and Licensed Mental Health Professionals will be paneled with the Delaware Medicaid MCO's.
- Unlicensed or uncertified therapists must participate in weekly clinical supervision provided by a licensed mental health professional. For Substance Use, supervision may be provided by a LCDP/CADC. Documentation of weekly supervision is required and will be presented to DPBHS upon request.
- Therapist training and certifications will be documented and presented to DPBHS upon request. This includes documentation of reported degrees by accredited universities and certifications to deliver evidence based practices, etc.
- Psychiatric services will be provided by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
- Maintain professional boundaries and behavior, as specified by their professional Code of Ethics/Conduct, during interactions with all staff and clients.
- Providers should be capable of third party billing.
- Be properly insured to provide contracted services.
- Comply with additional requirements as stated in the DPBHS Provider Manual, the DSCYF Operating Guidelines and the Office of Child Care Licensing Regulations for Day Treatment.

ADMISSION CRITERIA: *Youth meets ALL criteria 1-3:*

1. Youth is under the age of 18 and is found eligible for DPBHS services;
2. Youth is diagnosed with a covered DSM 5 / ICD 10 by a Licensed Mental Health Professional or a LCDP/CADC for Substance Use services.
3. The CASII and other relevant information indicate the youth qualifies for Day Treatment services;

And at least one of the following criteria:



4. Youth presents with mental health and/or behavioral health challenges which interfere with the youth's ability to achieve success in their traditional school setting;
5. There is reasonable evidence that participation in a Day Treatment Service will improve the youth's ability to function in their traditional school setting.
6. The child's school is agreeable to collaborating with the Day Treatment provider to meet the educational and therapeutic needs of the youth and is agreeable to accept the child back into the youth's home school upon completion of the Day Treatment service.

CONTINUED STAY CRITERIA: *All of the following criteria are necessary continuing treatment at this level of care:*

1. Severity of illness and resulting impairment continues to require this level of service;
2. Services are focused on maintaining community based living or reintegration of the individual into the community and improving his/her functioning in order to decrease utilization of more intensive treatment alternatives (i.e. residential or inpatient);
3. Continued progress towards goals;
4. Treatment planning is individualized and appropriate to the individual or family's changing conditions;
5. Participation in the service is expected to improve the youth's ability to manage their behavior and function successfully in a traditional school environment;
6. The youth and family are actively involved in treatment. Or, there are active, persistent efforts being made that are expected to lead to engagement in treatment;

DISCHARGE CRITERIA: *Any of the following criteria are sufficient for discharge from this level of care:*

1. Individual or family's treatment plan and discharge goals have been substantially met;
2. Consent for treatment is withdrawn;
3. Individual or family meets criteria for a less/more intensive level of care; and/or
4. The child has successfully participated in a minimum of 2 school transition sessions with adequate educational and therapeutic supports present.

EXCLUSION CRITERIA: *Any of the following criteria are sufficient for exclusion from this level of care:*

1. Individual or family chooses not to participate in program.
2. The individual meets criteria for a more or less intensive level of care.
3. The individual cannot safely be maintained in this level of service.

Day Treatment Clinical Necessity Criteria

Day treatment provides intensive psychiatric services and a milieu facilitating a more successful adaptation to community and regular educational environments when 24 hour care and intensive psychiatric/medical monitoring are not necessary. Services are provided five (5) days a week.



Primary consideration:

I. At least one of the following:

- A) **Self harm:** The client within the last two years has made a significant suicide attempt or gesture and currently threatens self -harm or self -mutilation, especially in combination with a history of substance abuse, significant depression, borderline personality disorder, or other significant psychiatric conditions.
- B) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the psychiatric condition that may result in serious physical assault, sexual assault, or fire setting, or other major harm to others.
- C) **Severe or Chronic Psychiatric disorder:** The client exhibits a psychiatric disorder such as major depression or chronic conditions that compromises functioning in multiple areas, and requires intensive psychotherapeutic intervention and/or a milieu that facilitates social skill development and reintegration into a regular community school environment.

II. Least restrictive:

Twenty four hour inpatient hospitalization or RTC or partial hospital care is not necessary and outpatient treatment (including office or home based services, or crisis intervention) has been attempted or considered and the youth has not made progress, or cannot reasonably be expected to make progress.

III. Family participation: Family members and/or significant others, in the client's support network (relatives, case managers, mentors) will commit to regular participation in the treatment process and to the client's return to the community.

Residential Treatment Center, Mental Health (RTC)

Residential Treatment Center (RTC) service provides a 24 hour, supervised, residential living arrangement with intensive psychiatric services for children and adolescents with Mental Health and Substance Abuse disorders that impair their ability to be successful in community settings. Youth requiring RTC services are diagnosed with varying Mental Health disorders and may present as a risk to themselves or others, require intense supervision, have difficulty self-regulating their behaviors and have not been successful in the less intensive treatment services. Services will be delivered in a trauma informed environment in conjunction with other evidence based practices. The focus of treatment is to resolve the primary presenting problems that necessitated the youth's need for this type of structured residential treatment service.

Research shows improved outcomes with shorter length of stay, increased family involvement and stability and support in the post-residential environment (Walters & Petr, 2008). Treatment supports the Building Bridges Initiative framework which promotes closely coordinated partnerships and collaborations between family, youth, community and residential treatment



providers, advocates and policy makers. Services will embrace the following Core Principles of BBI:

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services (between settings & from youth to adulthood)

Medical and educational collaboration are also essential components to a child's overall wellbeing and success. These professionals must be consulted when developing treatment and transition plans.

Target Population

- Male and female youth, ages 12-17.
- Youth with a primary Mental Health diagnosis and an impairment of the client's functioning across settings.
- Youth whom the DPBHS CFCC has determined this level of service is clinically necessary.

Service Capacity and Utilization

- The facility is licensed by the Office of Child Care and Licensing to serve ____ youth.
- DPBHS and the contractor will collaborate on planned admissions and discharges to minimize admission delays.

Scope of Clinical Service

- Use of evidence based practices provided in trauma informed care setting. Practices may include:
 - Trauma Focused Cognitive Behavioral Therapy
 - Cognitive Behavioral Therapy
 - Motivational Interviewing
 - Collaborative Problem Solving
 - 7 Challenges
 - Positive Behavioral Interventions and Support
 - Sanctuary Model
 - Functional Family Therapy
- Comprehensive integrative assessment, utilizing standardized assessment measures. Assessment is a continuous process that begins at admission and continues throughout the various stages of treatment. Assessment types may include:
 - Achenbach System of Empirically Based Assessment (ASEBA)
 - The Addictions Severity Index
 - Child and Adolescent Needs and Strengths (CANS)
- Customized, flexible treatment with a minimum of once weekly individual, group and family therapy sessions with the ability to implement more frequent sessions to meet the particular needs of the youth and family.
- Therapies will be conducted by Masters or doctoral level clinical staff with a maximum caseload of 10.



- Unlicensed therapists will be supervised by a licensed mental health professional as required in the DPBHS provider manual.
- Psychiatric assessment and medication management by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
- On-site substance abuse counseling for youth with a secondary Substance Abuse diagnosis or a history of substance abuse.
- Develop and/or strengthen independent living skills and improve self-care.
- Community integration activities will be provided for youth who can safely participate under appropriate supervision.
- Case management services in coordination with CFCC.
- Case reviews will occur regularly as agreed upon by CFCC, the Provider and family. Reviews will include participation from the family and other supports when possible. Progress reviews will address the following elements: frequency and types of therapy provided, family engagement efforts and progress, family involvement /participation and progress toward achieving goals specified on the child's discharge plan.
- Comprehensive discharge and aftercare planning in conjunction with the DPBHS CFCC and/or other designated DSCYF resources. Discharge planning will be closely coordinated with involved family/caregivers and additional supports as identified.

Crisis Management

- All youth entering residential services will have a crisis response plan developed in collaboration with the youth and their family.
- Residential service provider will assess and manage crisis situations within the facility by following safety plans, providing additional and/or more intensive supervision for youth when necessary and allows clients the opportunity to be safely removed from the stressor or trigger.
- A therapist will be on call after hours, on weekends and holidays to assist with crisis response, providing guidance and instruction regarding crisis management and assessment of necessary actions to deescalate the crisis situation.
- Child Priority Response (CPR) services should be contacted only in cases where the need for inpatient hospitalization is suspected.

Education

- Educational resources are provided by the DSCYF. The provider of residential service will work in collaboration with the DSCYF educational staff to maintain consistent communication and collaboration with the child's sending district.
- The goal is for the child to return to the least restrictive environment in the shortest time possible. When appropriate, the youth should continue to attend or be returned to their local school with transportation and supervision needed to support the student's success.
- Educational programming will address the unique needs of the student by providing individualized instruction, IEP implementation and monitoring, and transition planning to ensure the child's needs are being fulfilled.
- Instruction provided will:



- Align with the Common Core
- Be delivered in a trauma sensitive learning environment
- Provide academic and vocational learning opportunities
- Be geared toward credit attainment/acceleration/recovery
- Include proper assessment (formative/summative/ state required)
- Provide blended learning opportunities

Therapeutic Family Engagement

DPBH encourages programs to facilitate in-home family experiences as much as possible while a youth is in residential rehabilitative treatment. These in-home experiences include brief (1-2 hours) to extended (2-3+days) stays in the home/family or school environment to maintain and build positive relationships and skills related to safely living in at home or being at school while the youth and family are participating in residential-based treatment services. A vacancy assumption for Residential Rehabilitative Services and PRTF was considered in the development of rates for these services. Providers will not be reimbursed for days clients spent outside of the facility.

Discharge Planning

- Anticipated discharge date will be established upon admission and will be adjusted as indicated based on the child's progress in treatment.
- Ongoing assessments administered throughout treatment indicate the child is making progress as expected.
- The youth has reasonably achieved the goals established by the client and family as outlined in the treatment plan.
- Connection has been made with next treatment provider or service.
- Communication with the child's sending school has been made providing specific transition plans including date of return and supports provided.
- Youth no longer meets criteria for this service and is prepared to transition to a lower intensity service.

Outcomes:

- Reunification and maintenance of the youth with identified family or primary caregiver, alternate placement setting, or establishment of independent living arrangement as identified in the discharge plan.
- Continued success and participation in local school, vocational or trade school or other program as defined in the discharge plan.
- Successful transition to and participation in continued behavioral health treatment services and compliance with psychotropic medications as stated in the discharge plan.

Residential Treatment Center, Substance Abuse (RTC)

I. SERVICE OVERVIEW

A. Definitions

DFS	Division of Family Services
DPBHS	Division of Prevention and Behavioral Health Services
RFP	Request For Proposal

B. Description

The Joint Commission accredited residential treatment services purchased under this Contract comprise one element of the continuum of mental health treatment services provided by the DEPARTMENT'S DPBHS for children and adolescents. Services at this level are characterized by the provision of a 24-hour residential living environment, which is deliberately designed to create a structured therapeutic milieu, and which forms the basic foundation around which clinical treatment services are organized and integrated. Within the residential treatment level of the DPBHS continuum, programs and services are differentiated along several key dimensions:

- The restrictiveness of the milieu, in terms of both the physical characteristics of the environment and its proximity to the community;
- The nature and extent of clinical resources deployed in support of the milieu;
- The ratios of child care staff-to-clients, and the nature and extent of client supervision and care provided;
- The extent to which educational services are provided within the program, versus reliance upon the public school system.

II. TARGET POPULATION

Children and adolescents under the age of eighteen (18) years for whom the DPBHS Child and Family Care Coordination Team has determined residential treatment services are clinically necessary.

III. ADMISSION, DISCHARGES, AND FUNDING AUTHORIZATION

A. Referrals, Initial Service Authorization and Expected Length of Stay/Service, Funding Approval and Admission

Refer to the DPBHS Provider Manual.

B. Medical Services Not Covered by the CONTRACTOR

1. DPBHS Only Funded Youth:

Medical care provided during the DPBHS authorized service period will not be funded by DPBHS. As part of the admission process, the provider shall discuss insurance coverage and



fiscal liability for medical services with the parent. The provider is expected to make arrangements with local medical care providers to capitalize on the child's insurance, including documented efforts to encourage the enrollment of local providers in the Delaware Medicaid program. Prior to the initiation of a medical service, the parent/legal custodian will be notified, provide consent for services and will assume responsibility for any financial charges incurred. Exception: If PBH only funded youth are in the legal custody of the DEPARTMENT'S DFS, fee-for-service medical services may be covered provided the CONTRACTOR complies with the following requirements:

2. DFS Medical Preauthorization Requirements:

Herein, the term "Medical Services" shall be understood to include all services related to the dental, optical, pharmacy & over-the-counter medication needs of Delaware youth, as well as services traditionally described as medical in nature such as X-rays, laboratory work, etc. DFS desires to direct medical expenses to private insurance and/or Delaware Medicaid when possible. DFS expects all CONTRACTORS to assist in this effort by:

- i. Complying with DFS Preauthorization Requirements: All medical services, evaluations, treatments or diagnostic procedures not included in the per diem rate as described in the Budget Summary of this Contract require written preauthorization by the DFS Contract Manager or designee. The CONTRACTOR shall send a completed Medical Service Preauthorization Request form (Attachment C-1 of this contract) to the DFS Contract Manager prior to the scheduling/delivery of all such services. The DFS Contract Manager shall then fax or mail the signed preauthorization form back to the CONTRACTOR. Preauthorization may not be practical or possible for Emergency medical needs. On the next business day however, the CONTRACTOR shall fax a completed Medical Service Preauthorization Request form to the DFS Contract Manager for signature and return.
- ii. Adhering to the Requirements of Known Private Insurance Coverage for any Delaware Youth: The CONTRACTOR shall exhaust all private insurance benefits before submitting medical bills to DFS for payment. This may include and require preauthorizing services, obtaining exemptions from preferred provider networks, contacting insurers, providers, DFS Case Managers and/or parents/guardians for clarifications, etc. Documentation of claim denials will be expected to accompany any services billed to DFS for youth covered under any Private Insurance. An Explanation of Benefits (EOB) is the preferred verification or invoice from medical provider.
- iii. Assisting Local Health Care Providers with Delaware Medicaid: The CONTRACTOR agrees to contact their local medical providers of choice and request that they enroll with Delaware Medicaid. When Delaware youth in the CONTRACTOR'S program need medical services beyond the scope of the Program, the CONTRACTOR shall make every effort to use providers who agree to participate with Delaware Medicaid. Medical providers enrolled in the Delaware Medicaid Assistance Program (DMAP) agree to accept Delaware Medicaid's final payment disposition as payment in full for Medicaid covered services.

Additional information is available at the Delaware Medicaid website: www.dmap.state.de.us



Medicaid claims denied for billing errors will not be reimbursed by DFS. Medical providers should address these issues directly with EDS at:

- **Pharmacy line: 1- 800-999-3371**
- **Non-pharmacy issues with Provider Relations: 302-454-7154 or 1-800-999-3371**

- iv. Billing DFS for Medical Services: DFS youth may be covered by a variety of private insurances, Delaware Medicaid, both or none of these health care payment sources. Before submitting any health care service billing directly to DFS for payment, the CONTRACTOR must ensure that efforts to seek payment from these other sources have been unsuccessful.

ALL HEALTH CARE SERVICES BILLED DIRECTLY TO DFS MUST INCLUDE:

- Original invoice from medical provider;
- Signed/approved DFS Medical Services Preauthorization form (Attachment C-1);
- Documentation (EOB preferred) of Private Health Insurance denial, or invoice from medical provider with denial detail, if applicable;
- Medicaid denial if applicable – The assigned DFS Contract Manager will work with the CONTRACTOR and/or directly with their local medical service providers to assist with Delaware Medicaid claim processing and claim denials when necessary. CONTRACTORS and service providers must promptly alert the DFS Contract Manager of problems involving Delaware Medicaid claims. Claims submitted to DFS for payment without the documentation listed above are subject to denial by DFS.

IV. PROGRAM AND SERVICE COMPONENTS

- A. Residential treatment exists as one component of a continuum of care. The concept of establishing a therapeutic milieu with a strong clinical base is central to effective residential treatment. Therapeutic interventions, activities, milieu, clinical and educational components must be carefully engineered to create a total ecological treatment environment within which the development and growth of the child or adolescent in specific areas can be systematically fostered. Individual characteristics of such an integrated treatment environment include:
- Evaluation of psychiatric, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptomatology.
 - Counseling and psychotherapy, including individual, family and group therapies and problem-specific approaches (e.g., drug/alcohol counseling, etc.).
 - Programmed opportunities for the amelioration of presenting problems including the acquisition of skills and competencies. Specific program features include skill building with an emphasis upon interpersonal and problem solving skills; self-care and social skills; and activity and recreational programming.



- Monitoring and management of the environmental stimuli to which the child or adolescent is subject.
 - A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
 - Careful monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
 - Provisions for educational opportunities. Educational programming appropriate to the level and individual educational needs of the client.
 - Treatment focus is designed to achieve the ultimate goal of returning the client to the least restrictive clinically appropriate setting within the shortest clinically appropriate timeframe.
- B. This contract was awarded in FY06 in response to the successful submission of a proposal to provide Services. This proposal was submitted by the CONTRACTOR in response to a Request for Proposals (RFP) issued by the DEPARTMENT. The DEPARTMENT is purchasing those services as described in the proposal submitted by the CONTRACTOR. The CONTRACTOR is responsible for immediate notification of the DEPARTMENT in the event of any substantive changes or modifications to the services as described in the original CONTRACTOR's proposal.

V. PERFORMANCE EXPECTATIONS

- A. Treatment Outcome Expectations: DPBHS expects contracted services for children and youth to support the DEPARTMENT'S overall goals of safety and positive outcomes for children and youth in provider services. Provider child outcomes may be evaluated in one or more of the following ways:
1. Percent of children requiring another service of the same or greater level of intensity/restrictiveness or the same provider service within six months of service discharge.
 2. Child safety incidents related to service delivery process errors/failures.
 3. Percent of children moving to a more intensive/restrictive service for more than four days while receiving services from a contracted provider.
- B. Process Expectations: DPBHS expects providers to be responsive to contractual stipulations related to the timeliness of service activities and reporting requirements and to the manner in which services are provided. Provider service delivery process performance may be evaluated in one or more of the following ways:
1. Services are delivered in conformance with the standards of the agency's accrediting body.
 2. Timeliness of expected/required activities.
 3. Timeliness, accuracy and completeness of required reports.
 4. Child and family satisfaction rates.

Residential Treatment Centers (RTC) Clinical Necessity Criteria



Residential Treatment Centers (RTC) offers 24 hour structure and supervision and provide safety and a context for intense individual, family, and milieu treatment services.

Primary considerations:

I. **Mental health problems (one required):** The client exhibits clearly identifiable mental health problems or symptoms such as mood disorders, significant anxiety disorders (e.g. PTSD), and/or self injurious behavior/ideation which:

- A) Result in serious impairment in the client's functioning across settings including school, family, and community; or
- B) Make it impossible for the client to self-regulate their behavior without 24 hour support and management by mental health professionals; or,
- C) Create a high level of risk of direct injury to self or others without 24 hour supervision and therapeutic intervention by mental health staff.

II. **Least restrictive:**

Twenty four hour inpatient hospitalization is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day treatment of partial hospitalization) and has not made progress, cannot reasonably be expected to make progress, or is regressing, or there is evidence that the client could not be safely be treated in any less restrictive level of care.

III. **Family participation:** Family members and/or significant others in the client's support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client's return to the community.

However, clients affected by these conditions may have mental health concerns that should be treated at the appropriate level of care. Inter-Divisional and/or interdepartmental planning and intervention will frequently be necessary to address other conditions.

Following these guidelines, based on criteria and complicating conditions, each case is reviewed individually in order to establish the most appropriate course of intervention and treatment.

Residential Transition Service (RTS)

Residential Transition Services (RTS) are services provided to prepare for a child's return home from a residential facility and continue, with the same provider, during and after the transition home. Services are designed to begin working with the family and child prior to discharge from the facility with intensified service delivery as discharge approaches. The service identifies natural and community supports and utilizes these resources to promote successful transitions to the home, school and community. Throughout the transition period, the intensity and frequency of the transition service will match the client and family needs as clinically appropriate.

Research shows improved outcomes with shorter length of stay, increased family involvement and stability and support in the post-residential environment (Walters & Petr, 2008). Treatment supports the BBI framework which ensures closely coordinated partnerships and collaborations between family, youth, community and residential treatment providers, advocates and policy makers. Services will embrace the following Core Principles of BBI:

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services (between settings & from youth to adulthood)

Target Population

- Male and Female youth ages 12-17 with plans to successfully discharge from a residential service within 30-90 days.
- Youth whom the DPBHS CFCC has determined this level of service is clinically necessary.
- Youth with an identified caregiver who resides within reasonable commuting distance from the facility and who the child will be living with upon discharge.

Service Utilization

- Services will vary in frequency and intensity throughout the transition period.

Scope of Service

- Use of evidence based and best practices, such as:
 - Functional Family Therapy
 - Multi-systemic Therapy
 - Parenting with Love and Limits
 - Trauma Focused-Cognitive Behavioral Therapy
 - 7 Challenges
 - Collaborative Problem Solving
 - Positive Behavioral Interventions and Support
 - Cognitive Behavioral Therapy
- Continued assessment, utilizing standardized assessment measures. Assessment tools may include:
 - Achenbach System of Empirically Based Assessment (ASEBA)
 - The Addictions Severity Index
 - Child and Adolescent Needs and Strengths (CANS)
- Customized, flexible treatment options to meet the needs of the particular child and family including weekly family and individual sessions which will occur in the child's home, school and community. Family therapy sessions will increase in frequency and intensity as the youth's transition home approaches.

- Clinical services will be available 24/7. Services will be delivered when the family is available, including evenings, weekends and is available to support the child and family when the child is home on passes.
- Therapies will be conducted by Masters or doctoral level clinician.
- Unlicensed therapists will be supervised by a licensed mental health professional as required in the DPBHS provider manual.
- Psychiatric assessment and medication management by a Delaware Medicaid paneled and licensed child and adolescent psychiatrist, general psychiatrist, or Advanced Practice Psychiatric/Mental-Health Nurse Practitioner (who has a Collaborative Agreement with a psychiatrist). Assessment, prescribing and treatment practices will be consistent with all of the American Academy of Child & Adolescent Psychiatry Practice Parameters.
- Case management by the primary therapist (or designee) in coordination with the DPBHS CFCC.
- Identification of formal and informal resources for child and family to support successful transition.
- Coordination of community integration activities.
- Residential Transition Services begin at least 30 days prior to discharge from the residential facility and continue during the post discharge transition phase as clinically appropriate.
- Therapeutic support to promote successful transition to the school environment.
- Comprehensive discharge and aftercare planning.
- Successful connection with aftercare provider.

Crisis Management

- A crisis response plan, including a safety plan, will be developed in collaboration with the youth and their family. The plan will clearly outline who the family will contact should an emergency arise and specific actions and techniques to utilize to de-escalate the situation and ensure safety.
- Clinical staff will be on call after hours, on weekends and holidays, and available to respond by phone or in person, to conduct risk assessments, provide intervention and assist in de-escalating the emergent situation.
- A referral to Child Priority Response (CPR) services should be made in cases where the need for inpatient hospitalization or crisis bed is suspected.

Discharge Planning

- Anticipated discharge date from service will be established upon admission and will be adjusted as indicated based on the child's progress in treatment.
- Ongoing assessment of the child's progress will be made throughout treatment.
- The youth has reasonably achieved the goals established by the client and family as outlined in the treatment plan.
- Connection has been made with next treatment provider or service.
- Youth no longer requires transitional service and is prepared to participate in another service.

Outcomes:

- Reunification and maintenance of the youth with identified family or primary caregiver, alternate placement setting, or establishment of independent living arrangement as identified in the discharge plan.
- Continued success and participation in local school, vocational or trade school or other program as defined in the discharge plan.
- Successful transition to and participation in continued behavioral health treatment services and compliance with psychotropic medications as stated in the discharge plan.

Transitional Bed Service (TBS)

Transitional Bed Service (TBS) services provide supervised, supported care, including overnight, for youth with emotional disturbance or behavioral health issues. Transition Support Service may provide:

- Short-term stabilization.
- A safe, structured environment for youth awaiting placement. Youth utilizing these services must be active with DPBHS and the use of the service must support a positive transition to an appropriate longer-term service or placement.
- Occasional periods of overnight care for youth who are active with the provider's Residential Transition Service. The use of this service can significantly reduce stress in the family, enhance the family's ability to keep their child/youth at home in the community, and prevent or delay the use of more restrictive behavioral health services for the child. The use of a Transition Support Services may be planned in advance or be offered as an option in emergent situations.
- Should **not** to be used in lieu of a crisis bed, inpatient care or residential treatment. These beds are not designed to provide 1:1 supervision and should not be considered for youth requiring this level of observation.

Target Population

- Male and Female youth up to age 17.
- Youth with a primary Mental Health diagnosis who are active with DPBHS.
- Youth who are transitioning from one service to another
- DPBHS has determined this level of service is clinically necessary.

Service Utilization: DPBHS and the contractor will collaborate on planned admissions and discharges.

Scope of Service:

- Develop a targeted individualized service plan, specifying goals, objectives and time frame of the TSS stay. The plan will be developed in collaboration with the child, caregiver, CFCC, other involved Divisions and community providers as indicated.
- Provide positive role modeling, guidance and counseling to assist the youth in managing the demands of everyday living.
- Teach and foster the development of adaptive living skills by the youth.
- Provide general care and supervision of the youth.
- Manage emotional and behavioral situations in accordance with the client's plan.
- Maintain a therapeutic living environment that is well structured and designed to nurture and support the youth.
- Work directly with primary caregivers (when involved) to teach and model appropriate social, interpersonal, and parenting skills.
- Participate in meetings with the DPBHS Child and Family Care Coordination Teams and other Divisions for the purpose of planning and monitoring progress.
- The Provider will offer twenty-four hour consultation, support and intervention during the entire term of the client's stay.

Discharge Planning

- Discharge date will be established upon admission and may be adjusted as indicated.
- Service plan goals have been reasonably achieved.

- Youth is connected with a treatment service and an aftercare plan is in place.

Outcomes

- Reunification and maintenance of the youth with identified family or primary care-giver, alternate placement setting, or establishment of independent living arrangement as defined in the discharge plan.
- Return to and continued success and participation in local school, vocational or trade school or other program as defined in the discharge plan.
- Successful transition to and maintenance in continuing behavioral health treatment services as defined in the treatment plan.

Partial Hospitalization Program /Day Hospital

I. SERVICE OVERVIEW

A. Definitions

CFCC	Child and Family Care Coordination Team
DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
IEP	Individualized Education Plan

B. Description

Day Treatment is a 5-full-day intensive program that provides developmentally appropriate intervention for seriously disturbed children or adolescents who are unable fulfill the functional requirements of his developmental stage without this level of intensive service.

C. Dimensions

1. Staff-Secure - Unlocked facility in which movement inside the facility and egress from the facility is strictly limited by staff and/or by geographical circumstances, although doors can be opened without a key. Education is provided on-site.
2. Medium - Client attends for a full day (between 6-8 hours per day) 3 - 5 days per week. The program is available to meet with families after hours and in emergencies. The client receives multiple services each day which are included on a treatment/service plan and may include but are not limited to:
 - education
 - individual counseling
 - family counseling
 - supervised daily living
 - supervised recreational activities
 - medical/psychiatric services including nursing
3. Medium/High Team - Services provided with a team approach. The team must headed by a clinician with a graduate degree in a behavioral science and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master’s level in some human service discipline, RN, etc., and

- Trained, supervised staff specializing in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists, and
- Clinical staff available for consultation, and some intervention, e.g. physicians including psychiatrists and psychologists

II. TARGET POPULATION

- A. Age - under eighteen.
- B. Number to be Served - As referred and approved by the DPBHS CFCC.

III. SERVICE COMPONENTS

The program will be available to clients for 12 months of the year and must be open a minimum of 225 days per year for the minimum number of hours of a standard school day for the developmental level of the client served. Activities must also be provided in afternoons and/or evening to assure that working parents are able to participate in treatment. Activities will occur both on-site at the program and in the client's natural environment. They will include but not be limited to:

- A. Professional diagnostic and therapeutic services, e.g., psychological and psychiatric services, individual and family and family assessment, individual, group and family treatment, medication evaluation/monitoring and case management.
- B. Activities provided within a therapeutic milieu, e.g., individual and group therapeutic recreation, field trips, parent and school consultation, behavior management, and other psycho-social education activities.
- C. Crisis response for active clients:
1. The client and/or family will be able to reach a day treatment staff person in an emergency.
 2. If the client's behavior appears to signal that he/she may be approaching a crisis, the day treatment staff will alert the DPBHS crisis unit, including instructions for how to contact the day treatment therapist if there is an emergency.
 3. If the DPBHS mobile crisis team is contacted at any time, a member of the day treatment staff will be available to make telephone recommendations about disposition.
 4. During the regular working day, if an emergency occurs, the day treatment staff will notify the DPBHS CFCC, respond in-person to the crisis if possible, with the DPBHS crisis team if they are dispatched.
- D. Transportation to and from program activities.
- E. An educational program appropriate to the level and individual educational needs of the client and which includes classroom education provided by a certified teacher, educational and cultural activities, and physical, occupational and speech therapy as specified on the IEP. Additional requirements of Educational programs follow:
1. Some youth are placed (out of medical necessity or for legal reasons) in programs which inhibit or interfere with participation and attendance at the local sending school. In such cases the CONTRACTOR is responsible for ensuring that the youth continue to be educated at the appropriate level. To meet this need, CONTRACTORS must ensure compliance with the following processes:

- a. Prior to enrollment, the CONTRACTOR will obtain written consent from each parent or legal guardian to obtain records and maintain communication with the sending district.
- b. Within three business days of admission to the day treatment program, the CONTRACTOR will contact the youth's home school to determine current standing with the school (e.g. enrolled attending; enrolled not attending; officially withdrawn.). Written confirmation of status will be obtained. If the youth is attending school, the CONTRACTOR will obtain course schedule, level of credits and current grades.
- c. Within five business days, the CONTRACTOR will establish a written agreement with the sending school for "homebound" instruction to be provided by the school district or the CONTRACTOR.
- d. At the close of each week and at the conclusion of each month, written documentation will be provided by the CONTRACTOR to the school district regarding each student's participation and assignment completion during "homebound" instruction. This will include documented length of services per day/week and monthly. Course grades and/or actual assignments will be provided to the sending school at the close of each week and month.
- e. The services provided are in accordance with the student's
 - i. Grade Level
 - ii. Educational status as either a General or Special Education Student
 - iii. Parent/Guardian Permission(s)
- f. Students not participating in "homebound" instruction or pursuing a GED must be 16 years or older, have written consent by parent or legal guardian, AND be officially withdrawn from school. CONTRACTORS may receive written notification from the sending district that the youth has legally withdrawn from school. Parents and youth who are identified as needing special education services should receive the special education procedural safeguards prior to making this decision. Such decisions must be evidenced by written notification and parental signatures. (CONTRACTORS will receive training from DSCYF to ensure appropriate understanding of this requirement.)

2. Student Records File Folder

CONTRACTORS will maintain educational files in a separate, secure (locked) location Educational files shall include the following documents:

Section I

- 1.) Signed release of information for educational records and on- going communication
- 2.) Student Records Request form
- 3.) Record Review/Inspection Form
- 4.) Written "Homebound" instruction agreement
- 5.) Telephone/Mail Contact Log Form
 - a. Weekly/Monthly contact between Agency Teacher and School district
 - b. Assignment log with due dates
- 6.) Medical Alerts
- 7.) Official withdrawal from school notification

Section II- Special Education Students only

- a. Evaluation Report/Eligibility
- b. IEP/Section 504 Accommodation Form
- c. Teacher IEP Review Form

Section III-

- 1.) Student Progress reports
 - a. Attendance
 - b. Grades
 - c. Assignments Progress
 - d. Effort
- 2.) Home School District Transcripts/Report Cards
3. DSCYF Education Unit Support - The DEPARTMENT acknowledges the arduous task of educating youth needing such services. The student population is transient and most youth participating in these programs have scattered school histories. As such the DEPARTMENT'S education unit will provide the following supports:
 - a. Annual training and update of the most current regulations and guidelines found in Individual with Disabilities Education Act (IDEA) for CONTRACTOR education employees.
 - b. Model forms and processes
 - c. Focus review of each agency school site two times per year
 - d. Additional support(s) upon request in the areas of :
 - i. Academic Instruction
 - ii. IDEA – State and Federal regulations
 - iii. Technical Assistance

Partial Hospitalization Program /Day Hospital Clinical Necessity Criter1a

This level of care provides support and psychiatric services five days per week to clients living at home or in other residential settings. This level of care should be used for clients with severe, complex, or chronic psychiatric disorders requiring high intensity psychiatric medical services.

Primary Considerations:

I. At least one of the following:

- A) **Self harm:** The client has made suicide attempts or credible threats with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
- B) **Medical risk:** The client has exposed himself or herself to medical risk, for example, eating disorders, repeated drug overdoses requiring medical intervention, and noncompliance with medical intervention for serious medical illnesses.
- C) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
- D) **Severe, Complex, or Chronic Psychiatric disorder:** The client exhibits a severe, complex, or chronic psychiatric disorder that has led to compromised functioning in multiple areas which require frequent or intensive psychiatric or general medical evaluation or intervention which cannot safely or effectively be provided in alternative programs.

E) **Psychiatric oversight:** Is a necessary part of the client’s treatment.

II. Least restrictive :

Twenty four hour inpatient hospitalization or RTC care is not necessary, and the client has received outpatient treatment (including office or home based services, crisis intervention, and day program) and has not made progress, cannot reasonably be expected to make progress, or is regressing in outpatient treatment, or there is evidence that the client could not be safely be treated in any less restrictive level of care.

III. **Family participation:** Family members and/or significant others, in the client’s support network (relatives, case managers, or mentors) will commit to regular participation in the treatment process and to the client’s return to the community.

Inpatient Hospitalization, Voluntary

I. SERVICE OVERVIEW

A. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families

B. Description

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

C. Dimensions

1. Medical/Psychiatric Hospital - Locked medical facility for youth who are dangerous to self or others because of behavioral health problems. Movement inside the facility and egress from the facility are strictly limited. External doors and some internal doors cannot be opened from the inside without a key. Education is provided on-site. Use of this facility is limited and is to protect the client and/or the community from his/her dangerous behaviors.
2. High - This is a site-based twenty-four hour, seven day per week program with three shifts of awake staff. The client receives multiple services which appear on a treatment/service plan and may include but are not limited to:
 - education
 - individual counseling
 - family counseling
 - supervised daily living
 - supervised recreational activities
 - medical/psychiatric services including nursing
3. High Team - Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master’s level in some human service discipline, RN, etc.

- Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
- Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. TARGET POPULATION

Inpatient treatment services will be provided to children and adolescents under the age of eighteen (18) years.

III. SERVICE COMPONENTS

Inpatient treatment exists as one component of a continuum of care. Therefore, inpatient treatment is used primarily for short term acute care to address symptoms which cannot be addressed at other less restrictive levels of care. When the acute crisis is resolved, the client can continue treatment in a less restrictive program.

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

- Thorough evaluation of medical, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptoms.
- Management of the environmental stimuli to which the child or adolescent is subject.
- Careful monitoring of psychotropic medications and their effects on the client's behavior.
- A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
- Careful monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
- Programmed activities for the amelioration of presenting problems, including skill building, with an emphasis upon interpersonal and problem solving skills; self-care/life skills; activity and recreational programming.
- Counseling and psychotherapy, including individual and group approaches and problem-specific approaches.
- Family therapy with focus upon reintegration into the community within the shortest clinically appropriate time frame.
- Provisions for educational opportunities

Inpatient Hospitalization, Involuntary

I. SERVICE OVERVIEW

A. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
DYRS	Division of Youth Rehabilitative Services

B. Description

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

The CONTRACTOR, through this contract and in accordance with 16 Del. C. sections 5001(2) and 5135, is hereby designated by the DEPARTMENT Secretary as an appropriate facility for the diagnosis, care and treatment of mentally ill minors who are involuntarily admitted to the custody of the CONTRACTOR'S psychiatric hospital pursuant to 16 Del. C. section 5122 or section 5001 et. seq.

It is the intent of this contract to purchase from the CONTRACTOR involuntary psychiatric hospital services for minors only insofar as said services are required by and in compliance with pertinent provisions of 16 Del. C. Chapters 50 and 51, herein incorporated by reference. The CONTRACTOR will be familiar with pertinent provisions of 16 Del. C. Chapters 50 and 51 and associated legal and professional procedures governing involuntary hospitalization of juveniles. It is expected that the CONTRACTOR will seek clarification from the DEPARTMENT should questions or problems arise in the implementation of services under this contract.

C. Dimensions

1. Medical/Psychiatric Hospital - Locked medical facility for youth who are dangerous to self or others because of behavioral health problems. Movement inside the facility and egress from the facility are strictly limited. External doors and some internal doors cannot be opened from the inside without a key. Education is provided on-site. Use of this facility is limited and is to protect the client and/or the community from his/her dangerous behaviors.
2. High - This is a site-based twenty-four hour, seven day per week program with three shifts of awake staff. The client receives multiple services which appear on a treatment/service plan and may include but are not limited to:
 - education
 - individual counseling
 - family counseling
 - supervised daily living
 - supervised recreational activities
 - medical/psychiatric services including nursing
3. High Team - Services provided with a team approach. The team must be headed by a licensed mental health professional and includes, at minimum:
 - One or more trained clinical staff, e.g. minimum of master's level in some human service discipline, RN, etc.
 - Clinical staff available for consultation and some intervention, e.g. physicians including psychiatrists and psychologists
 - Trained, supervised staff may be added to the team. These individuals specialize in some aspect of behavior change, e.g. residential childcare workers or non-residential community interventionists

II. TARGET POPULATION

Inpatient treatment services will be provided to children and adolescents under the age of eighteen (18) years.

III. SERVICE COMPONENTS

Involuntary inpatient treatment should be used only in extraordinary circumstances where a minor meets the legal definition for involuntary admission, and a parent or legal guardian's signature for voluntary inpatient treatment is unavailable. Treatment is used primarily for acute crisis resolution to address behavior and symptoms which cannot be addressed at other less restrictive levels of care. When the acute crisis is resolved, the client should continue treatment in a less restrictive context.

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

- Independent psychiatric evaluation within 24 hours of admission.
- A thorough assessment of the medical, psychological, social, familial, behavioral and developmental dimensions of the client's situation within the context of the client's precipitating symptoms.
- Focused brief treatment and stabilization as medically necessary, including individual and group approaches and problem-specific approaches.
- Therapeutic stabilization of youth in crisis, including physically aggressive minors, and minors who are a danger to self or others.
- A safe and secure environment for all minors who are involuntarily admitted, including those who are violent and dangerous to themselves and/or others and those who have been adjudicated or are otherwise in the custody of the DYRS.
- Careful monitoring of psychotropic medications and their effects on the client's behavior.
- A high degree of structure, order, and predictability with regard to the routines of daily living, the management of behavior and the provision for basic needs.
- Monitoring and management of peer group interaction to promote social learning and minimize the negative effects of peer influence.
- Programmed activities for the amelioration of presenting problems, including skill building, with an emphasis upon interpersonal and problem solving skills; self-care/life skills; activity and recreational programming.
- Brief family therapy with focus upon reintegration into the community within the shortest clinically appropriate time frame.
- Provisions for educational opportunities.

IV. INVOLUNTARY HOSPITALIZATION PROCEDURES

The CONTRACTOR agrees to comply with all legal and DPBHS requirements governing admission, continued stay and discharge. In addition, the CONTRACTOR agrees to the following:

A. Admission

1. Accept All Admissions - The CONTRACTOR must accept for admission all minors who are presented to the hospital for involuntary admission in accordance with Delaware law.
2. Confirmation with the DEPARTMENT - The CONTRACTOR will inform the DEPARTMENT of the actual date and time of any involuntary admission as soon as possible, and no later than 2 hours following the actual admission of a youth to the facility; unless the involuntary admission occurs at a time when State offices are closed, in which case the CONTRACTOR will notify the DEPARTMENT within the first two (2) hours of the next working day. In the event that said notification is not received within the specified time frames, the DEPARTMENT reserves the right to deny payment for all or part of the minor's course of hospital treatment.
3. Due Process - In accord with 16 Del. C. Ch. 50 and 51 concerning involuntary and provisional admissions, the CONTRACTOR will ensure that all applicable legal safeguards and procedures governing involuntary provisional hospitalization are implemented promptly for all involuntarily admitted patients and their families.

B. Continued Stay

1. Treatment. The CONTRACTOR will provide treatment to the involuntary minor as is medically appropriate.
2. Involuntary Treatment Pursuant to Court Ordered Commitment. If a patient is committed for continued treatment to the CONTRACTOR'S hospital pursuant to a Court order, the hospital shall provide treatment to the involuntary patient in accordance with the order, applicable Delaware law, this Contract and generally recognized professional standards.
3. Emergency Procedure Authorization. In the event that an emergency procedure must be performed at the facility or elsewhere, DPBHS must be informed on the next working day, or payment for the procedure may not be authorized. DPBHS will only consider funding for medical procedures that are directly related to the diagnosis and/or treatment of a client's psychiatric condition.
4. Ancillary Procedures Authorization. Psychological or other specialized evaluations, treatment or diagnostic procedures not included in the comprehensive per diem will be funded only as authorized by DPBHS.

C. Discharge

1. Emergency Apprehension. If a youth is admitted pursuant to 16 Del. C. section 5122, the youth will be discharged from involuntary status within 72 hours unless admitted or committed under some other provision of Delaware law. The CONTRACTOR must provide discharge recommendations in consultation with DPBHS.
2. Provisional Hospitalization. If a youth is admitted pursuant to 16 Del. C. section 5003, the youth must be discharged from involuntary status within two (2) working days unless judicial commitment proceedings are undertaken pursuant to 16 Del. C. section 5007 *et. seq.*, in order to obtain legal authorization for continued hospitalization under a judicial commitment order. The CONTRACTOR must provide discharge recommendations in consultation with DPBHS.

V. PROGRAM DELIVERABLES

In addition to the specifications in the DPBHS Provider Manual and Involuntary Procedures Manual, the CONTRACTOR agrees to the following:

- A. The following must be delivered to DPBHS within 48 hours of admission:
 - 1. Admission Summary - including psychiatric evaluation with DSM IV diagnosis, initial treatment plan and signed by attending physician.
 - 2. Provider Certificate of Need.
- B. Monthly - The hospital will provide to the DPBHS Program Manager, at the close of every month a report which specifies how many minors were involuntarily admitted in the previous month, and for each patient, the level of care from which each patient was admitted, the level of care the patient was discharged to, the number of previous psychiatric hospitalizations, and whether the patient was involuntarily admitted or referred by an agent or employee of the hospital, or by a psychiatrist with admitting privileges at the hospital.

Inpatient Hospitalization Clinical Criteria

I. At least one of the following:

- A) **Self harm:** The client has made suicide attempts or credible threats of significant self injury with a plan and means. Risk factors to be considered include, but are not limited to: suicide of significant other, disturbed sense of reality, depression, hopelessness, previous suicide attempts, substance use, and recent losses.
- B) **Life threatening risk:** The client has exposed himself or herself to life threatening risk. Examples include life threatening eating disorders, repeated drug overdoses requiring medical intervention, and extreme noncompliance with medical intervention for serious medical illnesses.
- C) **Danger to others:** The client has a serious psychiatric disorder such as psychosis, or major affective disorder and displays behavior related to the disorder that may result in serious physical assault, sexual assault, or fire setting or other major harm to others.
- D) **Severe Psychiatric disorder:** The client exhibits a severe psychiatric disorder such as an acute psychotic state, or multiple disorders that require intensive or frequent psychiatric or general medical evaluation or intervention.

II. **Least restrictive:** Care cannot be provided safely or effectively in less restrictive level of care.

Adjunctive Services

I. SERVICE OVERVIEW

- A. Definitions

DPBHS	Division of Prevention and Behavioral Health Services
DSCYF	Department of Services for Children, Youth and Their Families
DYRS	Division of Youth Rehabilitative Services

B. Description

1. Supplemental Supervision - As an adjunct to the inpatient hospital and day/part day hospital programs operated under the contract, the CONTRACTOR, with authorization from DPBHS, may assign additional staff to provide one-to-one supervision for clients who are deemed to require that added service in order to make it possible to treat them safely and effectively at this level of care. When authorized, the additional staff member will be assigned solely and exclusively to the client, for whom the service was authorized, during agreed upon daily time periods, and for the duration of the authorization period.
2. Translation Service (subcontracted) - As an adjunct to the inpatient hospital and day hospital programs operated under the contract, the CONTRACTOR has the capacity to arrange for the provision of interpretation and translation services for clients who are not fluent in English or who are hearing impaired and require this service in order to participate in treatment.

II. TARGET POPULATION

Adjunctive services will be provided, when authorized and funded, to specific named clients who are DPBHS clients admitted to either the inpatient hospital program or the day hospital program within the CONTRACTOR'S system.

III. AUTHORIZATION AND FUNDING

A. Authorization

Adjunctive services must be specifically authorized for a named client by the DPBHS' Child and Family Care Coordination Team assigned to that client. The authorization will be for a designated and time limited period, subject to periodic renewal as client needs dictate.

B. Funding

The CONTRACTOR will bill separately for the cost of authorized adjunctive services at the rates specified in Attachment B-4.

Appendix 5 –Sample Format Client Progress Documentation

D.A.P. Progress Note Checklist

Data	Check If addressed
1. Subjective data about the client-what are the client's observations, thoughts, direct quotes?	
2. Objective data about the client-what does the counselor observe during the session (affect, mood, appearance)?	
3. What was the general content and process of the session?	
4. Was homework reviewed (if any)?	
Assessment	
5. What is the counselor's understanding about the problem?	
6. What are the counselors' working hypotheses?	
7. What are the results of any testing, screening, assessments?	
8. What is the client's current response to the treatment plan?	
Plan	
9. Based on client's response to the treatment plan, what needs revision?	
10. What goals, objectives were addressed this session?	
11. What is the counselor going to do next?	
12. When is the next session date?	
General Checklist:	
13. Does this note connect to the client's individualized treatment plan?	
14. Is this note dated, signed, and legible?	
15. Is the client name and identifier included on each page?	
16. Has referral information been documented?	
17. Are client strengths/limitations in achieving goals noted and considered?	
18. Are any abbreviations used standardized and consistent?	
19. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
20. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	

Treatment Planning M.A .T .R.S.: Utilizing the Addiction Severity Index (ASI): Making Required Data Collection Useful

S.O.A.P. NOTE

S = Subjective or summary statement by the client. Usually, this is a direct quote. The statement chosen should capture the theme of the session.

1. If adding your own explanatory information, place within brackets [] to make it clear that it is not a direct quote.
 - Example of session theme: "When he raises his voice, I just... What do I do?... Yes, I'll talk more in group."
2. If client refers to someone else's name, indicate that other person by initials. This makes it clear that the client is the focus, not the person the client is talking about. It also guards against any breeches in confidentiality. This is especially true when a client refers to another client.
 - Example of client using someone else's name: "She really made me mad... You think I should make an appointment to talk to her? I don't like dealing with this stuff [case worker S.P.]."
3. If the client didn't attend the session or doesn't speak at all, use a dash on the "S" line.
 - Example: S: ---

O = Objective data or information that matches the subjective statement. Descriptions may include body language and affect.

- Example: 20 minutes late to group session, slouched in chair, head down, later expressed interest in topic.

A = Assessment of the situation, the session, and the client, regardless of how obvious it might be based on the subjective and/or objective statements.

- Example: Needs support in dealing with scheduled appointments and taking responsibility for being on time to group.
- Example: Needs referral to mental health specialist for mental health assessment.
- Example: Beginning to own responsibility for consequences related to drug use.

P = Plan for future clinical work. Should reflect interventions specified in treatment plan including homework assignments. Reflect follow-up needed or completed.

- Example: Begin to wear a watch and increase awareness of daily schedule.
- Example: Complete Tx Plan Goal #1, Objective 1.
- Example: Consider mental health evaluation referral.
- Example: Contact divorce support group and discuss schedule with counselor at next session.

Adapted from work by Larry T. Mark and presented by Donna Wapner, Diablo Valley College. Handout included in materials produced by the Pacific Southwest Addiction Technology Transfer Center, 1999.

Appendix 6 – Document Deliverables

SCHEDULE OF DOCUMENT DELIVERABLES - CLINICAL INFORMATION FOR MENTAL HEALTH OR SUBSTANCE ABUSE SERVICES

# Days after completion to be Rec'd by DPBHS	CLINICAL DOCUMENTATION TO BE SENT TO DPBHS	Community Based Services	ACUTE CARE SERVICES	Residential Services	IP
5	Provider Certificate of Need Form				•
10	Admission Summary - with required signatures	•		•	
30	Comprehensive Treatment Plan	•		•	
7 Days after discharge	Discharge Summary	•		•	
Within 10 days of revision	Updated/Revised Treatment Plan	•		•	

ROUTINE OUTPATIENT SERVICES ONLY

DOCUMENT	OUTPATIENT DOCUMENTATION TO BE SENT TO DPBHS	Received at DPBHS
Initial Request for Service Authorization	Admission to Mental Health or Substance Abuse Outpatient Services	Immediately after 1 st Session
Request for Continued Service Authorization	Revised/current Treatment Plan Request for Re-authorization	By Expiration Date or by use of last units authorized
Discharge	Discharge Form	Within 18 days after discharge

*Transfer instruction sheet and safety plan are not required to be sent to DPBHS as a deliverable but should be kept in the client chart.

SCHEDULE OF DOCUMENT DELIVERABLES - ADMINISTRATIVE INFORMATION

ADMINISTRATIVE DOCUMENTATION	Provider Manual Reference	SUBMISSION TO
Incident Reports	DSCYF Operating Guidelines	Quality Services Administrator at E-Fax 1-302-661-7270 or secure e-mail at DSCYF_DPBHS_QI@state.de.us within 72-hours of the incident.
<p>Provider Documentation</p> <ul style="list-style-type: none"> • Business License, if applicable • Insurance: Proof of commercial liability and motor vehicle insurance, as applicable • Licenses as applicable • Most recent accreditation letter and certificate, survey results and PPR, ACQR, or self-studies completed for accrediting agencies. • Providers' contract manager information • Provider's contact for billing and authorization • Provider's Remittance Address • Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business • Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business • Audited Financial Statements, if available <p>If these are checked on the DSCYF Document Checklist)</p> <ul style="list-style-type: none"> • DSCYF Rate Certification Form • DSCYF HCFA Sanctions Certification Form • Copy of Agency Operating License(s) <p>Criteria for Provision of Inpatient Psych Services for Individuals under Age 21.</p>	<p>DSCYF Document Checklist</p> <p><i>Enclosed Annually with Contract</i></p>	<p>Submit with the signed contract to: DSCYF Contracts Unit 1825 Faulkland Road Wilmington, Delaware 19805</p>

<p>Annual Provider Documentation</p> <ul style="list-style-type: none"> • Business License, if applicable • Insurance: Proof of commercial liability and motor vehicle insurance, as applicable • Licenses as applicable • Documentation or assurance of Provider approval to provide special education from the state in which the Provider does business • Documentation or assurance that the Provider's teachers are qualified to serve students with disabilities in the State in which the Provider does business 		<p>Submit annually to: DSCYF Contract Administrator 1825 Faulkland Road Wilmington, Delaware 19805</p>
<p>Change in Documentation status including:</p> <ul style="list-style-type: none"> ○ Business License, if applicable ○ Insurance coverage ○ Licenses as applicable ○ Accreditation 		<p>Submit any changes or notices of investigations promptly by FAX to: the DPBHS Manager of Quality Improvement: (302) 622-4475</p>