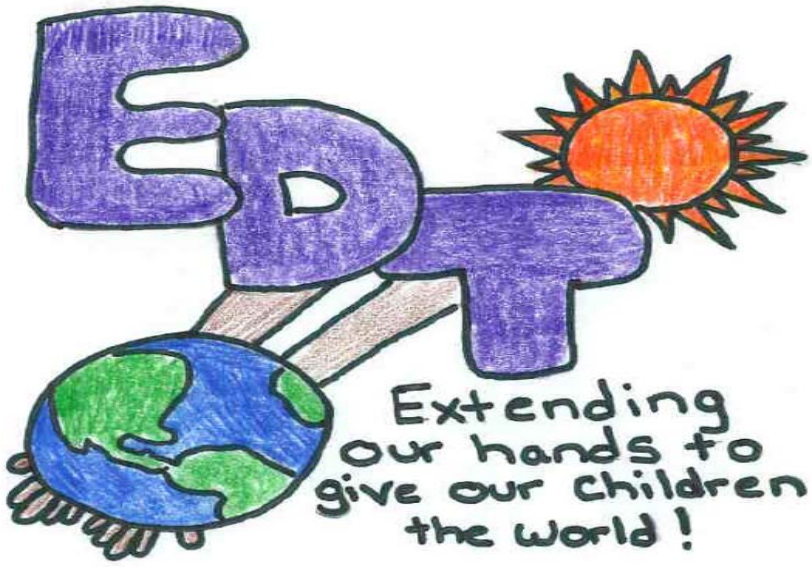
PRACTICE STANDARDS

for

EXTENDED DAY TREATMENT



Connecticut Department of Children and Families
Clinical and Community Consultation and Support Team

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BACKGROUND

The Practice Standards for Extended Day Treatment (EDT) were originally developed by a broad base of stakeholders and implemented on October 1, 1999. The intent was to delineate specific practice guidelines for the delivery of extended day treatment services. These practice standards are distinct from licensing regulations and they do not replace any contract requirements.

A need to update these standards was identified in 2006. The Department of Children and Families (DCF), in collaboration with the stakeholder community convened a review committee to achieve this goal. Committee members included: parents of children with Serious Emotional Disturbance (SED) who have used this service; EDT grant-funded service providers; staff from DCF Area Offices and Central Office; family advocates; staff from the Connecticut Community Providers Association; and staff from the CT Behavioral Health Partnership. These practice standards are derived from the experiences of those who developed and utilized them, current literature review including best practices, the needs of children and families in Connecticut, the report entitled Extended Day Treatment Defining A Model of Care in Connecticut (July 9, 2007) by the CT Center for Effective Practice/Child Health and Development Institute, and feedback from the broader stakeholder community.

The draft Practice Standards for Extended Day Treatment was reviewed by the diverse stakeholder community including The Children's Behavioral Health Advisory Council (CBHAC) and the State Advisory Council (SAC). The feedback was further reviewed by the committee and, as appropriate, incorporated in the final editing of this document. The final draft was reviewed and approved in June 2008. Subsequently, a revision was made to align the dates for treatment plan reviews to match the DCF licensing requirements, effective August 1, 2009. A second revision to address the amount of clinical versus rehabilitative behavioral health services to be delivered each day occurred in May 2012.

Connecticut Department of Children and Families
Bureau of Behavioral Health and Medicine

Extended Day Treatment
Practice Standards

I. Mission Statement

Our mission is to provide effective community-based behavioral health services for children and youth with psychiatric disorders and their families, in partnership with the system of care, to achieve optimal functioning and strengthen families.

II. Core Values

Extended day treatment services shall be:

a. Community-based;

b. Child-centered and family-driven, with the needs and strengths of the child and family dictating the blend of services provided;

c. Planned and delivered to meet the safety, permanency and well-being needs of the child and family; and

d. Empirically supported and culturally sensitive to address the individualized behavioral health needs of children, youth and families and to achieve defined outcomes.

III. Guiding Principles

Children with behavioral health needs should have access to a comprehensive array of services that address and support the child's emotional, developmental, social, educational, and physical needs.

Children with behavioral health needs should receive services in accordance with the unique needs and potential of each child, guided by an individualized service plan.

Children with behavioral health needs should receive services within the least restrictive, most normative environment that is clinically appropriate.

The families and surrogate families of children with behavioral health needs should be full participants in all aspects of the planning and delivery of services.

Each provider should continuously pursue an effective level of outreach, engagement and communication with the family/caregiver.

Children with behavioral health needs should be provided with service coordination/case management to ensure that multiple services are delivered in a coordinated and therapeutic manner, and that they can move through the system of care in accordance with their changing needs.
Children with behavioral health needs should receive services that are integrated, comprehensive, and coordinated with the child's ecology, i.e. family, peers, school, and community.

Children with behavioral health needs should be ensured smooth transitions to aftercare services including transitions to the adult services system, as appropriate.

The rights of children with behavioral health needs should be protected. Client and system-focused advocacy efforts should be promoted.

Children with behavioral health needs should receive services without regard to race, religion, national origin, gender, sexual orientation, physical disability or other characteristics.

Services should be sensitive and responsive to cultural differences and special needs.

Extended day treatment providers shall demonstrate commitment to and accountability for delivering empirically supported, quality services.

Extended day treatment services are directed towards assisting children, youth and families to master the skills necessary to successfully live, learn, play, and work in the community.

IV. Service Description

Extended day treatment is a community-based model of care that provides an array of integrated behavioral health treatment and rehabilitative support services for children and youth who have psychiatric disorders and their families/caregivers, in partnership with the system of care. The services are delivered through a structured, intensive, therapeutic milieu and through the broader ecosystem. Services are provided year round during non-school hours. A team of multi-disciplinary staff including psychiatrists, masters' and doctoral level clinicians, and paraprofessionals provide a broad range of treatment services and psychosocial interventions.

V. Service Goals

The goals are to assess and treat children with behavioral health needs and their families/caregivers for the purpose of achieving optimal functioning at home, at school and in the community.

The program serves as a critical resource for maintaining children and youth in their communities, with priority given as follows:

a. To divert youth at risk of more restrictive levels of care; and

b. To be a resource for children returning to the community from more restrictive levels of care.

VI. Ages Served

The target population includes children and youth, ages 5 through 17 and their families/caregivers. The provider serves an age-specific population, as specified in the extended day treatment license that is issued by the Connecticut Department of Children and Families (DCF).

VII. Geographic Coverage

Service sites are located across the state. Each provider shall offer services in specified towns and cities, per contractual agreement with DCF.

VIII. Target Population

A child/youth is a candidate for admission to an extended day treatment program if he/she meets the Intermediate Level of Care criteria, as defined in the Connecticut Behavioral Health Partnership - Child Psychiatric Level of Care Guidelines.
(Refer to: http://www.ctbhp.com/provider/handbook/ProviderHandbook_AppendixE_040907.pdf)

The child must display a moderate level of symptomotology, consistent with an Axis I diagnosis excluding V codes, that appears to be persistent in nature.

The behavioral health needs of the child/youth do not require a higher level of care and these behavioral health needs cannot be met in a lower level of care/less restrictive setting.

The frequency, intensity and duration of symptoms and behaviors require an intensive, structured, coordinated, and highly supportive therapeutic and rehabilitative milieu setting for several days each week, generally for a period of up to six months.

There is evidence that the child/youth will benefit from the service during this period of time.

Psychiatric oversight is necessary.

There is a high likelihood that the child/youth's condition will deteriorate if this level of treatment is not provided.

A. Inclusionary Criteria

The provider will accept and make all reasonable efforts to manage a broad spectrum of moderately challenging behaviors.
(Refer to: http://www.ctbhp.com/provider/handbook/ProviderHandbook_AppendixE_040907.pdf)

B. Exclusionary Criteria

1. The child/youth is at imminent risk of serious harm to self or others.

2. The child/youth has severe cognitive, developmental, and/or psychiatric challenges that preclude his/her ability to benefit from a group milieu setting;

3. The primary diagnosis and/or treatment issue is substance abuse;

4. The child/youth resides in a therapeutic or treatment foster care setting, unless there has been a formal review and approval by the DCF Behavioral Health Program Director or designee; and/or

5. After reasonable efforts have been made to involve the caregiver(s) in the treatment plan development and its implementation, the caregiver(s) refuses to participate.

IX. Service Access

EDT is a valuable resource within the continuum of care, but with a limited statewide service capacity. For all referrals that meet admission criteria, priority access is intended for youth referred by DCF and youth referred through a local system of care, provided the youth resides in the communities served by the EDT site, as described below.

A. First Priority: Referrals from the respective local DCF Area Office(s) as identified in the DCF/Provider contract;

B. Second Priority: Referrals from non-local DCF Area Office(s), provided the youth resides in the communities served by the program;[1]

C. Third Priority: Referrals from the respective local Systems of Care/Community Collaboratives; and

D. Fourth Priority: Referrals from the community-at-large including but not limited to: parents/caregivers; legal guardians; hospitals; schools; outpatient psychiatric clinics for children; and other service agencies.

The provider may offer additional slots that are exclusively paid by other sources provided the DCF slots (as specified by contract) remain available on a priority access basis to DCF.

[1] The priority schema is not intended to restrict access by other area offices in those unique circumstances when a child resides outside of the provider's catchment area. However, under these circumstances sharing slots is dependent on agreement and approval by the local DCF Behavioral Health Program Director or designee. An assessment of the best interests of the child including clinical appropriateness, distance(s) traveled, and acceptable transportation arrangements must be addressed.

The provider is expected to maximize revenues through sliding fee schedules and third party reimbursements.

EDT provider agencies will be active participants in their local systems of care and the Managed Services Systems. Close communication and collaboration with a variety of behavioral health and human services providers, clinics, agencies, schools and recreational staff are expected. Both formal and informal collaboration are necessary for planning purposes and to maximize resources available to children.

An identified DCF Area Resource Group Specialist (ARG), hereafter referred to as the DCF Area Office Gatekeeper will serve as the gatekeeper for referrals and admissions. DCF requests for services will be forwarded internally to the gatekeeper who will determine initial appropriateness for the service based on admission criteria. These referrals will be reviewed on a weekly basis with the EDT provider. Additionally, the DCF Area Office Gatekeeper will review all community referrals for DCF-funded slots and remain informed regarding the census statistics for the total population at each EDT program site.

The provider will submit a weekly census report regarding the total population served to the designated DCF Area Office Gatekeeper. For DCF-funded slots, the report will include the following information, at a minimum:

A. Names of children/youth;

B. Dates of referrals;

C. Sources of referrals;

D. Intake decisions with dates of anticipated admissions or dates of denials and reasons;

E. Dates of Admissions;

F. IOP or EDT levels of care;

G. Dates of Discharges or Anticipated Discharges; and

H. Number of vacancies.

Information for non-DCF funded slots will include the initials of the current participants, the number of vacancies, and the dates of anticipated vacancies.

Timely, consistent communication and collaboration between the DCF Area Office Gatekeeper and the respective EDT provider(s) will occur in order to address the following issues relative to access for DCF-involved referrals:

A. Screening and triage of referrals to support timely initiation of service;

B. Assessment of ongoing progress or lack thereof during the treatment phase; and

C. Planning for discharge and follow-up after care services.

X. Intake and Referral

The provider will be available to accept referrals during normal business hours, Monday through Friday, fifty-two (52) weeks per year.
The provider shall consider for admission all referrals regardless of race, gender, religion, sexual orientation, disabilities or ethnic origin.

For DCF-involved children, no referral shall be rejected due to lack of health insurance or inability to pay. For those referrals that involve excessive travel for the child/youth to the EDT program site, the decision regarding acceptance is made on a case-specific basis, with a comprehensive assessment of all relevant factors. The decision is made in partnership with DCF staff, whenever they are the referring agent.

A psychiatric evaluation and diagnosis is not necessary prior to making a referral. However, the EDT psychiatrist will be involved in the decision-making process for all admissions.

A standardized referral form will be utilized by referring agents including DCF social workers, system of care/care coordinators, and other community professionals. It will include information pertaining to reason(s) for referral, demographics, current medical and mental health status including diagnoses and medications, presenting concerns, other agencies/programs involved with the child/family and identified contacts, and the dates/signatures of the referral source and the DCF Area Office Gatekeeper. It is expected that the referring agent will provide copies of psychiatric evaluations, clinical assessments, discharge summaries from treatment providers, and any other relevant behavioral health information prior to the intake interview.

The referral information will be reviewed by the provider within two business days.

Every attempt will be made to schedule an intake interview/evaluation within ten business days, unless clinical need dictates otherwise. The face-to-face interview will be conducted with the child/youth and the parents/caregivers. The referring source will be invited to participate in the intake process. The evaluation will identify the comprehensive needs and strengths of the child in the areas of psychological development, social development, family relationships, education, physical health, recreation and life skills development. The needs and strengths of the family system will also be identified. Collateral contacts with other involved service providers will be made, as deemed necessary.

Following the intake evaluation a determination will be made regarding eligibility and date of admission, if clinically appropriate.

For children/youth who are accepted for admission, parents/caregivers, the referring agent and other involved parties will be notified, verbally and in writing, no later than thirty business days from the date of referral.

For children/youth who meet eligibility criteria through the Connecticut Behavioral Health Partnership (CT BHP), the Administrative Services Organization has the responsibility and authority for authorizing the service.

For each referral that is accepted for admission, the child/youth and parents/caregivers will be informed about the array of available services, the rights, roles, responsibilities and expectations of the child and parents/caregivers as well as the responsibilities of the provider, and the date of admission.

For each referral that is assessed to be clinically inappropriate and denied, the provider shall document the reason(s). The documentation will include a written explanation in the agency's record as well as written notification to the referring source and parents/caregivers no later than forty-five days from the date of receipt of the referral form. The documentation will also include recommendations for a more appropriate, alternative plan of care. The provider will offer an opportunity for a direct discussion, through either a telephone consultation or a face-to-face meeting with the parents/caregivers and the referring source. The discussion affords an opportunity for the involved parties to advocate for the child/youth, to develop an alternative plan of care that meets the unique needs, and to identify the appropriate party for pursuing the alternative plan.

XI. Transportation Services

Transportation services shall be provided for children and youth. Depending on the unique geographic and public transportation features of each area, the provider will deliver transportation services through utilization of available federal, state and community resources. Additionally, families/caregivers will be involved in planning and assisting, when feasible.

It is expected that efforts will be made to develop and implement formal agreements with Local Education Authorities (LEA) for transport from school to the service site when school is in session.

The provider may utilize local transportation resources such as public transportation, resources available through managed care companies and other insurance carriers such as Medicaid, private transportation vendors through contractual arrangements, or provider-owned vehicles.

State and federally funded resources such as Medicaid should be the payers of first resort.

Per Department of Social Services (DSS) regulations, children under the age of twelve who receive Medicaid-funded transportation services must be accompanied by an adult.

DCF will not supplement transportation costs except in special circumstances or for cases involving a notable hardship provided there is pre-approval by the DCF Area Office Behavioral Health Program Director or designee.

XII. Core Services

A diverse array of integrated psychiatric, clinical and rehabilitative support services will be provided to meet the individualized needs of each child/youth and their family/caregiver.

The menu of core services includes all of the following:

- Intake and Referral
- Child and Family Assessment
- Psychiatric Evaluation
- Medication Assessment and Consultation
- Medication Management
- Crisis Intervention[2]
- Individual Psychotherapy
- Group Psychotherapy
- Family Psychotherapy
- Social Skills Development
- Expressive Therapies
- Therapeutic Recreation
- Family Engagement and Outreach
- Family Support and Education
- Multiple Family Groups
- Service Coordination/Case Management
- Aftercare Planning/Discharge Services

The intake phase includes the tasks of Intake/Referral and Child/Family Assessment. Following admission to an EDT program, all services are therapeutic and intended to address the psychiatric, emotional, behavioral and/or social needs of the client and his/her family, as specified in the client's individualized treatment/rehabilitation plan. There are three levels of therapeutic services that are provided, as specified below.

1. Psychiatric Services - These services may include: Psychiatric Evaluation; Psychiatric Consultation and Monitoring; Medication Assessment and Consultation; and Medication Management. These services are delivered by a board certified or board-eligible child and adolescent psychiatrist and/or an Advanced Practitioner Registered Nurse. The type and frequency of these services is dictated by the child's level of need as prescribed in the treatment/rehabilitation plan.

2. Clinical Services - These services may include: Individual Psychotherapy; Family Psychotherapy; Group Psychotherapy; Social Skills Development; Expressive Therapies; and Multiple Family Groups. These services are delivered by a master's level mental health professional, either licensed, license-eligible, or non-license eligible. (Graduate level interns who are completing an internship, practicum or field experience at the provider agency may provide clinical services, when supervision is provided by a licensed, master's level professional. For each client, a minimum of one-third of the therapeutic services delivered during the course of one week's programming time must be clinical services. The types and frequency of clinical services are based on the client's unique needs and specified in the treatment/rehabilitation plan.

[2] Includes 24 hour emergency and crisis intervention via telephone or pager availability; emergency mobile psychiatric services (EMPS) are not to be utilized as a common practice)

Crisis Intervention Services that are delivered by a master's level mental health professional may be necessary at times, however, these services are not included as part of the minimum one-third standard for clinical services each week.

3. Rehabilitation Services - These services may include: Social Skills Development; Expressive Therapies; Therapeutic Recreation (such as Life if Good Playmaker groups); Family Engagement and Outreach; Family Support and Education; Multiple Family Groups; Service Coordination/Case Management; and Aftercare Planning/Discharge Services. These services may be delivered individually or co-facilitated by either master's level professional staff or direct care staff, however, delivery by a master's level professional staff is not required. For each client, two-thirds of the therapeutic services delivered during the course of one week's programming time may be rehabilitation services. The types and frequency of rehabilitation services are based on the client's unique needs and specified in the treatment/rehabilitation plan.

A minimum of 3 hours of programming must occur each day of the week. These services may be provided in a setting other than the EDT milieu, i.e. at client's home, in the community, etc. Services provided outside of the milieu setting are considered to be part of the services delivered in accordance with the client's treatment/rehabilitation plan.

Providers may chose to deliver services beyond the 3-hour per day minimum programming requirement. If services are delivered beyond the 3-hour programming requirement, these cannot be billed through Medicaid, as there is a single all-inclusive daily Medicaid rate. If services are delivered beyond the 3-hour per day programming mandate, there are no specific requirements for clinical versus rehabilitation services for the extended hours.

Evidence-Based and/or Promising Treatments. It is expected that the provider will utilize evidence-based practices and interventions that have proven effectiveness for the population served.

XIII. Service Setting

A. On-Site

The site shall meet all requirements for licensure by DCF, as specified in the DCF Agency Regulations, Licensing of Extended Day Treatment Programs.

B. Off Site

Services may be delivered in the child/family's/caregiver's home, at school, at a community recreational center, at a park, or other community locations. Off-site services are delivered in a manner that assures the child/youth's right to privacy and confidentiality.

XIV. Hours of Operation

The provider will deliver services during non-school hours at a minimum of three hours per day, five days per week, and shall operate during breaks from the school year. However, the program may be closed due to state and federal holidays as well as for weather-related conditions.

An individual child/youth may have a schedule of attendance of 2, 3, 4, or 5 days per week depending on the level of need and in accordance with ongoing treatment planning.

XV. Treatment Philosophy

It is recognized that children and youth must be treated within the context of the family/caregiver system. Services must be congruent with the family's unique strengths, culture and environment. Pro-active outreach to families is a critical component of care to encourage and support participation and to engage families/caregivers as collaborative partners in the treatment process.

A resiliency and recovery framework, complemented by the CT Kid Care System of Care principles provides a solid foundation for all aspects of treatment and support. Building resiliency to foster successful, sustained integration in the community is necessary. Activities are focused on identifying and enhancing strengths and functional abilities that promote positive growth and development. The goal is to achieve the highest level of functioning in the community.

The treatment team applies an ecological or child-in-environment perspective that emphasizes the interfaces between the child and his environment, e.g. family/caregiver, peers, school, and community. The child's natural support systems such as the family/caregiver and significant others play an integral role in all aspects of treatment and care.

The treatment process is active, dynamic, participatory and evolutionary with an emphasis on hope, optimism and a positive orientation to the future. Expectations are for normal, healthy behaviors and functioning with a focus on the development of competencies and skills necessary to succeed in the family and community.

XVI. Length of Treatment

Extended day treatment services are provided for a period of up to six months. Length of stay may vary slightly depending on the unique needs and circumstances of the youth and family. The level and intensity of services may fluctuate over time based on the treatment needs.

Continued Stay Criteria

The youth and family/caregiver may continue involvement beyond the typical six month timeframe provided the following conditions exist:

1. The child/youth continues to meet eligibility criteria; and
2. The child/youth and his parents/caregivers, the DCF Area Office Gatekeeper or the System of Care Coordinator, if involved concur.

XVII. Service Requirements

A. Child and Family Assessment

A comprehensive child and family assessment will result in the formulation of multi-axial diagnoses and a concomitant treatment plan. Qualified clinical staff, in consultation with the clinical treatment team, shall be responsible for completion of the assessment. The purpose of the assessment is to determine treatment goals and objectives that will allow the child to achieve optimal functioning in the family and community setting. The assessment provides a clinical integration of medical, psychosocial, educational, treatment histories, and family relationships. It is a written document that addresses the needs and strengths of the child within the context of his family and social community.

The comprehensive assessment is based on clinical interviews with the child/adolescent, parents/caregivers, DCF/System of Care staff, and other treatment providers, as applicable. Areas of inquiry include presenting issues, symptoms, functional strengths and deficits, mental status, family history, educational history, relevant medical background, psychological/psychiatric treatment history, and alcohol/substance abuse history. All methods and procedures used in the assessment process shall consider the child's age, cultural background and dominant language or mode of communication. Any testing or screening results used in the assessment process shall be included in the child's case record.

B. Treatment Plan

A written treatment plan that is individualized, comprehensive, child-focused and family-driven is developed with each child/family/caregiver through a collaborative process that engages all parties. The plan is designed to meet the unique treatment needs of the child and family and addresses the major ecological domains.

The treatment plan must be developed within thirty calendar days of admission and include the following:

1. Strengths, needs, and preferences of the child/family that will guide service provision;

2. Clinical issues that will be the focus of treatment;

3. Child, family/caregiver, and peer/community goals and objectives that are measurable and include target dates for anticipated completion;

4. Specific services to be provided to meet the needs, and identification of responsible parties;

5. Units and frequency of services to be delivered;

6. Defined treatment outcomes and criteria for discharge;

7. Anticipated discharge date and identified supports/resources required for discharge;

8. Primary person responsible for coordinating and implementing the plan; and

9. Date and signatures of the supervising psychiatrist, child/youth, parents/caregivers, legal guardians, and treating clinician.

The provider must ensure that the written treatment plan and any subsequent revisions are fully reviewed with the child/youth, his parents/caregivers, and legal guardians in language and terms that are understandable.

C. Treatment Plan Review

To assess the progress toward the accomplishment of treatment objectives, the treatment plan shall be reviewed and revised, as necessary with the child/youth, parents/caregivers, and the legal guardians initially sixty (60) days after the completion and approval of the initial treatment plan. Thereafter, individual treatment plans shall be documented and reassessed at sixty (60) working day intervals.

The treatment plan review will include:

1. An assessment of the progress and any barriers regarding each goal and objective on the treatment plan;

2. Identification of any modifications to the treatment plan;

3. Date/time of the next treatment plan review and list of participants;

4. Discharge planning update; and

5. Date/signatures of the participants including but not limited to the supervising psychiatrist, child/youth, parents/caregivers, legal guardians, and clinician.

D. Progress Notes

Written progress notes are required for every day of attendance and must be maintained in the child/youth's case record. These must include, at a minimum, the following:

1. Child's name;

2. Identification of the specific services delivered, including the specific intervention and the setting;

3. Brief assessment of the progress related to the specific treatment goals/objectives;

4. Date(s) and units of service provided; and

5. Signature and discipline of the staff person who provided the service.

E. Service Coordination

The provider will work closely with parents/caregivers and a broad range of community stakeholders to provide coordinated and integrated services. Community stakeholders may include but are not limited to health, education, child welfare, juvenile justice, system of care/care coordinators and recreation providers. The providers, in partnership with parents/caregivers will work collaboratively with stakeholders, as appropriate to develop and implement a coordinated plan of care for each child/family, and will attend any case-specific team meetings.

The provider will participate in Administrative Case Reviews, convened by DCF. The provider will participate in other meetings with DCF social work staff, and provide case-specific reports, as requested.

The provider will participate in Individual Education Plan (IEP) meetings at the local school districts, as necessary.

F. Discharge Planning

Collaborative discharge planning begins at the time of intake, continues throughout the course of treatment and actively involves the child/youth, parents/caregivers, school staff, DCF social worker or system of care coordinator, if applicable, and other involved service providers. A series of discussions throughout the course of treatment focus on discharge needs and shape the discharge plan.
A child/youth may be discharged when the treatment goals and objectives have been met and discharge linkages have been secured, or the client no longer requires a level of intermediate care, and a transition plan to another level of care is indicated. The plan will address behavioral health, educational, social and family support needs.

The provider is expected to make demonstrable efforts to keep the child/youth and family/ caregivers engaged and avoid any precipitous discharge. However, under certain circumstances it may be necessary to consider discharge prior to the successful completion of treatment goals.

Administrative discharge may be considered in the following situations:

1. A lack of participation by the child and/or family/caregivers, as defined in the individualized treatment plan; or

2. A child/youth's behavior creates safety concerns within the milieu.

Prior to finalizing a decision to discharge, the provider will make every effort to meet with the child/youth, if age appropriate, the parents/caregivers, school staff, DCF social worker or system of care coordinator, if applicable, and other involved service providers to discuss the circumstances leading to consideration of discharge, the actions taken by the EDT staff to avoid the discharge and the reasons for these actions, and if a decision to discharge is made, to identify and secure alternative treatment options, to the extent possible.

For some cases the parents/caregivers may decide that services are no longer needed or desired. It is expected that the provider will extend an invitation to the child/youth and parents/caregivers to discuss the impact of this decision and to recommend alternative resources, as appropriate.

G. Discharge Summary

A written discharge summary is completed within thirty days of the date of discharge.

The discharge summary must contain:

1. Summary of services provided;
2. Summary of progress or lack thereof relative to treatment goals and objectives;
3. Current mental status and diagnoses;
4. Current medications;
5. Identification of behavioral health needs that remain to be met;
6. List of aftercare services in place, and list of recommendations and referrals made;
7. Discharge date; and
8. Date/Signature of licensed clinician.

Discharge documentation must be maintained in the child's case record.

XVIII. **Staffing Requirements**

A. Staffing Levels

The provider must assure that there is psychiatric oversight for extended day treatment services by a board certified or board-eligible child and adolescent psychiatrist. It is a preferred practice that there is on-site availability by the psychiatrist.

The program director or site coordinator shall be a licensed mental health practitioner. The provider will maintain the following direct care, supervisory and clinical staffing levels:

Positions	Minimum Staffing Levels Required
Direct Care Staff	1:4
Direct Care Supervisors	1 hour per week of Clinical Supervision per Direct Care Worker

Clinical Staff	1:8
Psychiatric Staff MD and/or APRN	1 hour per week for every 4 children

B. Staff Development and Training

EDT is a medically necessary service for children/youth requiring intensive clinical intervention provided within a structured therapeutic milieu. Staff must be trained and highly skilled in dealing with complex emotional-psychiatric-behavioral disorders.

All staff will be trained in the use of therapeutic procedures to prevent assaultive incidents and to contain such incidents if they should occur. Such training shall include, but not be limited to verbal defusing or de-escalation and prevention strategies. Where physical restraint is utilized as an intervention, staff must be trained in the following areas: types of physical restraint; the differences between life-threatening physical restraint and other varying levels of physical restraint; the differences between permissible physical restraint and pain compliance techniques; monitoring to prevent harm to a person physically restrained or in seclusion; and recording and reporting procedures on the use of restraints and seclusion.

Staff will be trained in interpersonal skills including effective listening and positive limit-setting.

All staff will receive ongoing training and professional development of sensitivity concerning cultural diversity and competency. The provider is expected to meet the linguistic needs of the population served.

C. Staff Supervision

All staff shall receive weekly supervision.
Clinical staff will receive supervision by a licensed mental health professional.

Non-clinical staff will receive supervision that is overseen by a licensed clinical staff person.

All staff will participate a minimum of one hour per week in clinical team meetings that are conducted by a licensed staff person.

XIX. Supervision and Management of the Population

Children/youth enrolled in EDT are, by definition, in a sub-acute phase of a psychiatric impairment. These disorders may manifest through overt behavioral acting out, self-injurious gestures or verbal threats, thought disorders, or possibly hallucinations. Or, conversely, these disorders may be evidenced by negative symptoms such as avoidance, withdrawal, flat affect, eating disorders, etc. These behaviors, if exacerbated, are potentially dangerous. Participating in EDT is designed to allow the client an opportunity to benefit from additional therapy and structured group activities as tolerated by the client's immediate emotional/behavioral status. A licensed mental health practitioner is responsible for assuring that the

supervision and management at various levels of intervention is sufficient to ensure the safety of each client in the program.

The provider must have written policies and procedures for the management of children/youth at risk, that are consistent with the statutory requirements governing physical restraint, medication and seclusion of persons receiving care, education or supervision and licensing regulations (Refer to: http://www.dir.ct.gov/dcf/regslaws/Regulations/REGS17a-147-1.htm.) The provider must ensure that all staff is trained accordingly.

The psychiatrist will be available for case-specific evaluations and consultations, as needed, treatment plan and treatment plan reviews, and consultation to the program director/site coordinator and staff.

XX. Case Records

Confidential case records shall be maintained for each child/family. Each record must be safeguarded to protect confidentiality as required under state and federal regulations regarding protected health information.

The case record shall contain but not be limited to the following information:

1. Reasons for referral;
2. Demographic information;
3. Child/Family Assessment;
4. Psychiatric Evaluations and other medical information;
5. Medications;
6. Treatment Plan;
7. Progress Notes;
8. Treatment Plan Reviews;
9. Discharge Summary;
10. Releases of Information/Authorizations; and
11. All other documents received and required for treatment purposes.

The parents/caregivers shall be entitled to receive, upon written request and within applicable statutory authority, reports and information contained in the case record.

Disposal of client records will occur according to the schedule and standards required by state and federal regulations.

XXI. Cultural Competency

In accordance with the core values and guiding principles of systems of care, services will be developed and delivered in a culturally competent manner.
The provider must assure that their policies, practices, staff recruitment and service delivery are sensitive and responsive to the needs of culturally, racially and linguistically diverse children and families. The provider will strive to obtain staff and establish community linkages, which are representative of, and effectively support, the cultural, racial and linguistic characteristics of the population served.

XXII. Ethical Standards

Providers will follow the ethical standards of their respective agencies and practitioners will adhere to the ethical standards of their respective professions. At a minimum the standards shall address the following:

1. Ensure the dignity and worth of all clients by acting with integrity and respect;
2. Serve the identified needs of clients and their families to the best of staff abilities, without knowingly using forms of treatment that are not safe, effective, efficient and in the clients' best interests;
3. Utilize seclusion and restraint procedures, in accordance with the laws of the State of Connecticut (General Statutes - Chapter 814e) rarely and as a last resort;
4. Provide uniform standards of care and conduct regardless of any client's race, ancestry, color, age, gender, religion, marital status, disability, national origin, mental disorder, sexual preference, or ability to pay; and
5. Ensure that the client's confidentiality is maintained.

XXIII. Child and Family Rights

The provider shall have a written policy outlining clients' rights and responsibilities appropriate to the service. Families/caregivers will be notified of this policy at an appropriate time during the intake process. This policy shall include the following.

1. Informed Consent. The provider shall notify families/caregivers of their right to participate in service and discharge planning, including the right to refuse or question any services offered.
2. Confidentiality. The provider shall inform families/caregivers of their right to confidential services. In addition, all clients should be encouraged to respect the confidentiality of others who are participating in the program. All clients and guardians must also be informed of the limits of confidentiality including mandated reporting, risk of injury to self or others, and disclosure by court order.

3. Grievance Procedure. A grievance policy which clearly outlines the grievance process will be established by each provider. All clients shall be informed that this policy exists as part of their general rights and responsibilities.

4. Access to Records. Clients/legal guardians, upon request and within applicable statutory authority, will be provided with access to and/or copies of their records. The provider shall educate families relative to the right to access records.

XXIV. Reporting Requirements

The provider will submit to DCF the required financial, programmatic and other reports necessary for establishing payment schedules and grant formulae; monitoring and evaluating services; tracking service utilization, measuring program performance, and monitoring child/family outcomes. These reports shall be submitted according to the timeframes established by DCF.

Incidents Reporting

The provider shall maintain an Incident Reporting System and develop a form to monitor activity that may impact the health and safety of clients and staff. An incident report will be completed for all EDT-related accidents, incidents or unusual occurrences involving staff and/or clients. The provider shall determine the content and specific execution of the form as well as the protocol for access to these incident reports.

Staff is mandated reporters under the laws of the State of Connecticut (Conn. Gen. Stat. 17a-101(b)). In accordance with this mandate, it is required that EDT staff comport with the specific steps and tenets outlined by the applicable statutes. At a minimum, EDT providers must make a report to the DCF Hotline and complete a Report of Suspected Child Abuse/Neglect (DCF-136) for any child that they suspect has been abused or neglected. The DCF Administrator should be notified if there is a serious injury or death of a child in their custody or guardianship. They should also be notified if there is an issue of the safety of one of their children. If circumstances warrant, a DCF Area Office's on-call Administrator may be paged by the Hotline.

XXV. Quality Assurance

A. Quality Assurance Plan

In order to monitor program effectiveness and to continuously improve the quality of services, an internal quality assurance plan shall be in place and shall include a review of the behavioral health data that is collected, the consumer satisfaction survey responses, and any pertinent findings from service delivery.

B. Consumer Satisfaction Surveys

The provider shall conduct periodic consumer satisfaction surveys. The information gathered will be analyzed by the Program Director and considered as part of the overall continuous quality improvement plan.

The surveys must be administered at the end of services, and at other times as determined by the provider. The method for administering surveys will be determined by the provider; however surveys must be disseminated to all participants prior to or within 14 days following the date of discharge.

The format and design of the satisfaction surveys will be determined by the provider. However, the following standard areas of inquiry should be incorporated into all surveys and assessed to determine quality improvement activities.

1. Level of satisfaction relative to communication about the program and the progress of child/family;

2. Timeliness of responses to client concerns/complaints;

3. Level of satisfaction regarding family/caregiver involvement in treatment planning, treatment, and discharge planning;

4. Most and least helpful aspects of services; and

5. Level of satisfaction regarding the child/family's cultural needs.

C. Performance Measures

The provider will be required to maintain, track, evaluate and report specified performance measures. These will include child, family and system indicators.