



Performance Standards

Summer Therapeutic Activities Program

Performance Standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performances, to increase the consistency of service delivery and to improve outcomes for members

Disclaimer: These Performance Standards should not be interpreted as regulations. Entities providing services as part of the HealthChoices program must first be enrolled in the Pennsylvania Medical Assistance program as the appropriate provider type. Providers must then comply with all applicable Pennsylvania laws, including Title 55, General Provisions 1101, licensing program requirements and any contractual agreements made with Community Care Behavioral Health Organization in order to be eligible for payment for services.

SUMMER THERAPEUTIC ACTIVITIES PROGRAM (STAP)

PERFORMANCE STANDARDS

INTRODUCTION

On January 1, 1994, the Department of Public Welfare (DPW) added Behavioral Health Rehabilitation Services (BHRS) to the Medical Assistance (MA) fee schedule as a new outpatient psychiatric mental health service. BHRS includes several community based behavioral health services that MA recipients under the age of 21 may receive if they meet medical necessity as a result of a diagnosis of mental illness or serious emotional disturbance (SED). In general, BHRS are available for children who present with social, emotional, or behavioral issues that result in impairment that substantially interferes with or limits the children's role or functioning in family, school, or community activities. BHRS are reasonably expected to improve or stabilize certain behavioral symptoms exhibited by children. BHRS are not intended to assist children and their families in dealing with the normal and expected behaviors related to the child's stage of growth and development.

BHRS are part of the comprehensive mental health system of care for children, adolescents and their families approved by Congress in 1984 for the Child and Adolescent Service System Program (CASSP). This children's system of care is based on a well defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are summarized in six core statements also known as the CASSP Principles:

- *Child centered:* Services meet the individual needs of the child, consider the child's family and community contexts, and are developmentally appropriate, strengths based and child specific.
- *Family focused:* Services recognize that the family is the primary support system for the child and participates as a full partner in all stages of the decision making and treatment planning process.
- *Community based:* Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community.
- *Multi-system:* Services are planned in collaboration with all the child serving systems involved in the child's life.
- *Culturally competent:* Services recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of the child's and family's ethnic group.
- *Least restrictive/least intrusive:* Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

On April 25, 1996 DPW released MA Bulletin 50-96-03 adding STAP for children and adolescents to the selection of available BHRS. STAP provides a range of age

appropriate specialized therapies which may include art, music, dance and movement, play, recreational or occupational therapies, and/or therapeutic activities, which may include more traditional structured therapeutic group activities, in a group format. These groups are designed to aid in the development of interpersonal relationships, daily living, decision making, problem solving, and coping skills for children and adolescents meeting medical necessity. STAP requires that such group activities are provided by appropriately qualified staff.

STAP services are generally provided in an outdoor environment for the purpose of furthering individualized therapeutic goals as described in the child's individualized treatment plan. STAP services are integrated into the overall mental health treatment of the child and are meant to be all-inclusive during the program hours.

These performance standards are the result of a series of meetings facilitated by Community Care, with representatives from network BHRS providers, county representatives, and representatives from oversight entities. The goal of the meetings was to develop standards to expand upon the current regulations. Input from other stakeholder groups, including family and member representatives, was also sought prior to the finalization of this document. These standards are intended to clearly articulate Community Care's expectations of BHRS providers offering STAP and define the parameters of reasonable standards of practice for the provision of these services. The standards are intended to provide a foundation and serve as a tool to promote continuous quality improvement and progression toward best practice performance, to increase the consistency of service delivery, and to improve outcomes for children, adolescents, and their families. In some instances, the standards set the bar higher than baseline performance standards. Overall, this is reflective of the current level of quality within the network and the commitment of all involved stakeholders to continually strive to improve the quality of BHRS.

These standards should not be interpreted as regulations, but rather a progression towards a better performance standard. These standards will not be utilized as a means of requiring or prohibiting specific interventions for specific individuals. Each child or adolescent receiving STAP services will have a uniquely developed treatment plan, which identifies strengths and addresses needs.

BHRS providers are expected to monitor adherence to the standards and to take corrective actions where indicated to comply with the standards. Community Care will assess compliance to these performance standards during medical chart reviews conducted by our quality staff and will include feedback through the comprehensive provider evaluation process (CPEP). As Community Care and our providers implement monitoring activities to assess compliance with the standards and establish baseline measures, Community Care may move to pilot less intense utilization review processes or alternative reimbursement methodologies with high quality BHRS providers.

SERVICE DESCRIPTION

Summer Therapeutic Activities Program (STAP)

STAP is a voluntary mental health treatment service for children and adolescents. Summer therapeutic activities programs provide a range of age appropriate specialized therapies (defined as art, music, dance and movement, play, recreational or occupational therapies) which require appropriately qualified staff and/or therapeutic activities (defined as the more traditional structured therapeutic group activities designed to aid in the development of interpersonal relationship, daily living, decision making, problem solving, and coping skills). These services are generally provided in an outdoor environment for the purpose of furthering individualized therapeutic goals as described in the individualized treatment plan. Summer therapeutic activities programs are expected to be integrated into the overall mental health treatment of the child. Parental participation is recommended to occur one time a week with a focus on informing parents of the skills being taught to their child and encouraging the transfer of these skills to the home environment.

The program should include both specialized therapies as well as indoor/outdoor activities. Skill building activities such as feelings identification, social skills, anger control, self-esteem, goal setting, problem solving, conflict resolution, and effective communication should occur a minimum of one time a day. Positive practice of skills should be modeled and encouraged by staff throughout the week. A child with immediate individual needs should be able to take part in a 1:1 session with a staff person to resolve the situation. The program should also include both structured therapeutic activities and community integration such as going to the library, adopt a park, swimming, factory tours, visiting state park educational centers, visiting the environmental center, and other activities as available in the community. The main objectives for STAPs are to provide structured activities in a therapeutic social setting, encourage the building of new skills, enhance positive practice of previously learned skills, and an overall goal of generalization of skills to the home, school, and community.

Core Services of a STAP include:

- A range of age appropriate specialized therapies and structured therapeutic activities including, but not limited to arts and crafts, music, dance and movement, drama, pet therapy, equestrian therapy, play therapy, recreational or occupational therapies, sporting events, interpersonal relationships, socialization, life skills, decision making, feelings identification/expression, assertiveness training, cognitive behavioral therapy, effective communication, problem solving, coping skills, anger control, self-esteem building, conflict resolution, team building, behavioral therapy, and goal setting.
- Skill building activities such as feeling identification, social skills, anger control, self-esteem, goal setting, problem solving, cognitive behavioral therapy, assertiveness training, conflict resolution, and effective communication must occur a minimum of one time a day. Positive practice of skills should be encouraged and reinforced throughout the week.

- Child centered interventions, including individual and group therapy using a strengths based approach, which vary according to the individualized needs of the child.
- Community integration activities, which may occur in neighborhood centers, recreational areas, local businesses, and volunteer agencies. These activities may include picnics, awards ceremonies, friendship practice assignments, career exploration, etc. The purpose of the community integration activities is to assist the child in developing appropriate behaviors and responses in the community context.
- The program should include both indoor and outdoor activities for the purpose of furthering individualized therapeutic goals as described in the child's treatment plan.
- Parental participation is required to occur at least one time per week with a focus on attainment of treatment individualized treatment goals, informing parents of the skills being taught to their children, and encouraging the transfer of these skills to the home environment.
- Children with immediate individual needs (aggression, isolation, dangerousness, abuse, excessive sadness/crying, and repeated peer conflicts) must be able to take part in a 1:1 session with a staff person to address or resolve the situation. This 1:1 interaction must be documented in the child's daily progress note.
- Any program in excess of three hours must provide time for lunch. A snack time is also recommended for programs of three hours duration. The program must clearly define the process for making lunch available, e.g., child brings own lunch/snack, or the lunch/snack is provided by program, the time lunch will occur, etc. If children are required to bring their lunch, nutritional food and beverage must be available for any child that forgets or does not bring his/her own food or beverage.
- Transportation to and from the program must be arranged prior to the start date of the camp and may include transportation from provider, parent, Medical Assistance Transportation Program (MATP), school district, public transportation, or any other appropriate arrangement.
- STAPs will make medications available to children in the program as per the provider's policy. The provider's policy for medication availability must be discussed with each parent/child prior to the child's attendance in the program.
- Specialized needs will be addressed on an individual basis with the parent and child, e.g., assistance with toileting, feeding tubes, diabetic needs, and disabilities.

The STAP Site: The site in which a STAP is held must be appropriate to the age and developmental needs of the children served. The site must meet all applicable federal, state, and local requirements for safety, fire, and health.

The Program Requirements for STAP: According to MA bulletin 50-96-03, new STAP providers must submit a service description following the procedures and requirements of this bulletin to the Office of Mental Health and Community Care. For subsequent years, if there is **no change** to the most recently submitted and approved STAP service description, the annual service description does not need to be submitted to the state for review and approval. However, if there are **any changes** to the most recently approved STAP service description, including a request for a fee above that on the MA fee schedule, a new service description must be submitted to the state for review and

approval at least 45 days prior to the opening of the program or before services are provided. All service descriptions submitted must follow the procedures and requirements as outlined in MA Bulletin 50-96-03.

Providers already approved by the Office of Mental Health and Community Care are only required to submit a program description to Community Care if they make a change to the current service description or are requesting a rate above the rate previously approved by Community Care. If the program has not changed from the previous year and the provider is willing to accept the previous approved rate of reimbursement, only notification to Community Care is required.

All STAPs must be consistent with the principles of Pennsylvania's Child and Adolescent Service System Program (CASSP).

The Type of Children in a STAP: Summer therapeutic activities programs are a voluntary mental health program for children and adolescents under the age of 21 with an SED who are receiving MA through DPW. Children enrolled in STAP must also meet MNC as determined by DPW for this type of service.

Average Length of Stay: As per the regulations, and depending on the treatment needs of the child, STAPs are child specific and may be provided for a minimum of three hours and a maximum of six hours per day. A child specific service period is a minimum of two weeks with a maximum of five weeks per calendar year, unless otherwise approved by Community Care.

Expected Member to Staff Ratio: A summer therapeutic activities program unit of one to 12 children must have the following clinical staff:

- One mental health professional with a graduate degree in a mental health field and one year of experience in a CASSP system. If specialized therapies are to be provided, the mental health professional must meet the qualifications as defined above.
- One mental health worker with a bachelor's degree and one year experience in a CASSP system.

A summer therapeutic activities program unit of 13 to 18 children must have the following clinical staff:

- One mental health professional with a graduate degree in a mental health field and one year of experience in a CASSP system. If specialized therapies are to be provided, the mental health professional must meet the qualifications as defined above.
- Two mental health workers with a bachelor's degree and one year experience in a CASSP system.

Additional full or part time clinical staff may include:

- Nationally credentialed art, music, dance and movement, play, recreational, or occupational therapist.
- Psychologist and/or psychiatrist.
- Therapeutic aides.

A summer therapeutic activities program unit may not exceed 18 children, but a summer therapeutic activities program may be comprised of multiple units.

Other Staff Requirements:

If a summer therapeutic activities program or unit uses specialized therapies, e.g. art, music, dance and movement, play, recreational, or occupational therapies, clinical staff must have appropriate qualifications in those therapy areas. Appropriate qualifications include:

- A nationally credentialed art, music, dance and movement, play, recreational or occupational therapist.
OR
- A mental health professional with 12 credit hours in the specialized therapies and at least one year of supervised experience in the use of specialized therapies.
OR
- A mental health professional supervised by a nationally credentialed activities therapist, or any other comparable combination of education, training, and/or experience.

Billing for STAP: STAP is billed on a rate per hour basis per child. The MA fee schedule rate for STAP is \$9.50 per hour; however, this is negotiable with both the state and Community Care pending provider request. All requests for an enhanced rate must be approved by the state and/or Community Care. Requests must be accompanied by a service description, program schedule, and program budget.

REFERRAL PROCESS

Access Standards

Upon receipt and acceptance of a referral for an initial evaluation, evaluators or facilities providing evaluation services are expected to schedule an appointment with a child and family within seven days of the referral date. In HealthChoices, access to routine care is expected to be provided within seven days. According to MA Bulletin 01-01-05, 29-01-03, 33-01-03, 41-01-02, 48-01-02, 49-01-04, 5001-03 DPW expects each authorized BHRS to begin no later than 60 days after the initial request for services, unless the evaluation prescribes different timeframes. An initial request for service may be made by telephone, in person, or in writing. In order to meet this timely access to services standard, it is necessary for evaluators to complete evaluations in a timely manner.

If an evaluator offers an appointment within seven days, but this date and time is not agreeable with the family, and all agree to a date outside of the access standard, the

evaluator is expected to document that an appointment within the access standard was offered to the family and the reasons for the date chosen.

When an evaluator is unable to offer an appointment for an initial evaluation within seven days, the family is to be given information about available options. The evaluator may offer the family appointment options outside of the access standard. The evaluator is also expected to inform the family that other evaluators may be available to offer an earlier appointment date. If the family chooses to accept an appointment outside of the access standard, the evaluator documents this choice. If the family would like to seek a referral to another evaluator, Community Care is to be contacted. Community Care will facilitate a referral to an evaluator that is able to meet the access standard.

Best Practice/Life Domain Evaluation

Prior to receiving STAP services, a child must receive a Best Practice/Life Domain evaluation conducted by a licensed psychiatrist or psychologist recommending STAP as the least restrictive, least intrusive treatment necessary to meet the behavioral health needs of the child. An initial Best Practice/Life Domain evaluation expires after 60 days and re-evaluations after 45 days. The BHRS packet requesting STAP must be received by Community Care within 60 (initial request) or 45 (continued stay request) days from the day of the Best Practice evaluation. The outline for the Best Practice/Life Domain evaluation must follow the *Life Domain Format for Psychiatric/Psychological Evaluations, 2nd edition*, as defined by Dr. Hodas in the Guidelines for Best Practice in Child and Adolescent Mental Health Services, Copyright 2001, can be seen in [Addendum I](#). All Best Practice/Life Domain evaluations must also include a mental illness/substance abuse (MISA) screen, a screen for domestic violence and abuse, and a global standardized functioning measure.

Process for Referral to STAP

- A structured program is suggested for the summer months by the parents, psychologist, MT, BSC, teacher, camp staff, intermediate unit, case manager, therapist, psychiatrist, primary care physician (PCP), Children & Youth Service (CYS), county CASSP system, and/or county MH/MR.
- The current behavioral health provider or case manager (if applicable) reviews the potential options for summer camp with the child and family and school (if the school has made the referral):
 - Can the child attend a community based camp on his/her own without support?
 - Is the child in need of an extended school year (ESY) program?
 - Does the child require the support of behavioral health staff in a community based camp?
 - Is the child in need of a self-contained behavioral health camp, e.g., STAP?
- If STAP is recommended, the current behavioral health provider or case manager makes the referral to a licensed psychologist or psychiatrist to prescribe this service.

- A licensed psychologist or psychiatrist prescribes STAP in one of the following ways:
 - For *children without a current BHRS authorization*, STAP is prescribed via a face-to-face Best Practice/Life Domain evaluation.
 - For *children without autism/PDD with extended authorizations, i.e., authorizations greater than six months*, STAP must be prescribed via a face-to-face addendum by the original prescriber.
 - For *children already approved for BHRS* during the camp time period, (with an authorization of six months or less) the prescriber collaboration form may be used to add STAP to the child's treatment plan.
- A STAP provider is chosen by the family and the camp slot is secured.
- An interagency service planning team (ISPT) meeting is held to address the addition of STAP to the treatment plan.
- A treatment plan is developed or updated to include STAP.
- A request for authorization for STAP is made via one of the following:
 - A full BHRS packet for STAP is sent to Community Care for authorization for a child new to BHRS (a child not already receiving BHRS).
 - An addendum for STAP for children with autism/PDD with extended authorizations, a plan of care summary, ISPT meeting summary and treatment plan are sent to Community Care for authorization.
 - A prescriber collaboration form, plan of care summary, ISPT summary and updated treatment plan are sent to Community Care for authorization for children with BHRS already approved for six months or less.
- Community Care determines medical necessity.
- If medical necessity is met for the level of service requested, the service is approved.

MISA Requirements

In 1999, the report of the MISA Consortium emphasized the fact that early identification of the existence of co-occurring disorders is crucial to ensuring that individuals receive appropriate behavioral health services. The report of the MISA Consortium recommended an initial screening process and identified essential components of a MISA assessment, to be conducted at the point of entry into either the mental health or the drug and alcohol service delivery system.

Community Care is committed to furthering the implementation of the recommendations outlined in the MISA Consortium Report. Therefore, it is the expectation of Community Care that all members 12 years of age and older be screened for the presence of symptoms of mental health issues and issues related to alcohol and other drug usage. For BHRS evaluations and re-evaluations, providers are expected to screen for the presence of mental health and substance abuse issues. The purpose of the screening process is to assess the member's immediate needs and whether emergency services are warranted. It is also our goal to ensure that each member is screened and then referred for an assessment for co-occurring disorders when indicated.

Consistent with the 1999 MISA Consortium Report, the MISA screening process is to be conducted by appropriately trained individuals and is to identify:

- Alcohol and other drug issues:
 - Substances used and intensity of use
 - Likelihood and severity of withdrawal
 - Medical and behavioral risk secondary to intoxication
- Mental health issues:
 - Suicidal, homicidal ideation/intentions/plans/history
 - Impairment of function and/or judgment
- Medical issues:
 - Pregnancy
 - Conditions posing an immediate risk of harm to self or others
 - Current medications and recent ingestions of any non-prescribed drugs or alcohol
- Special needs:
 - Barriers to access
 - Environmental risks

When contacting Community Care to request an initial authorization for services for a member, the care manager will ask if a MISA screening has been conducted for the member in question. All providers are expected to screen for the need for mental health services **and** drug and alcohol services for each individual that approaches them for treatment and to assist the member in accessing necessary services. Providers are also expected to re-assess for the existence of co-occurring disorders at each re-evaluation for BHRS. When conducting routine medical chart audits, Community Care will determine provider compliance with this expectation for all levels of care. In addition, at site visits by our Credentialing Department, Community Care will ask for verification that providers have a policy and procedure in place that demonstrates the provider's commitment to assess all of the individuals they serve for mental health and substance abuse issues.

Family Choice

After an evaluation or assessment is completed recommending STAP, the child and family must choose a BHRS provider to deliver this service. According to the MA Bulletin, "all MA recipients have the freedom to select the providers from whom they receive their behavioral health services without undue influences. Providers **must** comply with all federal and state regulations regarding an MA recipient's freedom of choice and should in no way attempt to alter or to influence the recipient's decision and choices."

Once a provider has been chosen the provider will schedule an ISPT meeting within seven to 14 days of the evaluation or assessment recommending STAP.

Interagency Service Planning Team (ISPT) Meeting

Within seven to 14 days after the Best Practice/Life Domain evaluation has been completed, an ISPT meeting is held. The main goal of this meeting is to gather input from all entities involved with the child including: the child, his/her legal guardian, community affiliates as defined by the child/family, a school representative (required if services are to occur at school), all behavioral health service providers involved with the child, the Community Care care manager, and the county MH/MR representative to develop a comprehensive treatment plan. The ISPT meeting provides a forum in which the child's unique needs can be addressed and the family and child's voice heard. By drawing on the contributions of individuals with multiple perspectives who best know the child, the meeting can enable a unified approach, with a single plan and offer a structure for the potential attainment of unity among all involved stakeholders.

Once the team members agree on STAP as the least restrictive/intrusive level of care that can meet the child/family's needs, the treatment goals are defined. The treatment plan is then written by the STAP provider and approved by the family. An effective treatment plan should be both informative and practical. A person reading a treatment plan should be able to grasp the major concerns and how they are being addressed. As a "work plan," the initial treatment plan identifies the work to be done. Subsequent ISPT meetings are held to further develop the treatment plan and identify what is currently being done, what has recently been achieved and work and services planned for the future. By defining goals and objectives which can be monitored, the treatment plan becomes an instrument of accountability. The team can actively track identified goals, objectives, outcomes, and make modifications to the treatment plan as needed.

ADMISSION PROCESS

Targeted Member/Client Population for STAP

A child with a behavioral health diagnosis, who is in need of a structured therapeutic setting for at least two days a week during the summer months to encourage the building of new skills, enhance positive practice of previously learned skills, and to generalize these skills to the home, school, and community is often the recipient of STAP. Due to the risk of displaying physically aggressive or unsafe behaviors on a near daily basis, the child is less likely to be accepted into or able to successfully complete a community based summer camp program. STAP is aimed at assisting the child with the development of interpersonal relationships, daily living skills, decision making skills, problem solving skills, and/or coping skills via an individualized treatment plan focusing on these STAP goals.

Exclusions to STAP include:

- A child with active suicidality, homicidality, and/or active psychosis.
- A child with an uncontrolled medical condition (such as seizures and diabetes) who cannot be adequately monitored outside of a medical setting.

Medical Necessity Criteria (MNC)

According to OMAP bulletin 50-96-03 the MNC for STAP is as follows:

- To participate in a summer therapeutic activities program, a child must have a documented need for the program, prescribed or recommended as medically necessary by a licensed physician or licensed psychologist, as reflected in a current (within 45 days) psychiatric or psychological evaluation that supports a DSM IV diagnosis, Axis I through V, or an *ICD-9-CM* diagnosis along with Axis III through V of the *DSM IV*.
- The program must be recommended by a county interagency service planning team with representation of the county mental health program and, if applicable, the county children and youth agency or juvenile probation program and, if applicable, the managed care program; representatives from all other community services systems currently providing service to the child and family, including the education system; the child and the parent and/or legal guardian; and the prescribing physician or psychologist when possible. The team meeting must be conducted before service delivery begins, and the team's recommendation must be maintained in the child's case record.

STAFFING REQUIREMENTS

STAP Staff Requirements, Qualifications, Training, and Supervision

Minimal staff requirements for STAP units with one to 12 children:

The STAP must be a separate, identifiable organizational entity with a director/supervisor and staff assigned to the program unit during the hours of operation. The organizational structure of the program shall be described in an organizational chart. When this summer program is a component of a larger organizational structure, the director/supervisor of the program shall be identified and his or her responsibilities clearly defined.

The STAP director/supervisor may direct multiple STAP units and/or other behavioral health programs within a larger organizational structure. The unit director/supervisor must be a mental health professional with a master's degree in a behavioral health field and two years of clinical experience, including one year of clinical supervision and one year experience in a CASSP system. The one year of clinical supervision may be concurrent with the one year of CASSP experience. A unit director/supervisor may also serve as the clinical staff mental health professional if this individual meets the criteria for both the unit director/supervisor and the mental health professional.

If a summer therapeutic activities program or unit uses specialized therapies, e.g., art, music, dance and movement, play, recreational, or occupational therapies, clinical staff must have appropriate qualifications in those therapy areas. The service description must demonstrate that clinical staff is qualified to provide the activities and/or therapies which will be included in the STAP. Appropriate qualifications include; a nationally

credentialed art, music, dance and movement, play, recreational or occupational therapist, **or** a mental health professional with 12 credit hours in the specialized therapies and at least one year of supervised experience in the use of specialized therapies, **or** a mental health professional supervised by a nationally credentialed activities therapist, **or** any other comparable combination of education, training, and/or experience.

A summer therapeutic activities program unit of one to 12 children must have the following clinical staff:

- One mental health professional with a graduate degree in a mental health field and one year of experience in a CASSP system. If specialized therapies are to be provided, the mental health professional must meet the qualifications as defined above.
- One mental health worker with a bachelor's degree and one year experience in a CASSP system.

A summer therapeutic activities program unit of 13 to 18 children must have the following clinical staff:

- One mental health professional with a graduate degree in a mental health field and one year of experience in a CASSP system. If specialized therapies are to be provided, the mental health professional must meet the qualifications as defined above.
- Two mental health workers with a bachelor's degree and one year experience in a CASSP system.

Additional full or part time clinical staff may include:

- Nationally credentialed art, music, dance and movement, play, recreational, or occupational therapists.
- A psychologist and/or psychiatrist.
- Therapeutic aides.

All staff working with the children must have Act 33 (Pennsylvania Child Abuse History Clearance), Act 34 (Pennsylvania State Police Criminal Record Check), and FBI Background Check prior to the provision of services. The provider must also have a policy in place that requires Act 33/34 clearances and FBI Background Check for employees working with children ages 18 years and under.

A minimum of a 1:4 or 1:5 staff to child ratio is recommended for safety and therapeutic coverage.

STAP Staff Training:

Master's level staff: Agencies typically utilize master's level staff from already existing behavioral health programs, e.g., mobile therapists or outpatient therapists for the STAP director, supervisor and/or mental health professional positions. If a master's level staff

is newly hired for a camp position, a minimum of one week of training and orientation including the following topics is recommended:

- Professional ethics, conduct, and legal issues, including child protective services and mandated reporting, and confidentiality.
- Understanding CASSP Principles and implementing and supporting those principles in actual clinical practice.
- The use of community resources to support the child/adolescent/family.
- Crisis intervention, behavior management, and safety.
- Overview of serious emotional disturbance and other behavioral needs in children and adolescents.
- Collaboration with families.
- Normal child/adolescent development.
- Behavior management skills.
- CPR, first aid, universal precautions, and safety.
- Documentation skills.
- Psychotropic medications, including common side effects.
- Leadership.
- Team building.
- Group therapy skills.
- Policies and procedures specific to the agency.

Bachelor's level staff and therapeutic aides: must have a minimum of one week of orientation/training including topics such as:

- Leadership.
- Team building.
- Group therapeutic skills.
- Policies and procedures specific to the agency.
- Other training topics as identified in the July 1, 2001 MA Bulletin for therapeutic staff support, including but not limited to:
 - Professional ethics.
 - Conduct and legal issues, including child protective services and mandated reporting, and confidentiality.
 - Understanding CASSP Principles and implementing and supporting those principles in actual clinical practice.
 - The use of community resources to support the child/adolescent/family.
 - Crisis intervention, behavior management, and safety.
 - Overview of serious emotional disturbance and other behavioral needs in children and adolescents (with particular emphasis on the specific diagnoses of the children/adolescents with whom the staff may be working).
 - Collaboration with families.
 - Normal child/adolescent development.
 - Behavior management skills.
 - CPR, first aid, universal precautions, and safety.
 - Documentation skills.
 - Psychotropic medications, including common side effects.

Staff Supervision:

- Master's level staff must receive weekly supervision with the unit director.
- Bachelor's level staff must receive weekly face-to-face individual supervision with the master's level supervisor; weekly team meetings, ongoing coaching and mentoring by the master's level therapist and other master's and/or bachelor's level staff in the program.
- Therapeutic Aides must receive weekly individual supervision with the master's level supervisor or bachelor's level primary counselor; weekly team meetings, ongoing coaching and mentoring by the master's level therapist and other master's or bachelor's level staff in the program.

Responsibilities of Clinical Staff:

- Master's level staff responsibilities include; facilitating groups; conducting individual sessions with a child as needed; development of treatment plans; assisting the team with the implementation of the treatment process; supervision of bachelor's level staff and aides; conducting functional assessments of children; weekly contact with each child's parent/guardian; feedback to family concerning the child's progress; leading the ISPT meetings; developing an aftercare plan for the child, and implementing behavioral interventions.
- Bachelor level staff responsibilities include; planning and implementing the therapeutic group activities, co-leading group therapy, implementing behavioral interventions, facilitating the therapeutic milieu, maintaining safety of the milieu, documentation in progress notes, contacting families as directed by the supervisor, and oversight of the therapeutic aides.
- Therapeutic Aides are to assist in the implementation of therapeutic activities, implementation of behavioral interventions, assisting in the facilitation of the therapeutic milieu, assisting in maintaining safety of the milieu, documentation in progress notes, and contacting families as indicated by the supervisor.

TREATMENT PLANNING PROCESS

Interagency Service Planning Team (ISPT) Meetings

The interagency team, through its formal meetings and its follow up activities, is expected to play a key role in planning, implementing, and monitoring the child's treatment. The ISPT meeting has more than regulatory relevance; it embodies CASSP Principles in action. For example, the ISPT provides a forum in which the child's unique needs can be addressed and the family's and child's voice heard (CASSP Principles #1 and 2: child centered and family focused). By drawing on the contributions of individuals with multiple perspectives who know the child, the ISPT can enable different mandates and interests to be reconciled and a unified approach, with a single plan developed (CASSP Principle #4: multi-system). In addition, the team draws upon natural supports and community resource persons (CASSP Principles #3 and 5: community based and

cultural competence). The clinical focus of the team plan is to help the child remain at home and in the community whenever possible, and to promote self-sufficiency as part of treatment (CASSP Principle #6: least-restrictive/least intrusive).

An effective ISPT meeting has two principal goals that set into motion an ongoing process to address the unique needs of the child and family. These goals are: a) to create a context for restoring hope to the child and family and b): to promote constructive, collaborative treatment planning to benefit the child and family.

In Pennsylvania, the ISPT meeting occurs after a Best Practice/Life Domain evaluation has already occurred, basic information has been gathered, and STAP has been recommended as the least restrictive level of behavioral health treatment necessary to adequately meet the child and family's mental health needs. The initial ISPT meeting takes place prior to the initiation of STAP. At minimum, the following individuals should be invited to this meeting: the child, if age 14 or older, the child's legal guardian, a representative from the child's school, the child's current behavioral health service provider, the care manager from Community Care, and the county MH/MR representative. An exception may involve the participation of school representatives if the parents/guardians object and the child is not attending STAP as part of an Extended School Year (ESY) Program. Another possibility is that the family desires limited participation by a particular system representative. This situation may arise when the family wants the school to participate but prefers that school staff not have extensive information about home events. In this situation, it may be appropriate, through a prior-arranged process, to invite the school representative(s) to "visit" with the rest of the team to provide information about the child in the school setting sometime at the beginning of the meeting and then leave. In addition, every effort should be made to obtain the participation of the prescriber at this meeting. Ideally, this occurs face-to-face. However, if this is not feasible, then telephone participation is preferable to none at all. If the ISPT agrees that STAP is the most appropriate treatment option, the provider develops the initial treatment plan. If the ISPT determines that STAP does not appear appropriate for the child and family, the case manager makes a referral to another level of care and/or supportive service deemed more appropriate.

Additional ISPT meetings take place during specific time increments to further develop the treatment plan at different stages in treatment. The initial ISPT meeting functions to develop the initial treatment plan. Subsequent ISPT meetings are held every four to 12 months as determined by the interagency team to update the treatment plan for each consecutive authorization period. In accordance with bulletin 01-0105, 29-01-03, 33-01-03, 41-01-02, 48-01-02, 49-01-04, 50-01-03, an ISPT meeting is required before BHRS are initiated and annually thereafter unless:

- Any member of the team, including the parent/responsible caregiver, requests that the team convene sooner, based on the needs of the child/adolescent (please note that the care manager from Community Care is a member of the treatment team).
- The child is receiving (or expected to receive) services from three or more service delivery systems, e.g., mental health, mental retardation, children and youth, juvenile justice, drug and alcohol, and education. In this instance an ISPT meeting and

treatment plan update is required at least every four months or more frequently if requested by any member of the treatment team.

In order to avoid being “just one more meeting” that exacerbates feelings of futility, the ISPT meeting should not begin with another recitation of “what’s wrong” with the child/family or a litany of the most pressing problems. Similarly, the meeting need not elaborate on every past service failure. It is also important to be realistic about time expectations. In most instances, an ISPT meeting cannot be completed in a single hour. It is also appropriate to guarantee that the appropriate stakeholders are present at the ISPT meeting because informed and meaningful decisions cannot be made until the right people are at the table. The child’s parents/guardians should be encouraged to invite anyone to the meeting that will provide support to the family and child. Professionals should take into consideration that families will not automatically understand that they can invite community support persons to an ISPT meeting unless they are informed of this option and encouraged to do so beforehand.

To be effective, an ISPT meeting needs to be guided by established ground rules and stages. Such structure helps set a constructive tone to the process, ensure that key issues are addressed, and promote effective use of time. Since there is more than one effective meeting protocol, the primary issues are a) that there is a protocol and b) that an individual familiar with it be designated as the meeting facilitator. When this occurs, the meeting is likely to flow smoothly. The meeting facilitator may be the same individual who invites and recruits participants or a different individual. The identification of this individual is best made prior to the start of the actual meeting. The meeting facilitator may be the case manager, a therapist or other mental health professional, a wraparound coordinator, a school counselor, or a family member. It is the responsibility of the meeting facilitator to start the meeting, explain the protocol, initiate introductions, and make other initial comments, as indicated.

Most ISPT protocols share elements:

Early discussion of strengths

Following the initial team building stage of the ISPT meeting, substantive discussion of the child and family should begin with strengths, not with problems, concerns, limitations, or failures. A meeting that begins with a focus on pathology is likely to activate feelings of pessimism.

Concern with child in multiple life domains

Regardless of the child’s specific presenting concern, the interagency team is interested in the whole child, understood in multiple life contexts (also known as life domains) and also within a developmental framework. Therefore, a treatment plan that only addresses specific problematic behaviors of the child without also promoting the child’s attainment of age appropriate functioning is not consistent with a wraparound approach. Life domains may include: spiritual, family, community, friends/social, health, emotional, legal, work, educational, safety, cultural, and others.

The key point is that an appropriate group of life domains be addressed, to ensure that each child is considered comprehensively, not just in terms of behaviors, symptoms, and disorders. When a child is considered comprehensively, information comes directly from the child and family, through the psychiatric or psychological interview, and the ISPT, not solely through written information and the judgment of professionals.

Avoidance of premature discussion of services

Service decisions, when appropriately determined, are made near the end of the meeting, not at the outset. It is only after identifying strengths, goals, barriers, and available resources at hand that a team is ready to consider professional services. Premature discussions of service, even if well intentioned, bypass the important information gathering and team building processes.

Active participation by family

An effective ISPT meeting is one in which family members offer their points of view early in the process. Active and early family participation is important not only because of the family's valuable perspectives offered but also as a way to signal to the child and family that this meeting is for them and that they are equal participants in the process. If the parents/guardians and child do not offer their ideas spontaneously, it is the responsibility of the meeting facilitator to enlist their participation in a nonthreatening manner.

Inclusion of a group envisioning process

The reason for the formation of the interagency team and the convening of the ISPT meeting is the presence of a child, functioning unsuccessfully in the current setting, who is at risk of endangerment and/or more restrictive placement and more intrusive treatment. For an ISPT meeting to be effective and for wraparound to be successful, there needs to be a collective capacity of team members to move beyond the present in an imaginative manner, in order to envision desired outcomes.

There is delineation of tasks and responsibilities prior to the end of the meeting

Since the goal of the ISPT meeting is to identify a plan to help the child and the family, it is essential that there be clarity about the tasks and responsibilities of various team members including the child and parent/guardian.

Other interagency tasks prior to ending the meeting include the following:

- Identify the individual responsible for completing the STAP treatment plan with the child and family.
- Identify the individual responsible for completing the necessary paper work and submitting the formal request.
- Identify the individual responsible for completing the meeting notes and distributing them to all team members.
- Identify the individual responsible for contacting team members absent from the meeting, to keep them in the loop.
- Identify the individual(s) responsible for contacting community agencies and natural supports identified during the meeting.

- Identify the individuals responsible during a crisis, and the nature of their specific roles.
- Identify the individuals who will follow through with other identified tasks and interfaces.
- Determine the mechanism for communication between meetings, and clarify as to the next meeting.

Linkages to Natural and Community Supports

Natural supports are those resources being used, or potentially available for use, by the child and family within the community, which do not involve formal behavioral health services, and which are consistent with the cultural beliefs and practices of the child and family. Natural supports may involve activities, community institutions, key resource individuals outside the immediate family, community beliefs, and a variety of informal supports found in the neighborhood or larger community. Natural resources are external to the child and family and, once accessed through active affiliation, become part of the child's and family's strengths.

Natural supports help to normalize the child's life. As the child's life becomes more normalized and more "typical" of that of others, the child becomes less isolated and lonely. Participation in appropriately chosen activities, such as a summer reading program, Scouts, a YMCA/YWCA program, enables the child to expand interest and experience competence and spontaneity.

Natural supports can also help the child's parents/guardians. Self-help groups for parents/guardians can be invaluable in sharing information and offering support. Neighbors and extended kin can help during times of crisis, and also offer the parents/guardians some time alone, by staying with the child in question or all of the children.

Finally, it should be appreciated that natural supports are important not just for children with mental health issues, but for all children. It is through use of natural supports that the child develops friendships, community ties, and competence in the real world.

Although the use of natural resources is often limited during a time of crisis, or when services are initiated, consideration of available or potentially available community supports should occur so that the treatment offered is holistic. Over time as symptoms and behaviors stabilize there is additional opportunity to explore those individualized natural supports suitable to the child and family. The balance between professional services and natural supports shifts over time, as the child and family symptoms get better. This shift in balance enables services to be tapered and eventually discontinued. When there is total or primary reliance on behavioral health services, it may never seem like the right time to discontinue services, and the transition, when it does occur, may be difficult.

The first authority on community resources is always the family itself. In addition, it takes professionals who are knowledgeable about communities in general and the child's community in particular to assist in the identification process. The case manager can play an indispensable role here. In general, the training of many mental health professionals tends to overlook the need to identify and incorporate community resources into the treatment process.

Participation in social activities, outings, and community programs will be incorporated into all STAPs. As a result, the camp programs will be able to provide parents/caregivers with useful information concerning their child's likes/dislikes, strengths in the community setting, and can make recommendations to the child's treatment for community linkages. STAPs should also attempt to provide "family activities" during the camp hours such as a talent show, a picnic where family members are invited to attend or other family type activities.

Standards for STAP Treatment Plans

All STAPs must develop a treatment plan following the Life Domain format for each child specific to the camp setting. The Life Domain format is comprised of the following components:

- *Child and Family Strengths*: including interests, abilities, activities, competencies, and past progress in treatment.
- *Needs, Concerns, and Problems*: including a specific description of symptoms and behaviors as described in the Best Practice/Life Domain evaluation or assessment (if Brief Treatment) and ISPT meeting. Both symptoms and behaviors must be operationally defined, e.g., what does the symptom/behavior look like or consist of for the specific child, including current rates, e.g., frequency, intensity, and domain in which the symptom or behavior is occurring. Problems identified in the treatment plan should also be prioritized making it easy for the child, family, and all other ISPT members to identify the problems being targeted during the current treatment period vs. those that will be targeted at a later date.
- *Statement of Goals and Measurable Objectives*: A goal is a global statement that reflects a positive resolution to the identified need or problem and indicates the specific area of functioning to be addressed, including an expected outcome. The objective is directly related to a specified goal, but is highly specific and identifies measurable steps toward achievement of the goal. Each problem targeted in the current treatment period must have a corresponding goal with measurable objectives, or steps leading to the attainment of the goal.
- *Methods/Interventions*: answering who, what, where, how, and how often:
 - Who is responsible for implementing each objective, e.g., the Host Home parent, child, parent, babysitter, teacher, or Boy Scout leader?
 - What are the tasks for which each person is responsible?
 - Where, or in what setting or circumstance, is this to occur?
 - How – what is the specific method of intervention to address the concern (the behavior plan, the skill being taught).
 - How often – identify the expected rate of intervention.

- *Target Date*: identify the date each objective is expected to be complete/attained.
- *Completion Date*: identify the date each objective was actually completed/attained.
- *Signatures*: Each participant should sign the treatment plan to indicate that he/she agrees with the treatment goals, interventions and his/her role in the treatment process. In addition, each participant should be clearly identified by name and role within the treatment plan as well as in the signature section. At minimum, the signatures of the parent, child and provider are required on all treatment plans.
- *Comments Section (Update on Progress or Lack of Progress)*: This section includes the following information:
 - A description of the actual rates of target behaviors.
 - A description of the skills acquired by the child and family.
 - A description of the child and family's response to treatment.
 - An outline of any obstacles to treatment.
 - A description of any special circumstances.

Involvement in a STAP is usually an adjunct to a child's already existing behavioral health treatment plan. Typically STAP goals focus on the Peer, Leisure/Recreation, Psychiatric/Psychological and Referral/Consultation Domains of the Life Domain Treatment Plan Format.

The *Peer Domain* includes all goals related to peers in school and in the community, including social skills development and the development or maintenance of positive peer relationships.

The *Leisure/Recreation Domain* includes the leisure/recreation needs of the child such as building community resources, identifying hobbies and special interests. The leisure/recreation domain also incorporates the available community resources in the child's neighborhood/community for generalization purposes.

The *Psychiatric/Psychological Domain* should be completed if the child is prescribed psychotropic medications. This domain outlines the behavioral health needs of the child up and above BHRS including, but not limited to, medication evaluation/management, specialized therapeutic needs, groups, and crisis services. Medication management appointments and medication changes are expected to be updated on a monthly basis in this domain.

The *Referral/Consultation Domain* is primarily used to document aftercare/discharge planning when the STAP ends. However, this section of the treatment plan is used to identify any referrals that need to be made for services in any service system, e.g., referral for a psychiatric evaluation, case management, social skills group, evaluation for special education, physical exam, neurology consult, sex abuse counseling, etc.

All STAP treatment goals should focus on skills development commensurate with the child's individualized needs in the above domains.

Plan of Care (POC) Summaries

The STAP must complete a POC for each child specific to the camp services. All POCs must include camp services, dates, requested units, and other behavioral health and non-behavioral health services the child is receiving.

Authorizations

For York, Berks and Adams Counties only: An initial BHRS request for a child receiving STAP only (without BHRS outside of camp) will be authorized for the entire camp period (three months maximum) rather than the nine week /nine week split. If a child has BHRS outside of the camp in addition to the camp hours, the nine week authorization will continue for initial packets.

For all counties: STAP can initially be prescribed in an already existing BHRS packet in which the authorization period includes the start date of the camp, i.e., camp begins within the packet time period. If STAP continues after the end date of a packet, a continued stay packet is needed to continue camp. However, if the camp is ending within two weeks of the expiration date of the child's authorization period, Community Care will allow an extension pending a request by the provider.

Ensuring Cultural Competency

According to CASSP principles, mental health professionals are required to address the cultural strengths and needs of each child and the child's family and recognize the impact of these strengths and needs on service delivery. Cultural competence has a direct impact on service delivery, and requires planning that incorporates the family as equal partners in the process. Culture has an impact on how the family defines itself, on who should be included in the assessment process, the language to be used in providing services, and the appropriateness of particular service modalities.

The fifth CASSP principle requires that multiple cultural factors be included in the formulation of services and treatment plans. Since few professionals are trained to address these factors, initial and ongoing training is required to ensure that multiple dimensions of culture are being explored and appropriately documented for each child and family.

Within a "wraparound perspective", the concept of relevant information includes: the child's strengths and interests, the family's religious and cultural beliefs, community resources, and the child and family's ideas about treatment. The assumption by wraparound staff is that each family and each constellation of family resources are unique and must be discovered. As the child and family are asked about and given the opportunity to discuss strengths, accomplishments, cultural needs and goals, the stigma associated with receiving help often decreases and the process becomes safer and more productive. In taking cultural competency into consideration during any level of behavioral health treatment, goals should be set by considering the functioning of a

typical student from the same cultural background as the child in treatment who is doing well (Hodas, 1996).

Coordination of Services with Other Agencies/Levels of BH Care

If an ISPT meeting for a BHRS continued stay packet takes place during the time period in which the child is attending camp, a camp staff person will be required to attend the meeting. The STAP discharge summary will serve as the primary source of communication with other agencies and levels of care. After obtaining the necessary releases of information, the camp will communicate the child's progress during the summer camp program to other agencies or behavioral health providers via the discharge summary. The STAP is expected to communicate with the child's psychiatrist via a written or verbal update on medication compliance, side effects and medication effectiveness. In addition, results of standardized scales completed during the STAP should be shared with the psychiatrist. A child's therapist, case manager and/or Community Care care manager may visit the camp and observe the child during the program hours to discuss the child's progress during the summer months. If the child has an MT and/or BSC he/she may consult with camp staff as needed and bill as authorized in the child's current BHRS plan. The discharge summary from the STAP should be available for review by the prescriber as needed for the next re-evaluation.

Discharge Planning

The STAP must complete a discharge summary for each child at the conclusion of the STAP. The Community Care discharge summary format for BHRS ([see Addendum II](#)) may be used or the provider may use their own format. At minimum, the discharge summary must include admission and discharge diagnosis, referral source, reason for referral, treatment goals and objectives, treatment modalities used, progress on treatment goals, relevant family issues, and aftercare plan/recommendations. Discharge summaries should be sent to the primary behavioral health provider, school, psychiatrist, case manager, and managed care organization (MCO) within 30 days of discharge from the camp program, pending that the parent and/or child have signed the appropriate releases.

QUALITY IMPROVEMENT

Documentation Standards for Treatment Plans, Progress Notes, Discharge Summaries, and Additional Documentation

Treatment Plan

The treatment plan identifies the child's strengths, including family and community strengths. It includes measurable objectives for treatment and conveys this to the child/family in a way in which they will understand. The treatment plan should identify realistic goals and set the pace by identifying the timeline for working on the treatment goals. Specific interventions to use with the child/family are identified with the

consideration of the cultural perspective in treatment. The roles and responsibilities of each team member, including the child and parents/guardians, are identified in reference to the goals and objectives in the plan. Discharge criteria and a plan for a reduction of service are included as well as a crisis/safety plan.

Progress Notes

Daily progress notes are required for all camps. Clinical activities as related to the child's treatment plan must be documented on a daily basis. All progress notes are to include the date and start/end time of each camp day. It should also identify the participants of the session, the goals/measurable objective for which the session pertains, the interventions used, and the client's response to the intervention. Other information that is to be included in the progress notes include the method of coordinating services with other team members, any specific occurrence during the camp day, and the staff's signature with credentials. Please refer to the attached sample progress notes for STAP ([see Addendum III](#)).

Discharge Documentation

A discharge summary is prepared by the STAP and sent to the care manager within two weeks of discharge. The summary must include the disposition plan and discharge appointments. The provider should also obtain the appropriate releases such that Community Care, the county, parent, new service provider, and others as needed, receive the discharge summary.

Additional Documentation

The client's chart should include the following additional documentation:

- Information regarding internal treatment team or supervision meetings.
- Communication with the prescriber.
- Communication with other treatment team members.
- Correspondence with the family
- Treatment consent.
- The child/family's bill of rights.
- Releases of information.
- Provider choice form.
- Parent education documents.
- Incident reports (if applicable).
- Childline reports (if applicable).
- Encounter forms.
- Parent's signature on all treatment plans.
- Parent signature on other BHRS documents (if indicated by the agency's policy and procedure manual).
- Standardized scales (if applicable).
- Coordination of services with the child's primary care physician (PCP).

Summer Program Process

Since STAP typically runs between June 1 and August 31 each year, Community Care will begin addressing the topic of STAP development with providers by February of each year. Providers will be required to notify Community Care and the county MH/MR by submitting a program description for STAP by March 31. Once all STAP have been approved by the respective entities, Community Care will develop a list of all camps in each county and distribute this to behavioral health providers including case managers, BHRS providers, and family based mental health providers.

At the September BHRS provider meeting, Community Care will review the STAP statistics with all BHRS providers. In addition, providers will discuss what worked, what did not work, and identify any deficits they experienced over the summer, e.g., not enough camp slots overall or the need to develop a program for certain age groups or diagnostic categories for example. If deficits are identified Community Care can work with providers to develop adequate programming for the next year.

Suggested Measures for Quality Improvement

The following items were identified by the STAP performance standards workgroup for use by Community Care in assessing the quality of in network providers authorized to provide STAP:

- Were the correct documents submitted to Community Care for authorization for a STAP?
- Did Community Care receive a discharge summary from the provider for all children being treated in a STAP?
- Was there documented weekly contact with parents?
- Were community supports utilized at least one time per week in each STAP?
- Did the daily progress notes contain individualized information such that the child's treatment goals and objectives were easily identified?
- Was there documented coordination of care with other behavioral health and/or service agencies?
- Was staff training and supervision adequately documented?
- Was there a documented medication policy for each camp?
- Did the camp conduct a parent/child satisfaction survey, and if so, what were the results?

ADDENDUM I: Life Domain Format for Psychological and Psychiatric Evaluations and Re-Evaluations

LIFE DOMAIN FORMAT FOR PSYCHIATRIC/PSYCHOLOGICAL EVALUATIONS: INITIAL AND CONTINUED CARE

2nd Edition

Note: This format is applicable to both initial and continued care evaluations. However, when writing an evaluation for continued care, it is recommended that Section III, Relevant Information, begin with an additional subheading called Brief Update that identifies and briefly summarizes the key events and changes during the most recent service period. The remainder of Relevant Information then follows the usual format, e.g., Strengths, Concerns, etc.

I. Identifying Information:

- Places the child in individual, family, cultural, residential, and educational/vocational contexts, e.g., age, date of birth, gender, race, ethnicity, cultural/religious beliefs, name and grade in school, type of class setting.
- Identifies family and household members, including each biological parent, stepparents, and siblings/half-siblings. Identifies marital status of parents and nature of child's contact with a non-custodial parent. Identifies employment status of current parental caregivers.
- Identifies custody of the child, and child's legal status, e.g., adjudicated or not. Identifies other team members, including involved professional agencies/systems, e.g., MH/MR, C&Y, juvenile justice, case management, child psychiatrist, special education, etc. and community supports.

II. Reason for Referral:

- A. Determine medical necessity for initial care or continued care service request.
- B. Identify additional purposes, as relevant, e.g., monitor medication or respond to crisis.

III. Relevant Information (begin with *Brief Update*, if a continued care request):

A. *Strengths*:

- Child/adolescent strengths, in multiple domains.
- Special attention to motivation and ability to form relationships and use support.
- Areas of greatest competence and independence.
- Family and community strengths.

B. *Concerns*:

- Clinical basis for current service request and recommended treatment.
- Nature, frequency, severity, and history of the child's behaviors/symptoms/serious emotional disturbance (SED) of concern.
- Identification of both externalized behaviors and internalized symptoms, comparing present to past.

- Other identified needs and concerns.

C. *Family:*

- Family composition (including relevant extended family), family relationships, strengths/concerns.
- For child in substitute care, foster family and natural family included.
- Family cultural and spiritual beliefs and practices, as relevant.
- Family history of psychiatric disorder, as relevant.

D. *School/Vocational:*

- The child's academic, social, and behavioral adaptations, including relationships with school peers and with teachers and/or level of functioning in vocational programming.
- Efforts to date of school to address current problems. Characteristics of current class setting.
- Current or past use of school-based services, if relevant.
- Current or past educational testing, CER, and IEF, Prior school placements.

E. *Community:*

- Place of residence-family home or apartment, group home, RTF, etc.
- Community activities and attachments.
- Use of leisure time.
- Community employment, current and in past.
- Degree of church or spiritual involvement.
- Nature of neighborhood, in terms of resources and culture, safety, specific conditions.
- Specific stressors, as relevant.

F. *Peer Relationships:*

- Patterns of peer relationships in the neighborhood and in school, including similarities and differences between the two settings.
- Predominant age of peers-same-aged, older, or younger-and gender of relationships.
- Predominant activities with peers, formal and informal. Nature of peer culture.

G. *Drug and Alcohol:*

- Child's current use/abuse of drugs and alcohol-type, frequency, severity.
- Child's past history of use.
- Child's past drug and alcohol treatment, response to treatment, involvement in self- help groups.
- Family substance abuse history, where relevant, including nature of use, type and effectiveness of treatment.

H. *Medical/Developmental:*

- Medical illness, acute or chronic infection, physical limitation, brain or other injury, past surgery.
- Lead or other toxicity.
- Medication allergies as relevant.

- Developmental history: pregnancy, delivery, neonatal period, developmental milestones.
- Mental retardation, atypical development, autism/PDD.
- Trauma history: neglect, physical abuse, or sexual abuse.
- Gender preference, when relevant and with consent of the child, and other issues of sexuality. Past pregnancy, when relevant.

I. *Legal:*

- Custody.
- Adjudication as delinquent or dependent.
- Other delinquent status indicators: probation, placement in juvenile facility, incarceration.
- Outstanding legal issues: pending charges, community service requirement, other.

J. *Services:*

- **Service History** - services used in past, reason, level of participation, and effectiveness. Include all levels of care, psychotropic medication, out-of-home placements (mental health and other), and services from other systems.
- **Service Update:**
 - Current services-including hours and sites-with summary of recent service history.
 - Impact of services:
 - Role of service providers and of family.
 - Progress/degree of attainment of treatment goals and objectives. Identify effective and ineffective interventions.
 - Receptivity of the child and family to services, and level of participation.
 - Nature of planned modifications of goals and services.
 - Specific indications for, and use of, psychotropic medication. Include names and dosages and, where applicable, blood levels. Indicate medication adherence and effectiveness of medication, when in use.
 - Nature of regular clinical updates to prescriber by involved mental health staff, during most recent service period.

K. *Other:*

- Other domains as relevant, or added to earlier information.

IV. Interview:

- A. Identification of participants.
- B. The child/adolescent's appearance, hygiene, self-care.
- C. The child/adolescent's manner of relating to the interviewer and other identified adults present. Emphasis on level of engagement, cooperation, openness to input.
- D. The child/adolescent's formal mental status. Include verbalized goals, needs, requests, response and commitment to treatment, degree of understanding and insight, other individualized ideas of the child/adolescent, and ability to contract for safety, when relevant. Compare with previous contacts, if applicable.
- E. Key issues/themes addressed, and areas of agreement/consensus.

V. Discussion:

- A. Overview/summary.
- B. Hypothesis/formulation.
- C. Diagnostic considerations.
- D. Rationale for recommended services.
- E. Nature of consensus and agreements with the child/adolescent, family if present, and others.
- F. Prognosis.

X. Diagnosis: 5-Axis diagnosis.

XI. Recommendations:

- A. Identification of each specific behavioral health service recommended, listing the amount, duration, and scope of each.
- B. Other treatment recommendations, both global and specific (e.g., other needed services and interventions for the team to consider; psychotropic medication referral or recommendation; additional recommended assessment(s); community referral(s) and natural supports; education and/or vocational recommendations; consultation with primary care physician; other)
- C. For continued care requests, criteria for service tapering or modification of level of care, and recommendations to increase natural supports.

ADDENDUM II: BHRS DISCHARGE SUMMARY

Community Care BHRS Discharge Summary

Discharge Information			
member's PsychConsult Number:			
Date of Discharge Report:			
provider:			
Reason for Discharge:			
Status at Time of Discharge: Improved/stable Improved/not stable Unimproved Worse Unknown <i>Please highlight and delete the answers that do not apply, leaving only the appropriate answer.</i>			
Date of Last Face-to-Face Appointment Prior to Discharge:			
Date of Discharge from BHRS:			
BHRS Care Manager:			
Discharge Diagnosis (All Axes Required)			
AXIS I:			
AXIS II:			
AXIS III:			
AXIS IV: None Mild Moderate Severe; Describe: <i>Please highlight and delete the answers that do not apply, leaving only the appropriate answer.</i>			
AXIS V: GAF-Current:		Past GAF:	
Medication at Discharge			
Name	Dosage	Frequency	Prescribing Doctor
Post BHRS Follow-Up Appointment(s)			
Facility	Clinician	Appointment Date	Appointment Time
Patient has follow-up services in place prior to discharge from BHRS services? <i>Please highlight and delete the answer, i.e., Yes or No, that does not apply, leaving only the appropriate answer.</i>			
*If No, please explain:			
Type of recommended follow-up:			

<i>Please delete those choices that do not apply, leaving only those services that have been arranged for the member at discharge from BHRS. Please identify the facility that will be providing the service(s). To delete choices that do not apply, highlight the row, right click, and select "Delete Rows."</i>
Outpatient Therapy @
Medication Management @
ICM/RC or Other Case Management @
BHRS Brief Treatment @
Social Skills Group/Program @
Family-Based Mental Health @
Partial Hospitalization @
School-Based Partial @
Crisis Services @
Drug and Alcohol Treatment @
Residential Treatment Facility @
IRT/CRRHH or TFC @
None
Comments:
Other Recommended Services/Resources:
Type of recommended follow-up: <i>Please delete those choices that do not apply, leaving only those services that have been arranged for the member at discharge from BHRS. Please identify the facility that will be providing the service(s). To delete choices that do not apply, highlight the row, right click, and select "Delete Rows."</i>
Education/School (describe):
Community Resources (describe):
Natural Supports (describe):
Living Arrangements (describe):
CYF
JPO
MR Services
None
Comments:
Form Completed by: Phone Number; Date D/C Summary Completed:
Care Manager's Initials:

Please note that the child's discharge caregiver's name, address, and phone number must be faxed or left on your care manager's voice mail to complete the discharge summary process. Community Care must receive all BHRS Discharge Summaries within 14 days of discharge.

Summer Therapeutic Camp

Name: _____

Daily Progress Notes
Page 2

Medical Record #: _____
Date: _____

3. _____

_____ **Signature/Credentials:** _____

4. _____

_____ **Signature/Credentials:** _____

5. _____

_____ **Signature/Credentials:** _____

6. _____

_____ **Signature/Credentials:** _____

7. _____

_____ **Signature/Credentials:** _____

Additional Comments and Plan for Next Day: _____

Signature/Credentials: _____