TN Department of Children's Services

Contract Provider Manual

Section Four (4) - Residential Treatment

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GENERAL RESIDENTIAL TREATMENT

1. General Characteristics

a) Residential Treatment provides thorough clinical services including psychiatric and educational assessment and therapeutic treatment program in a 24-hour-a-day residential facility for children and youth with significant emotional and/or psychological treatment needs.

b) The facility will be appropriately licensed according to the population served. Regardless of the type of license issued, Residential Treatment Facilities serving DCS children may not operate out of single-family dwellings. These settings are not conducive to providing the more intense clinical services and structure required for this level of service.

2. Admission/Clinical Criteria

a) Child/youth present with difficult and challenging needs/behaviors and have an immediate need for initial short-term or intermittent stays in the RTF setting. The following medical necessity criteria are met for admission to a Residential Treatment Facility:

- The child/youth has a significant mental health disorder (DSM-IV-TR or DSM-5) and is impaired in social, educational, familial and occupational functioning. This level of functioning is not due exclusively to intellectual or developmental disability or organic dysfunction. This disorder is amenable to "psychiatric treatment" and requires mental health treatment that cannot be successfully provided at a lower level of care. The youth needs psychiatric consultation and access to physician services as well as daily supportive guidance toward stabilization.
- The child/youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder, *not* developmental, social, cognitive or specific medical limitations.
- The child/youth's current living environment, family setting and extended community cannot provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).
- The child/youth cannot achieve successful adaptation for the purpose of stabilization, *at this time,* without significant structure and supportive residential guidance that can only be provided through twenty-four (24) hour intervention and supervision in a highly-structured environment.
- The child/youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.
- The child/youth does not require medical substance abuse treatment (e.g. detoxification) as the primary need and does not have contraindicated medical conditions that are primary and would supersede the psychiatric symptoms.

b) Child/youth may be of any adjudication type.

c) Child/youth may pose a high risk for elopement, instability in behavior and mental health status or occasionally experience acute episodes. These youth also experience persistent maladjustment of peer and other social relationships or other influencing systems which interfere with learning and social environments.

d) Children/youths with a primary diagnosis of intellectual disability are evaluated on a case-by-case basis for admission and a special needs contract. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe intellectual disability may not be appropriate unless the agency is able to make appropriate adjustments to the regular programming as needed.

e) The team consults with the Regional Licensed Mental Health Clinician prior to placing a child or youth in a Residential Treatment Facility.

3. Personnel

a) The provider has trained personnel who can meet the developmental, therapeutic, and supervision needs of all children/youths accepted for care and services. Inappropriate/questionable boundaries between youth and facility staff, as demonstrated by inappropriate physical interactions and/or preferential treatment, are prohibited by the Department. Agency trainings, policies, and supervision plans for staff are to be explicit regarding agency expectations of acceptable and unacceptable behavior between staff and youth and are made available to the Department upon request.

b) The program is under the direct clinical supervision of a licensed mental health professional with training and experience in mental health treatment of children and youth.

c) Staff is appropriately credentialed to provide individual and family counseling/therapy. The agency is responsible for providing the credentials of therapists upon request. If a specific treatment such as Trauma Focused Cognitive Behavior Therapy (TFCBT), Dialectical Behavior Therapy (DBT), or treatment for problem sexual behavior is being provided, the agency is able to demonstrate that the therapist is appropriately trained to deliver this treatment.

d) Educational staff will meet the employment standards outlined in the state Board of Education Rules, Regulations and Minimum Standards.

e) The program will maintain a written agreement with, or employ, a Tennessee-licensed physician as a medical consultant. If the consulting physician is not a psychiatrist, the facility will arrange for the regular, consultative and emergency services of a licensed psychiatrist (TCA 0940-5-37). The psychiatrist is available for consultation with program staff, parent/guardian and/or custodian. For further details see Section E, Service Components, below.

f) Residential Treatment Facility staff to child/youth ratio: 1:5 (one direct-care, awake staff for every five on-site youth) during the day and 1:8 (one direct-care, awake staff for every eight on-site youth) overnight staff. Staff persons counted in the staff-to- youth ratio are persons who have been hired and properly trained to provide direct program services. When necessary, other personnel who have completed appropriate training may also be assigned to perform direct care duties and, at that given time, may be counted in the staff-to-youth ratio. During normal sleeping hours the program will provide one direct-care staff person on-site in each building, or physically separated unit of a building in which children/youths are housed. Support staff such as clerical, housekeeping, van and bus driver staff or students involved in an onsite practicum for academic credit may not be counted in the staff-

to-child/youth ratio. While these are the minimum standards, it is strongly recommended that two staff be present at any time when children/youths are being supervised. Appropriate staff to youth ratio requires close proximity to youth, ensuring easy access at all times and in all settings. Documentation of facility staff to youth ratio compliance, accounting for every hour of every day, including during school hours, is available for Department staff to review upon request. This documentation includes: staff names and units supervised. Information documenting which youth were on each unit during the same times must also be available.

g) All prospective employees whose responsibilities include direct contact with youth will have a risk assessment/screening for tuberculosis within ninety (90) days of employment and annually thereafter.

h) The program will provide, at all times, at least one (1) on-duty staff member trained in First Aid and the Heimlich maneuver and certified in cardiopulmonary resuscitation (CPR) (Chapter 0940-5-37).

Note: For additional licensure information see Section 0940-5-37.03 Rules of Department of Mental Health and Development Disabilities.

4. Individualized Treatment Plan

a) An Initial Treatment Plan will be developed within the first 72 hours for each child/youth. This plan will be based on initial history and current assessment of child/youth's needs and strengths.

b) A more Comprehensive Treatment Plan will be developed after testing and/or assessment has occurred. The Treatment Planning process will include the family and youth per the CFTM model for collaborative planning. This will be completed within 30 days of admission.

c) The program will ensure that the following assessments are completed prior to development of the child/youth's comprehensive Treatment Plan:

- Assessment of current functioning, and a history in the following areas: Community living skills, living skills appropriate to age, emotional and psychological health, and Educational level (including educational history).
- Basic medical history and information;
- A six (6) month history of prescribed medication, frequently used over-the-counter medication and alcohol or other drug use;
- History of prior mental health and alcohol and drug treatment episodes; and,
- Assessment of whether child/youth is currently eligible for special education services in accordance with the State Board of Education Rules, Regulations and Minimum Standards.

d) The Comprehensive Treatment Plan will address referral concerns and identify treatment goals as related to safety, mental health, medical, and educational well-being. The Treatment Plan will include specific steps to work toward permanency, including a visitation plan. This plan may integrate information from tools such as the CANS, historical FAST, and Permanency Plan. For example, actionable items on the CANS (items rated 2 or 3) will be addressed.

e) The Comprehensive Treatment Plan will consider discharge goals and estimated length of stay. Discharge planning will begin at admission and will be an ongoing process.

f) Documentation of the Treatment Plan and of its implementation will be kept in the child/youth record and will include the following, per TCA 0940-5-37-.05:

- The child/youth's name on the Treatment Plan

- The date of development of the Treatment Plan
- Individual problems specified in the Treatment Plan which are to be addressed within the particular service/program component, including treatment and educational components
- Individual objectives which are related to specified problems identified in the Treatment Plan and which are to be addressed by the particular service/program component
- Interventions and staff responsible for addressing goals and objectives in the Treatment Plan
- Signatures of the staff providing the services
- Documentation of participation of child/youth and parent/guardian/legal custodian or conservator where appropriate in the Treatment Planning process. If any of the parties refuse to participate, reasons for refusal will be documented
- Standardized diagnostic formulation(s), based upon the current Diagnostic and Statistical Manual (DSM) or current International Classification of Diseases (ICD) where appropriate, and assessment documentation on file which is updated as recommended by treatment team
- Planned frequency of treatment contacts
- A plan for family involvement in the child/youth's treatment

g) A review of the Treatment Plan will occur at least every thirty (30) days or upon completion of the stated goals and objectives and will include the following documentation, per TCA 0940-5-37-.05:
   - Dated signatures of appropriate staff;
   - An assessment of progress toward each treatment goal and/or objective with revisions as indicated;
   - A statement of justification for the level of service(s) needed, including suitability for treatment in a less restrictive environment and continued services.

5. Service Components & Overview

a) All necessary mental health treatment services will be provided by the agency. This includes individual, group, and family therapy, medication management, alcohol and drug treatment, and mental health/behavioral treatment. The cost of all services is included in the per diem rate paid to the provider by DCS. Appropriate agreements with external providers will ensure that those providers will not also bill TennCare or any other insurance provider for the service as it is covered under the per diem.

b) For all youth in Residential Treatment Centers, psychological testing may be obtained from an outside BHO provider. Residential Treatment providers are not responsible for providing psychological testing as part of their daily per diem rate and scope of services.

c) In addition to a comprehensive treatment plan, other assessments may be requested by the following personnel: DCS Regional Licensed Mental Health Clinician, juvenile court personnel, the Local Education Agency (LEA), or the treating mental health provider.

d) If additional assessments are requested, the assessment will be completed and final report made available within thirty (30) days of the date the request was made.

e) Each child/youth will have a clinical team comprised of representatives from front line staff, nursing

staff, educators, therapeutic staff and a psychiatrist. The clinical team will participate in monthly documented clinical staffing for each child/youth.

f) The Program will provide an evidenced based model(s) as defined by SAMHSA or California clearing house. The program will be designed for the population served. The program will develop and maintain a manual that details the agency's plan for staff training in the model, maintaining model fidelity, and will define how staff will adhere to components of the manual.

g) Behavior management system emphasizing positive reinforcements;

h) Development of Individualized Crisis Management Plan, if warranted by youth behavior;

i) Utilization of a nationally-recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions.

j) Provision of recreational activities, social skills training, daily living skills and interdependent living skills. These activities will be appropriate to, and adapted to, the needs, interests and ages of the children/youths. More information about independent living may be found in the IL Core Services portion of this manual.

k) Group counseling/therapy conducted by an appropriately credentialed staff at least two (2) times per week with each session being at least one (1) hour in length and no longer than one and a half (1.5) hours. Group size is not to exceed ten (10). These are clinically-focused groups and are specific to the specialized needs of the youth such as alcohol and drug, mental health or sexually abusive issues;

l) One (1) hour of individual counseling/therapy will be provided by an appropriately credentialed staff member at least weekly, with sessions lasting no less than one-half (.5) hour.

m) Family counseling/therapy:

- Provided by appropriately credentialed/licensed staff to the family identified as the family of care or the permanency family. This family is identified by the DCS Family Service Worker (FSW) as soon as possible after coming in to custody or upon admission to the facility. The agency therapist will have contact with the family of care or permanency family and the DCS FSW either by phone or in person within the first week of admission.
- Provided at a minimum of two (2) times per month unless contraindicated
- Routine contacts with family and youth (visitation, phone calls) are not considered counseling/therapy
- Sessions will be one (1) hour in length
- Family schedules may necessitate minor changes in the length and frequency of counseling /therapy and these changes are to be documented in the case notes
- Contraindications to family involvement and family counseling/therapy will be documented in the Treatment Plan. Provider concerns regarding family involvement will be addressed in writing to the DCS FSW (e-mail notification is allowed)
- The provider agency is responsible for working with the family to overcome barriers to involvement such as transportation and schedules
- The DCS FSW will assist with coordination and help to overcome barriers; and,
- Family counseling/therapy is not contingent on the youth's behavior.

n) The provider agency will arrange for on-site services of a psychiatrist. The psychiatrist will document face-to-face contact for psychiatric evaluation within two weeks of the date of admission. Psychiatric

reviews, when appropriate, occur at least monthly and as needed for medication management.

6. Education of the Child/Youth

a) Youth will attend an in-house, non-public school that is approved by the Tennessee State Department of Education and recognized to educate students in custody by the DCS Education Division.
b) Please refer to the Educational Standards section of this manual for specific information related to the education of students in state custody.

7. Records Management

The individual record for each child/youth will contain the following information:

a) Documentation of the initial Treatment Plan (within 72 hours), Comprehensive Treatment Plan (within 30 days) and the Individualized Education Program (if required) and of their implementation;
b) Progress notes will be recorded daily and will include written documentation of child/youth progress and changes which have occurred within the implementation of the Treatment Plan. These progress notes will be dated and include the signature, title or degree of the person providing the service;
c) Psychological Evaluations and Psychiatric progress notes will be dated and include the signature, title or degree of the person providing the service;
d) Documentation of all medications prescribed and/or administered by the facility which indicates date prescribed, type, dosage, frequency, amount and reason for prescription;
e) Documentation of significant behavior and actions taken by staff;
f) A list of each article of the child/youth's personal property valued at one hundred dollars ($100.00) or more and its disposition if no longer in use.
g) Documentation of incidents of abuse, medical problems, accidents, seizures and illnesses. This documentation will include the treatment for such abuse, accidents, seizures, and illnesses and any reports generated as a result. Results of assessments are required by this rule;
h) Discharge summary which details the child/youth's condition at the time of discharge and the signature of person preparing the summary;
i) Documentation of an education plan developed for each child/youth that conforms to the Rules, Regulations and Minimum Standards of the State Board of Education and confirms the Individualized Education Program (IEP) test being developed by an appropriately constituted IEP Team for all "qualified students with disabilities";
j) The education plan may include education services provided either by the facility or by the Local Education Agency; and,
k) Appropriate consents and authorizations for the release and obtaining of information about the child/youth will be maintained and current.

8. Discharge Criteria

a) A preliminary discharge plan with discharge goals, projected length of stay, tentative discharge date, and tentative aftercare plan will be formulated and shared with the DCS Regional Licensed Mental Health Clinician, educational specialist, family services worker, and placement support worker.

b) A youth is ready for discharge when s/he no longer meets the admission criteria (outlined above) and sufficient aftercare services (e.g., mental health, education, family, medical/physical) have been arranged to allow for a smooth transition.

RESIDENTIAL TREATMENT SPECIALIZED: ADOLESCENTS WHO HAVE ENGAGED IN SEXUALLY ABUSIVE BEHAVIOR

1. General Characteristics:

The Scope of Services for Residential Treatment for Sexually Abusive Youth is designed to ensure that adolescent youth ages 13 through 17 who have engaged in sexually abusive behavior and are under the care of Tennessee Department of Children's Services receive quality assessments, treatment and programming that are based on the current research, literature and best practices. Medical necessity determinations related to intensity of services and level of care will be based on the risk and needs of the individual youth and community safety. The Department of Children's Services embraces a risk-need based placement decision making process which supports youth being moved to a lower level of care to continue treatment when appropriate. Programs providing services to these youth are responsible for adhering to best practices and evidence supported/evidence informed interventions, approaches and treatment. The application of this model is consistent the Department of Children's Services efforts to better serve our youth, their families and the community through quality assessments and services which impacts lengths of stay, improves decision making and solidifies coordination of continuous care planning.

2. Admission/Clinical Criteria

a) Youth may be of any custody type.
b) Youth between the ages 13 through 17 years and who have engaged in sexually abusive behavior as determined by court, Child Protective Services or by self-admission are eligible for consideration for placement in specialized residential level of care. The sexually abusive behavior includes offenses against children, adults and/or peers. Youth who have engaged in hands off offenses only, such as exhibitionism and voyeurism, will be considered on a case by case basis.
c) Youth are to be authorized/approved for admission by the Department's designated subject matter experts for sexually abusive youth who are responsible for determining if a youth meets medical necessity for placement in the specialized residential program.
d) Medical necessity encompasses risk/need and community safety. Specifically the youth's level of sex offending specific risk based on known factors related to risk for sexually abusive behavior in addition to other variables impacting the ability to safely manage the youth in a less restrictive environment are considered. Other variables may include: difficulty controlling sexual behavior, general risk, failure in outpatient or other treatment programs, significant psychiatric//mental health issues, history of aggressive behavior, history of runaway, significant behavior problems, significant emotional problems or other issues that interfere with the youth being safely managed in the community. In general, youth eligible for admission will exhibit a moderate to high risk for sex offending.
e) Youth approved for specialized residential have a level of sex offending risk, general risk, mental health or behavioral health needs that necessitate a higher level of supervision and intensive interventions.
f) Youth ineligible for this program are those who are in need of sub-acute or acute inpatient psychiatric care for the management of their psychiatric and mental health needs.

g) Youth meeting medical necessity who have a documented IQ of 70 or below, who have adaptive functioning consistent with an intellectual disability or who have other developmental disabilities will be evaluated on a case by case basis to determine if their needs would best be met under this Scope of Services or through the Specialized Residential: Adolescents Who Have Engaged in Sexually Abusive Behavior Who Have Low Intellectual Functioning or Developmental Disabilities Scope of Services.

3. Personnel:

The program will adhere to applicable Personnel requirements as outlined in the General Residential Treatment portion of this manual. Additionally, due to the specialized nature of the program, the following apply:

a) The program has qualified clinical staff, licensed or license eligible masters level, who can meet the developmental, therapeutic and supervision needs of all youth accepted for care and services.
b) Specifically therapists providing clinical services have appropriate training specific to this population of youth and the program. Training includes initial training/orientation and organized/formal continuing education activities to stay abreast of the current research, literature and best practices relevant to adolescents who have engaged in sexually abusive behavior.
c) There should be procedures and guidelines in place to ensure continuing education for clinical staff specific to the evaluation and treatment of sexually abusive youth.
d) The program person(s) responsible for providing clinical supervision and oversight of the clinical staff is to be knowledgeable of current approaches and best practices specific to adolescents who have engaged in sexually abusive behavior and familiar with approaches to general delinquent behavior. The program is responsible for this supervisor staying current on clinical practices/treatment related to this population including involvement in organized continuing education activities.
e) The program person(s) responsible for providing supervision and oversight of specialized evaluations and assessments is to have participated in training on assessment of sexually abusive youth, including risk assessment measures. The program is responsible for the supervisor staying current on assessment related to this population including involvement in organized continuing education specific to this group of youth including assessment focused training.
f) Program person(s) responsible for providing clinical supervision or supervising assessments/evaluations are to be licensed masters level or higher.
g) There should be at least one clinical staff person qualified to complete specialized assessments/evaluations specific to adolescents who have engaged in sexually abusive behavior including recognized adolescent sex offending risk assessment tools. The person is to be a licensed or license eligible masters level or higher. This staff member is to have participated in organized training specific to assessment of this population of youth and be involved in relevant continuing education activities.
h) Initial training and orientation of direct line staff should include adolescent development, a specific focus on sexually abusive youth and information about delinquent youth in preparation for their program duties.
i) In addition to the initial training and orientation, direct line staff should receive on-going in-service training relevant to the management and treatment of adolescents who have engaged in sexually abusive behavior.
j) The supervision of line staff will adhere to established guidelines and procedures of the program.
k) Staff serving in roles that have direct contact and responsibilities with youth, such as education staff and recreation staff, are to receive relevant training about adolescents who have engaged in sexually abusive behavior to assist in their work with the youth.
l) There should be a clear protocol, guidelines and/or procedures on how staff are trained and supervised.
m) Program is to maintain documentation of training and continuing education attendance and content.

4. Treatment Planning

In addition to the treatment plan components identified in the General Residential Treatment portion of this manual, the following apply:

a) The program is responsible for completing a psychosexual evaluation, including a recognized risk assessment tool, to assist and support treatment planning within 30 days of admission on youth admitted to their program if one has not been recently completed and available. The program is to provide a copy of the evaluation to key members of the youth's DCS team in a timely manner.
b) At such time that a youth is considered to be nearing readiness for a lower level of care/less intensive treatment, the program is responsible for completing an updated psychosexual evaluation, including a recognized risk assessment tool, to inform discharge decisions and assist in treatment planning and discharge/transition planning. The evaluation is to be completed within an agreed upon reasonable time period and a copy provided to key members of the youth's DCS team in a timely manner.

c) The program is responsible for completing a rating form/scale that is designed to assess progress on dynamic risk factors and other relevant factors; this is to be completed on a monthly basis to assist in addressing progress and inform treatment planning.
d) An individualized treatment plan specific to the youth will be developed for each youth. The plan is to include goals, objectives and interventions relevant to the youth's individualized risk/need, identify and address responsivity factors and identify and address other individualized issues that may be present.
e) Program will be able to produce clear written documentation of how dynamic risk factors, sex offending specific and general, as well as individualized issues are targeted in treatment.
f) While programs may include treatment manuals/workbooks as a component of treatment it should be clearly reflected that these are only a component and not viewed as being the program.
g) All treatment contacts will be documented with progress notes reflecting the focus and content of the sessions, dynamic risk factors addressed youth's response to the session and follow up plan.

5. Service Components & Overview

As applicable, the program will adhere to the Service Components and Overview items noted in the General Residential Treatment section of this manual. In addition, the program is responsible for the following Service Components & Overview specific to specialized residential for adolescents who have engaged in sexually abusive behavior:

a) The program will have a clear theoretical approach that outlines a philosophy and methods of treatment that are based on best practices for adolescents who have engaged in sexually abusive behavior and delinquent youth.
b) The program will demonstrate that it has the capacity to address sex offender and general delinquent dynamic risk factors in addition to other health, mental health, and educational needs.
c) Program will use a cognitive behavioral approach, focus on skills building and incorporate approach goals as well as avoidance goals.
d) Four and one-half hours of sex offender focused group therapy are to be provided weekly with each session being no longer than one and one-half hours and no less than one hour in length. Group size is not to exceed 8 *to* 10 youth in a group.
e) Youth will receive 3 hours of groups per week focusing on building relevant skills or other clinically related needs. Groups are to be a minimal of one hour in length and not exceed one and one-half hours. Group content meeting this expectation includes anger management, assertiveness, values clarification, stress management, emotional management, etc. Groups such as community, current

events, recreation and groups related to milieu management, while important, do not meet this expectation. Group content focused on life skills such as laundry, hygiene, nutrition, etc., while important, do not meet this expectation.

f) The Program will provide a minimal of one hour of individual therapy per week. Session will be no less than 30 minutes in length.

g) At a minimum, two face to face family sessions are to occur monthly; the program is encouraged to provide weekly family sessions as clinically supported.
   - Contact such as youth to parent phone calls, family visitation, phone call to update family about youth's behavior or routine contact phone calls not focused on therapy are not considered to fulfill this expectation.
   - Family therapy is to be at least one hour or equivalent per contact. At times work may be specifically with the parental unit or significant family members rather than involving the youth and the reasons for this are to be documented in the progress note.
   - Contraindications to family involvement or family therapy will be documented in the treatment plan. The program will notify the FSW via email to any contraindications, problems or concerns related to family involvement. Meeting to discuss the contraindication, problems or concerns will be set as needed.
   - The program will be responsible for assisting the family in transportation and other arrangements related to their involvement. DCS will assist in the coordination of family work as appropriate. DCS will work with the program regarding transportation and other barriers to the family's involvement.

h) Program will address responsivity issues and ensure appropriate therapist style that has been shown to be related to change.

i) Program will be cognitive behavioral in nature, incorporate social learning theory, include a skills building focus and ensure that therapies and interventions include techniques and approaches that promote learning.

j) Consistent with the current research and literature, the programming and treatment will focus on approach goals rather than solely focusing on avoidance goals.

k) Program will address the resident's progress and factors impacting progress and will ensure programmatic use of appropriate practices shown to be associated with change.

6. Education of the Child/Youth

Please refer to the General Residential Treatment Section of the Manual

7. Records Management

Please refer to the General Residential Treatment Section of the Manual

8. Monitoring Progress

Please refer to the General Residential Treatment Section of the Manual as well as I.4 specific to Residential Treatment Specialized: Adolescents Who Have Engaged in Sexually Abusive Behavior.

9. Utilization Review

a) Youth referred to the specialized treatment program are to have been approved/authorized for specialized residential treatment for adolescents who have engaged in sexually abusive behavior by the Department of Children's Services designated subject matter expert(s). This approval process is designed to ascertain medical necessity and ensure that the individual youth's level of risk and need are congruent with specialized residential placement and that he/she cannot be appropriately and safely served in a lower level of care.

b) A Central Office Network Development staff member will serve as point person to assist in coordination of aspects of the monitoring, review and evaluation components.
c) Youth authorized for specialized residential treatment for adolescents who have engaged in sexually abusive behavior are monitored through a formal Medical Necessity Utilization Review Process based on risk/need congruency. The formal Medical Necessity Utilization Review is specific to the individual youth and ensures that the individual youth is in an appropriate level of care as determined by medically necessity and his/her risk and needs (general, sexual abusive behavior and individualized) are being met.
d) Programs providing specialized residential treatment for adolescents who have engaged in sexually abusive behavior state custody youth are responsible for providing monthly clinical summaries on the designated date; these summaries are to follow the SORT Clinical Summary template and be completed by the youth's therapist. In addition other relevant information, documentation or materials may be requested as a part of formal Medical Necessity Utilization process.
e) Programs providing this type of specialized residential treatment are periodically reviewed through a formal clinical program evaluation process. The formal Program Evaluation process includes, but is not limited to, review of the program's admission criteria, assessment process, discharge criteria development, behavioral program, treatment planning, training material and documentation, programming and the continuous care process in general and other relevant aspects and components of the program.
f) It is the responsibility of the region to initiate the appropriate payment upon receiving notification that the youth is approved/authorized for specialized residential.
g) At the point the specialized residential placement is no longer authorized through the formal Medical Necessity Utilization Review process, the region shall assure that the needed change is made regarding payment type/contract. While authorization is based on medical necessity, a reasonable time period is authorized for discharge planning and transition preparation.
h) There is a process for re-review in the event that a program is not in agreement with the findings of the formal Medical Necessity Utilization Review that the youth no longer meets medical necessity for specialized residential. The process includes a first step informal, re-review and a subsequent formal review if needed.

10. Discharge Criteria

a) Discharge/Transition planning is a collaborative effort involving the program, DCS, the family and others in the support system as appropriate (i.e. identified foster parents, relatives, other support persons).
b) Discharge criteria is to be individualized, focusing on readiness for a lower level of care/less intensive services as determined by the youth's risk and needs; not "program completion".
c) An individualized Discharge/Transition Plan for the youth is to be maintained in the youth's file. The Discharge/Transition Plan is to encompass all aspects of the youth's needs related to risk and successful reintegration into the community. Documentation can be incorporated into the treatment plan and is to include: Information related to the specific plan, progress towards the plan, barriers to the plan and how barriers are being addressed.
d) The Discharge/Transition Planning process is to be initiated at admission and reviewed at least monthly with written documentation of the review; this may be a part of the treatment plan.
e) As a youth nears discharge, the Discharge/Transition Planning will include identifying continued treatment needs, determining what services are needed to meet those needs and coordination/collaboration on arranging and obtaining needed services.
f) For youth who have engaged in sexually abusive behavior in the home and return home is being considered or return home where vulnerable person(s) reside, best practices and guidelines for reunification, from the sex abuse and sex offender treatment field, will be utilized. Victim safety, well-

being and best interest are a priority in cases of sibling sexual abuse and consideration for initiation of reconciliation and/or reunification process. Consideration for discharge to home where victim or vulnerable person(s) reside clearly address safety issues and concerns with the well-being and safety of others being a priority.

- Tennessee's Joint Task Force on Children's Justice/Child Sexual Abuse has established criteria and recommended guidelines for reunification of adolescent sex offenders (persons 13 through 17) back into the home where the victim or other vulnerable children reside. The guidelines outline elements that are to be considered in a professional staffing that involves DCS, treatment professionals and service providers working with the individual and family. The *Considerations in the Reunification of Adolescent Sex Offenders With The Families Where the Victims (or other vulnerable children) Reside* can be downloaded in PDF by going to the Joint Task Force Focuses on Child Sexual Abuse Protection (2009) documents at the following link: ***http://children.sworpswebapp.sworps.utk.edu/jtf/***

RESIDENTIAL TREATMENT SPECIALIZED: INTELLECTUALLY DISABLED SEX OFFENDER

1. General Characteristics

The Scope of Services for Residential Treatment for Sexually Abusive Youth is designed to ensure that adolescent youth ages 13 through 17 who have engaged in sexually abusive behavior and are under the care of Tennessee Department of Children's Services receive quality assessments, treatment and programming that are based on the current research, literature and best practices. Medical necessity determinations related to intensity of services and level of care will be based on the risk and needs of the individual youth and community safety. The Department of Children's Services embraces a risk-need based placement decision making process which supports youth being moved to a lower level of care to continue treatment when appropriate. Programs providing services to these youth are responsible for adhering to best practices and evidence supported/evidence informed interventions, approaches and treatment. The application of this model is consistent the Department of Children's Services efforts to better serve our youth, their families and the community through quality assessments and services which impacts lengths of stay, improves decision making and solidifies coordination of continuous care planning.

2. Admission/Clinical Criteria

a) Youth may be of any custody type.
b) Youth between the ages 13 through 17 years and who have engaged in sexually abusive behavior as determined by court, Child Protective Services or by self-admission are eligible for consideration for placement in specialized residential level of care. The sexually abusive behavior includes offenses against children, adults and/or peers. Youth who have engaged in hands off offenses only, such as exhibitionism and voyeurism, will be considered on a case by case basis.
c) Youth meeting medical necessity who have a documented IQ of 70 or below, who have adaptive functioning consistent with an intellectual disability or who have other developmental disabilities will be evaluated on a case by case basis to determine if their needs would best be met under this Scope of Services or through the Specialized Residential: Adolescents Who Have Engaged in Sexually Abusive Behavior.

d) Youth are to be authorized/approved for admission by the Department's designated subject matter experts for sexually abusive youth who are responsible for determining if a youth meets medical necessity for placement in the specialized residential program.
e) Medical necessity encompasses risk/need and community safety. Specifically the youth's level of sex offending specific risk based on known factors related to risk for sexually abusive behavior in addition to other variables impacting the ability to safely manage the youth in a less restrictive environment are considered. Other variables may include: difficulty controlling sexual behavior, general risk, failure in outpatient or other treatment programs, significant psychiatric//mental health issues, history of aggressive behavior, history of runaway, significant behavior problems, significant emotional problems or other issues that interfere with the youth being safely managed in the community. In general, youth eligible for admission will exhibit a moderate to high risk for sex offending.
f) Youth approved for specialized residential have a level of sex offending risk, general risk, mental health or behavioral health needs that necessitate a higher level of supervision and intensive interventions.
g) Youth ineligible for this program are those who are in need of sub-acute or acute inpatient psychiatric care for the management of their psychiatric and mental health needs.

3. Personnel

The program will adhere to applicable Personnel requirements as outlined in the General Residential Treatment portion of this manual. Additionally, due to the specialized nature of the program, the following apply:

a) The program has qualified clinical staff, licensed or license eligible masters level, who can meet the developmental, therapeutic and supervision needs of all youth accepted for care and services.
b) Specifically therapists providing clinical services have appropriate training specific this population of youth and the program. Training includes initial training/orientation and organized/formal continuing education activities to stay abreast of the current research, literature and best practices relevant to adolescents who have engaged in sexually abusive behavior. In addition therapists have training specific to adolescents with low intellectual functioning and developmental disabilities.
c) There should be procedures and guidelines in place to ensure continuing education for clinical staff specific to adolescents with low intellectual functioning and developmental disabilities and the evaluation and treatment of sexually abusive youth.
d) The program person(s) responsible for providing clinical supervision and oversight of the clinical staff is to be knowledgeable of current approaches and best practices specific to adolescents who have engaged in sexually abusive behavior, adolescents with low intellectual functioning and developmental disabilities and familiar with approaches to general delinquent behavior. The program is responsible for this supervisor staying current on clinical practices/treatment related to this population including involvement in organized continuing education activities.
e) The program person(s) responsible for providing supervision and oversight of specialized evaluations and assessments is to have participated in training on assessment of sexually abusive youth, including risk assessment measures. The program is responsible for the supervisor staying current on assessment related to this population including involvement in organized continuing education specific to this group of youth including assessment focused training. The supervisor is to also be knowledgeable about assessment considerations specific to adolescents with low intellectual functioning and developmental disabilities.
f) Program person(s) responsible for providing clinical supervision or supervising assessments/evaluations are to be licensed masters level or higher.

g) There should be at least one clinical staff person qualified to complete specialized assessments/evaluations specific to adolescents who have engaged in sexually abusive behavior including recognized adolescent sex offending risk assessment tools. The person is to be a licensed or license eligible masters level or higher. This staff member is to have participated in organized training specific to assessment of this population of youth, including considerations specific to adolescents with low intellectual functioning and developmental disabilities, and be involved in relevant continuing education activities.
h) Initial training and orientation of direct line staff should include adolescent development, a specific focus on sexually abusive youth, information about delinquent youth and knowledge about adolescents with low intellectual functioning and developmental disabilities in preparation for their program duties.
i) In addition to the initial training and orientation, direct line staff should receive on-going in-service training relevant to the management and treatment of adolescents who have engaged in sexually abusive behavior as well as approaches for working with adolescents with low intellectual functioning and developmental disabilities.
j) The supervision of line staff will adhere to established guidelines and procedures of the program.
k) Staff serving in roles that have direct contact and responsibilities with youth, such as education staff and recreation staff, are to receive relevant training about adolescents who have engaged in sexually abusive behavior and adolescents with low intellectual functioning and developmental disabilities to assist in their work with the youth.
l) There should be a clear protocol, guidelines and/or procedures on how staff are trained and supervised.
m) Program is to maintain documentation of training and continuing education attendance and content.

4. Treatment Planning

In addition to the treatment plan components identified in the General Residential Treatment portion of this manual, the following apply:

a) The program is responsible for completing a psychosexual evaluation, including a recognized risk assessment tool, to assist and support treatment planning within 30 days of admission on youth admitted to their program if one has not been recently completed and available. The program is to provide a copy of the evaluation to key members of the youth's DCS team in a timely manner.
b) At such time that a youth is considered to be nearing readiness for a lower level of care/less intensive treatment, the program is responsible for completing an updated psychosexual evaluation, including a recognized risk assessment tool, to inform discharge decisions and assist in treatment planning and discharge/transition planning. The evaluation is to be completed within an agreed upon reasonable time period and a copy provided to key members of the youth's DCS team in a timely manner.
c) The program is responsible for completing a rating form/scale that is designed to assess progress on dynamic risk factors and other relevant factors; this is to be completed on a monthly basis to assist in addressing progress and inform treatment planning.
d) An individualized treatment plan specific to the youth will be developed for each youth. The plan is to include goals, objectives and interventions relevant to the youth's individualized risk/need, identify and address responsivity factors and identify and address other individualized issues that may be present.
e) Program will be able to produce clear written documentation of how dynamic risk factors, sex offending specific and general, as well as individualized issues are targeted in treatment.
f) While programs may include treatment manuals/workbooks as a component of treatment it should be clearly reflected that these are only a component and not viewed as being the program.

g) All treatment contacts will be documented with progress notes reflecting the focus and content of the sessions, dynamic risk factors addressed youth's response to the session and follow up plan.

5. Service Components & Overview

As applicable, the program will adhere to the Service Components and Overview items noted in the General Residential Treatment section of this manual. In addition, the program is responsible for the following Service Components & Overview specific to specialized residential for adolescents who have engaged in sexually abusive behavior.

a) The program will have a clear theoretical approach that outlines a philosophy and methods of treatment that are based on best practices for adolescents who have engaged in sexually abusive behavior and delinquent youth.
b) The program will demonstrate that it has the capacity to address sex offender and general delinquent dynamic risk factors in addition to other health, mental health, and educational needs.
c) The program demonstrates that it can effectively address and provide for youth who have low intellectual functioning/developmental disabilities.
d) Program will utilize therapeutic material developed and/or clearly adapted for youth with low intellectual functioning/developmental disabilities. There should be recognition that these youth may not just "learn slower" but may process information differently. The program will be able to demonstrate through program description and documentation in the youth's file that they use a variety of learning modalities to meet the youth's needs with less reliance on written material.
e) While the program is expected to adapt material and approaches to the needs of the youth, at times a written assignment may be utilized. Because these youth will have more difficulty completing written assignments, appropriately trained direct line staff needs to be available to provide individualized assistance
f) Youth with lower intellectual functioning may have more deficits in sexual knowledge and the ability to establish appropriate socio-sexual relationships than non-disabled peers. The program should demonstrate how they address these issues.
g) Program will use an adapted cognitive behavioral approach with a significant skills building focus.
h) Program will focus on approach goals and not just avoidance goals. For this specialized population programs may want to consider the Old Me/New Me concepts developed by James Haven for developmentally delayed/lower functioning sex offenders.
i) The program will recognize that these youth may need briefer, but more frequent groups to reinforce learning. Youth are to receive at least 4 hours of specialized/focused group therapy for sexually abusive youth per week. Group should not be longer than one and a half hours in length. Due to the needs of this population, groups are to be limited to 8 youth. The length of the group will be determined by the needs of the youth being served.
j) Youth will receive 3 hours of groups per week focusing on building relevant skills or other clinically related needs. As noted previously, the program will recognize that these youth may need briefer, but more frequent groups to reinforce learning. Groups are not to exceed one and one-half hours. Due to the needs of this population, groups are to be limited to 8 youth. Group content meeting this expectation includes anger management, assertiveness, values clarification, stress management, emotional management, etc. Groups such as community, current events, recreation and groups related to milieu management, while important, do not meet this expectation. Group content focused on life skills such as laundry, hygiene, cleaning, nutrition, etc., while important, do not meet this expectation.
k) The Program will provide a minimal of a total of one hour of individual therapy per week. Sessions will be no less than 30 minutes in length.

l) At a minimum, two face to face family sessions are to occur monthly; the program is encouraged to provide weekly family sessions as clinically supported.
   - Contact such as youth to parent phone calls, family visitation, phone call to update family about youth's behavior or routine contact phone calls not focused on therapy are not considered to fulfill this expectation.
   - Family therapy is to be at least one hour or equivalent per contact. At times work may be specifically with the parental unit or significant family members rather than involving the youth and the reasons for this are to be documented in the progress note.
   - Contraindications to family involvement or family therapy will be documented in the treatment plan. The program will notify the FSW via email to any contraindications, problems or concerns related to family involvement. Meeting to discuss the contraindication, problems or concerns will be set as needed.
   - The program will be responsible for assisting the family in transportation and other arrangements related to their involvement. DCS will assist in the coordination of family work as appropriate. DCS will work with the program regarding transportation and other barriers to the family's involvement.

m) Program will address responsivity issues and ensure appropriate therapist style that has been shown to be related to change.

n) Program will be cognitive behavioral in nature, incorporate social learning theory, include a skills building focus and ensure that therapies and interventions include techniques and approaches that promote learning.

o) Consistent with the current research and literature, the programming and treatment will focus on approach goals rather than solely focusing on avoidance goals.

p) Program will address the resident's progress and factors impacting progress and will ensure programmatic use of appropriate practices shown to be associated with change.

6. Education of the Child/Youth

Please refer to the General Residential Treatment Section of the Manual.

7. Records Management

Please refer to the General Residential Treatment Section of the Manual.

8. Monitoring Progress

Please refer to the General Residential Treatment Section of the Manual as well as I.4 specific to Residential Treatment Specialized: Adolescents Who Have Engaged in Sexually Abusive Behavior.

9. Utilization Review

a) Youth referred to the specialized treatment program are to have been approved/authorized for specialized residential treatment for adolescents who have engaged in sexually abusive behavior by the Department of Children's Services designated subject matter expert(s). This approval process is designed to ascertain medical necessity and ensure that the individual youth's level of risk and need are congruent with specialized residential placement and that he/she cannot be appropriately and safely served in a lower level of care.

b) A Central Office Network Development staff member will serve as point person to assist in coordination of aspects of the monitoring, review and evaluation components.

c) Youth authorized for specialized residential treatment for adolescents who have engaged in sexually abusive behavior are monitored through a formal Medical Necessity Utilization Review Process based

on risk/need congruency. The formal Medical Necessity Utilization Review is specific to the individual youth and ensures that the individual youth is in an appropriate level of care as determined by medically necessity and his/her risk and needs (general, sexual abusive behavior and individualized) are being met.

d) Programs providing specialized residential treatment for adolescents who have engaged in sexually abusive behavior state custody youth are responsible for providing monthly clinical summaries on the designated date; these summaries are to follow the SORT Clinical Summary template and be completed by the youth's therapist. In addition other relevant information, documentation or materials may be requested as a part of formal Medical Necessity Utilization process.
e) Programs providing this type of specialized residential treatment are periodically reviewed through a formal clinical program evaluation process. The formal Program Evaluation process includes, but is not limited to, review of the program's admission criteria, assessment process, discharge criteria development, behavioral program, treatment planning, training material and documentation, programming and the continuous care process in general and other relevant aspects and components of the program.
f) It is the responsibility of the region to initiate the appropriate payment upon receiving notification that the youth is approved/authorized for specialized residential.
g) At the point the specialized residential placement is no longer authorized through the formal Medical Necessity Utilization Review process, the region shall assure that the needed change is made regarding payment type/contract. While authorization is based on medical necessity, a reasonable time period is authorized for discharge planning and transition preparation.
h) There is a process for re-review in the event that a program is not in agreement with the findings of the formal Medical Necessity Utilization Review that the youth no longer meets medical necessity for specialized residential. The process includes a first step informal, re-review and a subsequent formal review if needed.

10. Discharge Criteria

a) Discharge/Transition planning is a collaborative effort involving the program, DCS, the family and others in the support system as appropriate (i.e. identified foster parents, relatives, other support persons).
b) Discharge criteria is to be individualized, focusing on readiness for a lower level of care/less intensive services as determined by the youth's risk and needs; not "program completion".
c) An individualized Discharge/Transition Plan for the youth is to be maintained in the youth's file. The Discharge/Transition Plan is to encompass all aspects of the youth's needs related to risk and successful reintegration into the community. Documentation can be incorporated into the treatment plan and is to include: Information related to the specific plan, progress towards the plan, barriers to the plan and how barriers are being addressed.
d) The Discharge/Transition Planning process is to be initiated at admission and reviewed at least monthly with written documentation of the review; this may be a part of the treatment plan.
e) As a youth nears discharge, the Discharge/Transition Planning will include identifying continued treatment needs, determining what services are needed to meet those needs and coordination/collaboration on arranging and obtaining needed services.
f) For youth who have engaged in sexually abusive behavior in the home and return home is being considered or return home where vulnerable person(s) reside, best practices and guidelines for reunification, from the sex abuse and sex offender treatment field, will be utilized. Victim safety, well-being and best interest are a priority in cases of sibling sexual abuse and consideration for initiation of reconciliation and/or reunification process. Consideration for discharge to home where victim or

vulnerable person(s) reside clearly address safety issues and concerns with the well-being and safety of others being a priority.

- Tennessee's Joint Task Force on Children's Justice/Child Sexual Abuse has established criteria and recommended guidelines for reunification of adolescent sex offenders (persons 13 through 17) back into the home where the victim or other vulnerable children reside. The guidelines outline elements that are to be considered in a professional staffing that involves DCS, treatment professionals and service providers working with the individual and family. The *Considerations in the Reunification of Adolescent Sex Offenders With The Families Where the Victims (or other vulnerable children) Reside* can be downloaded in PDF by going to the Joint Task Force Focuses on Child Sexual Abuse Protection (2009) documents at the following link: ***http://children.sworpswebapp.sworps.utk.edu/jtf/***

RESIDENTIAL TREATMENT SPECIALIZED: ALCOHOL AND DRUG

1. General Characteristics

This time limited program addresses the treatment needs of adolescents, ages 13 to 18. These youth display significant impairment in family, social, educational or occupational functioning due to alcohol and/or other drug use. The program is designed for adolescents who need continued structure beyond a typical family setting to provide protection from negative peer influences while promoting a sustained focus on their recovery and rehabilitation. The goal of the program is to attain permanency through reunification if at all possible, upon completion of the program or soon thereafter. The residential program uses a structured 7-day-a-week/24-hour therapeutic environment to achieve rehabilitation. The program will adhere to the General Residential Treatment portion of this manual unless otherwise noted below. The residential rehabilitative program is designed to be brief in nature and is not to exceed 60 days.

2. Admission/Clinical Criteria

a) The adolescent has a substance-related disorder as a primary diagnosis. Adolescents eligible for enhanced Alcohol and Drug treatment services may exhibit co-morbid substance-related and mental health disorders.

b) The adolescent is ineligible if he or she requires medical detoxification, is actively suicidal or homicidal, or has psychosis that is not controlled by medication. Adolescents with a diagnosis of Intellectual Disability are evaluated on a case-by-case basis. Adolescents with an I.Q. lower than 55, or who have adaptive functioning indicating moderate to severe Intellectual Disability are not appropriate, unless the agency is licensed for this service type.

c) There is documented evidence of, or a realistic indication of, serious, impending risk of physical harm to self or others directly associated to the continued abuse of substances. This documented evidence rules out treatment in a community-based setting.

3. Personnel

The agency will adhere to the Personnel requirements of a General Residential Treatment program. Additionally:

a) The agency will have a clinical services director who in addition to meeting the criteria in the Core section of this manual, is trained in and knowledgeable of current approaches in the field of adolescent addiction treatment.
b) There should be at least one credentialed addiction counselor to complete the assessments and provide consultation and supervision as needed to other staff.
c) Treatment should be provided by counselors with training in the area of adolescent addiction.
d) To better implement an enhanced program, non-clinical support staff who also have contact with or supervise children also need initial and ongoing training in the core functions of alcohol and drug counseling and support.

4. Individualized Treatment Plan

a) In addition to the treatment plan components identified in the General Residential Treatment portion of this manual, a nationally recognized A&D evaluation instrument must be administered by designated addictions treatment personnel or addictions-credentialed clinician.
b) Because Specialized A/D programs are brief in nature, the initial treatment plan will be completed within 24 hours of admission. The comprehensive assessment and clinical interview should be completed within three (3) days of program admission, and a comprehensive treatment plan developed within seven days of admission.
c) There must be pre & post-test measure employed to indicate progress in meeting treatment goals.

5. Service Components & Overview

a) The program will adhere to all of the same Service Components and Overview items noted above in the General Residential Treatment section of this manual, with the exception of frequency of therapy, which is outlined below.
b) Therapy includes a minimum of seven therapy contacts per week of at least 60-90 minutes duration per session. These seven contacts will be comprised of at least three group therapy sessions per week and at least two individual therapy sessions per week.
c) Group therapy sessions will have a minimum of four (4) and no more than twelve (12) participants for a valid group session. Groups over six (6) must be facilitated by at least two staff. The facilitator will have the appropriate credentials and will have training in group facilitation.
d) In addition to the seven therapy sessions per week, a minimum of five psycho-educational groups will be provided each week.
e) Family therapy will be provided at least once per week, with a minimum of two face-to-face sessions per month. Alternate forms of contact such as phone conferences are acceptable for the additional sessions. The provider will also engage families through education and support groups and will assist the family in getting referrals to a variety of community services to improve their general functioning.
f) The program may also provide additional services such as 12-step or self-help programs such as AA/NA or specialized relapse prevention therapy.

6. Education of the Child/Youth

Please refer to the General Residential Treatment section of this manual.

7. Records Management

Please refer to the General Residential Treatment section of this manual.

8. Utilization Review

The residential rehabilitative program is not to exceed 60 days. Continued stay beyond 60 days will require clinical evidence submitted to the Office of Network Development for utilization review to justify the ongoing severity of need requiring this intensity of service.

9. Discharge Criteria

Please refer to the General Residential Treatment section of this manual.

RESIDENTIAL TREATMENT SPECIALIZED: AUTISM SPECTRUM – NEURODEVELOPMENTAL DISORDERS RESIDENTIAL TREATMENT FACILITY (RTC)

In addition to adhering to the General Residential Treatment portion of this document, the program will have the following characteristics:

1. The program is highly structured and serves youth ages 6-17 who present with both a mental health diagnosis and an Autism Spectrum or Neurodevelopmental Disorder diagnosis. This includes youth with intellectual disabilities who also have a mental health diagnosis. The youth has an Autism Spectrum or Neurodevelopmental diagnosis, though their level of functioning is not due exclusively to intellectual or developmental disability or organic dysfunction. Difficulties with transitions and/or sensory integration do not impair the resident's daily functioning.
2. The facility will have the staffing capacity to provide a daytime staff to child/youth ratio of 1:4. The overnight staff to child/youth ratio will range from 1:8 to 1:4.
3. The program is appropriately licensed and is able to provide the services outlined in this document.
4. The program is under the clinical supervision of a licensed mental health professional with training and/or experience in the field of Autism Spectrum and Neurodevelopmental Disorders.
5. A physician with training and/or experience in Autism Spectrum and Neurodevelopmental Disorders is to serve as the medical consultant.
6. Direct treatment is provided by qualified clinical staff trained in the field of Autism Spectrum and Neurodevelopmental Disorders.
7. The program provides ABA services or equivalent.

RESIDENTIAL TREATMENT SPECIALIZED: AUTISM SPECTRUM - NEURODEVELOPMENTAL PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

In addition to adhering to the General Residential Treatment portion of this document, the program will have the following characteristics:

1. The program serves youth ages 5-17 who present with both a mental health diagnosis and an Autism Spectrum or Neurodevelopmental Disorder diagnosis. This includes youth with intellectual disabilities who also have a mental health diagnosis. The youth has an Autism Spectrum or Neurodevelopmental diagnosis, though their level of functioning is not due exclusively to intellectual or developmental disability or organic dysfunction.
2. The facility will have the staffing capacity to provide daytime staff to child/youth ratios ranging from 1:4 to 1:1, based on the clinical needs of any child/youth in the program. Children/youth requiring 1:1 supervision will be presenting with extraordinary clinical needs. The overnight staff to child/youth ratio will range from 1:8 to 1:1.
3. The program is appropriately licensed and is able to provide the services outlined in this document.
4. The program is under the clinical supervision of a licensed mental health professional with training and/or experience in the field of Autism Spectrum and Neurodevelopmental Disorders.
5. A physician with training and/or experience in Autism Spectrum and Neurodevelopmental Disorders is to serve as the medical consultant.
6. Direct treatment is provided by qualified clinical staff trained in the field of Autism Spectrum and Neurodevelopmental Disorders.
7. The program provides ABA services or equivalent.
8. The program provides medication management, up to weekly as needed.
9. The program is staffed with a Registered Nurse 24 hours a day.

RESIDENTIAL TREATMENT SPECIALIZED: PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) - SEVERELY EMOTIONALLY DISTURBED (SED)

In addition to adhering to the General Residential Treatment portion of this document, the program will have the following characteristics:

1. The program serves children/youth ages 5-17 who present with significant psychiatric needs and cannot maintain treatment or safety in the community, but who do not meet medical necessity for acute inpatient hospitalization. The child/youth's psychiatric status may be unstable and over the course of treatment and he/she may experience episodes of heightened acuity that require increased supervision.
2. The program will have the staffing capacity to provide continuous 1:1 supervision when a child/youth presents with extraordinary psychiatric needs.
3. The program is appropriately licensed and is able to provide the services outlined in this document.
4. The program is accredited by *Joint Commission*, *The Commission on Accreditation of Rehabilitation Facilities*, *The Council on Accreditation of Services for Families and Children*, or another accrediting organization with comparable standards.
5. A physician is to serve as the Medical Director for the program and will evaluate residents on a weekly basis. The Medical Director will be available on an on-call basis 24 hours a day.
6. The program is staffed with a Registered Nurse 24 hours a day.
7. The program will comply with all applicable state and federal regulations regarding the use of seclusion and restraint.
8. The program will have the staffing capacity to provide continuous 1:1 supervision for any child/youth at the facility, based on his/her level of clinical need. Children/youth requiring 1:1 supervision will be presenting with extraordinary psychiatric needs.

RESIDENTIAL TREATMENT: SPECIAL NEEDS JUVENILE JUSTICE (JJ) ENHANCED SAFETY MEASURES

In addition to adhering to the General Residential Treatment portion of this document, the program will have the following characteristics:

1. **General Characteristics**
   a) The program serves youth in Tennessee DCS custody ages 13 up to 19 who have been adjudicated delinquent.
   b) The facility has enhanced safety measures that include hardware security, in which construction fixtures are designed to physically restrict the movements and activities of juveniles or other individuals (such as fixed windows, perimeter security fencing and locked doors). This means that youth placed in the facility have no egress and those outside the facility have no ingress without the appropriate equipment (keys, key card, etc.). Facility is also staff secure.
   c) The facility is accredited by the Council on Accreditation (COA) or Commission on Accreditation of Rehabilitation Facilities (CARF).
2. **Admission/Clinical Criteria**
   a) Youth appropriate for admission have a history of major impairment in several areas, such as work or school, family relations, judgment, and thinking or mood. Youth have a history of multiple felony charges or one serious felony against a person, and/or a history of a multitude of behaviors including but not limited to: Self-harm, aggression, strong gang affiliation, moderate to serious incidents of sex offending behaviors or described as having conduct, oppositional, or defiant behaviors.
   b) Referrals to the facility will be first reviewed by DCS Office of Juvenile Justice (OJJ) and then provided to the provider for review. The provider works in close conjunction with DCS Central Office in determining appropriateness of referrals and defers to DCS Central Office regarding acceptance of youth. Youth who do not qualify by policy to be placed into this type of facility require a waiver issued by Central Office.
   c) Delinquent youth are placed in the community unless a hardware secure residential facility is determined to be the least restrictive environment. Placement in this hardware-secure facility may be appropriate if one or more of the criteria in Policy ***18.34, Criteria for Referral and Placement of Youth in a Hardware Secure Facility*** Section A, 1, a) are met.
   d) Intellectual Disabilities: Youth with Intellectual Disabilities are placed in a least restrictive setting and are not placed into a hardware secure setting without a waiver. Providers adhere to Policy ***19.6, Assessment and Placement of Youth with Intellectual Disabilities in a Hardware Secure Facility.***

3. Personnel

a) The following staff to child ratios are maintained: 1:8 (one direct- care, awake staff for every eight on-site youth during the day and 1:8 (one direct-care or auxiliary, awake staff for every eight on-site youth) overnight staff. Professional and auxiliary staff may be included in staff child ratio during overnight hours.

Additionally, facilities required by contract or federal regulations to be PREA compliant must ensure sufficient direct care, awake care staff to maintain a 1:16 ratio (one direct care, awake staff to maintain a 1:16 ratio (one direct care, awake staff of every on-site youth during overnight hours). For the purposes of calculating PREA compliant ratios, auxiliary staff may not be counted. For example, if during overnight hours, thirty-two (32) youth are present at the facility, the facility must have four (4) staff present during the overnight hours which may include two (2) auxiliary staff and at least two (2) direct care staff.
Same gender personnel are available to provide supervision and services as needed.

b) All personnel will adhere to the following:
   - Provide services in accordance with Standards of Practice comparable to those of the community and in compliance with State and Federal laws
   - Provide proof of licensure or certification to the Department of Children's Services (DCS) prior to providing services and provide a copy of each renewal upon request
   - Maintain licensure or certification and professional malpractice liability insurance in the State of Tennessee.

c) Psychiatrist: Psychiatric services may be provided by a psychiatrist as described in the General Residential Treatment portion of this chapter, or may be provided by a designated Nurse Practitioner working under the supervision of a Licensed Board Certified Psychiatrist. Qualified staff furnish DCS with a copy of their Drug Enforcement Agency (DEA) registration.

d) Group and Individual Therapists: Group and Individual therapists adhere to the personnel requirements outlined in the Core section of this manual.

e) Group and Individual Therapists providing treatment for youth who have engaged in sexually abusive behavior have specific training and/or experience related to sexual abuse and sexual offender counseling and therapy.

f) Group and Individual Therapists providing treatment for youth are supervised by an individual with experience in the area of alcohol and drug treatment.

g) Availability and Staffing Pattern Requirements – Provider adheres to the following:
   - Psychiatrist, group, and individual therapists provide on-call services for crisis intervention, 24 hours a day, seven days a week either through phone consultation or site visits. These individuals provide cell, home, office or other numbers to allow the facility to have immediate contact with them. These individuals as the crisis responders provide both phone consultation and on site face-to-face consultation as requested by DCS .
   - The provider will have at least one Clinical Services Director on site on campus from 8am-5pm Monday through Friday in order to oversee and ensure the provision of crisis

intervention and needed therapy services.

- Provider will employ full-time, on-site therapists with the ratio of one therapist per 12 youth.
- The Psychiatrist or Nurse Practitioner is available on site or by telehealth at least one day per week for the evaluation and treatment of youth.

4. Individualized Treatment Plan

Please refer to the General Residential Treatment section of this manual.

5. Service Components & Overview

a) The facility maintains a program that makes available a range of resources appropriate to the needs of the youth including, but not limited to, individual, group and family counseling, drug and alcohol education, family planning, HIV and AIDS education along with special management programs and treatment based on assessed risk and need.

b) Policies: The provider will adhere to policies found on the list entitled "***DCS Policies Applicable to Residential Treatment: Special Needs Juvenile Justice Enhanced Safety Measures***."

c) Psychiatric Services: The following services will be performed by the psychiatrist:

- Perform a comprehensive psychiatric evaluation on those youth referred for psychiatric services and/or a medication evaluation
- Provide psychiatric face-to-face and/or telehealth medication management at least monthly for youth currently prescribed psychotropic meds
- Review all psychotropic medication orders every 30 days
- Serve as consultant to the contract pharmacy to develop and maintain a drug formulary that adequately served the pharmacological needs of the student population
- Supervise any follow-up treatment prescribed when the youth returns from an off-campus mental health hospitalization or emergency visit

d) Group and Individual Therapy Services: The following individual and group therapy services are provided for youth at the request of DCS:

- Group therapy is provided for all youth at least four (4) times per week.
- Specialized individual and group therapy to meet individual needs of the youth (i.e. therapy targeting sexually abusive behaviors, gun violence, gun violence, etc.)

e) Specialized services for youth who have engaged in sexually abusive behaviors

- Provider will deliver all necessary therapy/counseling/treatment services to include individual, family, and group therapy for youth who have engaged in sexually abusive behaviors
- The focus of these specialized services includes the sexually abusive behavior as well as other identified emotional and behavioral needs
- Therapists serving youth who have been referred to receive treatment services for sexually abusive behavior are involved in clinical staffings and meetings related to the care of the youth as necessary. They may at times have an active role in preparing documents related to transfer, release, and other clinical situations.

f) Alcohol and Drug Therapy services

- Provider will deliver alcohol and drug therapy services to youth with substance abuse or alcohol and drug counseling needs.
- For youth with a history of possession for resale or extended environmental alcohol and drug issues, group therapy is provided for no more than thirty (30) contact hours.
- For youth with a DSM-5 Alcohol or Drug Use Disorder for whom alcohol or drug use has caused significant life problems, approximately fifty (50) hours of group therapy is provided.
- Duration of group participation will be determined by the Treatment Team. Group therapy participation will cease when treatment goals are met for the youth or when the maximum therapeutic benefit is reached.
- The provider delivers individual alcohol and drug therapy a minimum of twice per month as part of the weekly therapy sessions.
- The provider delivers individual prevention, relapse prevention, crisis intervention, and planning and case consultation services for students with alcohol and drug prevention needs.
- The provider develops culturally sensitive treatment objectives related to drug and alcohol use.

6. Education of the Child/Youth

Please refer to the General Residential Treatment section of this manual.

7. Records Management

The psychiatrist will keep records as follows:

a) Maintain a medical records on each youth that is kept up-to-date at all times

b) Develop and update individual treatment plans for students requiring close mental health supervision. The plan includes directions to medical staff and other personnel regarding their roles in the care and supervision of youth

c) Note in each youth's medical record:
   - Diagnosis
   - Data supporting the diagnosis
   - Identification and justification for treatment or medication
   - Result of such medication or treatment where applicable

d) Ensure that medical records are maintained and available at all on-site health encounters

e) Provide the following review activities during on-campus visits:
   - Review and initial all diagnostic reports (laboratory, pathology, etc.)
   - Review and co-sign all psychiatric associate's orders including referrals and mediation orders

8. Utilization Review

Please refer to the General Residential Treatment section of this manual.

9. Discharge Criteria

Please refer to the General Residential Treatment section of this manual.