



Residential Treatment Workgroup

Final Report and Recommendations

August, 2008

The Residential Treatment Workgroup was created in November 2005 as recommended in the Illinois Children's Mental Health Partnership's (ICMHP) June 2005 Report to the Governor. The Workgroup's scope is to examine children's residential mental health treatment services funded by the State of Illinois, with a primary focus on improving services for youth in residential treatment, youth at risk of such a placement or youth returning to the community after treatment.

The Workgroup membership includes representative stakeholders involved in residential treatment. These include: parents of youth in treatment, residential treatment providers, state agencies that assign and/or fund youth in treatment, community agencies assisting families with residential treatment and partnership leaders.

Workgroup Membership

The following are the active members of the Workgroup:

<i>Tanya Anderson</i>	<i>Department of Human Services/Division of Mental Health</i>
<i>Donna Atkinson</i>	<i>Parent</i>
<i>Barbara Kiely Berens</i>	<i>Parent</i>
<i>Carol Carrier</i>	<i>Parent</i>
<i>Ray Connor</i>	<i>Parent, Co-Chair</i>
<i>Ron Davidson</i>	<i>Department of Children and Family Services</i>
<i>Brenda Forster</i>	<i>Parent</i>
<i>Gaylord Gieseke</i>	<i>Voices for Illinois Children</i>
<i>Arlene Happach</i>	<i>Children's Home Association</i>
<i>Seth Harkins</i>	<i>Department of Human Services/Division of Mental Health</i>
<i>Les Inch</i>	<i>Children's Home + Aid</i>
<i>Ashleigh Kirk</i>	<i>Illinois Children's Mental Health Partnership</i>
<i>Kim Nolan</i>	<i>Parent</i>
<i>John Schornagel</i>	<i>Community Residential Services Authority</i>
<i>Sarah Sebert</i>	<i>Illinois State Board of Education</i>
<i>Mary Shahbazian</i>	<i>Allendale Association</i>
<i>Barbara Shaw</i>	<i>Illinois Violence Prevention Authority, Co-Chair</i>
<i>Amy Starin</i>	<i>Department of Human Services/Division of Mental Health</i>

The Workgroup has been meeting regularly since its formation. Initially the group did fact-finding and researched residential treatment. It visited two treatment facilities and had presentations from knowledgeable experts including Alan Morris, UIC; Amy Starin, DMH; Bob George, Chapin Hall, UC; and Dana Weiner, NU. Recent meetings have focused on producing the policy recommendations and action steps that follow.

What is Residential Treatment?

Definition

Residential treatment facility means a facility operated for the primary purpose of providing residential care and treatment to youth with serious emotional disturbance and co-occurring disorders under the age of 21 years. This level of care offers room, board, psychiatric and other specialized treatments, and access to education. The primary purpose of residential treatment is to stabilize behavior that is dangerous to self and/or others and improve overall functioning, including social and behavioral relationships and skills, so the individual can function adequately in a less restrictive community-based setting.

Goals of Residential Treatment

Placement in a residential treatment facility is appropriate when a youth cannot be effectively treated in the community. The goals of the placement are to treat the youth's psychological and behavioral illness, manage the youth in a safe environment, reduce behaviors that may be a threat to the youth, their family or their community, and facilitate the youth's appropriate and safe return to a less restrictive community-based setting.

Providers of Residential Treatment

According to DMH and DCFS, there are over 50 facilities licensed to provide residential treatment services to Illinois children and youth with psychological and behavioral issues. They vary considerably in size, services offered and youth served. Facilities range from those with fewer than ten residents to one facility with over 150 residents. There are also a number of out-of-state facilities used by Illinois families, most often because they offer specialized services not available in the state.

Facilities range from hospital-like settings serving extremely disturbed youth to more community-based residential treatment settings. The match between a particular youth's needs and the facility is complicated and must be assessed on an individual basis.

Criteria and Funding for Residential Treatment

Residential treatment is funded by several public agencies in Illinois. The Department of Human Services, Division of Mental Health (DHS/DMH) funds residential treatment services through the Individual Care Grant (ICG) program. The ICG program provides services to children and youth with serious emotional disturbance (SED) who have "Severely Impaired Reality Testing" and other symptoms of psychotic illness. This program is a unique Illinois state program that serves

the most troubled youth. ICG funded programming is family driven and will fund either community or residential services. Thus, this program is consistent with the guidelines for family- and youth-driven care advocated by the President's New Freedom Commission. (See Appendix A)

Local school districts, with federal financial support administered by the Illinois State Board of Education (ISBE), must fund residential treatment services when it can be established that residential treatment is required for educational progress. The decision is made by the Individualized Education Program (IEP) team as required by federal and state law. In determining eligibility for residential treatment services, IEP teams may vary in their interpretation and application of criteria. (See Appendix B)

The Department of Children & Family Services (DCFS) funds residential treatment services for Illinois wards when this level of treatment is necessary. DCFS has a process for assessing needs and identifying an appropriate placement. DCFS places a significantly larger number of youth in residential treatment facilities than the other agencies. (See Appendix C)

Both State and County juvenile corrections agencies also fund residential treatment services for youth when needs are identified during legal proceedings.

When an agency other than a school district places a student in a residential treatment center (RTC), the costs of treatment, room and board are included. Educational costs are the responsibility of the home school district if the youth is not a state ward. The school district in which the RTC is located is responsible for the educational costs of wards.

Background & Key Findings

- Residential treatment is an important option in a full range of treatment alternatives for youth and families.
- Best outcomes are achieved when there is extensive family and community involvement in treatment.
- Child and Adolescent Service System Principles (CASSP) and other principles of care apply to residential treatment services. (See Appendix E)
- Outcomes measures are essential, however consensus on applicable measures and measurement tracking is lacking.
- Illinois families have funding options not available in many other states.
- Information about State funding for residential treatment programs is not easily available. There is no single information source available to families, school districts and providers dealing with troubled youth.
- Reliable information about residential facilities is difficult to locate and assess. Families and others need to know what each facility does best, outcomes, lengths of stay, other family experience, etc.

- Transition from residential care to home and community-based services can be difficult and requires extensive planning, support, and collaboration among the individual, family, residential treatment provider, and community resources.

- Fiscal Year 2005 Placements of youth with mental illness (See Appendix C)

DCFS	998	67%
ISBE	169	11%
DHS/DMH	310	21%
JJ	NA	
Total	1,477	

- Out-of-state placements [~30% of Illinois Department of Human Services (IDHS) & Illinois State Board of Education (ISBE)] occur most often because Illinois lacks capacity for Mental Illness/Developmental Disability (MI/DD) dual-diagnosed youth and for those deemed in need of a locked facility.
- Out-of-state facilities are generally not more expensive; however, family involvement may be reduced by distance.
- School districts vary in their willingness to consider residential placement.

Recommendations and *Action Steps*

1. **Residential treatment is an important option in a full range of treatment alternatives for youth and families.** It is recommended that groups such as the Illinois Children's Mental Health Partnership (ICMHP) communicate the value and appropriate use of residential treatment to state policy-makers. Some youth require this level of care at certain times when community-based care is not sufficient or available in order to maintain the safety of the youth and others and to therapeutically address the psychological and behavioral illness in need of treatment. For some, especially adolescent youth, such treatment provides the last chance to become productive, contributing members of society and healthy adults. Residential treatment, while more expensive than community services, contributes significantly to the quality of life of young people with serious emotional disturbances and their families. It is a cost effective intervention, reducing potential future costs of caring for youth/adults in state corrections, long term adult mental health facilities, and the intangible cost of lost futures.

❖ *ICMHP should develop a communication initiative to inform state and federal policy makers about the conclusions and recommendations of this Workgroup. This should include the governor's office, key Illinois agency leaders and legislators, and key national audiences and organizations. Education about the role of residential treatment in caring for our seriously ill children and youth should be included.*

2. **Encourage evidence-informed treatment at residential treatment centers (RTCs).**

Critical components of evidence-informed treatment include:

- (a) Individualized treatment planning based on a comprehensive assessment
- (b) Family involvement in decision-making during treatment planning, discharge, and transition to community-based settings
- (c) Coordinated, multi-system discharge planning
- (d) Stability of post-discharge placement and availability of aftercare support
- (e) Measurable treatment and service outcomes

See Appendix D for a summary of research on residential treatment.

❖ *State agencies that fund residential treatment services should require in contracts that Evidence-Informed Practice processes be utilized in delivery of treatment services.*

3. **CASSP and other principles of care should apply to residential treatment.** See Appendix E for details.

- ❖ *State agencies that fund residential treatment services should require in contracts that the principles detailed in Appendix C be adopted by all residential treatment facilities.*
4. **The State of Illinois should develop in-state capacity to serve children and youth with a dual MI/DD diagnosis.** Out-of-state placements (~30% of all youth in DHS & ISBE placements) occur most often because Illinois lacks capacity for children and youth with a dual MI/DD diagnosis. While DCFS has fewer than 15 children placed out of state, the other state agencies and families find better facilities out-of-state for certain situations. While many out-of-state facilities provide excellent treatment and are not more expensive than comparable Illinois facilities, family involvement can often be increased if the placement is closer to home.
- ❖ *Encourage state agencies that fund residential treatment services to create incentives to develop capacity to serve children and youth dually-diagnosed with MI/DD in Illinois.*
5. **Encourage expansion of collaborative, multi-system, intensive community services as an alternative to residential treatment and as a critical component of community services during transition and post discharge from residential treatment facilities.** It is recommended that an intensive community services program, similar to the community-based Illinois Individual Care Grant (ICG) model be created and available to youth who are not eligible for the ICG Program or other publicly funded services. (See Appendix A)
- ❖ *ICMHP should promote the expansion of flexible funds for an intensive community services program, similar to the community-based ICG, for youth who have severe difficulties but are not currently eligible for services. For example, the Screening, Assessment and Support Services (SASS) flex funds may be a good option for expansion of such non-traditional mental health services.*
6. **State agencies should require that an appropriate discharge process be followed.** To be successful this process should include extensive planning for post discharge services and support. Residential facilities should provide a transition treatment protocol that facilitates safe hand-off of primary care to the family and community based providers and the appropriate level of community experiences well before discharge.
- ❖ *State agencies that fund residential treatment services should require providers to conduct a formal discharge and transition process that links to community services and accounts for the youth's needs in all life domains.*
7. **An ongoing interagency and stakeholder (families and residential providers) workgroup should be convened to examine and continuously improve coordination and availability**

of adequate and appropriate residential treatment services for all youth and families in need. This group will also monitor and track the implementation of the current recommendations.

- ❖ *ICMHP should promote the creation of this interagency and stakeholder (families and residential treatment providers) workgroup that will monitor residential treatment for Illinois youth and identify opportunities for improvement to policy makers and residential treatment providers on an on-going basis.*

8. **Formulate common outcome goals for implementing an outcomes measurement data system across all residential providers** including performance measures. These measures are currently lacking but are essential. It is impossible to demonstrate the benefits of treatment without quantitative measurements on the progress of youth. Currently there are few measurements in place that quantify a youth's progress in residential or community treatment. The Illinois Department of Children and Family Services (DCFS) recently instituted measurements for state wards in treatment and some results are beginning to be available.

The measurement system must allow individuals to be tracked within required confidentiality safeguards across multiple state agencies and provide information about client and family characteristics, the scope of services provided, and relevant intervening variables influencing outcomes and stability of therapeutic gains over time.

- ❖ *The interagency workgroup should develop common goals, outcomes and service tracking measurements for youth in residential treatment.*

9. **A set of variables should be developed for tracking children and youth who receive residential service across all funding agencies [DCFS, DMH, Illinois Department of Juvenile Justice (DJJ), ISBE] to provide consistent and coordinated data that would inform policy development, service planning and resource allocation.** Such variables might include demographic (non-personal) data, service utilization including pre-, during, and post- residential treatment, and service outcomes.

- ❖ *The interagency workgroup should develop a set of variables for data collection to be disseminated across all residential treatment service providers and funding agencies.*

10. **ISBE, DMH and ICMHP should conduct a joint effort to assist families and educators in how to navigate the publicly funded residential treatment and mental health service systems.** This could be accomplished by improving information through upgrades to state web sites and written communications, such as brochures and guidebooks. Information about these programs is lacking and difficult to find. There is no single information source available to families, school districts and providers dealing with troubled youth.

- ❖ *The interagency workgroup will encourage ISBE and DMH to make upgrades to their websites and written communications that will increase community awareness about the residential treatment system.*
- ❖ *ICMHP should incorporate into the Public Awareness Campaign website and informational materials, information useful to parents about navigating the residential treatment system in Illinois.*

11. Encourage the creation of a non-profit or university based information center about residential treatment facilities to increase parent/family knowledge of and access to information that can assist them in identifying and navigating residential treatment services. (See Appendix F). This could be accomplished through web-based options where information about residential treatment services is provided, and where families and youth can provide comments about their experience with residential services. Today, information about residential facilities is difficult to locate and assess. Families and others need to know what each facility does best, outcomes, lengths of stay, other family experience, etc.

- ❖ *Encourage parent/family organizations to undertake the development of a web-based information site that provides information about residential treatment for families. It should contain information about funding sources and residential treatment providers, including the types of services they provide and the situations they treat. This site should also have an area where families can provide information about their experience with residential providers.*

12. ISBE should have dedicated staff with appropriate expertise to provide assistance to school districts to ensure a more consistent approach to assessing the need for and providing funding for residential placement to eligible children and youth. Such staff should also actively participate in post discharge transition back into the community school district for all students returning from residential treatment, regardless of the source of funding for their residential treatment services. (See Appendix B)

- ❖ *ISBE should explore federal, state, or other resources to fund technical assistance positions to assist districts and families to create a more consistent approach to transition from any placement back to school with residential placement decisions and the eventual transition of youth back to the community.*

Summary and Conclusions

The workgroup finds that residential treatment in Illinois is providing important care for severely disturbed youth. Youth requiring this level of treatment at a particular time in their development are able to obtain state funding through several agencies.

There is, however, need for a number of improvements, detailed above in the workgroup's recommendations and action steps. These focus on five areas:

- 1) Assuring that all providers apply well-accepted treatment standards and principles consistently. These include CASSP principles, evidence informed treatment practices, an effective discharge process and extensive family involvement.
- 2) Implementing progress and outcomes measurements on state-funded residential treatment so that results can be quantified and improvements assessed.
- 3) Improving community-based services as an alternative to residential treatment and to support youth returning from residential treatment.
- 4) Creating an on-going interagency and stakeholder workgroup to monitor improvements and identify future opportunities for improvement.
- 5) Making information about residential treatment readily available to families, community agencies, schools, courts and others involved in placement decisions. This will include information about the services offered by residential treatment providers and funding options available.

In summary, residential treatment is an important intervention option for severely disturbed youth at critical times. State policy makers and agency management should support the workgroups recommendations so that this critical service option may be made more effective for youth with the most severe needs.

Appendix A

ICG Community-Based Services

The Individual Care Grant (ICG) program is an Illinois state program that provides services to children and youth with severe emotional disturbance (SED). The grant criteria are restrictive and require that the youth have "Severely Impaired Reality Testing" and other symptoms of psychotic illness. Once awarded the program is family driven and will fund either community or residential services. Thus, this program is consistent with the guidelines for family- and youth-driven care advocated by the President's New Freedom Commission.

The ICG community services are extremely flexible within the overall program structure and can be tailored to the needs of each family and youth. These services are designed to assist the youth in the following four areas:

1. Address the **safety** needs of the youth, family and community as they relate to the behavioral and emotional concerns. This should include crisis response services, and crisis training for the family.
2. Provide a daily **structure** that will enable a well-regulated and consistent schedule for the youth to follow with adequate supervision.
3. Provide a regular source of **socialization** for the youth that gives adequate supports sufficient to allow their success.
4. Provide consistent opportunities for **skill development** that leads the youth towards developmentally appropriate functioning in all life domains.

Case Coordination. Each ICG youth has a case coordinator assigned at the SASS agency providing ICG support. Whether they are in residential or community treatment their case coordinator works with them and their family to arrange services and assist them in dealing with other agencies such as schools.

Therapeutic Mentoring. Youth in community treatment are provided with mentors (called Therapeutic Stabilization Workers by the ICG program) who work with them on specific clinical issues related to success in the community and skill development.

Therapeutic Recreation/Socialization. Therapeutic recreation services are funded by the ICG program to give youth opportunities for normalizing activities in a safe and appropriately supervised environment. The services are often provided by Special Recreation agencies in the Chicago suburbs and larger cities outside the metropolitan Chicago area.

Behavior Management. The ICG program will fund family and youth training on behavior management techniques to assist the youth in developing coping skills needed for normal life in a community setting. These services are made available on an individual basis and are time-limited.

The following are the formal definitions of the 4 types of services that the ICG grant can cover in the community.

- 1) BEHAVIOR MANAGEMENT INTERVENTION - A time-limited, child and family training/therapy intervention focused toward amelioration or management of specific behaviors that jeopardize the child's functioning in the home/family setting. This intervention typically teaches/models techniques and skills that can be used by the parent/guardian and other family members.

- 2) CHILD SUPPORT SERVICES - Time-limited funding to cover costs that would otherwise be prohibitive to the parents for the child to participate in community activities when those activities are related to objectives in the child's current individual services plan.

- 3) THERAPEUTIC STABILIZATION - An essential part of in-home services, providing a timely one-to-one relationship between the child and a contractual agent of the SASS agency for the purpose of facilitating age-appropriate, normalizing activities of the child.

- 4) YOUNG ADULT SUPPORT SERVICES - Time-limited funding for young adults to cover costs of services and supports, not included under other programs for which the person may be eligible, to aid the young adult in his or her transition to community living. These funds can be applied to the costs of a supported living arrangement or other appropriate transitional services that help to integrate the young adult into his or her adult roles in the community.

Appendix B

Factors/considerations that can impact a School District's decision to place a special education student into a residential treatment facility

Legal/Procedural Limitations

Special Education is a broad federal entitlement with rigid and highly specific rules and procedures about how educational placement decisions are to be made. The Illinois State Board of Education and individual school districts are required to work within these federally prescribed boundaries.

- **Only the IEP team has the legal authority to make decisions about a student's placement.** While a parent(s) is a very important member of the IEP team, other team members have an equal decision making authority. Other IEP team members include: the student, special education teacher, regular education teacher, administrator, and other appropriate school personnel that may be involved with the child
- LRE (Least Restrictive Environment). **IEP teams required by federal and state laws to educate students in the least restrictive environment.** Residential placement is the most restrictive placement on the educational services/placement continuum. Typically, an IEP team does not consider *educating* a student in a residential environment until less restrictive placements have been tried and have proven to be ineffective. It must be clear that the student cannot benefit from educational services unless 24 hour programming is provided.
- **IEP teams can only residentially place a student in a facility which is on the Illinois State Board of Education approved list** and at rates specifically approved by the Illinois Purchased Care Review Board.

Financial Considerations

When an Illinois School district places a student in a residential treatment facility for educational purposes, it must pay for room and board costs as well as special education tuition costs. Billing and reimbursement for each of these costs are governed separately, each creating unique funding considerations and possible disincentives for districts placing students for residential treatment.

Room & board-treatment costs

When a school district residentially places a student, room and board costs are billed by the private provider (generally monthly) and the district is expected to pay those bills immediately.

- After an IEP team makes the decision to residentially place the student, the district applies for approval to claim reimbursement of the room and board costs from the ISBE (using Form 34-37). ISBE uses Federal-Part B funds that are specifically reserved for room and board reimbursement. In recent memory, the Part B Room & Board fund has been sufficiently large that placing districts have been reimbursed at 100%
- *All Illinois Districts (including Chicago 299)* are reimbursed for room and board costs for the current school year on a monthly basis, beginning in December (for the months of September through November). Claims for December services submitted in January (and for all following months through August) are paid immediately, provided that claim is error-free in terms of the 34-37, FACTS, and private facility approval. At that time, reimbursement is at 90% of the claim (i.e. the amount they have paid out). Districts have until November 1 to submit claims for the previous year. The remaining 10% is paid in January or February.

Potential disincentives

- For many districts (particularly smaller districts) the delayed reimbursement strategy can create financial hardships.....having to pay the room and board costs immediately but for 3 months not being reimbursed immediately, thus losing the use of the money during the interim period. This *cash flow problem* creates a disincentive for a district considering residential placement for a student. However, ISBE has attempted to make the delay in reimbursement as minimal as possible.
- There is a fear among districts that the Part B, Room and Board reserve may not be sufficient to cover all of the room and board claims during a particular year and that unpaid claims would need to be passed back to placing districts in the form of pro-rations. The funds allocated for this purpose cannot be used by ISBE for any other purpose so Room and Board reimbursement pro-rations are rare.
- *34-37 Accountability and Anxiety:* Once an IEP team commits on paper (IEP) to residentially place a student, it is obligated to pay for the associated costs. There is a fear among districts that if ISBE for some reason(s) elects to deny funding room and board reimbursement in the 34-37 process, the district will have no way to recapture those dollars. ISBE's role in residential placement is only to determine that proper procedures have been followed. Only a district that is willfully non-compliant with state and federal regulations runs the risk of not being able to successfully seek reimbursement from ISBE.

Special Education Tuition Costs:

When an Illinois School district places a student in a residential treatment facility for educational purposes, it must pay for the cost of special education services (tuition) associated with that placement. Educational services may be provided at the RTC in a public or nonpublic program, or off-campus in a public or nonpublic program. Districts then seek reimbursement from the ISBE. The following formula applies:

FOR PLACEMENT IN AN APPROVED NONPUBLIC SPECIAL EDUCATION PROGRAM (under Section 14-7.02 of the School Code)

- Placing districts are expected to pay a “double per-cap” or twice the local per capita educational expenditure (that is the amount that a district spends each year to educate students in their district) as their contribution for tuition expenses.
- The remaining amount of money spent on tuition in an approved nonpublic school is then reimbursed to the school district under procedures outlined in Section 14-7.02.
- If the ISBE tuition fund does not have enough funds to reimburse the placing district at 100%, those unpaid costs are passed back to placing districts in the form of pro-rations. The current pro-ration is 88%. The average pro-ration for the last 6 years is 89%.

FOR PLACEMENT IN A PUBLIC SCHOOL SPECIAL EDUCATION PROGRAM (under Section 14-7.01 & 14-7.02b of the School Code)

- Placing districts are expected to pay four per capitas as their contribution for tuition expenses.
- The remaining amount of money spent on tuition is then reimbursed to the school district under procedures outlined in Section 14-7.01 & 14-7.02b.
- The ISBE fund never has enough funds to reimburse the placing district at 100%, so those unpaid costs are passed back to placing districts in the form of pro-rations.

Non-voluntary tuition

When a child is residentially placed by any public agency/entity in Illinois, the resident school district is statutorily obligated to pay for the costs of special education services (tuition). In these situations, the child’s resident district has no control over the placement or the associated tuition costs and at times can make the case that the student was performing successfully in the district’s own program. As outlined above, tuition associated with a publicly funded residential placement can vary significantly if the child is educated in a public school program or if the child is educated in a nonpublic program. In the past, some school districts have refused to provide funding for educational services in cases such as these. To help alleviate this problem, Senate Bill 398 was passed in 2007, allowing school districts to claim 100% reimbursement for the educational costs of students placed residentially by other state agencies. However, no proration for funding was attached to this bill and until such time as funding is available, it would not appear that this bill will have an impact on districts’ willingness to fund educational costs.

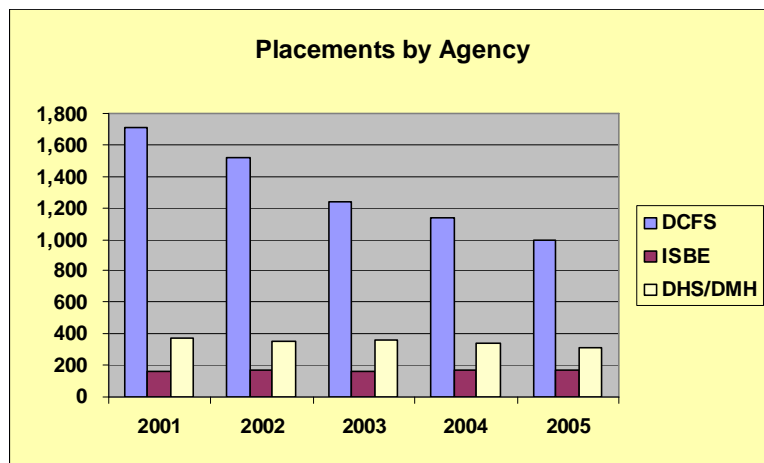
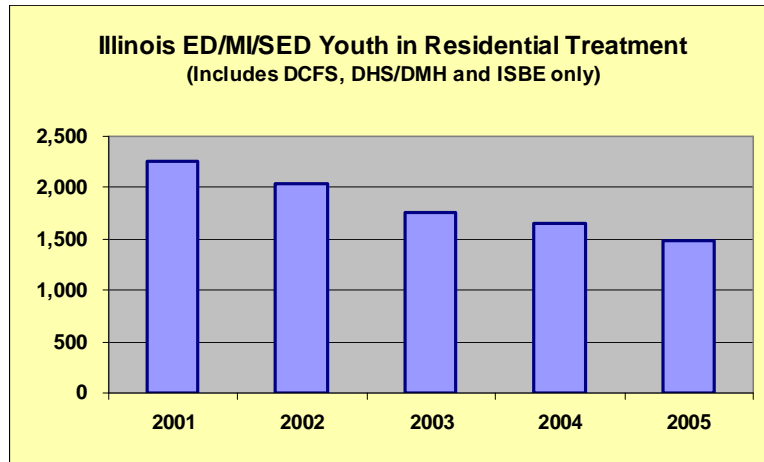
Multiple-agency Considerations

Students who might be considered for residential placement by their school district might also be eligible for residential placement and funding by other state agencies. Schools frequently seek to explore overlapping service and funding eligibility through other entities and systems *before* committing to residentially place a student for educational purposes. The tensions that are created between parents and schools and between schools and other systems as these multiple resources are explored tend to slow the residential decision making process and have frequently led to lawsuits.

District Superintendents, Special Education Directors, and Cooperative Directors in Illinois have long advocated for the development of a multiple–agency residential decision making process so that school districts and state agencies can more equitably share in the responsibilities and related costs for Illinois children who require residential treatment. Illinois has tried to promote interagency equity and decision making responsibility by use of Memorandums of Understanding, Interagency Agreements, and creation of interagency authorities. Each approach has been only partially effective. Disputes over responsibility and funding are both time and resource consuming.

Appendix C

Residential Placements of Youth with Mental Illness



Note that both State and County juvenile corrections agencies assign some youth to residential treatment but those numbers are not included

Definitions commonly used: ED --Emotional Disorder
 MI -- Mental Illness
 SED -- Serious Emotional Disturbance

Appendix D

Research On Outcomes and Effectiveness of Residential Treatment

Research Summary

Residential Treatment seems to be effective for most individuals when treatment success is measured at discharge. Although some symptoms may worsen (Lyons et al., 2001), and some individuals may be at high-risk not to succeed (Gorske et al., 2003), overall, the services offered at RTCs are typically able to stabilize behavior and functioning while individuals are in residence. However, there is much to be learned on which children benefit from which forms of RTC. There are many different models and many different levels of quality among providers.

The research also reflects concern that gains made in residential care are not maintained following discharge to a less restrictive setting. Factors that correlate with improved long-term outcomes are intensive family involvement and treatment during the course of the residential placement, thorough and early discharge planning and continued therapeutic supports in the community when the child returns home.

Appendix E

Values and Principles for the System of Care *

Children's mental health service delivery has undergone a major change during the past fifteen years. The introduction and implementation of the Child and Adolescent Service System Program (CASSP) has required a thorough reform of how children's mental health services are conceptualized and delivered. The State of Illinois supports the core values and guiding principles of the CASSP model.

Core Values

- 1) The System of Care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
- 2) The System of Care should be community based, with the locus of services as well as management and decision-making responsibilities resting at the community level.
- 3) The System of Care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the population they serve.

Guiding Principles

- 1) Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
- 2) Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
- 3) Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
- 4) The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
- 5) Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating service.
- 6) Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
- 7) Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
- 8) Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
- 9) The rights of children with emotional disturbances should be protected and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
- 10) Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

*CASSP Technical Assistance Center, Center for Child Health & Mental Health Policy, Georgetown University Child Development Center

Guiding Principles for Residential Treatment

The following, derived from CASSP and System of Care Principles, are recommended for residential treatment in Illinois

- 1) A comprehensive system of mental health care contains specialized services that address needs of clients. These services are informed by developmental and trauma theory. The theory guides the daily care, psychological treatment and case management provided to children, adolescents and young adults with mental, emotional and behavioral health challenges. Least restrictive and closest to home treatment characteristics are balanced with the recognition that residential in-patient treatment for mental, emotional and behavioral illness is the appropriate alternative for some youth at critical points in their development.
- 2) Treatment teams for children, adolescents and young adults in need of comprehensive mental health treatment services consist of the youth, their family, significant others in the youth's life, professionals from the residential treatment center and collateral professionals representing the educational/vocational professions, community based mental health services providers, and legal advocates as needed.
- 3) Treatment services are provided in environments that recognize the critical need to maintain safety of the child and others, provide crisis stabilization, and competent comprehensive assessment and individualized treatment planning/delivery attuned to the unique needs of the youth and family, and specifically addressing the conditions that prevent the youth from living in a less restrictive setting.
- 4) Treatment environments should be based on practices that address the attachment and relationship repair needs of the youth and fully partner with biological and surrogate families to ensure critical relationship connections are maintained, strengthened and committed to the long term care and nurturing of the youth. Treatment planning should immediately focus on the step-down pathway for the youth to an appropriately supported less restrictive level of care.
- 5) Treatment environments must address the unique developmental needs of the child, adolescent or young adult and provide for the youth's right to competent and appropriate opportunities for education/vocational preparation, recreation/play, socialization, community involvement and other normative or age-appropriate and enriched experiences that are necessary for healthy development and available to their peer counterparts elsewhere.
- 6) Treatment services should immediately consider post-treatment clinical and living support needs and plan with the youth and family for the availability of these supports, to ensure residential treatment lengths of stay are based on treatment needs only. Discharge planning for smooth transition to lower levels of care in environments with developmentally appropriate family and significant other connections is the responsibility of the entire treatment team.
- 7) A comprehensive system of mental health care assures the availability of an array of treatment options to adequately meet the treatment and developmental needs of youth and families that is focused on the best interest of the child/youth. These treatment options must be equitable in access to all youth and families in need. Eligibility for services and points of entry should be determined by youth need and not dependent on narrowly defined requirements designed to limit access, or on family financial resources.
- 8) A comprehensive system of mental health care recognizes the importance of prevention and supports public policy that addresses the mental health needs of children and families and ensures service access at par with physical health services. This parity in mental health prevention, early intervention and treatment delivery is infused in the public policy for 0-3, early childhood care and education, and local public and private health care and educational systems.
- 9) A comprehensive system of mental health care acknowledges that every child and family in the State is susceptible to mental, emotional and behavioral illness and the devastating effects of trauma via nature,

nurture and/or fate circumstance. This system provides, delivers and monitors necessary services in a coordinated, efficient and transparent manner, assuring family/youth a voice and choice in treatment with open and transparent access to information regarding treatment options and Residential Treatment Center performance, licensing and accreditation standings.

- 10) A comprehensive system of child and adolescent mental health care establishes as public policy priority the need for child and adolescent mental health residential treatment centers to be adequately and predictably funded, and encouraged to provide services representing excellent levels of care and professional expertise. Research on treatment effectiveness, outcomes and innovative program development for prevention, recovery and cure is encouraged, adequately supported and recognized as a long-term cost effective human and financial investment.

Appendix F

Roadblocks to Residential Treatment

Families with children in need of residential treatment often have difficulty accessing residential treatment programs. Residential treatment services are expensive and are beyond the ability of most families to afford. There are four public funding sources for residential treatment – Department of Children and Family Services (for Illinois wards), the Illinois Department of Human Services, local school districts, and the Department of Juvenile Justice. Most families look to the Illinois Department of Human Service’s Individual Care Grant Program or local school districts for funding. The ICG program is difficult to access because the clinical criteria for eligibility for serious mental illness is narrow and requires that applicants evidence severely impaired reality testing, which is most often associated with psychotic disorders.

Funding through local school districts is difficult for two reasons. First, it must be established that residential treatment is required for educational purposes. This means it must be demonstrated that education in lesser restrictive environments is not appropriate and the child is only educable in a twenty-four hour residential treatment center. Second, many school districts assert that they can provide a basic floor of opportunity within community settings, such as publicly funded therapeutic day schools. Disagreements over school funded residential treatment are often contentious and resolved through due process hearings, which are emotionally and financially challenging for most families. This is topic is well covered in the attached “*Factors/considerations that can impact a School District’s decision to place a special education student into a residential treatment facility.*” (Appendix B)

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Glossary

CASSP - Child and Adolescent Service System Principles

CRSA - Community & Residential Services Authority

DCFS - Illinois Department of Children and Family Services

DD - Developmental Disability

DHS - Illinois Department of Human Services

DJJ - Illinois Department of Juvenile Justice

DMH - Illinois Division of Mental Health

ED – Emotional r Disability

ICMHP - Illinois Children's Mental Health Partnership

ICG - Illinois Individual Care Grant

IEP – Individualized Education Program

ISBE - Illinois State Board of Education

JJ - Juvenile Justice

MI - Mental Illness

RTC – Residential Treatment Center

SASS - Screening, Assessment and Support Services

SED – Serious Emotional Disturbance