C·B·H
Community Behavioral Health

Psychiatric Residential Treatment Facility

Performance Standards

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CONTENTS

I. PURPOSE OF PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) PERFORMANCE STANDARDS

The PRTF Performance Standards describe expectations for quality in service delivery for children and adolescents (hereafter often referred to as "youth") and their families, whose treatment services are funded through Community Behavioral Health (CBH). They articulate requirements for PRTF programs and provide a guide for providers to design and monitor their programs.

These standards are grounded in the DBHIDS Practice Guidelines, as well as Child and Adolescent Social Service Program (CASSP) and System of Care principles and align with regulatory requirements. They were developed through collaboration with youth and family members, providers, system stakeholders, and in consultation with the Building Bridges Initiative. Select sections were developed by providers and family members through the CBH Community of Practice, and the complete standards have been reviewed by the City of Philadelphia Youth Residential Placement Taskforce, which includes system leaders, advocates, providers, family, and youth.

Providers entering the CBH network following the time of the publications of Standards will be expected to meet the Standards prior to their program start date. Existing CBH providers will be expected to implement the Standards over time, prior to their enforcement, through CBH oversight and monitoring processes.

The Standards emphasize permanent connections and sustained family and community reintegration for youth as the major goal of PRTF care; given the high percentage of youth in PRTFs with child welfare involvement, this requires strong collaboration with child welfare entities. An emphasis on permanent connections also calls for PRTF providers to prioritize consistent and active family engagement, deliver culturally and linguistically competent treatment for youth and families, and conduct inclusive discharge planning through collaboration with families, treatment providers, and community supports.

Another major aim for the PRTF Performance Standards is to ensure all providers have the capacity to treat youth and families who have historically encountered treatment barriers due to being turned away, expelled, or unsuccessfully returned home from residential treatment, leading to years of cycling in and out of residential care. All PRTFs must be able to treat complex, challenging, high-risk needs, including aggression, elopement histories, and trauma; additionally, PRTFs must be adept in engaging family members and treating challenges within the family system, ensuring, as noted, a primary focus on successful, sustained community reintegration for youth and their families. Treatment should encompass the whole health of the youth and include attention to their physical, educational, and recreational needs in addition to addressing their behavioral health challenges.

II. SCOPE OF SERVICES

PRTFs provide intensive treatment for youth and families whose needs are such that youth require 24-hour living arrangements while youth and their families receive intensive behavioral health treatment aimed at sustained returns to home and community. The residential intervention provides the opportunity for individualized and culturally and linguistically competent[1] treatment and supports, ongoing assessment, and skill-building tailored to the needs of every youth and family.

III. PHILOSOPHY OF SERVICES

The PRTF Performance Standards have been guided by best practices and seek to emphasize:

- Individualized, culturally and linguistically competent, strength/resiliency-based, trauma-informed services with a focus on skill building
- Youth/family voice and choice in all treatment, support, and program decisions
- Comprehensive and immediate family engagement and partnerships to support sustained, successful outcomes for youth with their families in the home and community following PRTF treatment
- Permanent connections for youth without identified permanency plans
- Standardized behavioral approaches to prevent aggression, which can lead to elimination of restrictive procedures within the PRTF

PRTFs must cultivate an organizational culture that reflects the tenets above. The PRTF objective to provide a nonviolent/nonrestrictive environment must be visible in the collaborative and egalitarian working relationships between and among all involved parties—PRTF staff members, leaders, youth, family, and partnering agencies and stakeholders. This includes youth and family involvement in all aspects of the PRTF, to inform both treatment planning and program development. To this end, each PRTF must implement the best practice of Six Core Strategies for Reducing Seclusion and Restraint Use©.

[1] The Pennsylvania System of Care Partnership defines "cultural and linguistic competence" as "the integration and transformation of knowledge, behaviors, and attitudes from and about individuals or groups that enable policymakers, administrators, youth, families, service providers, and system partners to work effectively in cross-cultural situations." "Cultural and Linguistic Competency," Pennsylvania System of Care Partnership, https://www.pacarepartnership.org/resources/cultural-linguistic-competency/.

IV. SUMMARY OF REQUIRED ELEMENTS

This document is intended to identify the required standards for providing the PRTF level of care as well as the recommended best practices and guidelines. Required elements are listed below and will be elaborated upon elsewhere in the document.

- Six Core Strategies for Reducing Seclusion and Restraint Use
- Adherence to CBH's access and referral process
- Family-driven, youth-guided, and culturally and linguistically competent organizational culture demonstrated through pre-admission outreach, treatment, and aftercare
- Assessment and treatment planning that includes a Comprehensive Biopsychosocial Evaluation (CBE), and evidence-based screening and assessment tools and treatment interventions
- Treatment modalities outlined on pages 6-15
- Coordination and collaboration with community resources, natural supports, and aftercare services to support community integration during treatment and community tenure following discharge
- Hiring, supervision, and training practices that support quality care and staff retention
- Support of the Best Interest Determination process in educational placement for all youth

V. PRTF COMPETENCY TO TREAT YOUTH RECEIVING SERVICES

Youth referred to PRTF treatment are experiencing and exhibiting challenging symptoms and behaviors, including emotional dysregulation and/or disruptive behaviors, suicidal/homicidal ideation, trauma symptoms, aggression/assaultive behaviors, self-injurious behaviors, impulsivity, affective impairment (i.e. withdrawn, reclusive, labile, reactive), substance use, and/or bulimia/anorexia nervosa. Many youth have histories of multiple placements and elopements. Their families are also often experiencing multiple challenges. CBH historic data indicates the primary diagnoses for youth ages 13-18 placed in a PRTF have included: posttraumatic stress disorder (PTSD), bipolar disorder, depression, autism spectrum disorder (ASD), and attention deficit hyperactivity disorder (ADHD). An approval for PRTF level of care indicates that a youth's symptoms and behaviors are severe enough to exceed the threshold of a less intensive treatment environment. According to CBH service utilization data, more than 50% of youth who receive PRTF treatment have Philadelphia Department of Human Services (DHS) involvement. Many youth have histories of chronic and complex trauma, including sexual abuse, physical abuse, neglect, multiple caregivers/placements, loss, and exposure to intimate partner and/or community violence. PRTFs must maintain robust clinical programming, including evidence-supported and trauma-informed practices appropriate to treat these needs.

PRTFs must be able to accept and accommodate the needs of LGBTQIA youth, including respecting and accounting for gender identity, gender expression, and sexual orientation in both placement recommendations and treatment, ensuring special medical needs are met for transgender youth, and

using youth-selected names and pronouns. Providers should align their programs and practices with the guidelines published by the American Association of Children's Residential Centers.[2] CBH welcomes partnerships with providers to address regulatory barriers to gender-affirming care.

VI. PRTF ACCESS AND REFERRAL PROCESS

The process to recommend and refer a youth and family to PRTF predicts the success the youth will experience during and after PRTF care. The PRTF must establish working relationships with families, crisis response centers (CRCs), acute inpatient hospitals, providers of community-based services, the Department of Human Services (DHS)/Community Umbrella Agencies (CUA) (for child welfare or juvenile justice-involved youth), and the CBH Utilization Management team to ensure smooth referral and admissions processes.

The PRTF recommendation and referral process is described below. It is understood that PRTF providers are not primarily responsible for some of the initial steps; however, the entire process is being included for clarity:

- An interagency meeting must be held with the participation of CBH Clinical Care Management and all other involved parties/agencies prior to submitting a formal recommendation for PRTF level of care.
- The legal guardian must be identified and comprehensive efforts made to include the legal guardian in the interagency meeting. All children under the age of 14 require legal guardian consent for admission to PRTF.
- Family members and caregiving resources must be identified during PRTF recommendation and referral processes. Additionally, support people, who are part of the youth's routine or easily accessible via the youth's social and/or spiritual networks, such as friends, neighbors, ministers, relatives, community groups, and others, should be engaged.
- Youth who are referred with no permanent/life-long connection should receive Family Search and Engage, Family Finding, or another organized approach to identifying and comprehensively supporting kin or others considered family to establish permanency for the youth. High-fidelity wraparound teams, with expertise in permanency practices, can also be utilized as resources to support all permanency for all youth.[3]
- The request for PRTF authorization must be submitted with a psychiatric evaluation completed no more than 60 days prior to the date of the request; the psychiatric evaluation must include a recommendation for PRTF based on medical necessity criteria. All PRTF providers are expected to communicate to CBH on a weekly basis about current bed availability, even if they do not have referrals in their queue.

[2] American Association of Children's Residential Centers, "*Redefining Residential: Ensuring Competent Residential Interventions for Youth with Diverse Gender and Sexual Identities and Expressions*."

- CBH will submit individual referral information to multiple PRTF providers to ensure access is as timely as possible. It is expected that CBH's provider network operates on a "no eject/no reject" basis; however, in the cases of complex psychiatric presentation, PRTFs are expected to complete a face-to-face interview prior to issuing a denial of acceptance.[4] Referring entities are expected to maintain contact with the PRTFs being considered and to document such contact.
- The child/family must be provided information in a culturally and linguistically accessible manner indicating why particular PRTF providers are being suggested to them based on the providers' abilities to meet the identified individual and family needs.
- PRTF providers are expected to inform, in a culturally and linguistically accessible manner, referral sources, youth, and families of their current capabilities and specialties, identifying program strengths and the profiles of the children and families they can most effectively serve. PRTF providers are expected to maintain up-to-date, family-friendly literature (e.g. brochures) inclusive of this information for referral sources and families to make informed choices.
- Once a referral is received, the staff must contact families, offer to arrange visits to the program prior to placement, and provide families with as much program information as possible to assist them in deciding what program best meets the needs of their child and family. PRTF providers should document all outreach and educational efforts extended to families to assist families through the pre-admission and admission process.
- Pre-admission visits must engage youth and families. The following interventions are recommended for pre-admission engagement: the PRTF should connect the youth and family to peer and family mentors/alumni who are willing to provide guidance. The PRTF should also provide written materials about the PRTF guidelines and approach to treatment, local community resources, and directions/parking. Youth and families should be given a site tour with introductions to staff and other residents and should be accompanied to visit the prospective school.
- While awaiting a youth's placement in the PRTF, the identified lead of the current interagency team is responsible for collaborating with the family to develop an interim plan for services and to oversee the implementation of this plan. The prescribing evaluator is expected to participate in the process.

VII. ADMISSION

PRTF staff must provide a warm welcome and orientation process for youth and families. This must include providing culturally and linguistically competent pre-admission outreach to the youth and family to reassure, support, inform, and engage them. Any steps of the pre-admission process that could not be completed prior to admission (e.g. due to the family being unreachable and/or hospitalization of the youth), including a site tour and connection to mentors, should be provided during the admission process.

[4] Provider Bulletin #18-14 Community Behavioral Health: Updates to Psychiatric Residential Treatment Facility and Residential Treatment Facility Referral Process: Pre-Admission Interview Requirement. August 21, 2018.

Examples of ways to orient youth and families are:

- A “Welcome Box” with small gifts and personal care items should be given to each youth and to each family upon admission, based on input from youth about what they need to feel comfortable and take care of themselves/their hygiene (e.g. items to do their hair). This gesture will help to ease the transition for arriving youth by making them feel safe and comfortable and support the family in understanding their own needs for comfort and support during this time of transition. The “Welcome Box” items should be reviewed monthly for any additions or updates needed.
- Youth and families should be asked how they define “success,” i.e. what will it look like when the youth is ready to end PRTF treatment.

VIII. ASSESSMENT AND TREATMENT PLANNING

Each child must receive a Comprehensive Biopsychosocial Evaluation (CBE) during PRTF treatment. For placement in Joint Commission-approved PRTFs, a board-certified child psychiatrist must complete a psychiatric evaluation. For placement in non-Joint-Commission-PRTFs, a licensed psychologist can complete a psychological evaluation.

Evidence-based/evidence-informed screening tools/assessments, including for exposure to potentially traumatic events (PTE) and traumatic stress symptoms, must be administered within the first 30 days to determine course of treatment. Ongoing screening tools and assessments are to be utilized as appropriate to measure symptoms and progress in treatment. High-risk behavioral assessments must be completed, including screening for suicidality, homicidality, and substance use. Review of prior records and collaboration with prior providers is also expected. The PRTF provider is expected to develop a proactive plan of action that ensures the child’s safety to the greatest extent possible in the event of a crisis.

Family engagement and building partnerships with families are major components of the assessment process. Family members must be engaged using best practices and culturally and linguistically appropriate approaches at the earliest stage of PRTF treatment possible (ideally prior to the start of treatment, as noted). The assessment is an opportunity to obtain their perspective regarding the factors that contributed to PRTF placement and the family goals for PRTF treatment. Family members must also be educated about PRTF treatment, the significance of their roles in treatment, and the range of information, educational, skill-building, peer, and other supports that will be provided to families.
The treatment team should meet with the child and family within the first 7 days to review the resiliency plan and revise as necessary.

An interagency meeting must be held approximately one month prior to the expiration of the current authorized service period to review progress toward goals, responsiveness to residential interventions for the youth and family, and to clinically review the need for continuing stay at this level of care.

IX. COURSE OF TREATMENT

PRTFs must provide a nurturing, safe, comfortable, culturally and linguistically competent, trauma-informed, and supportive clinical environment; all residential interventions in the home, community, and program, as well as in staff training, coaching, supervision, and evaluation, must be geared toward the individualized and interpersonal, not the standardized and uniform.

This includes compassionately and effectively addressing the etiology of conflict, rather than focusing solely on containment of behaviors. In concert with the organizational culture model, residential interventions should focus on supporting family learning and skill use in their homes and communities and on accessing the services and supports they need to successfully have their child at home. Additionally, residential interventions should have strong focus on strategies to increase youth capacity for self-control and self-regulation; improve interpersonal relationship skills; prevent loss of self-control (i.e. aggression) and eliminate restraint and other untoward events (e.g., police calls, hospitalizations, elopements); and promote developmentally appropriate autonomy to support a sustained ability to live and thrive as members of families and communities.

Treatment and support interventions must be individualized, strength-based, culturally and linguistically competent, youth- and family-driven (operationalized in treatment planning), trauma-informed (in accordance with an evidence-based or structured model, such as the guidelines issued by the American Association of Children's Residential Centers),[5] with interventions reflecting the specific needs and preferences of youth and families. Fully partnering with families is one of the most critical components of PRTF treatment and cannot be overstated; any barriers or reluctance of youth or family members to participate in treatment and support should be comprehensively debriefed, and consistently and patiently addressed, with staff creatively employing new engagement strategies as needed. Use of family and youth advocates/peer mentors is critical for successful partnerships. Moreover, if a youth is admitted to the PRTF without clear permanency/family involvement and engagement, cultivating family connections (however "family" is defined by the youth) must be established as the most important goal in the youth's treatment plan.

With the primary focus of treatment on family engagement in an individually-tailored manner, PRTFs should draw from select evidence-based/evidence-supported treatments and supports that are appropriate for families and youth (including Dialectical Behavior Therapy [DBT], Trauma-Focused

[5]American Association of Children's Residential Centers, "Redefining Residential: Trauma-Informed Care in Residential Treatment," https://togetherthevoice.org/sites/default/files/paper_8_trauma-informed.pdf.

Cognitive Behavior Therapy [TF-CBT], Applied Behavior(al) Analysis [ABA], Cognitive Behavioral Therapy [CBT], Ecosystemic Structural Family Therapy [ESFT], Multi-systemic Therapy [MST], Motivational Interviewing [MI], Trauma Systems Therapy [TST], Attachment, Regulation, and Competency [ARC], Risking Connections, Collaborative and Proactive Solutions [Dr. Ross Greene], Collaborative Problem Solving). PRTF providers are expected to work toward and achieve designation in at least one Evidence Based Practice (EBP) through DBHIDS's Evidence Based Practice and Innovation Center (EPIC)'s EBP Designation process.

PRTFs must establish methods to sustain treatment and support practices, including ensuring staff training, continual education, mentoring, coaching, and evaluation. Additionally, PRTFs must develop strong and sophisticated approaches to supervision that ensure fidelity to selected interventions; strategies for supporting staff, addressing vicarious trauma, and preventing attrition should be established. Treatment and support must include consistent use of standardized tools to measure treatment impact and supports used. Treatment must ensure families are provided with supports, knowledge, and skills to effectively support their child in the home both during and post-PRTF treatment.

Staffing patterns must ensure delivery of active treatment seven days per week, which includes providing nontraditional clinical hours during evenings and weekends and planning treatment times around family's preference and schedule. Therapy must occur twice weekly in some form based on descriptions and prioritizing described (family over individual; recreational over group).

PRTF Treatment must include the following modalities:

1. **Family Work and Support:** Work with family involves numerous types of interventions and supports, individualized to the unique cultures, strengths, and needs of each individual family member. Family members / support people must be viewed as equal partners in residential interventions and must be actively engaged before admission and throughout the PRTF residential interventions. Families should be kept informed of all aspects of the youth's care to enable them to make informed decisions and be actively involved in their care.

   Family insights and perspectives must be carefully and sensitively sought to help to identify the factors that contributed to the need for PRTF intervention, and the family goals for PRTF intervention, thereby increasing staff understanding of the youth within the context of their family. Siblings and other important family members should be included in the work with families. Work with families should foster enhanced relationships and communication to promote improved functioning in the family system and improved functioning following PRTF interventions. Family education and skill-building regarding the youth's behaviors in the context of their mental health, trauma, and other needs, and strategies for supporting self-regulation and addressing the youth's emotional and behavioral needs from this perspective, must be provided. Formal in-person work with and

support of family, ideally in their homes and/or community setting of their choice, must occur weekly at a minimum, with staff contact with family occurring, ideally, daily. Work with families should provide opportunities to discuss youth time at home, address strengths and challenges, replicate skill practices that are occurring in the PRTF setting, and incorporate skill practice specific to supporting a successful permanent return home. Goals for family treatment and support must be reviewed at least weekly, including ongoing dialogue regarding the family's strengths and community supports to enhance the treatment and support plan. Use of family advocates in work with families is a critical component of PRTF interventions. Technology should be utilized to enhance and ease direct support of family skill practices, including Skype/Zoom with staff during time with youth. Families should be connected with a respite resource during PRTF treatment for support following discharge.

2. **Youth time with family:** Spending time with family is a right, not a privilege, and is the primary treatment/support intervention for the youth and family that correlates to sustained success in the home/community post-residential discharge. Time with family/extended family in the home and community should occur at a minimum of two times weekly, beginning the week of admission, with at least one recreational/off-site contact outside of family therapy. In some cases, contact with family may need to build gradually with structured support to move toward more frequency and independence. Contact via phone between the youth and extended family members and support people (including siblings and approved friends of the youth) must occur daily, often multiple times daily, unless contraindicated or disallowed by a court of competent jurisdiction. When a specific family member is not allowed (i.e. legally) to have contact with the youth or only limited and supervised contact, then the primary goal of the PRTF will be to find and engage other family members. Staff of all disciplines should have skills for working with families in their homes and communities to teach the youth and family how to navigate everyday living together and how to build the necessary support and treatment networks in the community to ensure successful and sustained living together at home. Spending time at home with family is not to be denied as a punishment for behavioral infraction or youth rule-breaking.

   Moreover, if a youth is admitted to the PRTF without clear permanency/family involvement and engagement, this must be the primary and urgent treatment focus at the outset and should be identified as the most important goal of the youth's treatment plan. If any youth are transitioning to adulthood through an independent living arrangement, the PRTF must support youth in determining who they consider family and what supportive, safe, and caring relationships look like. Any youth transitioning to independence must be connected to at least one, and preferably many, caring adults who can provide support.

3. **Family engagement/addressing obstacles:** Providers must ensure they have capability for working with families in the home/community as the most preferred location for working with families. In rare situations where this is not viable, providers should have the capacity to use video for some contact with family members. Formal treatment team meetings need to occur in person. There must be a plan, as well, to transport families to and from the PRTF as needed. PRTF staff should make and document multiple attempts to reschedule meetings / planned time with families canceled by the family; one attempt is not enough. Debriefing with the family should occur in a sensitive and non-blaming manner to understand how to ensure family participation with future meetings. When a provider has been unable to engage a family in treatment and support after two weeks, CBH should be contacted. After one month, an interagency meeting to collectively address obstacles should be held. A comprehensive strategy should be immediately developed, inclusive of family, youth, and family advocates, to engage families with obstacles to consistent participation. This strategy should include debriefing about what, in the past, has not worked and why. A minimum of outreach every two weeks to families who have not been consistently engaged should occur to assess their level of satisfaction with services and what additional supports or modifications might assist them in increasing participation in treatment and supports.

4. **Groups:** Small groups constitute another treatment modality and support component of a PRTF, as long as the small groups are based on the individual treatment needs and strengths of each youth and are documented as such. PRTFs should provide an array of various types of groups to ensure individual treatment needs are met.

5. **Individual therapy:** Person-centered and culturally competent interventions in individual therapy must be provided with an emphasis on evidence-based approaches to the individual needs of each youth. Focus areas for youth with challenges who go to PRTFs sometimes include self-management, coping skills, negotiation, mediation, and conflict resolution. Trauma-specific treatment approaches that have evidence for the specific ethnicities of the youth and families served should also be employed. Treatment must continuously address individual barriers for the youth and family to live together successfully in the community; sometimes youth may need support with successful self-regulation, interpersonal functioning, and problem-solving challenges with school, friends, siblings and/or parents/caregivers. Individual therapy must be available to youth a minimum of once weekly and should occur more as dictated by individual need (more if clinically indicated and/or ,in rare cases, when family therapy is not occurring); the frequency of individual therapy should be based on the youth and family's progress in developing the skills and support needs for the youth's return home.

6. **Substance use treatment:** PRTFs should provide substance use treatment on-site for youth with co-occurring disorders. Substance use treatment should be provided via the above modalities as needed and should utilize EBPs such as Motivational Interviewing. For youth

whose substance use needs require a level of care or specialization provided off-site, options for receiving substance use treatment in the PRTF (i.e. via a mobile/co-located provider) should be explored with the substance use provider and CBH. All youth with substance use needs should be supported in becoming actively involved in community supports that can continue after they return home, such as Alcoholics or Narcotics Anonymous or community-based treatment.

7. **Recreational activities / allied therapy:** A range of recreational activities (e.g. walks, exercises, games, creative arts and crafts, leisure activities) should complement traditional therapeutic modalities and be a core part of everyday life for every youth served. Recreational activities serve as an opportunity for each youth to identify their strengths/interests/talents/areas of passion, and promote/engage in activities that match these interests (etc.), promoting increasing skills in the area(s) chosen. Youth should be enrolled in structured extra-curricular activities, such as music lessons or sports/fitness classes in the community (preferably home community). Recreational activities should also provide opportunities for interaction and social skills practice with pro-social youth in the community. These activities must occur in the community (preferably home community)—unless clinically contraindicated—and be agreed to by the entire treatment team. If there are emergencies or clinical contraindications that prevent recreational activities, then the treatment team should identify specific interventions aimed at readying the youth for community activities. The PRTF program, in partnership with the families and youth, must "do whatever it takes" to support each youth in capitalizing on their strengths, talents, and interests with activities in the community (including their communities of origin if possible) with pro-social peers.

8. **Ensuring safe, caring, and effective interventions—within the PRTF and in the home and community:** The PRTF must embrace a set of best practice values (e.g. family-driven; youth-guided; trauma-informed; culturally and linguistically competent; strength/resiliency-based; individualized) that are operationalized into defined practices that staff utilize daily to support families and youth and ensure safety first. Comprehensive staff training, ongoing coaching and mentoring, and evaluations against specific staff skills and practice expectations will result in the realization of safe, caring, and effective interventions—both within the PRTF (formerly labeled "milieu management") and in the home and community. All youth require structure to their days and expectations based on their age, individualized strengths and challenges, and each youth's family norms and daily structures to which they will return following PRTF treatment.

   The overall program structure must have flexibility built into it to address the individual strengths, challenges, needs, and cultures and home schedules of each youth and family served. Examples include: some youth use showers twice daily for calming/soothing; some youth have side effects from their medication that make them too tired in the morning to go to school, so a later start time could make the difference between school success and constant school challenges; some youth need to stand and move around or sit on a bouncy ball because of their anxieties or sensory needs during group meetings—the number of examples is in the hundreds.

Since a critical program component will be a focus on each youth being involved in community activities (ideally home/community) that match their strengths/talents/interests with pro-social peers, the need for identifying drivers as part of addressing overall program needs is imperative.

Since youth will spend part of their time within the PRTF, the program must have defined practices that ensure safety (e.g. environmental rounds to continually ensure safe, clean, and pleasant physical environments within the PRTF). Program leaders must ensure that the program environment and practices and staff skills all combine to create an organizational culture that reflects the program values. Examples include a strong commitment to non-violence by all staff through the promotion of individualized self-regulation approaches, and a commitment to eliminate restraint and other coercive interventions (i.e. police calls). The daily schedule must promote family/community connection and engagement, and flexible rules designed to meet the youth/family's needs (and not for organizational convenience), including holding therapeutic sessions and activities off-site. Each youth must be engaged in the PRTF service and encouraged in their role to promote the overall safety of other residents, staff, and visitors. The organizational practice framework, as referenced above, should ensure safe, caring and effective interventions.

9. **Psychiatric Care:** Psychiatric care must be comprehensive and include a psychiatrist who guides care by serving as a key member of the clinical leadership team, by participating in clinical team meetings, providing consultation to clinical staff, training direct care staff as indicated, and providing psychiatric evaluations that include input from family members and youth. A psychiatrist is uniquely skilled to inform and guide clinical formulation, differential diagnosis, treatment planning, and overall care monitoring. There must be regular and ongoing contact with treatment staff to formulate and monitor the implementation of the youth's treatment plan. Psychiatrists must coordinate and/or advise staff on medical matters, including the prescription and monitoring of psychotropic and other medication. Staffing of psychiatrists must be sufficient to allow for regular participation in clinical team meetings and weekly appointments for youth as needed, with monthly contact at a minimum. There must be regular and ongoing face-to-face or phone contact with the youth's family and contact with external community agencies and natural supports important to the youth's life. Psychiatrists will also perform and prepare psychiatric evaluations as required that meet CBH standards. Psychiatrists must guide aftercare planning, including ensuring connection to community-based psychiatric care following PRTF treatment.

   Psychiatrists must assess a child's medication needs during the first contact to ensure necessary treatment begins as soon as possible. Consent to initiate medication should be sought daily once medication is recommended and should be accomplished through informed consent with the youth and family. When indicated, medication administration should begin as soon as possible and generally within three to five days of admission. In extenuating circumstances when this is not possible, providers should contact CBH to discuss barriers.

Psychotropic medications should be prescribed judiciously and in conjunction with appropriate therapeutic and behavioral interventions to minimize the risk for side effects and overmedication of youth in residential settings. Psychiatrists should prescribe the minimum effective dose to achieve and sustain clinical stability. Polypharmacy—including utilization of more than one medication from the same drug class—and prescribing dosages outside of the approved dose range should be minimized and avoided when possible. If polypharmacy and prescribing outside of approved dose ranges is clinically warranted, the psychiatrist must regularly reassess the medical necessity of the medication regimen.

If a child was being treated by an outside psychiatrist at the time of admission, the PRTF psychiatrist must contact the outside physician. PCPs must be consulted for medically complex children and/or when medical input is required to make an appropriate and safe medication recommendation. Outreach attempts and collaboration should be documented.

When medication is being considered as part of treatment, there should be an interactive, well-documented[6] discussion with the youth and caregiver/guardian regarding:

- The rationale for initial prescription of medication, including the condition or targeted symptoms
- The FDA approved dose range for the condition or targeted symptoms and, if applicable, the clinical rationale for prescribing a dosage outside of this range
- The risks specifically associated with proposed use
- If the selected medication is off-label, the nature of off-label use and the reasons for choosing the non-FDA approved medication
- As applicable, the nature of any black box warnings as well as the regulatory requirements and monitoring schedules set forth by the FDA for these uses
- Proposed strategy for tapering and/or discontinuing the prescribed medication[7]

Literature and guidelines regarding pharmacotherapy best practices must be consulted and documented. In particular, this should include previously issues CBH Clinical Guidelines[8, 9] and all recommendations in the American Academy of Child and Adolescent Psychiatry *Practice Parameters for the Use of Atypical Antipsychotic Medications in Children and Adolescents*.[10]

[6] Documentation should clearly describe the details and rationale from the above list, as well as indicate that they were discussed with the child/adolescent and caregiver/guardian.
[7] Provider Bulletin #10-03: Community Behavioral Health: Use of Psychotropic Medications in Children and Adolescents (FDA-approved and Off-label). January 11, 2010
[8] Community Behavioral Health: Clinical Guidelines for the Prescribing and Monitoring of Antipsychotic Medications for Youth. July 30, 2018
[9] Community Behavioral Health: Clinical Guidelines for the Pharmacologic Treatment of Attention Deficit and Hyperactivity Disorder (ADHD). July 30, 2018
[10] R. L.Findling, S. S.Drury, & P. S. Jensen. *Practice Parameter for the use of Atypical Antipsychotic Medications in Children and Adolescents*. American Academy of Child and Adolescent Psychiatry. Accessed on March 7, 2012.

Medication side effects as well as relevant laboratory values should be monitored as clinically indicated. For those children and adolescents receiving atypical antipsychotics, metabolic monitoring to screen for weight gain, diabetes, and hyperlipidemia should be conducted and documented according to the following table:[11]

Screening Guidelines obtained from ADA, APA & AACAP Recommendations[9]							
	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 years
Personal & Family History[B]	X					X	
Weight (BMI)[A]	X	X	X	X	X		
Waist circumference [A]	X					X	
Blood pressure [A]	X			X		X	
Fasting Plasma Glucose [A]	X			X		X	
Fasting lipid profile (HDL, LDL ,TG, TC) [A]	X			X			X
[A] More frequent assessments may be warranted based on clinical status [B] Personal and family history of obesity, diabetes, dyslipidemia, hypertension, or cardiovascular disease							

X. RESTRAINT REDUCTION WITH THE GOAL OF ELIMINATION

Organizational Culture Model

PRTFs must enact an established approach to organizational culture that strives for eliminating restrictive procedures, most notably restraints. The implemented model for organizational culture must emphasize:

- Family and youth voice, in which youth are treated as equal stakeholders in driving treatment and developing the PRTF program
- Trauma-informed care marked by relational and collaborative, rather than punitive and coercive, approaches
- Supports for internal self-regulation, including teaching and coaching of family members in same approaches and their role in assisting the youth with self-soothing
- Individualized interventions that do not rely on the use of standardized behavioral approaches for all youth served
- Targeted hiring and staff support strategies, including training and coaching *all staff* in trauma-informed, compassionate de-escalation strategies and the use of a range of

[11] Provider Bulletin #07-07: Community Behavioral Health: policy regarding the Screening for and Treatment of the Components of Metabolic Syndrome. November 1, 2007.

prevention tools that support youth and families in learning and practicing self-regulation
- Protocol for debriefing following all restrictive procedures

Six Core Strategies to Reducing Seclusion and Restraint Use© is the preferred organizational model for PRTFs.

Crisis Prevention and Intervention Plan

PRTF staff, in collaboration with families and youth, must together develop individualized and trauma-sensitive prevention (e.g., warning signs; triggers; soothing strategies; what not to do when upset) and crisis intervention plans for every youth. PRTF staff and family members should also develop their own individualized prevention and, if applicable, crisis intervention plans to support their knowledge and understanding about warning signs, triggers, and strategies for self-calming/soothing. The family and youth need to receive education and support on use of these plans in the home and community, including "role play" and practice scenarios, and ensure the plans are relevant to the home and community and not to behaviors that happen only in the residential program. All systems and providers involved in delivering services to the youth are to be made aware of the prevention and crisis plans. A crisis plan should address, at a minimum:

- Identification of prior precipitants to crises
- Delineation of interventions to address precipitants
- Means of assessing the outcome of the interventions
- Specific youth-chosen alternatives to be tried prior to consideration of restrictive interventions
- Plan for communicating significant events in the child's life to members of the treatment team
- Inclusion of youth-selected staff in crisis planning

Debriefing Protocol

PRTFs must have an established debriefing policy and protocol to implement following all restrictive procedures, with the aim at preventing the need for future restrictive intervention. These protocols must adhere to the Department of Health and Centers for Medicare and Medicaid Services requirements[12] and should include the following best practices, particularly when youth have repeated restrictive procedures:

- Reviewing the de-escalation and the actual restraint/AWOL/police call
- Using a trauma lens to ensure staff, families, and youth learn from the experience, including identifying ways in which the restraint could have been prevented through

[12] Any elements of a debrief that cannot be completed within the required 24-hour timeframe should be addressed in the week following the incident.

identifying triggers and warning signs earlier in the day/past couple of days (which may not have been noticed by staff)

- Exploring opportunities for the family/youth community supports to become involved earlier in the process (i.e. when triggers were first displayed)
- Reviewing the youth's participation in the prior weeks in normalized community activities that match the youth's talents/interests/strengths
- Reviewing the youth's frequency (i.e. at least two to three times weekly) in spending time at home with family members and talking with different family members multiple times daily
- Reviewing the youth's comfort with their permanency plan
- Reviewing the youth's relationship with staff, and their skill levels, who were working during the time the crisis was developing
- Conducting trauma-sensitive interviewing of youth post-restraint/AWOL/police call, with a peer mentor and a trusted staff member who was not involved in the restraint, with an understanding that multiple 'compassionate inquiries' may be needed in non-traditional manners (e.g., playing basketball; taking a walk; eating a snack) to truly learn what the youth feels staff could have done differently long before the escalation, what has been missing in their life, what is needed, what strategies would have worked better to support them in self-regulation, etc.
- Emphasizing a culture of learning and growing over blaming the youth
- A separate debrief between the supervisor and involved staff member

While putting comprehensive emphasis on preventing and reducing restraints, PRTFs must continue to train and mentor staff to properly conduct restraints during regular training to ensure that, if a restraint does happen, it is done properly and youth are kept safe.

Communication: The PRTF staff, including the psychiatrist and mental health workers, and the youth and family, must participate in treatment team meetings at a best practice minimum of every 15 days and more often based on individual need.[13] Youth and families should always participate in these rounds to ensure that their voices and choices are heard, understood, and incorporated into everyday programming both in the program and in the home and home community. The PRTF management should ensure that there is time built-in during shift changes to allow for mental health workers and other staff to share expressed needs of youth and families, and any other pertinent information and updates in real time.

Out-of-area events: PRTFs must follow Office of Mental Health and Substance Abuse Services (OMHSAS) and CBH regulations to address out-of-area events (formerly known as "elopements"). Preventing out-of-area events must be a key goal of residential interventions, with youth voice and

[13] 15 days is best practice. Frequency of meetings should also be based on youth's proximity to discharge (i.e. use more frequent meetings to promote/plan for shorter discharge date).

choice actively part of developing of individual and program strategies to prevent these incidents and support one another in utilizing learned skills and sharing concerns.

XI. LINKAGES

Linkages and coordination with community resources and other providers are essential to providing active PRTF treatment and planning successful transitions to the next level of service. PRTFs must conduct utilization reviews with CBH. PRTFs must establish working relationships with outside medical providers and specialists to address routine and complex medical needs of youth. Similarly, PRTFs must work in close collaboration with the school district and local schools to ensure uninterrupted and appropriate education during PRTF treatment. Each PRTF staff member must provide an active role in sustaining linkages and mobilizing these linkages to plan a successful discharge for each youth and family.

When an acute inpatient stay occurs, there must be communication and collaboration with the inpatient team about the relapse plan to enhance continuity of care.

XII. AFTERCARE PLANNING/ POST-TREATMENT SUPPORT

As successful youth and family cohabitation after PRTF treatment is the major target of treatment and support (rather than stabilizing the child in the PRTF setting only), aftercare planning must occur continuously from pre-admission to discharge. An aftercare planning meeting must be held within 30 days of the projected return-home date. Living arrangements for the child following PRTF care must be established at admission, with details including routine and household rules to be confirmed during final stages of treatment. A lead agency should be identified 30 days prior to the youth returning home. All parties must be aware of the youth's triggers for escalation of behaviors and symptoms that would warrant re-admission, and a plan must be in place to help the family and child cope with these potential stressors. All follow-up appointments, including medication management, must be scheduled by the PRTF provider with the family.

The PRTFs must plan for supporting youth and families post-discharge. This should include a plan for a warm handoff with the clinicians and direct-care staff who have been working with youth and families in their homes and communities throughout the residential intervention, and they should remain available for outreach by new treatment providers after discharge if issues arise.

The transition home begins pre-admission and continues post-admission, with the major focus of the residential intervention on supporting the youth and families with the skills needed for success and building a support network at home and in the community. PRTFs must, from pre-admission, begin to develop collaborative relationships with community-based services and supports to ensure the

youths' successful reintegration into the community upon discharge. It is expected that youth and families will receive services and supports in the community during residential intervention, so the "warm handoff" to community providers and supports will have developed over time. Collaborative relationships include partnering with schools, community resources, and family members for post-PRTF opportunities and support.

Identification of community supports must be youth- and family-driven, with particular attention to their preference for location of supports, as youth and families will best know the neighborhood/communities that present risk for them vs. ones that present opportunities for safety and success.

PRTFs are encouraged to familiarize themselves with the Building Bridges Initiative (www.buildingbridges4youth.org) to enhance partnerships with community-based providers and resources, aimed at facilitating successful and sustained community re-integration for youth.

Coordination with past, current, and prospective providers is critical. Linkages with Philadelphia DHS/CUA will be essential to ensuring youth are connected to safe and supportive placements/families following discharge. PRTFs should also collaborate with DHS/CUA to conduct Family Finding if family is not identified at the outset of PRTF treatment. Special coordination will be required for transition-age youth who do not have options for family placement following PRTF stays; this includes partnerships with housing programs, Assertive Community Treatment (ACT), and case managers.

A CBH discharge planning meeting will occur for all youth served at intervals, to be determined based on clinical need. A transition and discharge plan should be developed and signed by the individual, the identified family, CBH, and all involved agencies. These plans should also include a safety component.

XIII. FOLLOW-UP PRACTICES

All PRTF providers are to complete telephonic discharge reviews within 24 hours of discharge. Discharge summaries are to be sent to all involved systems within 7 days of discharge.

- PRTF providers are to monitor the implementation of the discharge plan by following up with the child/family or caregiver at a frequency based on individual need; some families will need daily contact, others less frequent.
- At a minimum, follow-up should take place with all youth and families at 6 and 12 months after discharge.
- PRTF providers are to contact the lead agency to address any concerns that the discharge plan is not being implemented as planned by the interagency team.

- Providers are to be available for consultation with the interagency team to share knowledge about what has been helpful to a youth or family in the past to assist the team in addressing any problems the youth may be experiencing post discharge.
- All PRTF providers are expected to assess child and family satisfaction and feeling of safety on a routine basis.
- Satisfaction is to be measured at admission (with intake and admission process), during the stay (with treatment, facility, communication, staff), and post discharge (with support through transition, adequate discharge planning).
- Results of satisfaction measures are to be incorporated into the program's continuous quality improvement efforts.
- PRTFs must establish methods to sustain treatment and support practices, including ensuring staff training, continual education, mentoring, coaching, and evaluation. Additionally, PRTFs should develop strong and sophisticated approaches to supervision that ensure fidelity to selected models of treatment.

XIV. PERSONNEL

It is critical that PRTFs employ strategic hiring procedures to identify highly qualified candidates who can support the mission of the PRTF to provide compassionate, nonrestrictive care. Given the diversity in racial and socioeconomic background of youth and families who receive PRTF treatment and support, hiring strategies must aim to form a PRTF team whose diversity reflects that of the youth and families served. There must also be a clear plan for how the psychiatrist will provide regular oversight to the program and be informed of critical incidents or pertinent clinical trends (i.e. increased lengths of stay, restraints, elopements, etc.).

PRTFs must ensure that all staff meets the education, experience, and training requirements for positions held and possess all applicable clearances. To help prevent rapid turnover of staff, PRTFs must apply the following strategies:

- "Right hire" by having families and youth participate in the process.
- Assign staff mentors to new hires to support them as they begin their employment.
- Conduct six-month and yearly post-hire interviews.
- Disallow staff access to personal electronic devices while on shift, e.g. cell phones.
- Provide supervision on the job, in real time (in-the-family's-home/in-the-community/on-the-floor). This coaching allows leaders to be present while modeling, teaching, demonstrating competencies/best practice, and supporting staff.
- Emphasize supervision and regular meetings with management regarding their work with youth and families, program and staff strengths, program and staff challenges and needs, and use of restraints.

- Provide staff with appropriate training to promote positive relationships with youth and family

As a condition of employment, all direct care staff, including Child Care Supervisors and Child Care Workers, must be trained according to the CBH Manual for Review of Provider Personnel Files (MRPPF)[14] regulations without exception. This includes 55 Pa. Code § 3800.

XV. INFORMED CONSENT

Informed consent is a critical component of PRTF treatment. The informed consent process should be used as an opportunity to engage family members and emphasize family members' involvement as a predictor of the youth's success in treatment. The process must provide education about the goals of PRTF. The appropriate staff at the PRTF should assist the guardians with review and signing of consent documentation. Consent forms must be culturally and linguistically appropriate, and all releases of information must include names of the individual/agency, the information to be shared, and the date the consent was signed. Signatures on consent forms for treatment and releases of information should be obtained no later than 48 hours following admission to PRTF.

Consent should be obtained in accordance with state regulations for age and guardian consent. The PRTF should comply with the following statutes and regulations relating to consent to treatment, to the extent applicable:

- 42 Pa.C.S. § § 6301-6365 (relating to the Juvenile Act)
- The Mental Health Procedures Act (50 P.S. § § 7101—7503)
- The Act of February 13, 1970 (P.L. 19, No. 10) (35 P.S. § § 10101—10105)
- Chapter 5100 (relating to mental health procedures)
- The Pennsylvania Drug and Alcohol Abuse Control Act (71 P.S. § § 1690.101—1690.115)
- Other applicable statutes and regulations

Whenever possible, general written consent should be obtained upon admission, from the child's legal guardian, for the provision of routine healthcare, such as child health examinations, dental care, vision care, hearing care, and treatment for injuries and illnesses. A separate written consent should be obtained prior to treatment, from the child's parent or legal guardian, or, if the parent or guardian cannot be located, by court order, for each incidence of nonroutine treatment, such as elective surgery and experimental procedures. Consent for emergency care or treatment is not required.

[14] Provider Bulletin #17-13: Community Behavioral Health: Changes to Children's Psychiatric Residential Treatment Facility Staff Requirements. October 25, 2017

XVI. PHYSICAL PLANT

The interior of the PRTF must provide a comfortable living space with ideally no more than two youth per bedroom; access to outdoor space; room for youth and families to spend time together; and space to accommodate milieu activities, therapy sessions, meetings, and staff offices. Youth and families should know their care teams as well as which staff are on site at any given time, e.g. through name tags, staff shirts, staff photos, etc.

Details such as décor and layout should be thoughtfully considered to ensure the environment is trauma-sensitive and promotes a therapeutic milieu. This includes selection of home-like and soothing vs. activating colors and including youth and families in décor decisions as much as possible to increase a sense of choice and self-expression (including youth bringing items from home that meet safety standards).

XVII. DIVERSITY, EQUITY, AND CULTURAL AND LINGUISTIC COMPETENCE

All PRTF providers are expected to support the development of cultural competence regarding gender, age, race, ethnicity, spirituality/religion, gender identity, and sexual orientation within their programs through:

- Open, respectful communication with youth and families to better understand culturally- based values and belief systems that need to be considered when learning and practicing new self-regulation/supportive skills
- Documentation of all initiatives to further develop the cultural competence and sensitivity of staff and interventions to improve the overall equitability of their programs
- The presence of a diverse, prepared, and culturally and linguistically competent workforce
    - Staff receive ongoing training, coaching, mentoring, supervision, and evaluation on cultural and linguistic competence, with specialized additional training and support when families/youth from a culture that has not previously been served comes to the PRTF.
- Programming that recognizes the extent of cultural diversity among residents, and embraces the different ethnicities and cultures of the youth and families served
- Scheduling that ensures youth spend holidays and all special family events with their families in their homes and communities
    - Holiday and special event planning ensures youth build memories with families and not with staff.
    - When needed, staff support families in ensuring holidays can be celebrated—not just for the youth, but for all siblings.

- Opportunities for youth to engage in their religious practices, preferably in their home community, accommodating for religious holidays and dietary requirements, as well as providing appropriate space for prayer, meditation, and other spiritual practices; affirmation to the family and youth that the youth's spiritual preferences are welcome in the PRTF
- Respect for the wishes of families in all aspects of the youth's life
    - Haircuts, clothes shopping, doctor appointments happen in collaboration with the family and occur in the home/community.
- Inclusion of local neighborhood beliefs and values

As noted, PRTFs must be able to accept and accommodate the needs of LGBTQIA youth, including respecting and accounting for gender identity and sexual orientation in both placement recommendations and treatment, ensuring special medical needs are met for transgender youth and that youth-selected names and pronouns are used consistently.[15]

The PRTF must ensure knowledge and skills to meet all special communication needs (e.g. deaf, hard-of-hearing, visually impaired, ASD, dually diagnosed), reaching out to the broader community to increase their expertise and bring in experts/peers/families with similar needs to support the individual youth and family.

XVIII. EDUCATION

Placement

School engagement and progress are key to youth's well-being and preparation for adulthood, as well as a powerful counter to recidivism or placement instability. Absent a specific decree from the Courts, placement decisions must prioritize educational continuity for youth, in the least restrictive setting possible. Federal legislation and state guidance from child welfare, juvenile justice, and special education rights arenas document youth's educational rights, along with guidelines for shared decision-making.

Under the federal Fostering Connections Act and the PA Department of Education and juvenile court rules, youth should stay in their school of origin unless not in their best interest. For elementary students, staying in the school of origin is a priority for educational stability. Middle school students should be monitored for any signs of disengaging from school (attendance, behavior, grades), then connected to appropriate supports. High school students who are chronically truant may benefit from exploring other school options and should be actively involved in decisions.

Individual case factors that warrant shared decision-making and a possible school move:

[15] American Association of Children's Residential Centers, *"Redefining Residential: Ensuring Competent Residential Interventions for Youth with Diverse Gender and Sexual Identities and Expressions*."

- Safety concerns – e.g. bullying or community protection (delinquent placements)
- Move coincides with natural transition time – e.g. vacation or holidays
- Youth not making reasonable progress and/or academic needs would be better met at another school setting – e.g. IEP accommodations
- Significant commute that would have negative impact on youth

Family members, youth, the host school district, and PRTF staff must together make a "best interest determination" (BID) about the most appropriate educational setting. Participants in decision-making can include representatives from the placing agency (e.g. Philadelphia DHS), residential provider, youth's current school, local educational agency where the provider is located, case managers, probation officers, mental health resources, advocates, parents, or other caring adults.[16] Priorities to guide this shared decision-making include minimizing educational disruptions and ensuring immediate enrollment in an appropriate educational setting. Priorities in determining the best school option for each youth include:

- The least restrictive environment
- Placement with peers in general education to the "maximum extent appropriate." Special classes or separate schools should only happen when learning or attention issues are so severe that supplementary aids and services can't provide an appropriate education.
- Supports and accommodations to meet unique needs
- Specialized services available, modifications to learning and/or environment as necessary, youth making reasonable academic progress
- Curriculum aligned with graduation requirements and standards
- Access to grade-level coursework, including advanced classes, youth accumulate credits
- Access to positive extracurricular activities
- In youth's community of origin as much as possible

When a youth is placed, PRTFs must complete the PDE form "Notification of Admission to Facility or Institution and School Enrollment" and send it to the local "host" school district.[17] The Best Interest Determination process should be utilized to decide the youth's school assignment, unless there is a Court order which specifically mandates attendance at an on-grounds school. PRTFs must participate in shared decision-making for each youth via Best Interest Determination meetings.

[16] If neither the parent of a child who is eligible or thought-to-be-eligible for special education nor an individual who meets the definition of parent per 34 CFR § 300.30 Parent can be located, the host school district must appoint a surrogate parent per 34 CFR § 300.519 Surrogate parents.

[17] "Notification of Admission to Facility or Institution and School Enrollment," http://swantoolkit.org/wp-content/uploads/DPW-Bulletin-OMHSAS-10-02-NOTIFICATION-OF-ADMISSION-TO-FACILITY-OR-INSTITUTION-AND-SCHOOL-ENROLLMENT.pdf.

For youth placed outside of Philadelphia, the provider or host district must also send the 4605 form to the School District of Philadelphia when a student enrolls.[18]

Upon enrollment, school records—including transcripts and any Individualized Education Plans (IEPs) – should be requested immediately by the receiving school. Residential providers can request student transcripts and any Individualized Education Plans (IEPs) via SDP's online request portal.[19]

Other Educational Considerations and PRTF Responsibilities

- Support youth's transportation to school as needed, per ESSA guidelines and School District of Philadelphia provisions.
- Ensure alignment with Bureau of Special Education guidelines.[20]
- Notify youth's DHS, CUA, probation case manager of school placement, any challenges, or needed changes.
- Provide access to academic supports (e.g. tutoring, credit recovery) or instructional services individualized to participating youth.
- Maintain communication with youth's educational setting to ensure necessary accommodations are available and youth is attending and making progress.
- Plan for youth's timely school enrollment upon discharge.
- Provide or obtain the counseling services necessary to support a youth's transition into postsecondary education and training, including assistance with admissions, financial aid, and scholarship applications.
- Ensure that youth are in attendance and participating in all standardized tests administered by the school district in which the youth is enrolled, specifically the Pennsylvania System of School Assessment (PSSA).
- Avoid making appointments during school hours. Other than court hearings, the provider will arrange for the youth to attend appointments outside school hours. If it is necessary to schedule an appointment during school hours, the provider will document the reasons for doing so in progress notes in the case record.
- For youth who show signs of having academic problems, such as failing grades, low scores on standardized tests, behavioral problems in school, or the inability to progress academically, the PRTF should request that the school refer the youth to the appropriate school district's student assistance program (e.g. Philadelphia School District's Comprehensive Student Assistance Process (CSAP)).

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[18] "Determination of District of Residence for Students in Facilities or Institutions," https://www.education.pa.gov/Documents/Teachers-Administrators/Child%20Accounting/Forms%20and%20Instructions/ChildAcctg%20Determination%20of%20SD%20of%20Residence%20PDE-4605.pdf.

[19] "Philadelphia School District - Record Request Form," https://docs.google.com/forms/d/e/1FAIpQLSfYKQGXhnnaSDELIPK_5U6EVp7l40usAt6lDXrhx8VleBI-MQ/viewform.

[20] "Special Education," PA Department of Education, https://www.education.pa.gov/K-12/Special%20Education/Pages/default.aspx.

- Use the Academic or Training Program Progress Improvement Plan to help ensure the youth's progress on their educational or training goals. Academic or Training Program Progress Improvement Plans are used when the youth is at risk of failing a course or program and/or has received a final or interim grade of D or F in a class.
- Attend the youth's IEP meetings; offer input in the development of IEP and follow-up with school personnel on implementation of IEP recommendations. If the school does not allow the provider to participate in the IEP, the provider will put in writing to the school a request for a delegation of parental responsibility, commonly known as "surrogate parent."[21]

[21] "Special Education Timelines," PA Department of Education, https://www.pattan.net/getmedia/a11ccf9f-bdf9-4f8a-9fa9-629b21176d77/SpEd_TimeIns0518.