

Quality Standards for  
**Group  Care**



*Group Care Quality Standards Workgroup*

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# Executive Summary

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The draft standards included in this report were developed by the Group Care Quality Standards Workgroup established by the Florida Department of Children and Families (DCF) and the Florida Coalition for Children (FCC). This workgroup was comprised of group care provider agency experts, community-based care lead agency staff members, and DCF representatives. This report is to be considered by the DCF in licensing child-caring facilities, specifically group care programs/homes. The specific standards were informed by a review of standards-related literature to ensure the quality of group care and to determine the degree of consensus in standards that were suggested across nine of the most relevant source articles.

## The draft standards recommend that:

- Evidence-based assessment tools and a multidisciplinary treatment team (MDT) are used to assess safety risks, strengths, and the needs of a youth who is being referred to group care and to determine the level of care and services required to meet his or her behavioral health needs.
- Decisions about admission are made by experienced personnel and must include the youth who is applying for care and his or her parent or legal guardian. Youth applicants and their parents or guardians are provided with information about their rights and responsibilities and are always treated with respect and dignity.
- Youth and their parents or guardians are part of the MDT that is responsible for creating an individualized service plan/treatment plan. Plans should be strength-based and include the youth's personal treatment goals and objectives and information about any known trauma. The plan also must include goals related to the youth's family and building natural family supports. The youth has input on who participates in the service planning/treatment planning process. Plans are reviewed by the MDT every 90 days.
- The care environment must be safe and stable, and physical facilities must be clean and well-maintained. The basic needs (shelter, food, clothing, and personal items) of all youth are provided.
- Youth rights are well-specified and protected. Each youth has the right to file a grievance or appeal.
- Written policies are in place that prohibit corporal punishment or restraint as a form of punishment, and the use of any practices that are demeaning, shaming, or degrading, or that would constitute verbal or emotional abuse.
- A positive peer culture approach is promoted. However, youth are protected from the problem behaviors of other youth, bullying, and punishment by their peers.
- Staff members are trained in specific protocols for de-escalating and dealing with youth problem behaviors. Critical incidents, including any use of physical restraint, are documented and reported, and these reports are reviewed regularly by agency administration. Staff members are trained to immediately report critical incidents, including questionable or abusive staff practices or youth-to-youth incidents. Supervisors must be briefed immediately.
- Appropriate external agencies must be notified about all serious allegations of unsafe, inappropriate, or abusive practices or incidents.

- Mechanisms and policies are in place that enable youth and their parents or legal guardians to communicate their needs, report problems, and file grievances. Formal procedures are in place to assess the satisfaction of youth, parents/guardians and other key consumers.
- Policies and practices are in place to strengthen a youth's relationship and connection with his or her family and community (unless such contact is prohibited). Families are involved in treatment decisions, care, and positive activities. Youth and families should have opportunities for regular communication and visits where the youth is living, in the family's home, and in the community. Staff must be trained to be sensitive to each youth's racial, cultural, religious, and linguistic needs.
- The group care provider must maintain appropriately qualified staff members who are adequately trained in evidence-based/evidence-informed models of intervention. Staff members must demonstrate competency prior to independently caring for youth and must be supported by regularly scheduled, ongoing supervision by a qualified supervisor.
- Youth must receive care at the least-restrictive level of care and in a family-like environment.
- Youth should be allowed and encouraged to develop and maintain interests, talents, and hobbies, including participating in normal leisure/recreational activities that are appropriate to their age and developmental level.
- Policies and practices are in place that allow youth to express their personal identity and protect the privacy and dignity of the youth and their family.
- Group care providers must be licensed, accredited by a national entity, and implement an evidence-based/evidence-informed model of care. Youth have full access to required therapeutic supports that are provided by a trained, qualified, skilled workforce.
- All youth receive a medical assessment and a physical examination that determines a youth's health status. The group care provider should provide or facilitate provision of routine medical and dental care and teach healthy living literacy education. The group care provider should have 24/7 access to a qualified medical provider.
- Staff-to-youth ratio must be within licensing and accreditation standards. Youth follow a structured daily routine and are monitored in accordance with their individual needs.
- The group care provider should implement an effective Continuous Quality Improvement (CQI) program that provides supervision and coordinates care across services that are included in the service plan/treatment plan.
- The use of psychotropic medications by youth must be monitored by a board-certified psychiatrist and should be used at the minimum level for clinical needs.
- The educational needs of youth must be assessed and appropriate educational services must be provided or obtained. Youth are required to attend school and are encouraged to continue their post-secondary education by attending college, a technical school, or a certificate program.
- Every qualified youth should have a 504 Plan or an Individualized Educational Plan (IEP).
- Youth learn, practice, and consistently use prosocial skills and behaviors. An outcome-driven approach is used to help youth reduce symptoms and acquire skills, competencies, and knowledge needed for productive citizenship.

- Each youth's emotional, behavioral, and educational progress is reported regularly. Accountability for youth progress should be placed on program effectiveness and staff performance.
- Discharge planning should start at intake, should continue throughout treatment, and should involve the youth, his or her family or legal guardian, and key stakeholders.
- Where allowable, services should be provided that strengthen the family and support family reunification. Efforts are made to educate family members about and connect them with community resources, as needed. The group care provider provides support, after-care, and community service coordination for the youth and his or her family.
- Post-treatment outcomes for youth are monitored and include, at minimum: education outcomes, law-abiding and functional outcomes such as recidivism, success in lower levels of care, and outcomes related to the youth's connection/relationship with his or her family and community.





## ASSESSMENTS, ADMISSION, AND SERVICE PLANNING/TREATMENT PLANNING

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### 1.A.1 Assessment-Driven Services

- 1.A.1.1 Prior to admission, the referring agency must complete a functional assessment using evidence-based assessment tools that evaluates youth safety risks, strengths, and needs and includes:
- a. A recommendation that the program is the least-restrictive, least-intrusive treatment necessary to meet the behavioral health needs of the youth
- 1.A.1.2 Upon admission, a comprehensive assessment to determine the youth's strengths, needs, and service requirements is completed in a timely manner, either prior to or within the first 30 days of admission. The assessment must include a screen for alcohol and drug issues, mental health issues, medical issues, and special needs.
- 1.A.1.3 Assessments are conducted in a culturally and linguistically sensitive manner and take into account:
- a. Concerns identified from the youth's initial screening
  - b. The youth's overall psychological function
  - c. A description of known traumas or abuse
  - d. A review of the youth's known medical history and any ongoing health issues
  - e. A comprehensive history of the youth's family that includes a history of the parent/guardian and previous legal, religious, educational, and vocational details
  - f. Identification of trauma, attachment, abuse, and neglect issues that have impacted the youth
  - g. A comprehensive history of the youth's prior services and previous placements to date
  - h. A current description of the family environment
  - i. The youth's educational and vocational accomplishments
  - j. A description of any previous testing or assessments within the recent past
  - k. A description of the youth's and the parent's/guardian's strengths, skills, or special interests
  - l. A history of previous and current drug use by the youth and/or his or her family, including an assessment of the impact it has had on the family
  - m. Possible effects of group living on the youth

- n. The youth's ability to adjust to a group
  - o. The youth's previous out-of-home placements
  - p. Identification of how the youth's placement in group care will support and promote his or her welfare
- 1.A.1.4 Comprehensive service plans/treatment plans are developed by a multidisciplinary treatment team (MDT), which includes all individuals and entities involved with the youth (i.e., the youth, parent/guardian, school representative, all behavioral health service providers).
- 1.A.1.5 The facility arranges for an appropriate level of care and, as necessary, referrals to specialized treatment programs.
- 1.A.1.6 Re-assessments are conducted if specific events in the treatment process include any of the following:
- a. Significant improvement ahead of expectations
  - b. A lack of significant treatment progress
  - c. New symptoms are identified
  - d. Unusual behavioral changes are observed
  - e. Significant changes to a family situation or parental status
  - f. Significant environmental changes occur
  - g. A youth resident demonstrates a significant degree of self-destructive behavior or is hospitalized for a mental health condition
- 1.A.1.7 Placements with group care providers that do not have additional educational or therapeutic services on the same site should be made only after careful assessment.
- 1.A.1.8 Common practice frameworks include trauma-informed, needs-based, and strengths-based.
- a. All youth entering group care require a comprehensive assessment, and the intake process should include linking a youth's history of trauma, attachment, violence, and abuse, as well as resources and resilience, to his or her current needs and care/intervention responses.
  - b. The referral assessment should describe the youth's needs and strengths from the perspective of the youth, family, and referral/placement agency, as well as all other sources of accurate information.
  - c. Substantive discussions of the youth and family should begin with a discussion of strengths.
  - d. Available information should be used or an objective and comprehensive assessment of the family strengths, capabilities, and weaknesses should be conducted to determine if the family can assume responsibility for the youth's care and development.
  - e. In schools, group care staff should contribute to Individualized Educational Plans (IEPs) based on a careful assessment of strengths and

needs that shows how the curriculum could be adapted or enriched to accommodate the youth.

- 1.A.1.9 The initial assessment for all types of group care services should include risks posed by the youth to self or others (including staff, peers, or community) and risks of such a placement to the youth.
- 1.A.1.10 The referral assessment should describe the youth's racial, ethnic, cultural, and religious background.

## **1.A.2 Respectful Admission Process**

- 1.A.2.1 Admission decisions are made by experienced or licensed personnel in collaboration with the applicant and his or her parent or legal guardian if the applicant is a minor.
- 1.A.2.2 Intake, admission, service planning/treatment planning and review, discharge, and follow-up services are culturally and linguistically competent, trauma-informed, and respectful of the feelings and needs of youth and families.
- 1.A.2.3 Admission needs to be handled in a calm, positive, and reassuring way. A sensitively prepared admission procedure is required.
- 1.A.2.4 The youth and his or her parent or legal guardian participate in the admission process and are:
  - a. Informed of available options, benefits, and consequences of planned services
  - b. Prepared for admission, including the opportunity for a pre-admission visit, whenever possible
  - c. Informed of how the organization can support the achievement of desired outcomes
- 1.A.2.5 Organizations screen and inform residents of:
  - a. How well their request matches the organization's services
  - b. What services will be available and when
- 1.A.2.6 The program defines in writing:
  - a. Its eligibility criteria
  - b. The scope of services and the range of client issues addressed
  - c. Service options and levels of service
  - d. Opportunities for active family participation and support
  - e. Opportunities for the resident's participation in activities that promote normalcy
  - f. A description of how the facility promotes living-unit compatibility based on age, interests, and group composition
- 1.A.2.7 Prompt, responsive intake practices:
  - a. Ensure equitable treatment



### **1.A.3 Develop Youth-Involved Individualized Service Plans/ Treatment Plans**

- 1.A.3.1 Group care services should be flexible and tailored to the individual needs of the youth and family.
- 1.A.3.2 Individual service plans/treatment plans include an assessment of each youth's educational, social, emotional, behavioral, and health requirements, and identify how the placement will support and promote the welfare of each youth.
- 1.A.3.3 The initial service plan/treatment plan is developed within the first 30 days of a resident's placement.
- 1.A.3.4 Service plans/Treatment plans:
  - a. Should be designed to help the youth develop personal treatment goals and objectives
  - b. Must be written using the youth's native language
  - c. Should be written, in as practical a way as possible, using terms the youth can easily understand
  - d. Are signed by the youth if he or she is old enough to sign
  - e. Are discussed with the youth in person upon finalization
  - f. Are copied and provided to the youth and the parents/guardians who are participating in the youth's treatment
- 1.A.3.5 Extended family members and significant others, as appropriate and with the consent of the youth, may be invited to participate in case conferences and advised of ongoing progress.
- 1.A.3.6 Service plan/treatment plan reviews will be conducted every 90 days. The treatment team, youth, and when appropriate, his or her family participates in a documented quarterly review of the service plan/treatment plan to assess:
  - a. Progress toward achieving service goals and desired outcomes
  - b. The continuing appropriateness of the service goals
  - c. The need to revise, cancel, or add new goals and/or objectives
  - d. The team provides a forum in which the youth's unique needs can be addressed and the family's and youth's voice heard
  - e. Unmet service and support needs
  - f. Possibilities for maintaining and strengthening family relationships
  - g. The need for the support of the resident's informal social network
  - h. Agreed upon goals, strengths, desired outcomes, and timeframes for achieving them
  - i. Services and supports to be provided, and by whom
  - j. The signature of the resident, legal guardian as appropriate, and treatment team

- 1.A.3.7 Service plans/treatment plans, including various goals and objectives, must take into account any previously known traumas (trauma-informed). In addressing these traumas:
- a. Efforts will focus on the most supportive means of resolving them
  - b. Must take into account any legal, professional, or ethical ramifications involved
  - c. Will be addressed only by qualified staff adequately trained or certified in dealing with childhood traumas
  - d. In the event the facility does not have qualified staff, the facility will refer the resident to outside qualified resources
- 1.A.3.8 Staff interventions reflect an awareness of the impact of separation and loss, and, where applicable, neglect and abuse, on the youth.
- 1.A.3.9 The service plan/treatment plan must include the Child and Family Strengths component.
- a. Treatment goals will build upon the strengths of the youth and his or her family.
  - b. Providers are sensitive to trauma-related issues and their treatment.
  - c. Service plans/treatment plans will include the youth's major strengths as they were described in the initial assessment
- 1.A.3.10 Unless otherwise prohibited by court sanction or other limiting treatment issues, all service plans/treatment plans will address the youth's agreed-upon permanency goal.
- 1.A.3.11 Service plans/treatment plans will always address the youth's needs of greatest priority, with a specific focus on issues that impact his or her immediate safety, health, legal status, and welfare.
- 1.A.3.12 Service plans/treatment plans for all youth over the age of 12 will incorporate goals to develop the youth's skills for independent living.
- 1.A.3.13 The service plan/treatment plan must include goals related to the family and to building natural family supports.
- 1.A.3.14 The involvement of the family in the multidisciplinary treatment (MDT) team meeting provides a forum where family members can address the youth's unique needs and their voice can be heard.
- a. Treatment should be family-driven, with the family included in all aspects of care.
  - b. The provider should support and actively involve the family in care and positive activities.
  - c. There should be a high level of family involvement and engagement.

## 1.A.4 Establishing and Meeting Measurable Goals

- 1.A.4.1 The youth, family, and treatment team should identify measurable goals and objectives (individualized for both the youth and the family) that clearly define discharge expectations.
- a. A goal is a global statement that reflects a positive resolution to the identified need or problem and indicates the specific area of functioning to be addressed, including an expected outcome.  
**Service/Treatment Goals:**
    1. Should establish measurable goals and objectives
    2. Are based on the most current assessment of the youth
    3. Take into account the youth's developmental age
    4. Utilize discrete behavioral elements that can be tied to specific behavioral objectives
    5. Utilize a behavioral scoring system that can be easily calculated to develop a measurable context
    6. Are described in a manner the youth can understand, or that can be readily explained to the youth
  - b. The objective is directly related to a specified goal, but is highly specific and identifies measurable steps toward achievement of the goal.
  - c. Goals and objectives should be consistent with each youth's needs for safety, permanency, and well-being.
- 1.A.4.2 Service/treatment updates include the impact services are having on the youth, including progress on/degree of attainment of treatment goals and objectives. They also should identify effective and ineffective interventions.
- 1.A.4.3 The behavior support and intervention plan should include procedures for monitoring the effectiveness of behavior support and interventions. The service plan/treatment plan should include timeframes for the periodic review of progress toward service goals.
- 1.A.4.4 Managers have mechanisms in place for assessing the quality and effectiveness of the services being provided.



## POSITIVE, SAFE LIVING ENVIRONMENT

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### 2.B.1 Ensure No Physical, Verbal, or Emotional Abuse

- 2.B.1.1 Care environments must be stable and safe in order to counter the risks associated with ongoing loss, rejection, and re-traumatization of youth that can occur in unsafe environments or through further abuse, harmful practices, and frequent changes in the living environment.

### 2.B.2 Respect and Maintain Youth Rights

- 2.B.2.1 The provider organization has a clearly articulated philosophical and practice framework in which practitioners operate that ensures a consistent approach to working with youth.
- a. The group care provider should develop statements of rights and responsibilities and ensure that staff members understand and adhere to them in daily practice.
  - b. The youth's family is educated about the admission process, including the family's rights.
  - c. The group care provider's policies and care practices reflect and/or include the rights of youth and guidelines for participation in treatment. Youth and their parents are informed of their rights by supervising social workers and group care provider staff members.
  - d. Youth are made aware of groups and organizations that promote and protect youth rights and understand they may participate in the activities of these groups and organizations, if they choose.
  - e. Youth rights are respected and communicated.
- 2.B.2.2 Staff members who are the same gender as the youth should be available to assist with certain daily living or hygiene activities that require gender-specific assistance.
- 2.B.2.3 The provider should ensure that youth are informed that they can file a grievance or an appeal if they believe their rights have been violated.
- 2.B.2.4 Written policies that prohibit the following must be in place:
- a. Corporal punishment
  - b. The use of aversive stimuli and/or therapies
  - c. Interventions that involve withholding nutrition or hydration, or that inflict physical or psychological pain
  - d. The use of demeaning, shaming, or degrading language and bullying activities

- e. Unnecessarily punitive restrictions, including restricting contact with family as a disciplinary action
- f. Forced physical exercise as a way to discipline youth behaviors
- g. Unwarranted use of invasive procedures or activities as a disciplinary action
- h. Punitive work assignments that have no natural or logical connection to a youth's inappropriate or negative behavior
- i. Punishment by peers
- j. Group punishment or discipline for an individual's behavior
- k. The use of physical restraint as a sanction or punishment
- l. Verbal or emotional abuse
- m. Exposure of youth to unsafe situations or environments

### **2.B.3 Basic Needs Are Met**

(Shelter, Food, Clothing, Personal Items)

2.B.3.1 The following basic universal needs should be met for each youth:

- a. Shelter – youth has own bed and living space
- b. Food – proper nutrition and three meals a day
- c. Clothing (including shoes) – clothes fit the youth and are regularly laundered; clothing items are replaced as they wear out or as youth outgrow them
- d. Personal items – toiletries, towels, etc.

2.B.3.2 Youth have adequate quantities of nutritious and appetizing food and their food preferences are taken into account in planning menus.

### **2.B.4 Clean, Hygienic, Well-Maintained Facility**

2.B.4.1 Living environment is suitable, sanitary, and safe.

- a. The group care home, its premises, and its equipment should be kept clean, sanitary, and in good repair at all times.
- b. The group care home is kept in good structural repair and decorated to a standard that creates a pleasant ambience.

2.B.4.2 Service supervision meets with the direct care provider at least once a month to check the physical structure of the home.

2.B.4.3 A full home inspection is conducted annually by the provider agency or as part of annual state licensing.

2.B.4.4 Group care providers adhere to regulations established by local authorities (e.g., Department of Health, Fire Inspector).

2.B.4.5 For construction of a new group care home, the group care provider obtains

written confirmation from a certified engineer or a qualified architect that the home complies with all statutory requirements related to fire safety and building codes.

## **2.B.5 Keeping Youth Safe from Other Youths' Problem Behavior**

- 2.B.5.1 Policies and practices address the need to protect youth from abuse by their peers.
- 2.B.5.2 Youth are taught to develop respect for themselves and others.
- 2.B.5.3 During the admission process, a comprehensive assessment identifies behaviors of each youth that may pose a physical or emotional risk to other youth living in group care. Staff members are trained to address these types of behaviors and the living environment is appropriately monitored to ensure the safety of all youth.
- 2.B.5.4 The group care provider agency demonstrates that quick and effective action is consistently taken whenever a youth threatens or compromises the physical or psychological health and safety of other youth. Safeguards and mechanisms are in place to prevent youth from harming each other, either physically or emotionally.
- 2.B.5.5 Actively promote positive peer influences on the behavior of youth through the development of prosocial behaviors and values.
- 2.B.5.6 Use a positive peer culture approach, where peers provide support for one another (e.g., the group care provider has a written policy on bullying that promotes a positive and safe environment).

## **2.B.6 Effective Crisis Management (De-Escalation Training, Formal Policies)**

- 2.B.6.1 The behavioral management plan includes a model of implementation that includes step-by-step instructions on how to handle each youth's problem behaviors.
- 2.B.6.2 Incident reports are completed for any unusual incidents.
  - a. The group care provider should have a structured process and policy in place to respond to and review youth- and staff-related critical incidents.
  - b. The provider's policies and procedures should address documentation and reporting requirements for serious incidents and abuse prevention.
- 2.B.6.3 Staff members are able to document that they use other non-physical methods to de-escalate a volatile youth situation before resorting to physical restraint.
  - a. All staff members are trained in effective de-escalation techniques and anger management techniques to eliminate the need for seclusion or restraint.
  - b. All staff members are trained in a wide range of skills and content knowledge that will help prevent youth crises.

- 2.B.6.4 Staff members monitor causes of aggressive incidents and implement evidence-based/evidence-informed techniques to prevent recurrence.
- 2.B.6.5 All incidents of physical hold use or restriction of movement by staff are tracked and reviewed periodically by clinical and administrative staff.
- 2.B.6.6 Staff members respond quickly to crisis activity when it begins.
- 2.B.6.7 The group care provider conducts a thorough administrative review of all crisis events.
  - a. Reviews of the critical incidents should focus on the actions of all parties involved with the affected youth and/or staff, and use a multidisciplinary approach that includes representatives from community agencies and organizations that are involved in protecting and serving youth and their families.
  - b. Managers should review all incidents to see what lessons can be learned and should discuss limit-setting in regular supervision sessions. Staff should have access to a procedure in which they can raise concerns about inappropriate sanctions or controls others may be using. Once guidance is issued, the inspection units should set up procedures to monitor whether it is being followed.
- 2.B.6.8 When necessary, the group care staff uses a method of physical restraint that is evidence-based/evidence-informed, and is based on reputable practice. There is a written policy for use of physical restraint that all staff members and youth in the group care home understand. All staff members who are responsible for the care and supervision of youth shall be trained and demonstrate their mastery of acceptable methods of physical restraint. When physical restraint is used, it is applied in a way that is consistent with the policy requirements.

## **2.B.7 Limited Seclusion and Restraint**

- 2.B.7.1 Have a policy that strives for a restraint-free milieu consistent with national standards and regulations. This policy should be reviewed with staff members at least annually.
- 2.B.7.2 Have well-specified quality improvement processes, including periodic reviews of restraint episodes.
- 2.B.7.3 The group care provider should use restraint only in an emergency, when there is an imminent risk of harm to a youth or others and less-restrictive interventions are unlikely to be effective in reducing or eliminating the danger.
- 2.B.7.4 Physical restraint should be deployed using the minimum amount of force necessary and for the shortest period of time. The actions of staff members should be proportionate to the circumstances that resulted in a youth being physically restrained.
- 2.B.7.5 A group care manager records and closely monitors the use of physical restraint, and case managers and parents are informed of its use.

## **2.B.8 Prevention of Self-Harm**

- 2.B.8.1 Youth should expect to be protected from harm, including self-harm. An initial assessment and ongoing risk assessments will be completed.
- 2.B.8.2 If a youth is deemed to be at risk of harming himself or herself, or others, there should be a written protocol for assessing and determining if the youth should be transferred to an inpatient psychiatric facility.
- 2.B.8.3 Mechanisms are in place to prevent self-harm. If there is risk of harm to a youth, others, or property, the youth, the group care provider, and the parent/guardian should develop and sign a safety plan.



## EFFECTIVELY MONITOR/REPORT PROBLEMS

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### 3.C.1 Staff Are Trained to Immediately Report Problems

- 3.C.1.1 Group care staff/direct care staff are extensively trained and supervised and receive regular clinical oversight on practices related to youth behavioral health issues, including incident reporting, diagnosis, medications, behavioral interventions, crisis intervention, incident reporting, verbal de-escalation, and passive restraint techniques.
- 3.C.1.2 Require staff to immediately report any questionable or abusive staff practices or youth-to-youth incident and provide annual training in this area. Staff training also should include a crisis management policy.
- 3.C.1.3 If a staff member has used physical restraint, a supervisor must be briefed immediately regarding the circumstances. The incident should be recorded fully and notifications provided according to the group care provider's policy.
- 3.C.1.4 Debrief to review crisis management incidents and to complete documentation.

### 3.C.2 Grievance Process

- 3.C.2.1 Mechanisms and policies are in place so that youth can easily communicate their needs and experiences, and report problems.
- 3.C.2.2 Develop a method for youth and family/legal guardian to report a grievance and redress issues.
- 3.C.2.3 Youth in care and family/legal guardian should understand and have ready access to grievance procedures.
- 3.C.2.4 The program follows established grievance procedures and responds to complaints.
- 3.C.2.5 Records should include documentation of all consumer concerns and grievances and their resolutions, including providing evidence that steps were taken to respond to reasonable criticisms or suggestions by direct consumers.
- 3.C.2.6 Youth can make their complaints in confidence to any program staff member.
- 3.C.2.7 Staff members must listen carefully to an informal complaint and pass it on to the person who has the authority to deal with it.

### **3.C.3 Reporting Allegations to External Agencies and Independent Audit**

- 3.C.3.1 All allegations of unsafe, inappropriate, or abusive practices, regardless of who makes them, must be reported as a standardized part of the program. Notify required outside agencies of all serious complaints and allegations.
- 3.C.3.2 Ensure that all youth know they have regular access to an advocate outside of the group care program and that they can share any difficulties or concerns about their care with that advocate.
- 3.C.3.3 Appropriate external management and monitoring arrangements are in place.

### **3.C.4 Survey Stakeholders (e.g., Youth, Parent, Consumer)**

- 3.C.4.1 Utilize a survey to assess the satisfaction of youth, parents, and other key consumers and to allow them to express concerns or complaints regarding safety issues and how services are being provided.
- 3.C.4.2 Utilize an independent process for validating consumer satisfaction and for addressing consumer concerns and complaints.
- 3.C.4.3 Provide evidence that a high percentages of all youth are satisfied with the program on dimensions that are appropriate to their status and condition.
- 3.C.4.4 Provide evidence that a high percentage of key consumers, such as funders, guardians, or parents, are satisfied with the program's services.
- 3.C.4.5 To identify and evaluate outcomes, use a follow-up process that includes:
  - a. Measurements of overall satisfaction with the services provided by the group care provider
  - b. An examination of post-discharge outcomes using a consumer survey that focuses on youth experiences, outlooks, and perceptions while in group care
- 3.C.4.6 Implement a system to report survey results. Use this system to implement a continuous quality improvement program that collects and reports sufficient quality indicators, including satisfaction surveys from all stakeholders.



## PROMOTE FAMILY, CULTURE, AND SPIRITUALITY

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### 4.D.1 Maintain Youth's Emotional Link with Family and Community

- 4.D.1.1 The group care provider should help youth and their families strive for improved family relationships and connections, and, whenever possible, family reunification.
- 4.D.1.2 Youth and their families should have maximum regular contact unless prohibited by court sanction.
- a. Environment should allow for face-to-face contact between a youth and his or her family or others unless the treatment team determines that contact with a specific individual may be detrimental to the youth's treatment goals. Such information should be documented in the youth's record. Home visits for youth and telephone communication with family members or guardians, or with a court representative/case manager if the state has custody, should be encouraged.
  - b. A youth's family should have positive involvement in the youth's care in whatever fashion that is most feasible and appropriate.
  - c. For youth whose return to their family is not in their best interest, provide contact that promotes the preservation of family identity for the youth.
  - d. A youth's visits with family members, significant others, and friends are encouraged.
- 4.D.1.3 The group care provider promotes and utilizes community-based services or resources to provide access to normalization experiences.
- 4.D.1.4 Priority is given to having youth stay in one community so they can continue to attend the same school and build lasting relationships with friends, teachers, and care workers. This also allows youth to join local clubs and organizations that connect them with activities and people in the community while they are in care and possibly after leaving care. Staff members should make youth aware of community involvement opportunities and how to access them.
- 4.D.1.5 When services cannot be provided close to a youth's home or community, the group care provider should try to maintain family ties and involve the family in service planning/treatment planning and delivery by:
- a. Assisting the family with travel arrangements when possible
  - b. Coordinating or facilitating family services to be delivered in the community

- c. Employing methods for telecommunication through web-based or electronic systems

#### **4.D.2 Involve Families in Treatment Decisions, Care, and Positive Activities (Family-Centered)**

- 4.D.2.1 An effective multidisciplinary treatment (MDT) team is one in which family members can offer their point of view early in the process. Family members are equal partners in the process, and family resources and opportunities for participation in treatment should be identified.
- 4.D.2.2 The group care provider reaches out to family members and involves them in every facet of assessment, service planning/treatment planning, service implementation, and review.
- 4.D.2.3 Parents/caregivers are kept informed about events in their youth's life. Where possible, they have every opportunity to make a positive input in the care of their youth and are invited to participate in events such as school meetings, functions, and medical and dental appointments.

#### **4.D.3 Provide Training that Supports Reunification and Maintaining Family Connections**

- 4.D.3.1 For youth who are away from their families, reunification is the preferred outcome whenever that can be done safely.
- 4.D.3.2 Families should be given active support, encouragement, and training, as necessary, to help make reunification and permanency successful.
- 4.D.3.3 Clear plans and supports need to be offered to families when reunification is the service plan/treatment plan goal.
- 4.D.3.4 Discharge planning should provide families with strategies that can help their youth adapt to "family life" when they return home.
- 4.D.3.5 Processes need to be youth-friendly while remaining family-focused, with a goal of safe and stable reunification.
- 4.D.3.6 Group care employees receive training to better understand youth and family outcome measures. This training includes a clear understanding of the concepts of safety, permanency, and well-being, with an emphasis on the preservation of family connections, and how to be supportive of reunification strategies, when appropriate.

#### **4.D.4 Encourage Home Visits**

- 4.D.4.1 Efforts are made to ensure that youth have regular and increasingly frequent visits and interactions with key family members.
  - a. Visits assist in supporting the parent-youth attachment, promote reunification, and help in the decision-making process to establish permanency plans.
  - b. Strategies are in place to assist with visits for the youth's family, caregiver, and/or significant others in the youth's life.

- c. All efforts made by the group care provider for family and community visits/connections should be clearly documented.

4.D.4.2 Staff members should assist the youth in mastering the skills needed to live successfully in a family setting. This includes teaching and providing advice and support before, during, and after home visits.

4.D.4.3 Family visits in the group care setting and in the family's home should be planned, conducted, and monitored as a central part of services and transition plans.

*Note: Standards 4.D.2, 4.D.3, and 4.D.4 are not applicable if legal sanctions restrict parental involvement in a youth's treatment (e.g., parental rights have been terminated).*

#### **4.D.5 Community Involvement**

4.D.5.1 Connecting youth to the community in which he or she is receiving services should be a priority. This includes helping the youth develop and maintain peer friendships, maintaining a continuity of connection to people and resources of significance, and providing opportunities for youth to participate in community activities without demarcation. Youth should be made aware of community service options, what they offer, and how to access them.

4.D.5.2 Youth should have access (through the group care program) to community involvement activities that enhance normalcy in the youth's life while he or she resides in group care. Examples include religious activities, educational activities, family involvement, using social skills and life skills, extracurricular school activities, socialization opportunities, volunteer opportunities, student work programs, and tribal activities (where appropriate).

4.D.5.3 Proactive systems should be in place to identify potentially abusive practices regarding community involvement activities.

4.D.5.4 Discharge planning should involve coordination with community-based services to ensure a continuum of care.

4.D.5.5 The group care program should offer evidence-based/evidence-informed treatment that is specific to the youth's psychiatric, educational, developmental, and medical needs.

#### **4.D.6 Culturally Sensitive**

4.D.6.1 The group care provider must be sensitive to a youth's racial, cultural, religious, and linguistic needs. This should automatically be a part of the attention given to every youth's emotional development.

4.D.6.2 The group care provider will:

- a. Collaborate with other community partners for services that maintain a youth's cultural and religious connections

- b. Assist the youth by providing supportive communication and cultural activities through family visitations, and participating in tribal traditions (where appropriate), cultural educational activities, cultural community awareness opportunities, and other social support connections
  - c. Recognize and acknowledge that youth have an active voice regarding their religious activities, including their decisions about religious beliefs, religious traditions, and religious worship desires and preferences
- 4.D.6.3 Youth should have access within the group care program to activities that foster identification with the people and the values of a youth's community and cultural heritage.
- 4.D.6.4 For American Indian youth, the group care provider should strive to ensure the continuity of the youth's cultural connections and the involvement of the youth's tribal community in the treatment approach and services.
- 4.D.6.5 Each youth and family has the right to receive culturally competent and linguistically appropriate services.

#### **4.D.7 Help Youth Develop Religious, Spiritual, and Moral Values**

- 4.D.7.1 Develop relationships between youth and churches, synagogues, community service agencies, and any other agencies that support the growth and acceptance of positive values. Support youth's choice of worship activity/spiritual beliefs.
- 4.D.7.2 Provide youth with opportunities to develop religious practices consistent with their needs.
- 4.D.7.3 Provide staff modeling and teach a sense of spiritual well-being that includes a sense of personal worth, a sense of purpose in one's life, and a sense of connectedness to other people.
- 4.D.7.4 Help youth develop a sense of morality and responsibility for their actions.
- 4.D.7.5 Every youth has a right to be recognized for his or her uniqueness, including gender, culture, religion, and belief.



## DEVELOP AND MAINTAIN A PROFESSIONAL, COMPETENT STAFF

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### 5.E.1. Appropriately Qualified Staff

- 5.E.1.1 The group care home is managed by qualified persons who provide care according to state regulations and meet national accreditation standards.
- 5.E.1.2 Psychiatric group care services are informed by a child psychiatrist and team led by mental health professionals.
- 5.E.1.3 Staff should be specifically trained in the area of specialized need, and employment applications and human resources documentation should specifically address the criteria used to determine specialized qualifications.
- 5.E.1.4 The group care home has adequate levels of experienced staff to fulfill its purpose and functions. The group care home must have at least one qualified staff member at the child care-leader levels on each shift.
- 5.E.1.5 Staff are experienced and qualified to meet the complex array of needs of youth in care.
- 5.E.1.6 Salary standards are periodically reviewed to meet group care standards in order to attract and retain staff with sufficient ability and qualifications.

### 5.E.2 Staff Training

- 5.E.2.1 Staff members are trained in evidence-based/evidence-informed models of interventions.
- 5.E.2.2 Staff members are trained to protect youth, respect their rights, and prevent abuse.
- 5.E.2.3 Staff members are trained and retrained to teach educational, physical, and prosocial skills.
- 5.E.2.4 Training/instruction is skill-based and evidence-based/evidence-informed.
- 5.E.2.5 The program promotes close adult/youth relationships by carefully selecting and training staff members who have the most frequent and direct contact with youth.
- 5.E.2.6 Staff are appropriately trained in crisis intervention in accordance with state licensing and national accrediting standards as it pertains to the use of physical restraint.
- 5.E.2.7 The group care provider should provide a comprehensive program of preservice training so that all new staff members can acquire the knowledge, skills, and motivation needed to effectively provide direct services to youth and their families, including:
  - a. First-aid, CPR, medication management, fire safety, psychiatric diagnosis, crisis management, documentation, and behavioral management training



## **5.E.4 Supervision and Support for Staff**

- 5.E.4.1 All group care staff members will receive regularly scheduled supervision.
  - a. Sufficient supervisory, administrative, and support staff should be provided and be available as needed.
  - b. Supervision provides for individualized mentoring and coaching.
  - c. Supervision focuses on the model of care and supports implementation.
  - d. Supervision ensures that skills are effectively applied.
- 5.E.4.2 Clinical supervision occurs weekly and includes other members of the treatment team as needed.
- 5.E.4.3 Group care staff/direct care staff members must receive regular and ongoing supervision by a qualified program supervisor.
- 5.E.4.4 Therapist must receive weekly supervision with at least a licensed clinician.
- 5.E.4.5 Regular and formal supervision details are recorded.
- 5.E.4.6 Group care provider administrators should initiate systems to monitor the provision of supervision.



## PROGRAM ELEMENTS

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### **6.F.1 Provide the Least-Restrictive Level of Care**

- 6.F.1.1 Provide the safest and least-restrictive levels of care possible while continuing to act in the best interests of the youth.

### **6.F.2 Provide Care in a Family-Like Environment**

- 6.F.2.1 Permanence, stability, a sense of connectedness, cultural identity, and family-like support are all critical elements in the development of youth into healthy adults. The group care provider should endeavor to provide these critical elements and ensure their availability to every youth in its care:
- a. Family-style care is appropriate to a youth's needs
  - b. Staff members and youth do family activities together (e.g., eating meals, doing household chores, playing board games, etc.) and these activities are regarded as positive social events

### **6.F.3 Normalization Activities**

- 6.F.3.1 Youth have opportunities to develop and maintain interests, talents, and hobbies.
- a. Allow normal activities and freedoms that are appropriate to a youth's needs.
  - b. Promote access to the healthy activities and freedoms that are typically associated with normal youth development.
  - c. Identify a youth's talents, hobbies, and special interests.
  - d. Emphasize normalization and reintegration; for example, youth should receive educational services in the community or should attend their own school, whenever this is possible.
  - e. Access to participation in a wide variety of clubs or other prosocial activities should stimulate a youth's natural curiosities and interests.
  - f. The group care provider celebrates festive occasions and each youth's birthday in a special way.
- 6.F.3.2 Youth should have access to leisure/recreational activities. The leisure/recreation domain includes community resources in the neighborhood and community of the youth's foster care or permanent home.
- a. Allow socialization activities that are appropriate to the youth's needs.
  - b. Ensure youth have access to physical exercise and opportunities to practice and play sports.
  - c. Provide age-appropriate play and recreational facilities for youth.

- d. Develop recreational budgets that are sufficient to provide youth with structured weekend and holiday activities.

#### **6.F.4 Promote the Personal Identity of Youth**

- 6.F.4.1 Youth have opportunities to imprint their own identity in their rooms and on their belongings.
  - a. Youth have personal belongings.
  - b. Youth have a safe and protected space for their personal items.
  - c. Youth are encouraged to personalize their bedroom with photos, toys, and personal items.
  - d. Youth are encouraged to make appropriate choices about their personal appearance and clothing, with support and advice from their caregivers.

#### **6.F.5 Respect for Privacy**

- 6.F.5.1 Youth have private living areas (bedroom, bathroom) and private areas for family visits and therapy.
- 6.F.5.2 Every youth and family has a right to personal privacy, confidentiality, and dignity.
- 6.F.5.3 Space is provided within the group care home where youth can have visits from friends, family members, or social workers; the space is private and visits will not disrupt the rest of the group care home.
- 6.F.5.4 Case and care records are stored in a way that ensures effective care planning and maintains appropriate levels of privacy and confidentiality for youth and their families.
- 6.F.5.5 Youth can make and receive telephone calls.

#### **6.F.6 Strong Program (Research, Clear Model of Care, Best Practices, Model Fidelity)**

- 6.F.6.1 The group care provider will provide evidenced-based/evidence-informed programs/practices, including:
  - a. A clearly defined model of care
  - b. A sound theoretical perspective and overarching practice framework for group care service delivery, including outlining the key principles and features of trauma-informed care
  - c. Supports for staff members as they implement the model and its practice with consistency and fidelity
  - d. A clear statement of what conditions the program does and does not treat and the types of treatment provided
- 6.F.6.2 Offer different modalities of evidence-based/evidence-informed treatment.
- 6.F.6.3 Follow national and state guidelines for treatment of mental disorders.

- 6.F.6.4 An experienced and qualified person monitors the group care home on a regular basis to ensure compliance with standards and best practices.

### **6.F.7 Full Range of Needed Services**

- 6.F.7.1 Well-planned and well-resourced group care integrates a spectrum of services that includes transition supports, specialized clinical services, and a trained, qualified, skilled workforce.
- 6.F.7.2 Core elements include full access to required therapeutic supports for all youth.
- 6.F.7.3 All youth in care have early access to the best available services, expertise, and specialists they may require. Supervisors and group care provider staff members should keep a record of attempts to access these services.
- a. Obtain supports, seek advice from other service agencies and private practitioners on specific therapeutic issues
  - b. Identify specific therapeutic needs and options for each youth (e.g., speech and language pathology, occupational therapy, family therapy)
- 6.F.7.4 If a needed service is identified through the assessment and service planning/treatment planning process but is not available through the group care provider, the treatment team should work with referring agencies and the youth's family to advocate for and obtain the needed service.

### **6.F.8 Licensure and Accreditation**

- 6.F.8.1 Supervising therapeutic staff should hold appropriate licenses and credentials as required by local law and regulations.
- 6.F.8.2 Licensed professionals should have experience that is specific to youth diagnoses and family issues.
- 6.F.8.3 The group care program is licensed and has external monitoring on validated standards.
- 6.F.8.4 The group care provider will obtain a national accreditation in support of best practice standards.
- 6.F.8.5 The provider should adhere to licensing requirements and accreditation standards, use competency-based training, and institute periodic retraining of staff.

### **6.F.9 Physical Health of Youth**

- 6.F.9.1 The group care provider should have access to a qualified medical provider who is available 24 hours a day, 7 days a week.
- 6.F.9.2 All youth receive a medical assessment and physical examination in accordance with state licensing standards and national accreditation standards.
- 6.F.9.3 Referral assessments should describe a youth's health status, including current diagnoses, illnesses, injuries, communicable diseases, and current medications.

- 6.F.9.4 Youth should receive healthy living literacy education.
- 6.F.9.5 The group care provider should provide or facilitate provision of routine medical and dental services according to recommended well-child schedules.
- 6.F.9.6 Youth should:
  - a. Have access to a general practitioner
  - b. Remain registered with their family general practitioner, when possible
  - c. Be able to request the gender of the general practitioner who sees/treats them
  - d. Have a medical identification card that contains insurance information (private insurer, Medicare, Medicaid)
  - e. Be trained in the use of health insurance
- 6.F.9.7 Youth and parents are consulted regarding the health care of the youth.

### **6.F.10 Close Supervision of Youth**

- 6.F.10.1 Youth follow a daily structured routine that is designed to help meet their behavioral, treatment, and therapeutic needs.
- 6.F.10.2 Staff members supervise and monitor youth activities in accordance with the needs of each youth as specified in his or her service plan/treatment plan.

### **6.F.11 Quality Improvement Approach**

- 6.F.11.1 The group care provider should develop and conduct a continuous quality improvement program that is implemented across all services. The provider will identify staff members who conduct quality improvement.
- 6.F.11.2 The group care provider's quality improvement efforts ensure consistent program implementation and standard attainment across locations, services, and individual staff.

### **6.F.12 Regular Staff Meetings to Coordinate Care**

- 6.F.12.1 Staff meetings and other forums take place regularly to facilitate good communication, cooperation, and consistency among staff members in implementing service plans/treatment plans, providing consistency of care, and maintaining youth and staff safety.
- 6.F.12.2 The group care provider should incorporate regular meetings that include discussions of youth behaviors and daily/shift issues relating to youth treatment.

### **6.F.13 Collaborative Care (Multi-System Coordination)**

- 6.F.13.1 The group care provider has a multidisciplinary treatment (MDT) team.
- 6.F.13.2 Treatment is an extension of service plans/treatment plans formulated in previous clinical settings.
- 6.F.13.3 The group care team approach should include the following potential

participants: the youth and his or her parents, siblings, and grandparents; temporary caregivers; clergy; former teachers; counselors; group care staff members; and workers from the referral/placement agency and any other involved agencies.

- 6.F.13.4 Working cooperatively, the group care provider should clearly define the services for which each member of the MDT team is responsible. In order to provide the most effective services to youth and families, the working relationships among organizations should be collaborative and complementary.

#### **6.F.14 Strive for Smaller Groups, Low Youth-to-Staff Ratio**

- 6.F.14.1 Staffing ratios should be in accordance with state licensing and national accreditation standards.
- 6.F.14.2 Staffing levels must adequately meet the needs of all youth. Staff levels should be primarily based on the functions and objectives of the group care home and not on the numbers of youth being served.

#### **6.F.15 Psychotropic Medications Are Psychiatrically Monitored at the Minimum for Clinical Needs**

- 6.F.15.1 When medications are administered to youth, medication monitoring is provided by a board-certified psychiatrist, preferably one specializing in child and adolescent psychiatry.
- 6.F.15.2 A youth's psychotropic medication should be managed so he or she is receiving the minimum dosage required for clinical need.
- 6.F.15.3 If a youth is on psychotropic medications, he or she is being seen by a psychiatrist on a monthly basis for medication management.
- 6.F.15.4 All medication management meetings are documented.



## PROMOTE EDUCATION, SKILLS, AND POSITIVE OUTCOMES

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### 7.G.1 Academic Testing

- 7.G.1.1 The group care provider is responsible for ensuring assessment, consultation, and planning for the education of each youth who is receiving services; for acting as a liaison with community educational services (the schools youth attend or special community-based educational services); and for sharing with staff members the educational elements that may affect the youth's adjustment and development.
- 7.G.1.2 The group care provider's educational services should provide or obtain an accurate and comprehensive educational assessment of each youth using standardized/assessment tools. This should include assessing whether a youth needs special education services. If not previously done, academic testing, as well as vision, speech, and language testing, should also be included.

### 7.G.2 Education Progress

- 7.G.2.1 The group care provider should ensure that each youth receives the education that is most appropriate to his or her individual needs, either by providing it directly or through arrangement, contract, or agreement with other resources.
- 7.G.2.2 The group care provider will encourage/require each youth to attend school, or an alternative educational program, for as long as the youth is entitled to educational services. Youth should receive accredited educational services.
- 7.G.2.3 The group care provider should encourage each student to pursue continuing his or her formal education in college, technical school, or a certificate program. Each student who wants to continue his or her education should receive assistance to identify and explore education options.
- 7.G.2.4 Education is valued and the educational needs of each youth are addressed. Each youth is encouraged to reach his or her educational potential and receives necessary assistance toward that goal.
- 7.G.2.5 A formal educational plan should be in place for each youth within 30 days of admission. The plan should be coordinated with the student's home school.
- 7.G.2.6 A youth's educational progress should be routinely and frequently assessed using standardized, criterion-referenced assessments.
- 7.G.2.7 Outcomes should demonstrate that youth achieve one year of progress in standardized achievement tests, or progress that is commensurate with their abilities in cases where developmental limitations exist.

- 7.G.2.8 The group care provider's staff members take an interest in each youth's education, attend all relevant school functions and meetings, and support the youth.
- 7.G.2.9 Youth with deficits in educational attainment receive support through extra tutoring.
- 7.G.2.10 The group care provider will provide a responsible person(s) who shows interest in a youth's educational progress, encourages the youth to apply himself or herself, takes notice of school reports, and attends school events.
- 7.G.2.11 Students are given clear information about resources to which they are entitled or could apply for in order to further their educational development (e.g., music tutoring, study aids, computers, books).

### **7.G.3 Support for Special Education Needs**

- 7.G.3.1 Every qualified youth should have a 504 Plan or an Individualized Education Plan (IEP).
- 7.G.3.2 Where feasible, and no later than one week after admission, the group care provider requests and receives a youth's IEP or school records.
- 7.G.3.3 The educational services of the group care provider should adhere to the needs articulated in the youth's IEP and provide special education services as needed.
- 7.G.3.4 The group care provider should ensure that an IEP is developed for each youth with special needs for whom it is required by law and regulation.
- 7.G.3.5 A youth's engagement in education is supported through minimizing disruptions to his or her education.

### **7.G.4 Vocational Training**

- 7.G.4.1 When a traditional educational program is not viable for a youth, the group care provider's educational services should provide or obtain a vocational assessment for that youth.
- 7.G.4.2 Youth of graduation age are counseled on additional educational and vocational opportunities.

### **7.G.5 Development of Prosocial Behavioral Skills**

- 7.G.5.1 Staff members teach prosocial skills, values, and behaviors through youth supervision, crisis management, daily living support, prosocial skill development, recreational activities, behavioral intervention, youth advocacy, and participation in the assessment and service planning/treatment planning processes.
- 7.G.5.2 Youth learn, practice, and consistently use prosocial skills and behaviors.
- 7.G.5.3 Staff members teach youth how to work cooperatively with their peers and help them develop social skills, problem-solving capacity, and emotional support.

- 7.G.5.4 Each youth's prosocial skills include building positive relationships with family, peers, staff members, and others.

## **7.G.6 Symptom Reduction**

- 7.G.6.1 An outcomes-driven approach to symptom reduction should demonstrate that substantial percentages of all youth improve in their major referral areas.
- 7.G.6.2 A youth's progress should be validated by using standards such as objective assessment tools or independent, professionally credentialed external evaluators.
- 7.G.6.3 In identifying and evaluating outcomes, the group care provider should specifically target outcomes that reduce symptom severity during placement.

## **7.G.7 Skills, Competencies, and Knowledge Needed for Citizenship**

- 7.G.7.1 Youth should have opportunities to learn and master developmentally appropriate skills that move them toward maturity, autonomy, and self-sufficiency. Outcomes should be determined through the following post-departure measures:
- a. Stable family setting or independent-living status
  - b. Employment, education, or military status
  - c. High school graduation/GED rates
  - d. Low delinquency and arrest rates
  - e. Low readmission/recidivism rates
  - f. Successful transition to adulthood
- 7.G.7.2 The group care provider should teach a curriculum of independent-living skills that fits the age and developmental level of each youth.
- 7.G.7.3 In collaboration with the local CBC, the group care provider should use a standardized life skills assessment instrument as soon as possible after a youth's 14th birthday to establish a benchmark for progress on the development of skills in the areas of:
- a. Educational and vocational development
  - b. Interpersonal skills
  - c. Financial management
  - d. Household management
  - e. Self-care

### **7.G.8 Measure and Regularly Report Youth's Emotional, Behavioral, and Education Progress**

- 7.G.8.1 The group care program has the responsibility to collect data on treatment outcomes and assess whether the program is achieving positive service/ treatment outcomes in the interventions it provides.
- 7.G.8.2 The group care program should provide and document updates on the progress or lack of progress of youth in care, including the areas of target behaviors, skill acquisition by youth and family, youth's/family's response to treatment, obstacles to treatment, and special circumstances.
- 7.G.8.3 The group care provider should help the youth (as age-appropriate) and family members evaluate their services in light of their desired outcomes, and determine whether modifications are necessary to improve progress.
- 7.G.8.4 The group care provider should regularly review service goals and objectives with the youth and the family, make necessary revisions in the service plan/ treatment plan, and reinforce efforts to achieve desired outcomes.
- 7.G.8.5 Program managers have mechanisms in place for assessing the quality and effectiveness of services provided by the program, particularly in the area of positive outcomes for youth.
- 7.G.8.6 Staff members should periodically test youth on independent-living skills.

### **7.G.9 Place Accountability for Youth Progress on Program Structure**

- 7.G.9.1 Utilize an evaluation framework to support the development of understanding of how best to make a difference for youth as they move through group care.
- 7.G.9.2 Identify and measure progress in achieving outcomes for youth and families being served, as well as outcomes for the service system. Document success in meeting goals and be accountable to the youth and families being served and to the community.
- 7.G.9.3 Demonstrate a functional relationship between program methods and youth skill development through ongoing assessment of youth skill acquisition and skill needs.



## PRE-DISCHARGE/POST-DISCHARGE PROCESSES

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### 8.H.1. Transition Planning (Education, Employment, and Treatment)

- 8.H.1.1 The group care provider should begin discussing the transition and discharge process with the youth and family at intake, and they should know the projected transition goal and date as early as possible.
- 8.H.1.2 Transition planning should support a youth's education, employment, and treatment transition plans.
- 8.H.1.3 Transition from the service plan/treatment plan includes a focus on continuity of relationships, family connection, family healing work, and community connection.
- 8.H.1.4 Youth should be prepared for leaving the group care home in ways that are appropriate to their age, development level, understanding, and maturity. The preparation reflects their permanency plan.
- 8.H.1.5 Whenever possible and permissible, staff members will maintain ongoing supportive relationships and contact with youth who have left the program.
- 8.H.1.6 Unless restricted by court sanctions, a youth's family should also be involved in the transition planning process as much as possible, and the group care provider will work with the youth and family to develop a plan for the youth to live in the community.
- 8.H.1.7 The group care provider helps youth obtain or compile documents that enable them to function independently. At a minimum, these include a valid state identification or driver's license, Social Security information, health information, and financial literacy information.

### 8.H.2 Provide Services That Support Family Reunification

- 8.H.2.1 The group care provider coordinates follow-up and ongoing involvement with a youth's family or guardians.
- 8.H.2.2 In preparation for program departure, overnight stays by the youth with his or her parents/guardians provides an opportunity for the youth and family members to practice skills they learned during treatment. A visitation report is completed upon the youth's return from each visit and/or therapeutic leave.
- 8.H.2.3 The group care provider should deliver maximum support as youth prepare for transition. For youth and families whose goal is reunification, the provider should focus on delivering or coordinating support and connections they need to make reunification possible and successful.
- 8.H.2.4 Where indicated, the group care provider should actively engage the youth's family in counseling services to improve and support family functioning, examine special needs and stresses of the youth and family, facilitate

changing attitudes and behaviors that will increase the youth's opportunity for success after reunification, examine the family members' appropriate roles, and/or improve parenting skills.

### **8.H.3 Connect Family to Community Resources**

8.H.3.1 Discharge planning should review and take advantage of all applicable community services. The youth and family should be introduced to potential mentors, groups, and services that can support them during and after transition.

### **8.H.4 Aftercare**

8.H.4.1 The group care provider will provide support, aftercare, and community service coordination for the youth and family and help former youth residents connect with a wide range of personal or professional services. This includes providing referrals and making all appointment dates prior to a youth's discharge.

### **8.H.5 Educational Outcomes**

8.H.5.1 A youth's educational outcomes should be monitored through some form of follow-up process that includes measurements such as educational and vocational progress and gains.

- a. A substantial percentage of school-aged former youth continue their education.
- b. A substantial percentage of former youth who are older than 19 have graduated from high school or obtained a GED.
- c. Youth who receive group care services during adolescence should, at a minimum, be able to complete high school or obtain their GED after discharge.

### **8.H.6 Citizenship Outcomes**

8.H.6.1 Program measures this outcome by demonstrating that a substantial percentage of older youth are either employed, in school, or in the military.

### **8.H.7 Functional Outcomes**

8.H.7.1 Monitor outcomes by some form of follow-up process that includes measurements such as the level of restrictiveness of post-discharge living arrangements.

- a. Demonstrate that high rates of youth successfully depart to less-restrictive environments.
- b. Assess youth readmission to higher levels of care.
- c. Demonstrate that former youth maintain ongoing contact with family and friends.

- d. Document that former youth are active in community organizations.

## **8.H.8 Law-Abiding Outcomes**

- 8.H.8.1 Monitor outcomes by some form of follow-up process that includes measurements such as rate of recidivism.
  - a. Demonstrate that former youth have not been arrested or incarcerated.
  - b. Demonstrate that one-year post-discharge arrest rates for former youth are equal to or less than the norms for their age group.





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