

BEHAVIORAL HEALTH STANDARDS RELATED TO H.R. 911

Proposed Minimum Standards for Miller Bill (H.R. 911)

Child Welfare League of America (CWLA) Standards of Excellence

<p>(A) Child abuse and neglect shall be prohibited</p>	<p>3.57 Policies and procedures</p> <p>The residential service provider should develop behavior support and intervention policies and procedures that articulate the provider’s behavior management philosophy; safeguard the rights of children, families, and staff; govern allowed and prohibited practices; and institute oversight responsibilities.</p> <p>Provider policies and procedures should address:</p> <ul style="list-style-type: none"> • Proactive and preventive practices; • Development of behavior support and intervention plans for children; • Client rights, including complaint procedures; • Prohibited behavior intervention practices; • Restrictive practices, if any, that are allowed, and circumstances when they can be used; • Physical interventions, if any; • Staff training requirements; • Documentation and reporting requirements for serious incidents; • Abuse prevention and reporting requirements; • Informed consent of parents and guardians for use of behavior support and interventions; and • The residential service provider’s oversight process. <p>Best practices in behavior support and intervention are evolving rapidly. Agencies are strongly urged to refer to national accreditation and best practice standards when developing and reviewing their behavior support and management policies and procedures.</p> <p>The residential service provider’s behavior support and intervention policies and procedures should constitute a “hot to” manual for staff, stating clearly everything personnel need to know to adhere to the provider’s expectations concerning behavior support and intervention of children.</p> <p>3.63 Prohibited Practices</p> <p>The following practices should be prohibited under any circumstances: corporal punishment, such as slapping, spanking, paddling, or belting; marching, standing or kneeling rigidly in one spot, or any kind of physical discomfort; denial or deprivation of sleep or nutrition; denial of access to bathroom facilities; verbal abuse, ridicule, humiliation, shaming, or sarcasm; punishing a group of children for the actions of one or a select few; withholding family visits; other impingements on the basic rights of children to care, protection, safety, and security; and chemical, mechanical, or peer restraint.</p> <p>4.24 Protection of the rights of children and families</p> <p>The residential agency should develop and maintain a clients’ rights policy that supports and protects the fundamental human, civil, constitutional, and statutory rights of all children in its care.</p> <p>These rights include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Every child and family has equal access to services regardless of race, religion, ethnicity, sexual orientation, ability, or gender. • The dignity of every child and family is recognized and respected in the delivery of services. • Every child and family receives care according to individual need.
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	<ul style="list-style-type: none"> • Service is provided within the least restrictive and most appropriate setting. • Services are periodically reviewed for and with every child and family. • Every child and family has the right to file complaints and grievances. • Every child and family is informed at the time of intake, in a language they commonly use, of the agency’s policies and procedures regarding their rights, including the grievance policy. • Every child and family receives a copy of client rights on admission and is given an opportunity to discuss it with staff. • Every child and family has the right to review their own case files and service records. • Every child and family has a right to personal privacy and confidentiality. • Every child and family has the right to receive culturally competent and linguistically appropriate services. • Every child and family has the right to be involved, as appropriate to age, development, and ability, in assessment and service planning. • Every child has the right to receive services that promote his or her growth and development. • Every child has the right to consult with clergy. • Every child and family has the right to refuse treatment. • Every child has the right to safety. • Every child has the right to contact the human rights officer and/or personal advocate. • Every family has the right to give and withhold informed consent. • Every child has a right not to be exploited or have his or her privacy invaded by agency publicity or fundraising efforts. • Every child has a right to private familial and significant other contact (face-to-face, telephone, etc.) unless clinically contraindicated. • Every family is notified following any use of seclusion and restraint, suicide attempt or completed suicide, medical emergency, or any other seminal event in the life of their child. <p>The child, parents, or guardian cannot waive these rights.</p> <p>The residential agency’s policies regarding clients’ rights should be an integral part of the staff orientation program.</p> <p>4.32 Ethical conduct Ethical practices related to service delivery, professional practices, financial management, and business management should be developed by the service provider and include provisions for:</p> <ul style="list-style-type: none"> • written policy outlining procedures used regarding allegations of staff or volunteer misconduct; • written policy prohibiting sexual, emotional, and physically abusive relationships with clients;
(B) Disciplinary techniques or other practices that involve the withholding of essential food, water, clothing,	<p>3.14 Clothing, accessories, and personal appearance</p> <p>The residential service provider should ensure that each child has adequate, seasonable clothing appropriate to the child’s age, gender, and individual needs. Clothing and shoes should be attractive, of proper size, of the style and character worn by peers, and adequate in amount to permit laundering, cleaning, and repair.</p>

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<p>shelter, or medical care necessary to maintain physical health, mental health, and general safety, shall be prohibited</p>	<p>Whenever possible, the child's family should be responsible for providing clothing. Children should be involved in selecting their clothing.</p> <p>Clothing contributes to feelings of self-worth and dignity, shows a respect for individuality, and demonstrates that someone cares for and values the child. Clothing should be provided in a manner that helps the child develop self-esteem and a sense of personal responsibility. Staff should take into consideration any cultural issues around clothing when dealing with children and youth.</p> <p>Each child should be taught developmentally appropriate skills for selecting and caring for clothing. Children who are able to take part in budgeting for the purchase of their own clothing should be encouraged to do so. Adolescents should have clothing allowances and should be given opportunities to increase their independent in shopping for clothing.</p> <p>The residential service provider should develop a written policy concerning the limitations, if any, it places on clothing style and appearance, jewelry and other accessories, body decorations, hairstyles, or any other guidelines for personal appearance. The residential service provider should not mandate a single hairstyle for all children and should not require haircuts or head shaving on admission.</p> <p>If the residential service provider prohibits certain items, (e.g., clothing with cigarette, alcohol, and/or drug related logos and symbols), the reasons for such prohibitions should be explained fully to children and parents during intake. Any prohibitions should be related to maintaining the safety and well-being of the children receiving services.</p> <p>If the residential service provider institutes dress requirements, they should be consistent with current styles of dress. Clothing should fit properly.</p> <p>Children should not be forced to wear specific clothing or accessories, and items of clothing (including footwear) should not be removed from children as punishment or to indicate that they have previously engaged in negative behavior</p> <p>The residential service provider should be sensitive to ethnic and cultural norms when evaluating the advisability of placing limits on clothing, accessories, or personal appearance.</p> <p>3.19 Chores</p> <p>Chores should be similar to the chores of children living in home settings (e.g., doing laundry, sweeping or vacuuming a room, making and changing beds).</p> <p>Children should not be required to do work that replaces the work of paid staff.</p> <p>The amount of work expected should recognize differences in age, maturity, ability, and attention, as well as the degree and quality of the adult supervision required for the task involved.</p> <p>3.60 Behavior support and intervention plan for each child</p> <p>In conjunction with the child and family, the residential service provider should develop a behavior support and intervention plan for each child receiving services.</p>
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	<p>At a minimum, the behavior support and intervention plan should include:</p> <ul style="list-style-type: none"> • Physical interventions to be used, if any; • Specific goals and objectives that address target behaviors requiring physical intervention; • Informed consent for the use of restrictive interventions; • Procedures for monitoring the effectiveness of behavior support and interventions; • Timelines for reviewing the plan; • Assurance that all persons implementing physical interventions are trained and certified in behavior management; • Documentation of any physical interventions used with the child; • Documentation that the child and family participate in the development and review of the behavior support and intervention plan; and • Written consent to the plan by the child, family, and/or legal guardian. <p>3.61 Consequences of unacceptable behavior</p> <p>Consequences, when applied, should relate to and be proportionate with the unacceptable behavior and reflect the nature of real-world experiences. Consequences should also recognize the child’s maturity level and cultural context.</p> <p>Providing children with consequences for negative behaviors can be a valuable teaching tool. To have the most positive impact and meaning, consequences for behavior must be administered in a timely fashion, as close to the event as possible.</p> <p>Groups should not be punished for the misbehavior of an individual child.</p> <p>The provider should establish guidelines for consequences by clearly defining staff responses and possible consequences for the range of behaviors children may exhibit. In terms of their severity and duration, however, consequences should be individualized based on the child’s developmental level, cultural context, and previous patterns of behavior.</p> <p>Staff members administering consequence should have an awareness of self and be able to recognize when they themselves are angry and out of control.</p> <p>Staff members will experience a range of emotions when working with challenging groups of children. They should remove themselves, or be removed, from the situation whenever their own reactions and emotions appear to interfere with sound judgment.</p>
<p>(C) The protection and promotion of the right of each child at such a program to be free from physical and mechanical restraints and seclusion (as such terms are defined in section 595 of the Public Health Service Act (42 U.S.C. 290ii) to the same extent and in the same manner as a non-medical,</p>	<p>3.63 Use of Physical Restraint and Seclusion</p> <p>The residential service provider should use restraint and seclusion only in an emergency, when there is an imminent risk of harm to the individual or others, and no less restrictive intervention has been or is likely to be effective in averting the danger.</p> <p>Recognizing that restrictive interventions have the potential to produce serious consequences (such as physical and psychological harm, retraumatization, loss of dignity, violation of an individual’s rights, serious injury, or death), providers must continually explore ways to prevent, reduce and eliminate their use. Nonphysical interventions should always be the first choice, unless safety issues demand an immediate physical response (CWLA, 2002b).</p>

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<p>community-based facility for children and youth is required to protect and promote the right of its residents to be free from such restraints and seclusion under such section 595, including the prohibitions and limitations described in subsection (b)(3) of such section</p>	<p>Any provider who uses physical interventions should complete a comprehensive assessment of the child during intake, before or at admission, and should provide family and guardians with required written information and consents (see Intake assessment and Chapter 2).</p> <p>Supervisors, senior staff members, or designated individuals should provide direct, third-party monitoring of physical intervention incidents. Monitoring should assess the child’s psychological and physical well-being during the use of restraint and seclusion to ensure that the intervention is being completed in a safe and appropriate manner and that the agency’s policies and procedures are being upheld. The monitoring of restraint and seclusion should be for the duration of the incident.</p> <p>Debriefing should occur within 24 hours or as soon as possible after the use of restraint or seclusion. Separate debriefing meetings should be held with senior staff and the staff member(s) involved, the child involved, witnesses to the event, and family members. Debriefing provides an opportunity for the staff, child, and family to discuss their feelings and perceptions of the crisis and establish a plan to reduce the need for physical intervention.</p> <p>A residential service provider that authorizes staff to use physical intervention must require them to complete appropriate orientation and training. At a minimum, the provider should adhere to licensing requirements and accreditation standards, use competency-based training, and institute periodic retraining of staff.</p> <p>Every use of restraint and seclusion must be documented and must undergo administrative review (see Incident reporting and risk management, Chapter 4). In addition, an established internal review process should be established to monitor the use of restrictive interventions.</p> <p>The review process should examine every incident of injury to a child or staff, any restraint or seclusion of unusual duration, and any pattern of restraint or seclusion by a particular staff person or on a particular shift.</p> <p>The review process should not take the place of incident debriefing, internal investigations, or investigations in response to allegations of abuse or neglect.</p> <p>3.64 Prohibited restraint and seclusion practices</p> <p>Restraint and seclusion should never be used as a threat of punishment, as a form of discipline, in lieu of adequate staffing, as a replacement for active treatment, or for staff convenience.</p> <p>The following practices are prohibited in restraint and seclusion:</p> <ul style="list-style-type: none"> • Pain compliance, slight discomfort, trigger points, pressure points, or any pain-inducing techniques; • Hyperextension of any body part (pushing or pulling of the knees, elbows, shoulders, limbs, joints, fingers, thumbs, or neck) beyond normal limits; • Putting the person at significant risk of hyperextension by placing any part of the person’s body in a position that is beyond normal limits (e.g., holding one or both arms behind the back and applying pressure, pulling, or lifting); • Joint or skin torsion (twisting or turning in opposite directions); • Pressure or weight on head, chest, lungs, sternum, diaphragm, back, or abdomen, causing chest compression;
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	<ul style="list-style-type: none"> • Straddling or sitting on any part of the body; • Any maneuver that puts pressure, weight, or leverage into or on the neck or throat, on any artery, or on the back of the person’s head or neck; • Any position or maneuver that obstructs or restricts circulation of blood or obstructs an airway; • Any type of choking, hand chokes, arm chokes, or sleeper hold; • Any type of head hold where the head is used as a lever to control movement of other body parts, or any type of full or half nelson or head lock; • Any technique that involves mouth, nose, eyes, or any part of the face, or covering the face or body; and • Any maneuver that involves punching, hitting, poking, pinching, or shoving. <p>4.24 Protection of the rights of children and families The residential agency should develop and maintain a clients’ rights policy that supports and protects the fundamental human, civil, constitutional, and statutory rights of all children in its care.</p> <ul style="list-style-type: none"> • Every family is notified following any use of seclusion and restraint, suicide attempt or completed suicide, medical emergency, or any other seminal event in the life of their child.
<p>(D) Acts of physical or mental abuse designed to humiliate, degrade, or undermine a child’s self-respect shall be prohibited</p>	<p>3.63 Prohibited Practices The following practices should be prohibited under any circumstances: corporal punishment, such as slapping, spanking, paddling, or belting; marching, standing or kneeling rigidly in one spot, or any kind of physical discomfort; denial or deprivation of sleep or nutrition; denial of access to bathroom facilities; verbal abuse, ridicule, humiliation, shaming, or sarcasm; punishing a group of children for the actions of one or a select few; withholding family visits; other impingements on the basic rights of children to care, protection, safety, and security; and chemical, mechanical, or peer restraint.</p>
<p>(E) Each child at such a program shall have reasonable access to a telephone, and be informed of their right to such access, for making and receiving phone calls with as much privacy as possible, and shall have access to the appropriate State or local child abuse reporting hotline number, and the national hotline number referred to in subsection (c) (2).</p>	<p>3.43 Family Contact and Visits The residential service provider’s policies, procedures, staff, and environment should encourage and facilitate visits and contact by families with their children (see also Protection of the rights of children and families, Ch. 4)</p> <ul style="list-style-type: none"> • Unless contraindicated or prohibited by court order, residential service providers should actively encourage families and children to be in regular contact by telephone, mail, email, and visits in the program and at home. • Policies and procedures regarding visits and contact should be explained fully. Families should be clearly informed if there are approval procedures for visits and contact. If the program places limits on the number and/or frequency of telephone calls, it should also make such limits clear to families. • Unless local law and regulation indicate otherwise, contact between families and children should be restricted only on the basis of appropriate service planning, court order, or decision by the legal guardian. • The residential service provider should cooperate with court orders and service plan requirements for supervised visitation by providing appropriate space and/or staff to accommodate supervised visits. <p>4.24 Protection of the rights of children and families The residential agency should develop and maintain a clients’ rights policy that supports and protects the fundamental human, civil, constitutional, and statutory rights of all children in its care.</p> <ul style="list-style-type: none"> • Every child has a right to private familial and significant other contact (face-to-

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	face, telephone, etc.) unless clinically contraindicated.
(F) Each staff member, including volunteers, at such a program shall be required, as a condition of employment, to become familiar with what constitutes child abuse and neglect, as defined by State law.	<p>4.57 Orientation program The orientation program should be provided to all staff members prior to their taking on responsibility for any direct services with children and families. The orientation program should include these topics:</p> <ul style="list-style-type: none"> • staff member responsibilities, particularly those related to professional issues such as mandated reporting, confidentiality, and respect for clients, family members, and coworkers <p>*6.7 Staff Training Staff training is an essential element in the prevention of child abuse and neglect in child-serving agencies. To be effective, training regarding child abuse and neglect should not be a one-time event but part of an ongoing staff development process. It should be developed for all staff in the child care setting and customized to their job duties and individual training needs. All staff should receive training in identifying and preventing child abuse and neglect in the facility. Staff training regarding child abuse and neglect should be comprehensive in nature. It should</p> <ul style="list-style-type: none"> • Include, but not be limited to, the dynamics of child abuse and neglect, child development, appropriate discipline techniques, supervision of children, and separation and attachment issues; • Use standardized material but also allow for flexibility to address local and regional issues; and • Be provided by staff with the skills and competencies to conduct the training.
(G) Each staff member, including volunteers, at such a program shall be required, as a condition of employment, to become familiar with the requirements, including with State law relating to mandated reporters, and procedures for reporting child abuse and neglect in the State in which the program was located.	<p>4.57 Orientation program The orientation program should be provided to all staff members prior to their taking on responsibility for any direct services with children and families. The orientation program should include these topics:</p> <ul style="list-style-type: none"> • staff member responsibilities, particularly those related to professional issues such as mandated reporting, confidentiality, and respect for clients, family members, and coworkers <p>ⁱ1.15 Assessing and Planning for the Child’s Immediate Safety The agency providing care outside of the home should take immediate steps to protect the child by removing the person alleged to be responsible for the maltreatment from access to the child and other children and should implement a specific action plan detailing how it will keep the child safe pending contact by child protective services.</p> <p>If a child is removed from a facility, the responsible agency should speak with the parents to determine if they intend for the child to return to that facility (e.g., a child care center), and, if so, what steps the agency and the facility will take to keep the child or other children safe.</p> <p>[‡]3.3 The Role of Community Agencies and Service Organizations In providing leadership within the community, the child protection agency should encourage community agencies and service organizations to:</p> <ul style="list-style-type: none"> • Collaborate with other members of the community in outreach programs to engage at-risk families and to assure that those in need of services and support have timely and easy access to them;

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	<ul style="list-style-type: none"> •Assure that their service programs promote healthy child development and are responsive to the individual needs of children and families; •Assure that staff are properly trained and skilled in their area of expertise, as well as in the recognition and reporting of child abuse and neglect, community development, teamwork, and advocacy;
<p>(H) Full disclosure, in writing, of staff qualifications and their roles and responsibilities at such program, including medical, emergency response, and mental health training, to parents or legal guardians of children at such a program, including providing information on any staff changes, including changes to any staff member's qualifications, roles, or responsibilities, not later than 10 days after such changes occur</p>	<p>1.3 Attributes of all types of residential service <i>Required staff constellation and staff ratios</i> All residential staff should have regular, scheduled supervision. Sufficient supervisory, administrative, and support staff should be provided and available as needed.</p> <p><i>Staff qualifications</i> Clearly defined minimum qualifications should be established, including required education and experience, roles, and responsibilities for every position within the residential service.</p> <p><i>Staff responsibilities</i> Child care workers should provide general child supervision, crisis management, daily living support, prosocial skill development, recreational activities, behavioral intervention, child advocacy, and participation in the assessment and service planning process.</p> <p>2. The process of service delivery <i>Goals</i> IV. The residential service provider reaches out to family members and involves the child and family (and tribe if the child is an American Indian child) in every facet of assessment, service planning, service implementation, and review. V. Intake, admission, service planning and review, discharge and follow-up services are culturally competent and respectful of the feelings and needs of children and families. VI. The residential service provider ensures that there are measurable, attainable goals, objectives, and desired service outcomes for each child; a process for measuring attainment; and a process for adjusting expectations as necessary. VII. Services to each child and family are continued as long as necessary, but not longer than necessary.</p> <p>2.8 Initiation of the intake process</p> <p>The residential service provider should begin the intake process when a child or parent requests or is referred for services.</p> <p>The residential service provider should conduct the intake process in a manner considerate of the child and family members, respectful of cultural identity, and in a spirit that encourages self direction. The provider should ensure that:</p> <ul style="list-style-type: none"> • The referral is appropriate and the provider has the ability to meet the child's needs; • The referral is made with the proper legal and regulatory authority; • The civil rights of the participants, especially the child and the family, are respected and upheld; • Participants are informed of their status, rights of grievance and appeal, and the policies that will be used to determine when to make changes in the child's placement status and when to discontinue services; • Every effort is made, unless contraindicated, to engage the child and family members in the intake process;

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	<ul style="list-style-type: none">• All written information is provided in a language commonly used by the child and family, and that, when necessary, the family is provided translation, interpreter, and/or literacy services to facilitate their understanding;• All contacts with and services to the child and family are culturally competent and responsive (see also Cultural competence, Chapter 3);• If the child is an American Indian child, the tribe has been contacted and invited to participate in the intake process;• Families are encouraged to bring a support person/advocate to intake if it will facilitate the process; and• The standard intake process is applied equally to all children and their families, regardless of the source of the referral and regardless of voluntary or mandated status. <p>The ability to engage the child and the family during intake is an important determinant of the effectiveness of the service. The process of empowerment should begin with the first contact with the child and family member, whether by phone or in person, by encouraging them to define their own problems, needs, strengths, and service priorities (see also Universal service characteristics, Chapter 3).</p> <p>The residential service provider should recognize that services are not “given” or “performed on” children, but rather offer opportunities to “work with” them.</p> <p>The child’s desire to receive residential services should never be presumed. The child therefore should be actively engaged in the process whenever possible. Opinions and requests should be sought and heeded if the child is to become a full participant in the process.</p> <p>2.9 Purpose of intake</p> <p>The residential service provider should establish clear criteria for admission and should evaluate each referral for service against those criteria. The residential service provider should use the intake process to determine whether and how it can meet the needs of the child and family.</p> <p>The residential service provider should consider its potential to provide the required services based on the referral assessment and consideration of its own resources.</p> <p>During the intake process, the residential service provider should:</p> <ul style="list-style-type: none">• Establish a clear understanding of the strengths and needs of the child and family;• Acquaint the child and family with the program of services offered by the residential service provider;• Demonstrate concern about the child and family, and make known the provider’s readiness and capacity to be of help;• Minimize trauma for the child and family (see also Creating a trauma-sensitive culture, Section 3.34);• Present and obtain all information in the language commonly used by the child and family, and provide translation/interpreter services are necessary;• Solicit the information necessary to determine what services are needed and how they can best be provided and/or obtained;• Make clear to the child and the family what types of help are available, how services will be provided, and the requirements for using the services (such as regular interviews or fees);
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	<ul style="list-style-type: none">• Discuss the child’s and family’s rights and the agency’s responsibilities;• Provide the child and family the opportunity to share how they are feeling and answer any questions they might have;• Determine whether the child and family’s needs can be met by the provider and how any specific cultural issues will be addressed;• Arrive at tentative plans for service and discharge;• Consider the funding and financial implications of the service plan;• Examine the potential of the child’s and family (and the child’s tribe, if an American Indian child) to work together with the provider to accomplish desired outcomes; and• Discuss alternatives if the provider determines that it cannot provide appropriate services to the child and family. <p>2.10 Steps in the intake process</p> <p>The residential service provider should establish a planned intake process. Except in detention and emergency or crisis situations (when intake and admission may be simultaneous), the intake process should occur prior to admission and should afford the child and family sufficient time to consider fully the service options and alternatives. The residential service provider should accept only those children whose needs it believes it can meet.</p> <p>The intake process should include the following steps:</p> <ul style="list-style-type: none">• Review by the provider of a written referral that includes at a minimum the information described in section 2.2;• An opportunity for the child, family, a representative of the child’s tribe if an American Indian child, and referring worker to have an interview, visit the program, talk about what the child needs to feel comfortable and safe, meet with caregivers, and ask questions;• An explanation to the child, family, and referring worker of the rules and expectations of the provider, including behavior management practices used;• Completion of a trauma assessment, past history of violence, and a de-escalation preference survey;• An opportunity for the child, family, and referring worker to tour the facilities, including living areas, classrooms, and any time-out and quiet rooms;• Full explanation to the child and family, in the language commonly used by them, of their rights and responsibilities, decisions they will be asked to make, and forms they will be asked to sign;• An opportunity for the provider, child, family, the child’s tribe if an American Indian child, and referring worker to assess and make informed decisions about the appropriateness of the program for meeting the child’s and family’s needs;• Referral to other more appropriate service providers, if the child and family’s needs cannot be met; and• Signing of necessary authorization, consent, and agreement forms. <p>2.11 Admission</p> <p>The residential service provider should establish an admission process that welcomes the child, involves the family, accomplishes necessary admission paperwork, and launches a cooperative relationship among everyone involved in planning, obtaining, and funding services for the child and family. The child’s family, caseworker, and/or other trusted individuals should be invited to accompany the child for admission.</p>
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	<p>The provider should be sensitive to the impact that leaving home or transferring from another setting may have on the child and family. Important attachments are often disrupted. Addressing the trauma and loss often associated with separation is an important aspect of assuring the child's safety and emotional well-being during the admission process.</p> <p>The child and family should be given time to talk about how they feel and an opportunity to ask any questions they might have.</p> <p>At admission</p> <ul style="list-style-type: none">• If it has not already been provided, the child and family should be given, in writing, the provider's rules, privacy policy, description of behavior management and physical intervention practices, and complaint and appeal procedure.• The child and the family should be given a demonstration of physical intervention procedures.• The child and family should be informed that feedback on the program and services they receive during the child's placement is encouraged. <p>2.12 Role of the child in the assessment and service planning process</p> <p>The residential service provider should encourage and assist the child to participate in assessment and service planning processes.</p> <p>The child, as age appropriate, should:</p> <ul style="list-style-type: none">• Contribute to assessment of strengths and needs,• Develop personal goals and objectives,• Identify desired outcomes of residential service and relevant outcome measures,• Provide feedback to other assessment and service planning participants as to his or her point of view• Evaluate the effectiveness of services from his or her perspective, and• Participate in periodic service plan reviews <p>Children should participate in decision-making regarding their services, commensurate with their development. Parents, physicians, and other caregivers should never exclude children from the decision-making process, unless there are compelling reasons to do so. Any decision to exclude a child from the assessment and/or service planning process should be made only with full consideration of the child's legal rights.</p> <p>2.13 Role of the family in the assessment and service planning process</p> <p>The family should be engaged in the assessment and service planning processes whenever possible, and whenever in the best interests of the child. The residential service provider should develop a trusting and helpful relationship with the family.</p> <p>Staff should establish credibility with family members by demonstrating knowledge and skills; listening intelligently and having an open mind to their views; showing respect for their background and culture; and developing an understanding of the child and family's past experiences, current situation and views, strengths, wants, and needs.</p> <p>The residential service provider should explain to the parents that their participation in assessment and service planning is both vital and encouraged. The family should be encouraged to have a support person/advocate present during the assessment and service planning process if that would help them.</p>
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	<p>Although it is not always possible, the residential service provider should make every effort to enable the family to participate fully, recognizing that family involvement is very important to the child and to positive service outcomes (see also Family services, Chapter 3).</p> <p>Specifically, family members should be encouraged to:</p> <ul style="list-style-type: none">• Provide accurate information about the child and family, their past experiences, and their current status, including the child's behavior and attitude at home, with family members, and in the community;• Represent their child's interests during assessment and service planning, particularly when their child is very young or otherwise unable or unwilling to speak for himself or herself;• Identify previous interventions that have been helpful and those that have been unsuccessful;• Help the child to understand the service plan and service planning process; and• Represent the needs of the other family members. <p>2.21 Monitoring and evaluating progress</p> <p>The residential service provider should set a timeframe for regular, periodic review of the service plan to determine how well services meet the needs of the child and family. The review should involve the service planning team. The review should involve the service planning team. The review should determine the extent to which service goals and objectives have been met and whether changes in the service plan should be made.</p> <p>The residential service provider should help the child (as age appropriate) and family members to evaluate services in light of their desired outcomes, and determine whether any modifications would improve progress. The residential service provider should regularly review service goals and objectives with the child and the family, make necessary revisions in the service plan, and reinforce efforts to achieve desired outcomes.</p> <p>The service plan should be a living document that is revised, amended, and adjusted to reflect the child's current needs and progress. At a minimum, service plan reviews should comply with federal, state or provincial, or local regulatory requirements. The frequency of formal service plan reviews for an individual child and family should be dictated by the length of stay, changes in legal status, or unexpected events. More frequent or less formal reviews and modifications should not be precluded by the regular, periodic review requirement.</p> <p>The review process should afford the child, family, and all team members the opportunity to air questions and concerns and redefine roles and responsibilities. It should serve as an arena for engaging all parties in working cooperatively toward the achievement of service plan goals and objectives. When multiple providers and/or agencies are involved, the service plan review process offers an excellent opportunity for inter-provider and cross-system collaboration and cooperation.</p> <p>3.3 Child-centered, family-focused services</p> <p>Residential services should be child centered and family focused.</p> <p>The residential service provider should recognize that a problem affecting one family member affects the whole family. A child should be seen in the context of the immediate and extended family, and the family in the context of its larger economic,</p>
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	<p>social, cultural, religious, and political environment.</p> <p>Among the residential service provider's highest priorities should be affording services that assist families to stay together, to reunite successfully, and to make decisions that will assure family continuity and permanency for children. As needed, the provider should offer family preservation and family support services, or should assist families to access such services.</p> <p>3.40 Communication with families</p> <p>The residential service provider should have a comprehensive written plan for working with and communicating with families. The plan should address:</p> <ul style="list-style-type: none">• The written information to be provided to families during intake and at admission;• Obtaining necessary routine parental authorizations and consents and identifying the persons responsible for granting permission and consent for special activities;• Informing families of relevant rules and expectations;• Explaining the rights of children and families, including any limits or restrictions;• Discussing culturally specific issues;• Informing families of the benefits and services to which their children are entitled;• Developing plans for visits and contacts with children;• Engaging families in assessment and service planning, unless contraindicated or prohibited by court order;• Notifying families of their children's progress;• The circumstances under which the residential service provider must contact families (e.g., in the event of illness or injury); and• Mobilizing families' strengths to engage them in permanency planning. <p>The residential service provider should establish a policy defining the circumstances under which families will not be contacted.</p> <p>The residential service provider should consult legal counsel to ensure that its policies adhere to relevant law and regulation (e.g., if the person being served has been declared an emancipated minor and/or does not wish to have parents contacted).</p> <p>4.54 Competency-based staff development</p> <p>The agency should clearly define the qualifications and competencies required of all staff. Direct care competencies should include the following:</p> <ul style="list-style-type: none">• effective communication;• development of healthy relationships;• maintaining a healthy, safe, secure work environment;• enabling children to maintain their personal hygiene and appearance;• enabling children to achieve and maintain personal comfort;• protecting children from maltreatment;• fostering equality, diversity, and rights;• knowing age- and population-specific competencies;• preparing food and drink;• receiving, transmitting, and retrieving information;
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	<ul style="list-style-type: none"> • dealing with medication; and • handling special-needs populations.
<p>(I) Each staff member at a covered program described in sub-clause (I) or (II) of section 2(4)(A)(i) shall be required, as a condition of employment, to be familiar with the signs, symptoms, and appropriate responses associated with heatstroke, dehydration, and hypothermia.</p>	<p>1.3 Attributes of all Types of Residential Service <i>Required Staff Constellation and Staff Ratios</i></p> <ul style="list-style-type: none"> • All staff members should be trained and expected to provide backup support for crisis situations, emergencies, or other unforeseen situations, and should help ensure a safe and healthful living environment. <p>3.9 Daily living programs</p> <p>The daily living program should help children experience daily life while protecting them from the hazards and dangers they are unable to manage effectively.</p> <p>Residential service providers have an obligation to protect children receiving services from risk and harm. Simultaneously, children need to experience the normal risks inherent in childhood to learn and grow.</p> <p>Residential service providers must constantly weight the risks and benefits of their programs and activities to assure that children have appropriate normal learning experiences. No activity of daily living should be undertaken until the potential for its safety has been studied and staff members in charge of the daily living program have been properly trained to conduct the activity and are prepared to manage any unexpected events that may arise (see Safety and risk management, section 4.66).</p>
<p>(J) Each staff member, including volunteers, shall be required, as a condition of employment, to submit to a criminal history check, including a name-based search of the National Sex Offender Registry established pursuant to the Adam Walsh Child Protection and Safety Act of 2006 (Public Law 109-248; 42 U.S.C. 16901 et seq.), a search of the State criminal registry or repository in the State in which the covered program is operating, and a Federal Bureau of Investigation fingerprint check. An individual shall be ineligible to serve in a position with any contact with children at a covered program if any such record check reveals a felony conviction for child abuse or neglect, spousal abuse,</p>	<p>4.37 Selecting staff When selecting staff, the agency should:</p> <ul style="list-style-type: none"> • verify information provided during the interview process, including but not limited to education, prior employment and experience, and criminal and child abuse history; • administer drug screening to all potential employees; <p>4.48 Policies and procedures for use of volunteers The residential group care agency should establish written policies and procedures for the operation of its volunteer program. The policies should include:</p> <ul style="list-style-type: none"> • a process for screening and selecting volunteers, similar to that used for paid staff members; <p>4.49 Criminal and child protective services record checks The background of all prospective staff, volunteers, and contracted consultants should be assessed for their ability to work with children and families. Background assessments are particularly important for staff who will have direct contact with children.</p> <ul style="list-style-type: none"> • The agency should conduct initial criminal and child abuse screenings on all staff. • The agency also may require drug screening for staff in direct service positions. • Motor vehicle department screening should be required for all staff who will be transporting children. <p>If a candidate or staff person is found to have a criminal or child abuse history, the incident(s) should be thoroughly reviewed. The agency should not hire or retain staff who might be a danger to children, families, or other staff.</p> <p>*6.4 Prelicensure and Preemployment Checks</p> <ul style="list-style-type: none"> • Community agencies and organizations should work with child protection agencies to

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<p>a crime against children (including child pornography), or a crime involving violence, including rape, sexual assault, or homicide, but not including other physical assault or battery.</p>	<p>conduct comprehensive screenings of potential employees, licensees, and volunteers.</p> <ul style="list-style-type: none"> • The screening of potential employees and licensees is an important step in ensuring the safety of children. In addition to screening its paid employees, the child-serving organization should establish and conduct a comprehensive screening process for its volunteer and contracted staff members. • Preemployment and precensure checks should include criminal background checks, obtained through state/provincial or federal law enforcement agencies, and child abuse and neglect screenings that directly seek information regarding past records. Criminal background checks and child abuse and neglect screenings should be carried out with adequate protections for confidentiality and an individual’s civil rights. If the state or provincial statute allows for screening of an individual’s child abuse and neglect history, the agency should access this information prior to employment. • As part of its screening process, the child-serving organization should ask: <ul style="list-style-type: none"> • Has the applicant ever been convicted of any crime of violence against a person, crime against children, or a sexual offense against children, or is the applicant currently charged with any such crime? • Is the applicant currently under investigation by a law enforcement or child protection agency for child abuse or neglect, assault on a child, or other crimes against a person? • Has the applicant been the recipient of a dispositional finding of substantiated child abuse or neglect as a result of an assessment or investigation into one of the above alleged acts? <p>The types of offenses referred to in the questions may indicate potential problems in someone caring for children. An affirmative answer to these questions, however, should not be an automatic bar to licensure or employment.</p>
<p>(K) Policies and procedures for provision of emergency medical care, including policies for staff protocols for implementing emergency responses.</p>	<p>1.3 Attributes of all Types of Residential Service <i>Required Staff Constellation and Staff Ratios</i></p> <ul style="list-style-type: none"> • All staff members should be trained and expected to provide backup support for crisis situations, emergencies, or other unforeseen situations, and should help ensure a safe and healthful living environment. <p>1.6 Characteristics of Residential Treatment Programs <i>Services Provided</i></p> <ul style="list-style-type: none"> • Medical Services: Available 24 hours, on site or on call. • Psychiatric Services: Available 24 hours, on site or on call. • Clinical/mental health services: Available 24 hours, on site or on call. • Case management: May be provided by the residential service provider or by the referring agency. <p><i>Required Staff Constellation and Ratios</i></p> <ul style="list-style-type: none"> • All staff members should be expected to provide backup support in crisis situations and help to ensure a safe, healthful, and therapeutic living environment. • The residential treatment provider should have an on-call schedule and have the capacity to mobilize and employ additional staff members in an emergency or crisis situation. <p>Medical personnel should be available, either on the staff or by contact to all residential treatment programs.</p> <ul style="list-style-type: none"> • Larger programs, or programs where children have special medical needs or receive psychotropic or other prescribed medication, should employ medical staff members on site, full time. • Where prescribed medication is used, a physician should regularly monitor medication needs and side effects.

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	<ul style="list-style-type: none">• All medication should be dispensed to children by nurses or other trained staff members, and medical experts should be available as part of the treatment team to assist with case planning and staff training. (see Health services, section 3.76) <p>4.1 Administrative structure To provide quality services to children and families, the agency must have:</p> <ul style="list-style-type: none">• established written policies and procedures that support the agency’s mission and purpose;• clearly defined qualifications, roles, and responsibilities for staff, board, and volunteers;• criteria for conducting and assigning work and monitoring staff performance;• financial, staffing, and training resources to meet the desired outcomes;• clearly defined procedures regarding community education, involvement, and participation;• a long-term plan; and• a Continuous Quality Improvement process <p>4.50 Responsibility of health care staff members/consultants Written policies and procedures should delineate the provision of health, medical, and dental care, including the administration of both prescription (including psychotropic) and nonprescription medication. The health care staff member/consultant should assist the agency in meeting the following needs of the children in care:</p> <ul style="list-style-type: none">• immediate health care, including a health screening before admission;• a comprehensive assessment of the health needs of all children on entry into group care;• an individual health plan for each child integrated with the service plan, including ongoing supervision of all prescription and nonprescription medication;• quality health care services that are comprehensive, continual, and coordinated for all children in group care, with proper referral on discharge to ensure a continuity of health care;• creation of a specialized health services management unit (or individual) within the agency responsible for implementing its health program; and• training of caseworkers, child and youth care workers, and all other staff members to understand the health care needs of the children in care. <p>The agency should establish a monitoring and evaluation process to ensure the quality and appropriateness of the health care provided to the children in its care.</p> <p>4.57 Orientation program The orientation program should be provided to all staff members prior to their taking on responsibility for any direct services with children and families. The orientation program should include these topics:</p> <ul style="list-style-type: none">• the agency’s philosophy and approach to behavior management and crisis intervention;• the agency’s philosophy and approach to treatment;• signs and symptoms of trauma in children and families;• health and safety procedures, including those required by law or regulation, such as first aid, CPR training, communicable diseases, and administration of medication; and <p>4.66 Safety and risk management</p>
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	<p>The residential agency should implement a safety and risk-management program to prevent and reduce injury to its clients and personnel, minimize liability, and protect and preserve its assets.</p> <p>The agency should establish preventive policies and procedures to minimize the risk of negligent or willful misconduct of employees, theft and fraud, conflicts of interest, and physical injury to clients, staff members, and volunteers.</p> <p>The safety and risk management process should include the establishment of written policies and procedures to both manage and reduce the liabilities to which the organization may be subject. Such policies and procedures should include but not be limited to the following:</p> <ul style="list-style-type: none">• Fire prevention and fire safety;• Disaster reponse;• Emergency plans, including evacuation plans;• Universal precautions;• Suspicious or hazardous materials;• Security;• Vehicle and driver safety;• An on-call, chain-of-command response system that is well communicated, accessible, and posted in critical locations, including the staff office; and• A process for formally reviewing accidents, illnesses, grievances, etc. <p>The agency should also provide training for all staff, at hiring and yearly thereafter, to assure staff competency in all safety and risk procedures and to update staff on new procedures.</p> <p>The agency should provide opportunities for staff, children, and others on the premises to practice the safety and risk procedures on a regular basis, documenting each practice event and any problems noted. Staff should be observed as they carry out safety and risk procedures, their performance should be evaluated, and any needed corrective measures or additional skill development should be addressed in a timely manner.</p> <p>The agency should create other ongoing mechanisms for ensuring safety, such as a cross-agency safety committee that meets regularly to review safety concerns, conduct safety inspections, and make recommendations to management regarding improvements.</p> <p>4.67 Critical incidents and crisis management</p> <p>The agency should have a structured process and policy in place to respond to and review child- and staff-related critical incidents.</p> <p>Child- and staff-related critical incidents can suddenly compromise the safety of children in the agency's care, the routine functioning of staff, and the regular operations of the agency.</p> <p>Critical incidents include, but are not limited to</p> <ul style="list-style-type: none">• The serious injury or death of a child receiving residential care services;• The flight or unexplained absence of a child receiving residential care services; and• Threats or acts of violence to staff providing residential care services. <p>Because they are often unanticipated and potentially life threatening, critical incidents, whether they be child- or staff-related incidents, have a tendency to create confusion,</p>
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	<p>anxiety, and chaos when they occur. In the absence of a prompt yet methodical response, critical incidents can escalate in severity and endangerment. Therefore, written policies and procedures should be developed to:</p> <ul style="list-style-type: none"> • Identify the list of concrete tasks to be completed by those involved; • Delineate the expectations of agency personnel and the chain of command; • Improve communication within the agency; • Respond proactively as opposed to reactively; • Lessen the anxiety inherent in these situations; and • Increase direction, guidance, and support. <p>To provide adequate guidance on critical incidents, protocols and procedures should address:</p> <ul style="list-style-type: none"> • Definitions and examples of critical incidents; • The interagency and interagency notification processes (specifically, formal contact with law enforcement), as well as community and public disclosure; • Crisis coverage, including staff composition and function in the wake of the critical incident; • Fact-finding processes that vary depending on the nature of the critical incident; • Risk-management procedures; • Policies regarding administrative leave; • Policies regarding media inquiries; and • Counseling and supportive services for affected parties. <p>Reviews of the critical incidents should focus on the actions of all parties involved with the affected child and/or staff. The review should:</p> <ul style="list-style-type: none"> • Assess the actions and events that surround the critical incident, • Detail the individual and agency factors that may have contributed to the incident, • Determine what individual and agency factors should be addressed to reduce the likelihood of comparable critical incidents in the future, and • Amend the written policies and procedures to reflect the changes indicated in the review process. <p>Although the focus of the critical incident review will vary depending on the nature of the incident and the specific expectations of the agency and the involved community, the review should:</p> <p style="padding-left: 40px;">Use a multidisciplinary approach that includes representatives from the community agencies and organizations involved in protecting and serving children and their families;</p> <p style="padding-left: 40px;">Involve professionals who have been involved with the child and his or her family (when the critical incident is a child-related incident) as well as community members;</p> <p style="padding-left: 40px;">Respect the privacy and reputation of all involved parties and adhere to the statutory provisions related to confidentiality and immunity;</p> <p style="padding-left: 40px;">Document findings of case-specific analyses to identify strategies through which the agency and the provider community can better protect children and support and families; and</p> <p style="padding-left: 40px;">Inform and educate the public, to the extent permissible, to increase understanding of and support for the needs of children who are receiving residential services.</p>
(L) All promotional and informational materials produced by such a program shall include a hyperlink to or the URL	<i>Not Addressed</i>

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<p>address of the website created by the Assistant Secretary pursuant to subsection (c)(1)(A)</p>	
<p>(M) Policies to require parents or legal guardians of a child attending such a program—</p> <ul style="list-style-type: none"> i. to notify, in writing, such program of any medication the child is taking; ii. to be notified within 24 hours of any changes to the child’s medical treatment and the reason for such change; and iii. to be notified within 24 hours of any missed dosage of prescribed medication. 	<p>3.76 Medication</p> <p>To ensure the safe administration of medication, the residential service provider that prescribes, dispenses, and/or administers medication should develop written policies and procedures that address the prescribing of medication by qualified persons, the training and credentials required for staff who administer medication, medication storage and disposal, required documentation, required consents and authorizations for medication, and self-administration procedures, if applicable.</p> <p>Possible risks, benefits, and alternatives should be explained fully to children and their families whenever medication intervention is considered. Written documentation of informed consent by the person with legal responsibility for decisions should be maintained in the child’s case record.</p> <p>The provider should establish documentation requirements for administration of all prescription and nonprescription medication, whether administered by staff, supervised by staff, or self-administered.</p> <p>Minimum required documentation should include the child’s name, date, medication administered, person administering, documentation of refusal, and reason for refusal, if applicable.</p> <p>The provider should have a system for documentation and review of medication errors (see also Risk management)</p> <p>3.40 Communication with Families</p> <p>The residential service provider should have a comprehensive written plan for working with and communicating with families. The plan should address</p> <ul style="list-style-type: none"> •The written information to be provided to families during intake and at admission; •Obtaining necessary routine parental authorizations and consents and identifying the persons responsible for granting permission and consent for special activities; •Notifying families of their children’s progress •The circumstances under which the residential service provider must contact families (e.g., in the event of illness or injury);
<p>(N) Procedures for notifying immediately, to the maximum extent practicable, but not later than within 48 hours, parents or legal guardians with children as such a program of any—</p> <ul style="list-style-type: none"> i. on-site investigation of a report of child abuse and neglect; ii. violation of the health 	<p>3.40 Communication with Families</p> <p>The residential service provider should have a comprehensive written plan for working with and communicating with families. The plan should address</p> <ul style="list-style-type: none"> •The written information to be provided to families during intake and at admission; •Obtaining necessary routine parental authorizations and consents and identifying the persons responsible for granting permission and consent for special activities; •Notifying families of their children’s progress •The circumstances under which the residential service provider must contact families (e.g., in the event of illness or injury)ii

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and safety standards described in this paragraph; and violation of State licensing standards developed pursuant to section 114(b)(1) of the Child Abuse Prevention and Treatment Act, as added by section 7 of this Act.	
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ⁱ From CWLA Standards of Excellence for Services for Abused or Neglected Children and Their Families

ⁱⁱ See Appendix D and E - CWLA standards for Accreditation Authorities & Additional Standards of Excellence for Residential Services