

Program Specifications

Service Type: Short-term residential setting for adolescent males or females with problems related to substance use with or without concurrent psychiatric disorders

Licensure Category: Child caring facility

Program Model:

DCF is seeking providers who are able to provide short-term congregate care treatment on a fee-for-service basis for adolescent males or females with problems related to substance use with or without concurrent psychiatric disorders. Start-up funds will not be available. Similarly, the Department will not fund capital expenses that are not part and parcel of the rate which will be determined by the Department. No guarantee of usage, either specific or implied, is made herein.

The program sought is envisioned as a fee-for-service 6-25 bed short-term congregate care treatment setting for adolescents, ages 12-18 years of age, who have problems related to substance use with or without concurrent mental health conditions. The program will include residential **and** home-based treatment services for youth and their families. Proposals for co-ed congregate care programs must include gender specific living units and gender responsive programming.

The ideal program model will utilize an adaptation of Multi-Dimensional Family Therapy (MDFT), a family-based, comprehensive treatment system for adolescent drug abuse and related behavioral and emotional problems (Liddle, Dakof, & Diamond, 1991). The MDFT model is widely recognized in the United States and abroad as an effective science-based treatment for adolescent substance use disorders and delinquency (e.g., Liddle et al 2008; Liddle et al 2009; Rigter et al, 2005; Vaughn & Howard, 2004; Waldron & Turner, 2008). MDFT has been successfully implemented and sustained in community-based organizations throughout the United States, Canada, and Europe. MDFT is theory driven and combines various frameworks including family systems, developmental psychology, and the risk and protective model of adolescent substance abuse. It incorporates key elements of effective adolescent drug treatment, including comprehensive assessment, an integrated treatment approach, family involvement, developmentally appropriate interventions, specialized engagement and retention protocols, attention to qualifications of staff and their ongoing training, gender and cultural competence, and focus on a broad range of outcomes (Austin et al., 2005; Brannigan et al., 2004; Jackson-Gilfort et al., 2001; Liddle et al., 2006). MDFT is both a tailored and flexible treatment delivery system, and depending on the needs of the youth and family, can be conducted from one to three times per week over the course of three to six months.

Therapists work simultaneously in four interdependent treatment domains-- the adolescent, parent, family, and extra-familial—each of which are addressed in 3 Stages:

Stage 1: Building a Foundation for Change, Stage 2: Facilitating Individual and Family Change, and Stage 3: Solidify Changes and Launch. At various points throughout treatment, therapists meet alone with the adolescent, alone with the parent(s)/caregiver(s), or conjointly with the adolescent and parent(s)/caregiver(s), depending on the treatment domain and specific problem being addressed. In **Stage 1**, overall therapeutic goals are similar for both the adolescent and parent domains to develop a therapeutic alliance and enhance motivation to participate in treatment and to change their behaviors. Developing a strong therapeutic alliance with youth and parents/caregivers, and enhancing in each their motivation to truthfully examine oneself and be willing to change one's behavior are the primary goals of Stage 1. Accomplishment of these goals set the foundation for Stage 2, the longest stage in MDFT, where the emphasis is on behavioral and interactional change. In **Stage 2** there are distinctive goals for each of the four domains. In the *adolescent domain* the therapist works collaboratively with the parent/caregiver and youth to help the youth communicate effectively with care giving adults, develop coping, emotion regulation, and problem solving skills, improve social competence, and establish alternatives to substance use and delinquency. For the youth, in particular, the therapist helps him or her feel safe to reveal the truth about his or her life generally, and substance use in particular to his or her family and the therapist. This is accomplished by the therapist being non-punitive and non-moralistic about drug use, helping families move to a more sympathetic and problem solving stance, encouraging the youth to have positive goals (to dream and hope) for himself, and then highlighting for the youth the discrepancy between goals (e.g., graduate from high school, go to college, get a good job, avoid going to jail, get their own apartment) and continued drug use. In the *parent domain*, MDFT focuses on increasing the parents' behavioral and emotional involvement with their teen, and improving parenting skills especially monitoring their teen's activity, clarifying expectations, limit setting, and articulating both negative and positive consequences. Work within the *family domain* focuses on decreasing family conflict, deepening emotional attachments, and improving communication and problem solving skills. The MDFT therapist helps youth and families view substance use as a health and lifestyle problem (e.g., it can interfere with youth getting what he/she wants out of life). Drug tests are used in the treatment as a way to encourage open communication about substance use, and hence avoid the debate about whether or not the youth is using. Within the *extrafamilial domain*, MDFT fosters family competency in interactions with social systems (e.g., school, juvenile justice, recreational). **Stage 3**, Solidify Changes and Launch, helps parents, foster parent and teens strengthen their accomplishments in treatment to facilitate lasting change, create concrete plans addressing how they will each respond to future problems (bumps in the road such as relapse, family arguments, disappointments), and reinforce strengths and competencies necessary for a successful launch from treatment.

More information about MDFT can be found in the link from the National Registry of Evidence Based Practices and Program sponsored by the US Department of Health and Human Services, SAMHSA: http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=184

Target Population

The target population for this program is male and/or female adolescents ages 12-18 years of age who have problems related to substance use with or without co-occurring mental health disorders. Because this program will provide services to youth and their families, adolescent clients must have a family member available to participate in treatment. MDFT defines family broadly to include biological parent(s), adult siblings who provide care, extended family members, foster families, or other significant adults in the youth's life who provide care. All appropriate youth with a nexus to DCF may be referred to this program. The provider should have plans to help support family participation and involvement in this program.

Weekly Programming

The provider will follow a standardized weekly programming schedule consistent with the MDFT short-term treatment model. The components of the treatment model are designed to build a therapeutic alliance between the therapist and the youth and family, increase motivation for change, repair family relationships, empower parents, replace harsh or ineffective parenting practices with clear parenting practices that emphasize parental teamwork, enhance parental involvement with the youth, enhance love and commitment between youth and parents, improve family problem-solving, explore the adolescent's drug use, develop goals with the adolescent, and address individual, parent and family issues that may be a barrier to success. The standardized weekly programming is listed below.

WEEK	ACTIVITIES
Weeks 1-2	"Cool down" period. MDFT therapist conducts initial home visit with family (Family Session #1).
Week 3	Adolescent Session #1 at facility.
Week 4	Family Session #2 in the home. Adolescent Session #2 at facility.
Week 5	Family Session #3 in the home. Adolescent Session #3 at facility.
Weeks 6-8	Weekly Parent/Family sessions as determined by the needs of the case. Parent/family sessions can be individual, multi-participant, in the home, or at the facility as determined by family and youth's needs. Weekly individual Adolescent Sessions
Weeks 9-11	Weekly Parent/Family sessions as determined by the needs of the case. Parent/family sessions can be individual, multi-participant, in the home, or at the facility as determined by family and youth's needs. Individual Adolescent Sessions occur every other week.
Week 12	Weekly Parent/Family sessions as determined by the needs of the case. Parent/Family sessions can be individual, multi-participant, in the home, or at the facility as determined by family and youth's needs.
Week 13	Weekly Parent/Family sessions as determined by the needs of the case. Parent/family sessions can be individual, multi-participant, in the home, or at the facility as determined by family and youth's

	needs. Individual Adolescent Session
Weeks 14-16	Weekly Parent/Family and adolescent. All sessions occur in or near the home, including the individual adolescent session. Transition to community MDFT provider.
Week 14	Therapists work with family/youth
Week 15 - 16	Community therapist takes the lead with family/youth. During week 16, adolescent participated in an individual session with community therapist.
Discharge from MDFT treatment center	Weekly youth and family sessions with community MDFT therapist continue.

Service Elements

The program will provide access to an array of clinical services consistent with a short-term model initially based in a treatment center, (including individual therapy, family therapy, etc.) medical services, educational services (e.g., special and regular education, educational assessment, etc.), supportive services (mentoring, vocational and recreational, etc.), and will eventually move to a home-based service. Providers who propose to establish a residential treatment center for the out-of-home component will need to operate an on-grounds school. Family interventions must focus on a family's readiness to take a child home. Family participation in all aspects of treatment will be expected.

In addition to clinical services, the program will be expected to provide or routinely access a range of services that include: health (medical, dental, vision) nutrition, and wellness promotion, independent living skills development, social support and skill development/enhancement, opportunities for friendships, personal enrichment, recreation, and mentoring.

Daily activities, services, and supports will be guided by an individualized MDFT youth and family treatment plan that will identify areas of strength to be built upon and which will highlight the youth and family's capacities to overcome identified challenges. Treatment goals will be the result of collaboration between team members, DCF and program staff, family members, and youth. The provider will offer a predictable, consistent, engaging, supportive, and structured environment that promotes growth and enhances stability, and which supports the physical and emotional safety of all the residents. Each youth will attend school daily or, for those who have completed their education (for youth 18 years and older in order to remain in a DCF licensed facility they must be in full time attendance at a technical school, a college or a state-accredited job training program), will be involved in a meaningful vocational activity at least 20 hours per week. Other structures inherent in the program will include time for personal care, leisure/quiet time, involvement in activities such as shopping, meals and meal planning, vocational, social skill work, activities of daily living skills training, and individualized

schedules for appropriate and positive youth identified activities. The development of friendships and meaningful activities will be encouraged and facilitated.

It is anticipated that youth served in this program will return home where they will transition to community-based MDFT treatment services. To this end, providers will be expected to develop and maintain relationships with community providers of MDFT treatment. Ideally, in-home services will also be provided by the contractor.

Consistent with MDFT treatment principles, clinical services must incorporate comprehensive assessment, integrated treatment, family involvement, gender, age and developmentally appropriate services, specialized engagement and retention protocols, and, attention to qualifications of staff and their ongoing training. Clinical services should address area such as trauma, mental health issues, behavior problems, family readiness, parenting skills, family problem-solving, social development, relational development, and any parental, individual or extra-familial barriers to success. Each youth entering the program must undergo a comprehensive assessment, which includes the Global Appraisal of Individual Needs (GAIN) or other tools required by DCF, within 30 days of admission. The comprehensive assessment will cover the psychological, medical, education, socio-emotional, spiritual, specialized clinical and legal needs of the child and will build upon assessments previously completed. It will be a strength and resiliency-based assessment and will include a review of previous placement and treatment histories, and pre-dispositional materials, including any clinically focused assessments that are available. These assessments shall assist with the development of an individualized treatment plan consistent with MDFT principles. In addition, ongoing assessment of the youth will occur. Minimal clinical service expectations, as informed by a comprehensive global assessment of the youth and the MDFT model, include: structured, individualized programming for the youth and family independently and jointly, therapeutic supports and approaches, coordinated care management, parenting practices, mental health services including evaluations as needed, medication management, family therapy, and comprehensive transition planning.

Quality Assurance

The program must demonstrate experience with or capability of delivering MDFT treatment services by having staff trained and certified in the model.

Providers will be required to comply with all requirements of the MDFT model including training, certification, re-certification, supervision, staffing guidelines and submission of performance evaluation data.

Anticipated Length of Stay

The target length of stay for the out-of-home component service is approximately 16 weeks. The Department recognizes that a flexible approach to length of stay may be necessary to accommodate family readiness and to facilitate successful transitions to home and community-based care for the youth and families. It is expected, however, that transition planning will begin on admission and progress toward discharge from congregate care will be reviewed at least monthly and in conjunction with the

Connecticut Behavioral Health Partnership as appropriate. The provider will utilize the Treatment Outcome Package (T.O.P.) and GAIN to monitor and inform clinical progress in treatment. Additional specialized psychometric and risk assessment instruments may be used as clinically indicated and required by the model.

Staffing Model

Staffing for a 6-25 bed congregate care setting should include the following positions: Program Director, Clinical Director, Licensed Clinician(s), Registered Nurses and LPNs, Milieu Supervisor, and Recovery Counselors/Youth Advocates. The applicant must detail the staffing ratios and number of positions needed to provide the required services. The staffing model must be consistent with the treatment approach. MDFT clinical services must be provided within the program's staffing model. Psychiatry time may be provided on a limited basis within the staffing model or with an outside psychiatrist on a fee-for-service basis.

Applicants must detail the supervisory model for the program and include a plan for supervision of all program staff that is consistent with the MDFT model. All staff must possess the education, experience, competencies, training and certifications necessary to meet the needs of the target population using the MDFT approach. Assessment, crisis intervention, and treatment services must be available daily for youth. Providers must consider how they will assess the competencies of all potential employees in the requisite areas as opposed to simply focusing on paper requirements. That is, providers will need to give thoughtful consideration of the knowledge set, skill set, and personality style(s) best suited to work with youth with problems related to substance use and co-occurring mental health problems using the MDFT approach. Characteristics of successful MDFT therapists include: optimism, respect for the youth and parents, comfort working in close emotional proximity, have a "do what it takes" attitude, non-punitive and non-judgmental, always seeking to improve their skills and outcomes, ability to see the complexities of a case, skilled in family therapy, and knowledge of and skill with dealing with social systems.

The respondent will provide to DCF plans to recruit and retain professional and para-professional staff that are culturally and linguistically competent and diverse. Staff must have the ability to provide services to all eligible participants, regardless of English language limitations. While the successful respondent must provide for the most common languages, it may be necessary to make special arrangements for interpretive services to communicate with those speaking less frequently encountered languages.

Supervision Model

Providers must outline a plan of how they will comply with and implement the MDFT supervision model which includes consultation, training, certification, case reviews, phone check-ins, case conference and videotape review, and live supervision.

Siting policy

Providers must conform to the Department's promulgated guidelines and policy on siting congregate care programs. Providers will need to notify towns/cities of the program. A program with a licensed bed capacity greater than 6 will require zoning approval. If a provider's existing site is used for this program, the provider will need to comply with the requirements of C.G.S 17a-145. (i.e., "If the population served at any facility, institution or home operated by any person or entity licensed under this section changes after such license is issued, such person or entity shall file a new license application with the commissioner, and the commissioner shall notify the chief executive officer of the municipality in which the facility is located of such new license application, except that no confidential client information may be disclosed.").

Collaborative Agreements

If the provider plans to offer access to any specialized service through a collaborative agreement with another agency, the respondent must provide the details of these agreements with the Department. The provider must submit copies of any Memoranda of Agreement or subcontracts they intend to utilize.

Budget

Budget information must be submitted on the required DCF forms. DCF budget forms are obtainable by contacting Margaret Glinn, Fiscal Administrative Manager I, at telephone number (860) 550-6544, or by email address: m.glinn@ct.gov. Selected program(s) will be categorized as a residential treatment center. Future calculations will be determined under the Single Cost Accounting process in accordance with Department regulations.

The budget document needs to display all of the elements that are requested under this proposal's model.

The Department prefers to a support funding distribution that apportions along the following percentage lines: Salary and Fringe representing sixty-five percent (65%) of total budget cost, Fixed expenses* reflecting approximately an eight percent (8%) level, and Other expenses around the twenty-seven percent (27%) level. This is a recommendation of appropriate budget line cost allocation, not a hard and fast rule.

(* Fixed expenses are recognized as: rent, heat, light & water, depreciation, telephone, and insurance)

All full-time positions are recognized on a forty hour work week. To assist in the establishment of price points for position wage submission, the Department recommends the following position title wage ranges:

Annual Wage Range-	Low	High
• Program Director	\$60,840.00	\$70,720.00
Hourly wage	\$29.25	\$34.00
• Clinical Director	\$57,720.00	\$68,120.00
Hourly wage	\$27.75	\$32.75
• Consulting Psychiatrist	\$271,380.00	\$326,895.00

	Hourly wage	\$130.47	\$157.16
•	Licensed Clinician	\$41,080.00	\$55,120.00
	Hourly wage	\$19.75	\$26.50
•	Registered Nurse (RN)	\$40,040.00	\$60,320.00
	Hourly wage	\$19.25	\$29.00
•	Licensed Practical Nurse (LPN)	\$33,800.00	\$39,520.00
	Hourly wage	\$16.25	\$19.00
•	Milieu Supervisor	\$32,760.00	\$44,720.00
	Hourly wage	\$15.75	\$21.50
•	Recovery Counselors/ Youth Advocates	\$28,080.00	\$37,440.00
	Hourly wage	\$13.50	\$18.00

Compensation levels, by position title, should be commensurate with the position's need, education and credentialing requirements, and years of experience. Please consider the following guidelines in preparing a budget submission:

Fringe benefit package should not exceed twenty-five percent of the aggregate salary cost. Should the fringe benefit level exceed twenty-five percent, the budget narrative should provide justification for the components of the fringe package.

Rent cost, should it be included, will require that the provider organization demonstrate to the Department that the cited rent expense is both arms length and at market level.

Depreciation cost must be on a straight-line basis. All depreciable items must be aged in accordance with the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" guide.

Residential treatment providers are expected to provide adequate replacement clothing for residents. The Department's maximum allowance for this cost is \$642.00 annually per bed.

Indirect expense should range in the vicinity of ten to fourteen percent. Indirect expense exceeding fourteen percent of the aggregate budget must be justified in the budget narrative, which must provide an itemized list of the items included.

All remaining non-salary budget line items require the submission of a supportive narrative explaining the basis of the budgeted amount. It is imperative that the amounts identified in the budget narrative tie back to the amounts identified in the budget document.

In addition, the proposed budget should identify any anticipated third party, non-Department, income sources or in-kind contribution. Such income sources should clearly be identified by respective payer and projected amount. Income that is restricted to items included in the budget must be applied to offset the requested budget amount.

The Department will not negotiate any rates outside of the proposal process.

Outcomes

The Contractor will provide quality improvement data to the Department in a format approved by DCF as requested. These data will include but will not be limited to the following:

- a. Data on notable events while in placement including restraints, seclusions, AWOLS, arrests, suicide attempts, emergency services, incidents, and hospitalizations);
- b. Data on school attendance
- c. Data on youth's satisfaction with his/her experience in the program
- d. Data on programmatic information (e.g., number of family sessions per week, number of adolescent or family individual sessions per week, average number of hours per week of family treatment, percentage of children and families receiving services in their primary language, length of stay, family satisfaction with treatment, etc.).
- e. Demographic Information (e.g., name, date of birth, gender, ethnicity/national origin, town of origin, DCF status, prior placement setting, admission date);
- f. Clinical and Diagnostic Information (e.g., DSM-IV TR, anticipated length of stay, targeted behaviors, GAIN assessment);
- g. Treatment Progress Data (e.g., participation in Administrative Case Reviews, critical incidents, participation in positive youth development activities, transition to community-based MDFT services), and will require monthly treatment update reports;
- h. MDFT program-specific quality data collected to inform progress and outcomes, and,
- i. Discharge Information (e.g. reason for discharge, discharge placement setting, reason for any discharge delays, level of improvement for targeted behaviors)

Submission of Proposals

Proposals will be accepted on a rolling basis. Proposals should be submitted in triplicate to the Bureau Chief of Behavioral Health and Medicine, 8th Floor, 505 Hudson Street Hartford, CT 06106.