Building Bridges Initiative
Performance Guidelines and Indicators Matrix

Referral/Entry 'Bridge' Guidelines and Indicators	During/Within Residential 'Bridge' Guidelines and Indicators	Transition and Post-Residential 'Bridge' Guidelines and Indicators

Cross-Cutting Performance Guidelines

(to be assessed through surveys or interviews with youth, families, and providers)

Child and Family Team

- A Child and Family Team (CFT) conducts treatment planning. The team includes youth, family, providers, and others chosen by the youth and family.
- CFT membership assures the greatest possible continuity and communication to support the long-term success of the youth in the community.
- CFTs that are in place prior to residential treatment are expanded to include residential treatment providers.
- If a new CFT is established upon entry into residential treatment, key community providers and supports are actively encouraged to be CFT members.
- Families, youth, providers, administrators, and community members embrace the concept of shared decision-making and shared responsibility for outcomes.
- The family is seen as the expert regarding their child/youth while professionals act as consultants to the family.
- Decisions are reached by consensus. All members have input into the individualized treatment and support plan and all CFT members have ownership of the plan.
- Goals are youth/family driven, strength-based, oriented to the least restrictive options and used to regularly measure progress.
- Teams:
  - stay focused on reaching attainable goals and regularly measure progress.
  - meet regularly, not only in response to crises.
  - address a full range of life needs that could impact the youth and the family.
  - work to increase family choice and independence.
  - develop a crisis plan to help the family utilize supports and ensure the safety of the youth and the family.
  - develop a process to address situations in which family and youth preferences/choices are not concordant.
  - make a commitment to unconditional care.
- The significant positive correlation of family engagement and youth positive outcomes is fully evident. Program practices, as well as staff training and support mechanisms, reflect this value.

Family-Driven, Youth-Guided

Family members and youth:

- are provided with the supports they need to take a lead in all aspects of treatment and support planning.
- are meaningfully engaged in organizational and system-level governance, planning, decision-making and evaluation.
- report that the process, services, and outcomes during each of the three phases *(entry/during residential/post-residential)* are respectful and effective.

Family members and youth have choice:

- in selecting members of their Child and Family Team.
- of providers and services, whenever possible.
- of Family Partners and Youth Advocates *(from the community and from within the residential provider organization)*.

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- of providers they deem respectful of and responsive to their cultural and linguistic preferences.

Collaboration and Communication Among System Partners

The community system of care participants *(e.g., residential and community-based providers, schools, public systems, family organizations, etc.)*:

- have a comprehensive preventive capacity *(including a range of services from early identification to intensive in-home services)* to reduce the need for residential treatment.
- have policies and practices that promote open, meaningful and ongoing contact between youth, families, the community, including throughout the youth's time in out-of-home care.
- establish a cross-system, interagency process with the authority to reduce barriers to services for multi-system youth and their families.
- are perceived by families, youth, and purchasers to effectively and regularly communicate with each other.
- develop agreements that describe how they will work together on behalf of the youth and families served, and how they will resolve differences that may emerge in determining treatment and support plans.

Cultural and Linguistic Competency

- Cultural and Linguistic Competence *(including for youth and/or families who identify as LGBTQI2-S)* will be demonstrated throughout all aspects of service planning and delivery including: the assessment process and tools, the CFT process, staff diversity, training, provider choice, the use of EBP demonstrated to be effective with specific populations and/or modified based on practice-based evidence, respect for culturally-based healing practices, etc.
- Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.

Quality Assurance and Quality Improvement

- Quality assurance/quality improvement (QA/QI) data are collected, summarized, and reviewed routinely as part of the community's and provider organizations' QA/QI processes.
- Staff has access to QA/QI data in "real time"/dashboard type format.
- QA/QI data are publicly available and used at the community level for planning purposes.

Building Bridges INITIATIVE
Advancing Partnerships. Improving Lives.

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Referral/Entry Performance Guidelines ▪ Formal and informal supports, services, and relationships *(existing and needed)* are inventoried in a comprehensive Community Resource Assessment (CRA) (*See page 5)* ▪ The residential 'intake' process is coordinated with existing care providers to reduce duplication of assessments, paperwork, etc. ▪ Youth and families are informed about a) residential treatment interventions/supports; b) why residential treatment is a part of their child's treatment plan; c) the goals, benefits, risks, and alternatives to residential treatment; and, d) specific treatment and support approaches and possible outcomes based on past performance of the provider *(and available research)*. ▪ Families are provided with data on the use of restraint, seclusion, AWOL and other critical incidents. ▪ Families receive a written statement that the organization is working to prevent the need for and reduce the use of all coercive interventions, including restraint and seclusion. ▪ Treatment and support plans a) incorporate information from trauma-informed assessments; b) for those with histories of trauma, incorporate trauma treatment approaches; c) focus on strength-based and collaborative approaches; d) include information on youth-specific triggers, warning signs and strategies to support the youth to maintain self-control; and, e) specify a plan for family role in soothing and supporting the youth.	**During Residential Performance Guidelines** ▪ Formal and informal supports, services and relationships identified in the CRA are actively involved during residential treatment. ▪ Frequent and meaningful youth and family contact is a priority fully and flexibly supported by policies and practices. Youth and families, including siblings, have unimpeded contact unless otherwise specified by the CFT. ▪ A plan to support youth and family visits will be developed by the CFT. This includes a specific plan for the first visit after the youth enters care and, ideally, more frequent, longer, and in-community visits over time. ▪ Visits cannot be cancelled or abbreviated by staff without the approval of the CFT. ▪ Youth are actively and meaningfully involved in everyday decision-making about the program and their care, and have multiple, developmentally appropriate, opportunities on a daily basis to exercise choice in all aspects of their care. ▪ Families are consulted routinely regarding everyday care and support of their child *(e.g., haircuts; school achievements, etc.)*, and having regular and meaningful roles in key decisions that need to be made regarding their child's care. ▪ Family members are actively engaged and supported in identifying and accessing the supports, services, or referrals they need to promote long-term positive outcomes for their family *(e.g., training, counseling, linkage to needed treatment services and support, assistance with concrete issues such as housing, transportation, etc.)* ▪ Treatment interventions and supports are regularly and clearly monitored and changed in response to changing needs *(e.g., not blaming the youth and family)* and in response to outcome or performance data. ▪ Documented actions are taken by the residential provider to: a) reunify youth with their families of origin whenever possible; and/or b) establish a permanent alternative family resource for	**Post-Residential Performance Guidelines** ▪ The transition plan is a component of the treatment plan. The transition plan: a) maximizes service and provider continuity; b) actively involves community providers and informal supports well before discharge; c) assures that youth who will live independently have demonstrated skills or are enrolled in a comprehensive community-based independent living program at discharge; and, d) specifies the supports families and youth will receive during transition and for as long as necessary to increase positive outcomes. ▪ Formal and informal supports, services and relationships that were available before entry into residential treatment or developed during residential treatment remain active following discharge. ▪ Community-based providers will use best-practice approaches to engage families and youth in services. ▪ Caregivers have access to respite as needed. ▪ Youth have access to crisis beds as needed. ▪ Services and supports specified in the treatment and support plan are available for a minimum of three months following discharge and will not be terminated without CFT approval. **Post-Residential Performance Indicators** ▪ Percent of youth and families who have been contacted by the residential treatment and support provider within 48 hours of discharge. ▪ Percentage of youth and families who receive a care-coordination visit within 7 days post-

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▪ For readmissions, factors from family, community, and prior residential episode that led to readmission are assessed and addressed in the new treatment episode. ▪ The CFT develops discharge criteria. ▪ Discharge planning is initiated during intake and incorporated into the treatment and support plan. **Referral/Entry Performance Indicators** ▪ Percent of youth and families provided with objective quality assurance and performance data about providers to inform choice. ▪ Percent of youth and families who receive information about residential and support staff qualifications and training. ▪ Percent of youth and families for whom a cultural inventory *(e.g., cultural/ethnic identity, language, values, spiritual life, family traditions, gender and sexual identity issues, other relevant preferences, etc.)* is completed and used to develop the treatment and support plan. ▪ Percent of youth and families for whom a strengths-based assessment is completed. ▪ Percent of youth and families for whom a CRA is completed. ▪ Percent of referrals completed within the time frame recommended by CFT. ▪ Percent of treatment and support plans that specify a) purpose and anticipated outcomes of residential treatment and support; b) criteria for discharge. ▪ Percent of treatment and support plans that specify how individual and family strengths will be used and developed.	youth who are not able to return to their family of origin *(e.g., search and engagement activities)*. ▪ Treatment and support planning and implementation fully integrate educational goals and progress is monitored continuously. ▪ Program practices recognize the importance of and provide a variety of flexible supports to ensure educational achievement. ▪ Youth are afforded opportunities to learn social skills and life skills necessary in home, school and community settings. This is facilitated through participation in age-, culturally- and developmentally-appropriate activities in a variety of community settings. ▪ Leaders act upon quality improvement data to increase the degree to which best practices are implemented and effective in preventing the need for emergency safety interventions. ▪ Families and youth are fully involved in the implementation and monitoring of the individualized behavior support plan *(which is integrated into the treatment plan)*. ▪ Staff receives ongoing training and demonstrates competency in such skills as: identifying triggers and warning signs, understanding and implementing a range of primary/early interventions/strategies/soothers, etc. **During Residential Performance Indicators** • Percent of youth and families for whom the treatment and support plan is implemented as specified by the CFT. • Percent of treatment and support plans revised within specified timeframes. • Percent of youth receiving services *(e.g., groups, skills and job training, etc.)* with youths living in their community; • Percent of youth participating in typical community recreation and youth development programs. • Rates of days spent in classroom versus missed because of behaviors.	discharge. ▪ Percentage of youth and families who continue to receive planned aftercare services for three months post-discharge. ▪ Percent of youth and families who receive services while in residential treatment from at least one of the same providers who will provide services following discharge. ▪ Percent of youth and families who are discharged when planned. ▪ Percent of youth and families for whom the transition plan is fully implemented *(including receipt of all services as planned)*. ▪ Percent of transition plans that include a mutually agreed upon crisis response plan to support the youth and family in the community. ▪ Rates of readmissions to the same/similar or higher level of care a) within 90 days, and, b) within one year of discharge.

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▪ Percent of treatment and support plans that specify how family, peer, and community resources will be used and strengthened to support the youth and family. ▪ Percent of treatment and support plans that specify how recovery-oriented approaches will be implemented. ▪ Percentage of treatment and support plans that specify how family members *(or surrogate or significant support person)* will actively participate during residential treatment. ▪ Percentage of treatment and support plans that specify youth-specific, non-coercive strategies and practices to support self-control and prevent the need for emergency safety interventions.	• Percent of direct care staff who received training in a) trauma-informed care, b) primary prevention strategies and other techniques to avoid the need for restraint and seclusion. • Percent of treatment and support plans that include behavior support plan. • Percent of emergency safety interventions that have a formal debriefing with staff, youth and family members. • Percent of emergency safety interventions in which the behavior support plan was followed, including the plan for family involvement, use of youth-specific prevention and soothing strategies, etc.	

Selected Outcome Measures:

Stable living environment	Educational measures *(attendance, achievement, etc.)*	Stable housing	Employment/training/post-secondary education
Level of functioning	Community tenure *(%age of days in community)*	Suicidal behavior	Criminal behavior *(e.g., arrest rates)*
Substance use rates	Teen pregnancy rates	Readmission	

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Community Resources **Community Resources** are the community services, supports, and relationships that a youth has and needs to live successfully in the community. These include, but are not limited to: immediate family relationships, other supportive relationships *[e.g., relative(s) and non-relative adult(s) and peer(s)]*, non-residential clinical services providers *(e.g., psychiatric, counseling, crisis intervention, etc.)*, other formal service providers *(e.g., medical, social services, probation, community-based education, etc.)*, recreational affiliations, transportation for the youth and family, housing, faith-based affiliations, job training, employment, financial resources for child and family. The goal is to support the continuity and development of a youth's community connections even as s/he is receiving residential treatment and promote the use of residential treatment as an intervention embedded in a community-based system of care. A **Community Resource Assessment** (CRA) is conducted prior to admission to inventory resources in the community that are currently available, that need to be in place following residential treatment, and that need attention/development during treatment.		

For a full understanding of the Building Bridges Initiative Framework for Self-Assessment, please refer to the following documents all available at www.BuildingBridges4Youth.org:

- ***Joint Resolution:*** *Building Bridges Between Residential and Community Based Service Delivery Providers, Families and Youth: Joint Resolution to Advance a Statement of Shared Core Principles*
- ***Self-Assessment Framework:*** *Building Bridges Initiative: Framework for Self-Assessment for Organizations and Communities*
- ***Matrix:*** *Building Bridges Performance Guidelines and Indicators Matrix (this document)*
- ***Self-Assessment Tool:*** *Building Bridges Self-Assessment Tool (S.A.T.)*
- ***Glossary:*** *Glossary of terms used throughout these documents.*

Oversight and partial support for the Building Bridges Initiative comes from the Child, Adolescent and Family Branch of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.