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Overview of the *Rhode Island Children's Behavioral Health Consent Decree: System Review*




Presentation to the Rhode Island Children's Behavioral Health Consent Decree Advisory Committee
January 28, 2026

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Orientation to the Report

- Table of contents is hyperlinked
- All sources and citations are linked through endnotes that are included at the end of the document.
- Appendices:
  - 1: Participants in interviews & focus groups
  - 2: Semi-Structured Interview/Focus Group Prompts
  - 3: Documents Reviewed
  - 4: Table of Recommendations
- Quotes from interviews and focus groups are included throughout the document, including in call-out boxes
- Each section has
  - An assessment of the topic, including findings and observations
  - Recommendations
- Overarching and cross-cutting observations are included under “Preliminary Observations” at the beginning of the document and in the final set of Recommendations (starting on page 42)

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As you review, please keep in mind…

- These are the reflections, observations, findings, and recommendations of the Innovations Institute technical assistance & consultation team, *not* the State of Rhode Island and *not* the Court Monitor
- The report reflects the best information that the team had available and the team's understanding of that information at the time of the report's issuance
- This is *not* a strategic plan or implementation plan.
- This report is about the Focus Population and the Consent Decree, not the total population of children in Rhode Island.

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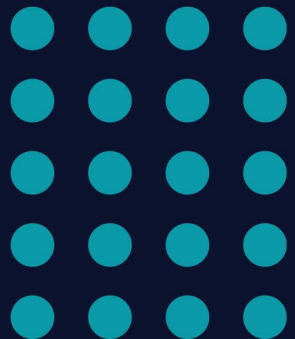
Acknowledgments

This work was completed under contract with the Rhode Island Department of Children, Youth, and Families (DCYF).

Thank you to the many individuals, providers, organizations, and stakeholders across Rhode Island, including youth, young adults, and family members, who shared their time and expertise for this report.

Special thank you to Ashley Deckert, Director; Brandi DiDino, Deputy Director; Chris Strnad, Associate Director for Community Services & Behavioral Health; and the DCYF leadership team for providing numerous resources, connecting the team to additional stakeholders, and being readily available to answer questions and share honest reflections.



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Reminders: Consent Decree Purpose and Focus Population

- **Purpose of the Consent Decree:** To reduce avoidable and unnecessarily prolonged psychiatric hospitalizations of children in the Focus Population by expanding and improving access to appropriate community-based services and supports, including timely transitions from inpatient care to family-based settings.
- The Consent Decree defines the **Focus Population** as children who have an open case with DCYF and meet one or more of the following criteria:
  - Are currently admitted to Bradley Hospital for acute inpatient psychiatric treatment;
  - Were admitted to Bradley Hospital for acute inpatient psychiatric treatment within one year prior to January 7, 2025 (the Effective Date of the Consent Decree);
  - Are admitted to Bradley Hospital for acute inpatient psychiatric treatment at any point during the term of the Consent Decree; or
  - Are deemed at serious risk of admission to Bradley Hospital for acute inpatient psychiatric treatment due to three or more emergency department visits within a twelve-month period since January 7, 2025, related to a current or subsequent diagnosed behavioral health disability.

Purpose of the System Review –Consent Decree ¶21-23

- An independent, qualified third-party consultant is to review Rhode Island's children's behavioral health system
- This review is to provide **preliminary observations and recommendations** related to:
  - DCYF's processes to identify children in the Focus Population;
  - DCYF's discharge and transition planning once a child in the Focus Population is admitted to Bradley Hospital;
  - DCYF's service and care coordination for children in the Focus Population;
  - The capacity and sufficiency of Community-Based Services available to children in the Focus Population;
  - The capacity and sufficiency of mobile crisis response and crisis prevention, intervention, and stabilization services available to children in the Focus Population;
  - The capacity and sufficiency of Therapeutic Foster Care for children in the Focus Population; and
  - Relevant policies, standard operating procedures, and mechanisms for data collection and coordination across agencies, including Medicaid-funded HCBS waivers, state plan policies, reimbursement structures, and payment methodologies, to determine what changes may be needed to ensure compliance with the Consent Decree.
- This review is designed to inform the Implementation Plan developed by the State, which is due 90 days from the submission of the System Review

There is a separate needs assessment being conducted by Innovations Institute on the behavioral health needs of children in Rhode Island, inclusive of the child welfare and juvenile justice systems, which will build upon this assessment and be completed by June 30, 2026.

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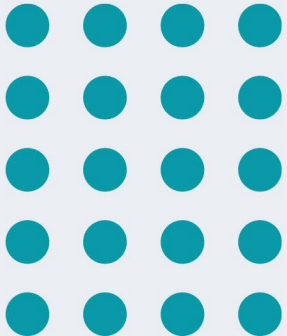
Methods & Approach



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Site Visits & Record Reviews

- March, May, October, December 2025
- Reviewed individual records of children in the Focus Population
- Observed Family Court
- Met with the Office of the Child Advocate and other stakeholders, including DCYF staff
- Toured
  - Bradley Hospital
  - Hasbro Children's Hospital
  - Harmony Hill School
  - Turning the Corner
  - The Bradley Center

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Interviews & Focus Groups, including members of the Advisory Committee

- Brown University Health, including Bradley Hospital, The Bradley Center, and Hasbro Children's Hospital
- Center for Southeast Asians
- Consent Decree Advisory Committee (including individuals with lived experience)
- Consent Decree Monitor
- Harmony Hill School
- Neighborhood Health Plan of Rhode Island (NHP)
- Parent Support Network of Rhode Island (PSN)
- Rhode Island Children's Behavioral Health System of Care Family Engagement Workgroup (including caregivers with lived experience)
- Rhode Island Coalition for Children and Families (Coalition) (including community-based and residential provider members)
- Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH)
- Rhode Island Department of Children, Youth & Families (DCYF)
- Rhode Island Department of Health (RIDOH)
- Rhode Island Executive Office of Health and Human Services (EOHHS)
- Rhode Island Executive Office of Health and Human Services (EOHHS) - Medicaid
- Rhode Island Family Court - Court Appointed Special Advocate (CASA)
- Rhode Island General Assembly
- Rhode Island Office of the Child Advocate (OCA)
- Rhode Island Office of Management and Budget (OMB)
- Turning the Corner

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Document Review

- Over 50 documents, reports, and websites were reviewed
- Appendix 3 of the report provides a list of the documents reviewed, along with the year of the document, a summary of the document, and a link (if available)
- Documents and reports fell into the following categories:
  - DCYF Reports (14)
  - DCYF Departmental Operating Procedures & Reports (16)
  - EOHHS Reports (3)
  - OCA Reports (4)
  - Other Reports (5)

Notes & Considerations

- Many of the observations, findings, and recommendations in this report are consistent with the findings from reports of the past decade.
- The primary audience for the report is DCYF and the State to inform the development of the Implementation Plan.
- This report does not attempt to systematically quantify statewide service demand or capacity beyond the Consent Decree's Focus Population. The report examines the structure, functioning, and implementation of existing systems and services for children who are hospitalized at, or at serious risk of admission to, Bradley Hospital.
- The Consent Decree requires an assessment of the "capacity and sufficiency" of several types of services and interventions.
  - Assessments of service capacity and sufficiency consider multiple dimensions of access and effectiveness, including geographic availability, timeliness, cultural and linguistic responsiveness, and the ability of services to meet the needs of children with complex or specialized needs, including children with intellectual and/or developmental disabilities (I/DD).
  - Comprehensive information was not always available for every service type. This review describes what is known, identifies gaps, and offers planning considerations where additional information or system development may be required.
- Emphasis was placed on areas most relevant to compliance with the Consent Decree and to informing feasible and sustainable system changes.
- The findings are anchored in national and Rhode Island data, including from the *Baseline Data Report* (see pages 8-11).

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Observations & Recommendations

NOTE: Recommendations are abbreviated; full recommendations are included in the relevant sections of the report and in the Appendix of the report.

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Preliminary and Cross-Cutting Observations: Strengths

- Strong and engaged leadership at DCYF
- Increased engagement from workers and managers and willingness by DCYF and Bradley Hospital to evolve and change
- Strong core service array and commitment of providers to support families
- Willingness to engage across sectors to improve systems

Preliminary and Cross-Cutting Observations; Challenges (p.11-16)

> "The way the system currently is [operating] isn't working for children and families. We need to acknowledge that to feel good about the changes that need to take place."

- Access to children's behavioral health care can be confusing and stigmatizing.
- There is fragmentation and a lack of coordination at the individual and system levels.
- There is lack of trust across many public and private agencies, providers, and organizations.
- There appears to be an aversion to perceived risk across systems and organizations, which exacerbates other challenges.
- There is a lack of meaningful family and youth engagement and voice at the service delivery and care planning level.
- The relationship between the Family Court and other partners was identified by multiple stakeholders across public and private agencies as an ongoing challenge.
- There are overarching challenges with the service array.
- There are challenges with the placement referral process.
- Language used across systems is not always consistent with best practices and systems of care values.

> "No matter how clear the definitions are written, [we] don't all speak the same language. All entities not functioning to the greatest capacity within own roles--should be strengthening each other but we don't have basic agreements on definition and function."

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DCYF's Processes to Identify Children in the Focus Population (p.16-18)

- Challenges with timely identification of a child in the Focus Population's admission to Bradley and how this information in communicated
- Recommendations:
  - DCYF and Bradley Hospital should collaborate **to strengthen Bradley Hospital's intake process** to consistently screen for and document all forms of DCYF involvement to support more timely identification of children in the Focus Population and earlier coordination with DCYF.
  - DCYF should develop a **comprehensive tracking spreadsheet** for leadership review that includes youth admitted to Bradley Hospital and youth who experience two or more emergency department visits.
  - DCYF should **update the facilitated case review process** for youth with two or more ED visits to include families and youth as participants in the team meeting to identify goals, challenges, and strategies.
  - The State should establish a **mechanism to notify NHP** when a youth is hospitalized, enabling them to partner with Bradley Hospital, DCYF, and the family, particularly when the youth might need substance use treatment services.
  - Once intensive care coordination (ICC) is implemented, DCYF should establish **clear ICC referral protocols** for youth in the Focus Population.
  - To the extent feasible, the State should **identify, collect, and report additional data**.

DCYF's discharge and transition planning once a child in the Focus Population is admitted to Bradley Hospital (p.18-22)

- Discharge planning is highly resource-intensive, dependent on numerous internal and external factors, and inconsistent. Discharge pathways are often shaped by what can be operationalized within the existing service array, rather than by individualized clinical recommendations and youth and family preferences.
- Observations and challenges were identified regarding
  - Service array availability, confidence, and utilization;
  - Discharge planning processes and decision-making
  - DCYF referral practices and information quality
  - Transition coordinator role implementation
- Recommendations:
  - DCYF should **standardize early and proactive transition planning** for children admitted to Bradley Hospital.
  - DCYF should **fully implement the Transition Coordinator positions** with necessary supervisory support, training, and coaching related to best practices.
  - DCYF should **update its residential placement referral policy** and associated forms and documentation.
  - DCYF should **support workers to identify community-based resources** that can be provided in the home, including MRSS, and ensure that referrals are made for ICC once implemented.
  - DCYF should implement a **referral tracking process** that provides near real-time information on referrals submitted to programs and their status. DCYF should use these data at both the individual and system levels to improve practices.
  - DCYF should use a **transitional planning tool** to help with consistent assessment of a youth's readiness to transition from hospitals residential interventions, even when all treatment goals may not have been completed.

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DCYF's Service and Care Coordination for Children in the Focus Population (p.23-27)

"There is no one person or group that owns the care and listening to what they need and connecting to care. Even in DCYF, despite how well-intentioned, families get dropped and moved back and forth between units and workers."

- Service planning and care coordination for children in the Focus Population occurs across multiple agencies, funding streams, and provider systems, resulting in variable practices and inconsistent accountability.
- The Consent Decree requires DCYF to implement a statewide Intensive Care Coordination model to support children with complex behavioral health needs and to improve service planning, continuity, and outcomes. Most stakeholders agreed that the absence of such a child- and family-driven team planning model represents a critical gap in the current system.
- There are opportunities and challenges within existing approaches, system challenges, and opportunities to leverage existing planning processes, including related to the System of Care Grant and Olmstead.
- Recommendations include:
  - The State should implement a **single point of entry or access to complement the existing No Wrong Door approach** to facilitate consistent access to services across the Focus Population.
  - The State should **implement ICC using Wraparound** for the youth in the Focus Population, including implementation of CFTs as a core component of ICC.
  - DCYF should **conduct a care pathway analysis** in partnership with Medicaid and BHDDH to identify the services and supports that children and youth in the Focus Population are accessing in the 12 months prior to their ED visit or hospitalization.
  - The State should **strengthen youth and family partnership** as a core expectation of service planning, transition planning, and care coordination.
  - **The ICC model should be implemented with careful attention to specific populations** within the Focus Population, including youth with co-occurring mental health and SUD and/or I/DD service needs.

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The capacity and sufficiency of Community-Based Services available to children in the Focus Population (p.27-34)

- Findings and observations made re:
  - Certified Community Behavioral Health Clinics (CCBHCs)
  - Intensive In-Home Services
  - Substance Use Disorder Treatment
  - Respite Care
  - Family Peer Support
  - Psychiatric Services and Medication Management
  - Other Service Needs
- Recommendations:
  - The State should **clearly define and maintain a unified description of the children's behavioral health service array** for the Focus Population.
  - The State should **prioritize sustainable development and implementation of key home- and community-based services** and, to a lesser extent, residential interventions, to provide specialized and intensive care and treatment for youth with co-occurring SUD treatment needs; co-occurring mental health and I/DD treatment needs; current or past aggressive behaviors; and concerning sexual behaviors; as well as for youth who have experienced trafficking.
  - DCYF **should review the forthcoming comprehensive children's behavioral health service array needs assessment** when it is completed and identify opportunities to integrate recommendations into an updated Implementation Plan.
  - DCYF, BHDDH, and Medicaid should **engage in a review of service utilization data** to better understand who is using which services with what frequency and identify any outcomes associated with service provision.
  - The State should **enhance monitoring of community-based service sufficiency and timeliness** to support Consent Decree compliance.
  - The State should **identify strategies to recruit and retain clinicians and translators** who speak Spanish and K'iche'.
  - The State should **continue to support the CCBHCs in strengthening services for children, youth, and their families**, including the delivery of developmentally appropriate and customized interventions for youth in the Focus Population.
  - The State should **explore opportunities to provide family peer support** as a Medicaid benefit for youth and their families.
  - DCYF **should hire or contract for a full-time Medical Director and Child and Adolescent Psychiatrist**

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The capacity and sufficiency of mobile crisis response and crisis prevention, intervention, and stabilization services available to children in the Focus Population (p. 35-39)

- While Rhode Island has developed core components of a community-based crisis continuum, capacity limitations, financing constraints, and fragmentation across systems continue to affect the State's ability to consistently meet the needs of children with the highest behavioral health acuity, including children in the Focus Population.
- Recommendations:
  - The State should **clarify and rationalize crisis system access points** to improve accountability and system performance.
  - The State will need to **ensure that the crisis hotline has sufficient capacity, uses standardized decision-making criteria, and reliably results in timely mobile crisis response and stabilization when needed.**
  - EOHHS, Medicaid, and DCYF should **ensure that the proposed Medicaid State Plan Amendment for MRSS is comprehensive and aligned with national best practices** for the implementation, delivery, and quality and outcomes monitoring of MRSS.
  - The State should **collect more robust, standardized data** on referral sources, response times, service duration, outcomes, and utilization of hotlines, MRSS, and other crisis services by children in the Focus Population to enable an assessment of whether capacity is sufficient and equitably distributed across regions and if the State continues to rely on hospital-based care instead of home- and community-based models.

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Capacity and sufficiency of Therapeutic Foster Care for children in the Focus Population (p. 39-41)

- Observations made regarding
  - Capacity and availability
  - Recruitment and retention
  - Matching and referrals
  - Financing and sustainability
- Recommendations:
  - DCYF and the TFC providers should **continue to meet regularly to identify and discuss systemic barriers** to the service and develop specific strategies to meet needs of the youth in the Focus Population.
  - DCYF should **examine TFC capacity and utilization for individual programs** to better understand variation in eligibility criteria, specialization, and fit.
  - DCYF should **monitor foster family placement criteria**, language capacity, geographic distribution, alignment with cultural needs of children, and willingness to serve children with significant behavioral health needs.
  - DCYF and providers should **prioritize strategies to support recruitment and retention of TFC families**—including respite, clinical consultation, and flexible supports—to sustain capacity over time.

All relevant policies, standard operating procedures, and mechanisms for data collection and coordination across agencies…to determine what, if any, changes may be needed to assure the State's compliance with this Consent Decree (p.41-44)

- Additional findings & Observations
  - There are regulatory barriers to developing residential services for 16–25-year-olds with co-occurring mental health and SUD treatment needs based on requirements and restrictions for youth under 18.
  - Some stakeholders shared that DCYF attorneys have very high caseloads and that children in the Focus Population would benefit from DCYF having more robust legal representation.
  - Stakeholders raised concerns about the changes to the rates for DCYF-contracted services that will be moving to Medicaid
  - Important gaps limit the effectiveness of the State's data infrastructure for comprehensive oversight and real-time coordination.
  - There are challenges with interagency collaboration across the state.
- Recommendations (see detail in report!):
  - **Streamline the children's behavioral health system and improve interagency coordination and accountability—without requiring families to access children's behavioral health services through the child protection system.**
  - Strengthen **relationships**
  - The State should work internally and with partners to **update language and standards for how children and families are discussed and described** to ensure they are reflective of best practices and system of care values.
  - The State should conduct a **review of regulations associated with residential services for youth 16-25**, identify barriers to providing services, and propose changes as needed to reduce barriers to care.
  - The State should **review the caseloads of DCYF attorneys** and explore whether there is a need to make any recommendations for further action, including related to more and/or specialized attorneys to ensure robust legal representation.
  - The State should work with providers and other stakeholders to **clarify concerns about the proposed new rates and reimbursement structure for DCYF-contracted services**
  - **Data collection, reporting, and analysis**
  - **Oversight and quality management**

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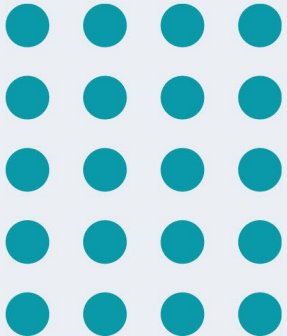
Conclusion



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Magic Wand (selected responses) p.44-46

- "When someone needs something, they get it. Right now, despite enormous infrastructure and service array, it's hard to get what is needed when it is needed. Kids start to feel like they don't know what is happening and why they were removed from their home because they aren't getting anything better or more helpful. We need to do better; if we are going to remove them from their home, we have to do better."
- "[We] need to have care coordination put into place. In every setting, care coordination will make a huge difference in what is available. But also, how are we working to get kids to where they need to be for the right time and the right duration. We have an uncanny ability to Rhode Island-ize anything and we try to make models our own but fidelity to the model is important."
- "Create an accessible system for anyone who needs it, anyway they need it. Talking about Single Point of Access and being able to get access quickly via their phone. [We] want to make sure when kids in Rhode Island need something, their families know where to get it and can access it however they are most comfortable . . . phone, in-person, text, online form. [We] want the system to work harder than the parent."
- "We need a stronger home-based service array to get kids home. More supports in the home. In a perfect world, repurpose and shrink the residential intervention unit to do more things with that team. More services wrapped in homes and fewer youth ever leaving the home. Start this earlier; see more parent skill-building earlier for both MH and IDD needs, and with foster parents. Help manage behaviors earlier before they become a crisis. Know these behaviors are emerging but, instead of going to CRAFT, wrap supports around those youth to avoid some of them coming in and out of hospital and residential. Learn the skills *while the child is in the home;* don't get the work done well when kids are out of the home."
- "Have more family support organizations with extensive resources like the family support organizations in New Jersey. Provide more family peer support."
- "Reorganize around residential services and make them work for youth so they don't have to leave Rhode Island. Make sure they have the necessary rates, quality, provider engagement, and state expertise."

"Let kids have as normal a life as possible. That is what this should be about."

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Full List of Recommendations

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Recommendations: Processes to Identify Children in the Focus Population

DCYF and Bradley Hospital should collaborate to strengthen Bradley Hospital's intake process to consistently screen for and document all forms of DCYF involvement to support more timely identification of children in the Focus Population and earlier coordination with DCYF.
DCYF should develop a comprehensive tracking spreadsheet for leadership review that includes youth admitted to Bradley Hospital and youth who experience two or more emergency department visits. This interim tool should support ongoing case review and proactive engagement with families and workers until the new data system is implemented and should incorporate additional data elements as feasible. DCYF and Bradley Hospital should develop protocols for the transition coordinators to be notified promptly when a youth who may be part of the Focus Population is admitted to Bradley Hospital and align the data collection and tracking activities of the transition coordinators with those of other workers to reduce duplication.
DCYF should update the facilitated case review process for youth with two or more ED visits to include families and youth as participants in the team meeting to identify goals, challenges, and strategies. As part of this process, DCYF should consider inviting MRSS providers to support crisis planning and establish relationships with families before another ED visit or crisis occurs.
The State should establish a mechanism to notify NHP when a youth is hospitalized, enabling them to partner with Bradley Hospital, DCYF, and the family, particularly when the youth might need substance use treatment services.
Once intensive care coordination (ICC) is implemented, DCYF should establish clear ICC referral protocols for youth in the Focus Population.
While the Baseline Data Report provides important descriptive information about children in the Focus Population, it does not include sufficient data to fully assess clinical needs, service appropriateness, or system performance for the Inpatient and At-Risk Groups. To the extent feasible, the State should identify, collect, and report additional data to improve understanding of the following:
DCYF and Bradley Hospital should collaborate to strengthen Bradley Hospital's intake process to consistently screen for and document all forms of DCYF involvement to support more timely identification of children in the Focus Population and earlier coordination with DCYF.
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While the Baseline Data Report provides important descriptive information about children in the Focus Population, it does not include sufficient data to fully assess clinical needs, service appropriateness, or system performance for the Inpatient and At-Risk Groups. To the extent feasible, the State should identify, collect, and report additional data to improve understanding of the following: • Children's clinical diagnoses, functional impairments, or acuity levels at the time of inpatient admission, discharge, and repeated ED visits; • The specific behavioral health, crisis, or community-based services children received prior to hospitalization, between ED visits, or following discharge; • Whether children were able to access services that were clinically appropriate, timely, and sufficient to stabilize their needs; • The extent to which service availability, capacity limitations, or coordination challenges contributed to prolonged inpatient stays, repeated admissions, or repeated ED utilization; and • Whether children in the At-Risk Group subsequently experienced psychiatric hospitalization, or whether inpatient admission was averted through effective community-based intervention.

Recommendations: Discharge and Transition Planning from Bradley Hospital

DCYF should standardize early and proactive transition planning for children admitted to Bradley Hospital. • Transition planning should begin at the point of admission for all children in the Focus Population, rather than being delayed until a child is deemed clinically ready for discharge. • Transition planning should be guided by a standardized framework that incorporates the child's strengths, needs, preferences, and family circumstances, and that anticipates service, placement, and court-related barriers early in the hospitalization.
DCYF should fully implement the Transition Coordinator positions with necessary supervisory support, training, and coaching related to best practices. • Ensure that the transition coordinators have the necessary support to facilitate shared decision-making and elevate the voices of youth and families along with other members of the team. • Provide initial and ongoing training and coaching for the transition coordinators and supervisors, including continued training on FOCUS (intermediate care coordination model). • Establish clearly defined procedures and expectations and map responsibilities of the transition coordinators to that of other partners, including the hospital and NHP.
DCYF should update its residential placement referral policy and associated forms and documentation to require that: • All referrals include the youth, family, and team's goals for the youth's care and treatment; the youth and family's strengths, interests, and preferences; the specific services and supports needed within a residential intervention; relevant information about the youth's diagnoses, history, and current or prior services; and other information that will help support a match between the youth and the intervention. • Referrals are submitted only to residential interventions that are reasonably aligned with the youth's demographic characteristics, identified service and treatment needs, and the strengths and needs of the youth and family. • All updated policies, forms, and protocols are accompanied by initial and ongoing training and clear communication for both internal and external stakeholders.
DCYF should support workers to identify community-based resources that can be provided in the home, including MRSS, and ensure that referrals are made for ICC once implemented.
DCYF should implement a referral tracking process that provides near real-time information on referrals submitted to programs and their status. DCYF should use these data at both the individual and system levels to improve practices.
DCYF should use a transitional planning tool to help with consistent assessment of a youth's readiness to transition from hospitals residential interventions, even when all treatment goals may not have been completed.

Recommendations: DCYF's Service and Care Coordination for Children in the Focus Population

The State should implement a single point of entry or access to complement the existing No Wrong Door approach to facilitate consistent access to services across the Focus Population. The single point of access should triage, conduct assessments, coordinate and refer for care (consistent with the youth's plan of care), support utilization management activities, and assist with data collection. A single point of access can both refer to and receive referrals from parents and caregivers, youth, hospitals, schools, MRSS, community providers, and system partners without necessitating entry through DCYF or the child welfare system.
The State should implement ICC using Wraparound for the youth in the Focus Population, including implementation of CFTs as a core component of ICC. • The State should procure one or more independent CMEs to implement ICC using a conflict-free case management approach. • The CME should be required to ensure that all care coordinators and supervisors are appropriately trained and certified (initially and ongoingly), consistent with the National Wraparound Initiative (NWI). • The State should implement fidelity and outcomes monitoring to ensure that ICC is delivered in accordance with NWI standards. • Policies should be developed to ensure that the CFT has the necessary authority to facilitate care planning and access services, with recommendations for treatment and interventions provided by the Team, inclusive of the youth, family, system partners, and natural supports. • Comprehensive implementation supports will be necessary, including communication and marketing materials, procedures, continuous quality improvement, reimbursement structures, and other necessary elements
DCYF should conduct a care pathway analysis in partnership with Medicaid and BHDDH to identify the services and supports that children and youth in the Focus Population are accessing in the 12 months prior to their ED visit or hospitalization. This can inform the implementation of a single point of access and development of a clear and consistent care pathway.
DCYF should conduct a care pathway analysis in partnership with Medicaid and BHDDH to identify the services and supports that children and youth in the Focus Population are accessing in the 12 months prior to their ED visit or hospitalization. This can inform the implementation of a single point of access and development of a clear and consistent care pathway.
The State should strengthen youth and family partnership as a core expectation of service planning, transition planning, and care coordination. • Policies and procedures should explicitly require meaningful youth and family participation in CFT meetings, discharge planning, and transition decision-making, unless participation is declined. • The State should identify and address practical barriers to participation in CFT meetings, including transportation, scheduling, language access, and preparation supports.
The ICC model should be implemented with careful attention to specific populations within the Focus Population, including youth with co-occurring mental health and SUD and/or I/DD service needs.

Recommendations: Capacity and Sufficiency of Community-Based Services for Children in the Focus Population

The State should clearly define and maintain a unified description of the children's behavioral health service array for the Focus Population. • The State should develop a single description of community-based behavioral health services available to children in the Focus Population, including services funded by DCYF and services accessed through Medicaid, including CCBHCs. • This description should clearly specify service purpose, eligibility criteria, level of intensity, referral pathways, geographic availability, and hours of operation, and should be accessible to families, providers, and system partners. • The unified service array should be used to support consistent access, appropriate service matching, effective care coordination, and accountability for Consent Decree implementation, and should be regularly reviewed and updated to reflect changes in funding, capacity, or service design.
The State should prioritize sustainable development and implementation of key home- and community-based services and, to a lesser extent, residential interventions, to provide specialized and intensive care and treatment for youth with co-occurring SUD treatment needs; co-occurring mental health and I/DD treatment needs; current or past aggressive behaviors; and concerning sexual behaviors; as well as for youth who have experienced trafficking. In particular, the State should strengthen the youth SUD service continuum as an integral component of community-based care and should strengthen the availability, intensity, and reliability of intensive in-home services as a functional alternative to hospitalization and residential care. • The State should establish clearer access pathways for youth SUD services, including adolescent-specific outpatient, recovery-oriented, and co-occurring treatment options. • In-state residential SUD capacity for youth should be expanded and monitored to reduce reliance on out-of-state placements and support continuity of care. • The State should strengthen data collection and cross-agency reporting on youth SUD services, including identification of SUD needs within the Focus Population, service availability, referral-to-service timelines, waitlists, in-state and out-of-state placement, length of stay, and continuity of care following hospitalization or residential treatment, to inform ongoing planning and Consent Decree monitoring. • The State should assess whether existing intensive in-home services are available at sufficient scale, intensity, and timeliness to meet the needs of children in the Focus Population, including evenings and weekends. • The State's data collection should distinguish between authorized capacity and staffed capacity and track referral-to-service timelines, service intensity, duration, and outcomes. • The State should prioritize expansion of in-home models with demonstrated capacity to manage risk, provide 24/7 crisis response, and support families during high-acuity periods. • DCYF and BHDDH should identify specific strategies to improve the availability and accessibility SUD treatment service array for youth and young adults.
DCYF should review the forthcoming comprehensive children's behavioral health service array needs assessment when it is completed and identify opportunities to integrate recommendations into an updated Implementation Plan.
The State should enhance monitoring of community-based service sufficiency and timeliness to support Consent Decree compliance. • The State should develop mechanisms to routinely track services identified in service plans that are not initiated within required timeframes, consistent with the Consent Decree's data and quality assurance provisions. • Data should be used not only for reporting, but for proactive identification of service gaps, regional disparities, and systemic barriers requiring corrective action. • Findings from Quality Service Reviews (QSRs) should be systematically linked to system-level improvement strategies and provider development efforts.
The State should identify strategies to recruit and retain clinicians and translators who speak Spanish and K'iche'.
The State should continue to support the CCBHCs in strengthening services for children, youth, and their families, including the delivery of developmentally appropriate and customized interventions for youth in the Focus Population.
The State should explore opportunities to provide family peer support as a Medicaid benefit for youth and their families.
DCYF should hire or contract for a full-time Medical Director and Child and Adolescent Psychiatrist.

Recommendations: Capacity and sufficiency of mobile crisis response and crisis prevention, intervention, and stabilization services for Children in the Focus Population

The State should clarify and rationalize crisis system access points to improve accountability and system performance. • Clear guidance should be established regarding the role of 988, Kids' Link, CCBHC crisis lines, and direct MRSS access to ensure consistent routing, response, and follow-up. • Statewide reporting should be implemented to track crisis demand, response times, service linkage, and unmet need, with specific attention to children in the Focus Population.
The State will need to ensure that the crisis hotline has sufficient capacity, uses standardized decision-making criteria, and reliably results in timely mobile crisis response and stabilization when needed.
EOHHS, Medicaid, and DCYF should ensure that the proposed Medicaid State Plan Amendment for MRSS is comprehensive and aligned with national best practices for the implementation, delivery, and quality and outcomes monitoring of MRSS.
The State should collect more robust, standardized data on referral sources, response times, service duration, outcomes, and utilization of hotlines, MRSS, and other crisis services by children in the Focus Population to enable an assessment of whether capacity is sufficient and equitably distributed across regions and if the State continues to rely on hospital-based care instead of home- and community-based models.

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Recommendations: Capacity and sufficiency of Therapeutic Foster Care for Children in the Focus Population

DCYF and the TFC providers should continue to meet regularly to identify and discuss systemic barriers to the service and develop specific strategies to meet needs of the youth in the Focus Population.
DCYF should examine TFC capacity and utilization for individual programs to better understand variation in eligibility criteria, specialization, and fit.
DCYF should monitor foster family placement criteria, language capacity, geographic distribution, alignment with cultural needs of children, and willingness to serve children with significant behavioral health needs.
DCYF and providers should prioritize strategies to support recruitment and retention of TFC families—including respite, clinical consultation, and flexible supports—to sustain capacity over time.

Recommendations: Policies, procedures, mechanisms for data collection and coordination, Medicaid policies and reimbursement structures, and changes needed to support the Children in the Focus Population (Part 1)

Streamline the children's behavioral health system and improve interagency coordination and accountability—without requiring families to access children's behavioral health services through the child protection system.

- DCYF, BHDDH, and Medicaid should review eligibility criteria for voluntary children's behavioral health services and identify barriers to accessing services, including restrictions associated with court involvement.
- DCYF should review its organizational charts and descriptions and develop an accessible overview of each division and its purpose and responsibilities, using consistent language.
- The State should explore how to elevate the children's behavioral health system to be a co-equal division to child welfare and implement the Court Monitor's expectation that the State hire, train, and support a leader for the children's behavioral health system.
- As discussed above, the State should implement a Single Point of Access, which will eliminate the need for families to access services through the child protection system as appoint of entry.
- The State should identify specific opportunities to improve coordination between DCYF and BHDDH, including whether adolescent SUD treatment services should move within DCYF.
- The State should review the Children's Cabinet structure and consider strengthening it to serve as a governance structure for children's systems. Such a structure requires the necessary decision-making authority regarding resources and policies needed to build and sustain the children's behavioral health system, including assuming shared accountability across systems for the Focus Population and, more broadly, Rhode Island's children and families. A governance structure on behalf of all of Rhode Island's children and families would require all parties to embrace shared liability and accountability.

Strengthen relationships:

- DCYF should collaborate with the Court Monitor to explore opportunities to partner with the Family Court and better understand their priorities, concerns, and challenges. Through this process, the Family Court may be able to identify opportunities to participate in the Consent Decree implementation process to provide unique expertise and inform the design and development of the system.
- DCYF should consider implementing a Staff Council to assist with the Consent Decree Implementation Plan.
- Medicaid and BHDDH should be increasingly active members of the Consent Decree's Advisory Committee and participants in DCYF's standing Consent Decree implementation meetings.

The State should work internally and with partners to update language and standards for how children and families are discussed and described to ensure they are reflective of best practices and system of care values. This includes removing language that refers to children as being AWOL, replacing that term with *missing,* and creating guidance for documentation and referral forms.

The State should conduct a review of regulations associated with residential services for youth 16-25, identify barriers to providing services, and propose changes as needed to reduce barriers to care.

Recommendations: Policies, procedures, mechanisms for data collection and coordination, Medicaid policies and reimbursement structures, and changes needed to support the Children in the Focus Population (Part 2)

The State should review the caseloads of DCYF attorneys and explore whether there is a need to make any recommendations for further action, including related to more and/or specialized attorneys to ensure robust legal representation.

The State should work with providers and other stakeholders to clarify concerns about the proposed new rates and reimbursement structure for DCYF-contracted services. While the shift from a DCYF-contracted service to a Medicaid fee-for-service reimbursement model is not inherently problematic—and may actually create more consistency, transparency, and access for families—there are legitimate concerns about the rates and how they are implemented. In particular,

- As new services are developed or expanded, the State should ensure that they are incorporated into the Medicaid State Plan to promote long-term sustainability and that there is consistent access to children's behavioral health services for all children who are Medicaid-enrolled. This is recommended for ICC with Wraparound, any new in-home services, MRSS, and peer support in particular.
- Rates for services should be developed using costs to provide high quality care—with desired staffing ratios and expertise—to children and families in their homes and communities and should not be based on the cost to provide a related service to adults.
- Rates for services should reimburse providers for offering effective specialty care and customized services, participating in Child and Family Team meetings and care planning, necessary recruitment and retention, and, where appropriate, incorporating evidence-based and promising practices.

Data collection, reporting, and analysis:

- Overall, while the State has established core data capabilities and governance structures, it will need to do more to integrate, resource, and align data systems to support consistent, timely, and outcome-focused oversight of services for children in the Focus Population.
- DCYF should track ED visits, hospitalizations, placement referrals, and placement acceptances and denials to support ongoing continuous quality improvement activities. This can include using data that providers already collect and submit with their weekly census and vacancy information.
- The State should run at least weekly reports of children who are inpatient to ensure that the transition coordinators, workers, hospitals, and NHP all have shared information to support the Focus Population. As ICC is implemented, care coordinators should receive this information as well to ensure that the Focus Population gets access to supports and services as quickly as possible.

Oversight and quality management:

- The State should develop and implement continuous quality improvement (CQI) processes for services and interventions for the Focus Population, including fidelity and outcomes monitoring, to support implementation and effectiveness, which can be supported through the work of the Consent Decree's Quality Assurance Workgroup.
- The State and providers should share utilization and outcome data to improve trust, accountability, and coordination of care.
- The State and NHP should ensure consistency in the application of medical necessity criteria for in-network and out-of-network providers serving youth in the Focus Population.
- The State should develop a plan for utilization management for youth who have an inpatient hospitalization, partnering with providers and NHP to ensure that criteria are consistently applied without creating barriers to accessing care. This should be coupled with a review of outcomes data for the Focus Population.