Rhode Island Children’s Behavioral Health Consent Decree: System Review

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Introduction and Background

Children's Behavioral Health Consent Decree and Focus Population

On January 7, 2025, the State of Rhode Island entered into a Consent Decree with the U.S. Department of Justice (DOJ) in *United States v. Rhode Island*, Civil Action No. 24-cv-00531,[i] following a federal investigation that examined the State's use of psychiatric hospitalization for children involved with the Department of Children, Youth and Families (DCYF) between 2017-2022. The Consent Decree is intended to address the State's alleged noncompliance with Title II of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. In the Consent Decree, the State acknowledged the DOJ's findings and, while disputing certain aspects, committed to a shared goal of strengthening community-based behavioral health services for children with disabilities in the Focus Population (see Figure 1).

The purpose of the Consent Decree is 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 reflects the State's commitment to ensuring that children are served in the most integrated setting appropriate to their needs, consistent with child safety, psychosocial development, permanency, well-being, and overall family functioning. The signatories on the Consent Decree are the Rhode Island Executive Office of Health and Human Services (EOHHS), DCYF, and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), based on their shared responsibility for the provision of behavioral health services for the Focus Population.

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.

Figure 1: Focus Population Definition

Purpose of the System Review

Paragraphs 21-23 of the Consent Decree required the State to select an independent, qualified third-party consultant[ii] to conduct a review of Rhode Island's children's behavioral health system. This review, due six months from the completion of the Baseline Data Report, is intended to provide **preliminary observations and recommendations** based on the review and assessment of:

- 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;

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[i] Throughout this report, all references to the Consent Decree are to this document, which is available on the DCYF website (https://dcyf.ri.gov/media/4211/download?language=en).

[ii] DCYF contracted with Innovations Institute at the University of Connecticut School of Social Work to provide this review and technical assistance and consultation to DCYF in the implementation of the Consent Decree. This team at Innovations Institute is *separate* from the Court Monitor. While the technical assistance contract is between DCYF and Innovations Institute, EOHHS has established a separate contract with Innovations Institute for the court monitoring functions under the Consent Decree. The Court Monitor was interviewed for this review as one of the stakeholders of the Consent Decree.

- 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 report is a review and assessment of the areas outlined in the Consent Decree, specific to the Focus Population. This review is *not* a comprehensive needs assessment or system analysis, nor is it an implementation plan. The State is required to submit a proposed Implementation Plan to the Monitor and the United States that details the actions it proposes to take to fulfill the obligations of the Consent Decree, in light of the recommendations made in this report. This Implementation Plan will be due within 90 days of submission of this report. Additionally, DCYF has contracted with Innovations Institute at the University of Connecticut School of Social Work (Innovations Institute) to conduct a comprehensive needs assessment of the child welfare, juvenile justice, and behavioral health needs of children and families of Rhode Island to inform statewide service array planning and development; this comprehensive assessment will build upon this review and will be completed by June 30, 2026.

Methods, Approach, and Sources of Information

The observations and recommendations in this document originate from Innovations Institute's extensive experience in analyzing, evaluating, and advising public and private child- and family-serving agencies across the country on Medicaid, child welfare, juvenile justice, and behavioral health services for children, youth, young adults, and their families. Apart from our prior experience and lessons learned from across the country, our recommendations are grounded in System of Care (SOC)[iii] values, principles, and best practices: Systems that serve and support children, youth, young adults, and their families should be family- and youth-driven; home- and community-based; equitable; culturally humble, linguistically competent, and fully accessible; strengths-based and individualized; data driven and outcome oriented; and trauma-responsive.

For the past year, Innovations Institute has been partnering with DCYF and key stakeholders to learn about Rhode Island's children's behavioral health system, the Focus Population, and the service array and system structures. The team has been providing technical assistance and consultation to DCYF, including reviewing draft materials, providing presentations on systems of care and best practices in service delivery systems, care coordination, and Mobile Response and Stabilization Services (MRSS); providing training on FOCUS (an intermediate care coordination model); and participating in at least twice monthly meetings with DCYF leadership, the Consent Decree Advisory Committee, working meetings with DCYF managers and staff implementing the transition coordinator positions, and meetings among DCYF, the Office of the Child Advocate (OCA), and Bradley Hospital. Innovations Institute also partnered with DCYF to support the development of the Baseline Data Report. Unless otherwise noted, the observations and findings in this

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[iii] See Pires, S. (2010). *Building systems of care: A primer, 2nd Edition.* Human Service Collaborative for Georgetown University National Technical Assistance Center for Children's Mental Health. https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf *and* Stroul, B. A., Blau, G. M., & Larson, J. (2021). *The evolution of the system of care approach*. Innovations Institute. https://innovations-socialwork.media.uconn.edu/wp-content/uploads/sites/3657/2023/03/The-Evolution-of-the-SOC-Approach-1.pdf

report are based on these activities, along with the site visits, record reviews, interviews, focus groups, and document reviews outlined below.

Site Visits, Record Reviews, Interviews and Focus Groups, and Document Reviews

This system review was informed by an extensive document review coupled with site visits, record reviews, and stakeholder interviews and focus groups (see the Appendices for a list of site visits, interviews and focus groups, and documents reviewed.)[iv]

Over 30 interviews, focus groups, and site visits were conducted, with in-person site visits in March, May, October, and December 2025. During these visits, members of the team met with DCYF leadership and staff, reviewed individual child and family records, observed Family Court, met with the OCA and other stakeholders, participated in-person in the initial Advisory Group meeting, and toured Bradley Hospital (twice), Hasbro Children's Hospital, Harmony Hill School, Turning the Corner, and The Bradley Center. The site visits informed the team's understanding of system operations, interagency coordination, and individual-level processes related to children in the Focus Population.

Stakeholder interviews and focus groups were a central component of the review and provided critical context for understanding how the children's behavioral health system functions in practice. The review incorporates input from a broad range of stakeholders across Rhode Island, including representatives from state agencies; caregivers and young adults with lived experience; Bradley Hospital clinical and administrative staff; community-based, residential, and therapeutic foster care providers; advocates; legislators; staff of Neighborhood Health Plan (NHP); and other system partners. Interviews and focus groups focused on system processes, service availability, coordination across agencies, implementation challenges, and opportunities for improvement related to the Focus Population. (See the Appendix for the interview prompts.)[v]

Records were reviewed during on-site visits in March and December 2025. The records that were reviewed were selected to provide a point-in-time understanding of the experiences of some of the youth currently or recently hospitalized at Bradley Hospital and included in the Focus Population. Youth whose records were reviewed in March 2025 were identified by the Court Monitor as representing some of the youth with complex needs and long lengths of stay. Youth whose records were reviewed in December 2025 were identified by the technical assistance team from a list of children and youth elevated during a meeting with DCYF, the Office of the Child Advocate (OCA), and Bradley Hospital as individuals who were experiencing long lengths of stay and/or having a complicated discharge and transition planning process. This was *not* a random sample of records. Record reviews were conducted on-site at DCYF by accessing information in DCYF's RICHIST information system and reviewing paper case records.

DCYF and other stakeholders provided documents and reports for the review, and additional materials websites were analyzed throughout the process. Over 50 documents, reports, and website were reviewed, including relevant reports and presentations, committee meeting minutes, policies and procedures, legislative and Medicaid-related documents, strategic plans, and resource guides (see the Appendix for a table of documents reviewed and links to documents, where available). The *Baseline Data Report*[1] served as a primary source for understanding the characteristics of the Focus Population and services available to

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[iv] The UConn-Storrs Human Research Protection Program-Institutional Review Board Office determined that the system review, including interviews, focus groups, and document analysis, was Not Human Subjects Research as defined by federal regulations for the protection of human subject in research. (Protocol #NHSR25-0534). Advisory Committee members with lived experience were compensated for their time through DCYF, consistent with their role on the Advisory Committee. DCYF was not present for their interviews.

[v] Unless otherwise noted, quotes in callout boxes are from stakeholder interviews or focus groups conducted during fall 2025.

them. Additional materials were reviewed from DCYF, BHDDH, and EOHHS public websites, along with publicly available reports and materials from provider and partner agency websites. This review did not include findings related to DCYF's recent accreditation process nor information related to the federal Child and Family Services Review, which was conducted in December 2025. If relevant, information from those extensive processes should be incorporated by DCYF into the Implementation Plan to support future activities and alignment of work.

Consistency with Other Reports and Findings

Many of the observations, findings, and recommendations in this report are remarkably consistent with the findings from reports of the past decade, including, but not limited to:

- *Rhode Island Behavioral Health Project: Final Report* (Truven Health Analytics, 2015)[2]
- *Mental Health Hearings Findings & Recommendations* (Rhode Island Senate Health & Human Services Committee, 2017)[3]
- *Rhode Island Behavioral Health System Review Technical Assistance* (Faulkner Consulting Group & Health Management Associates, 2021)[4]
- *Rhode Island Behavioral Health System of Care Plan for Children and Youth* (Executive Office of Health and Human Services, 2022)[5]
- *Children in crisis can't wait: The case for system transformation*. (Rhode Island Coalition for Children and Families, 2024). [6]
- *Integration for All: Rhode Island Olmstead Plan 2025– 2030* (Executive Office of Health and Human Services, 2025)[7]
- *Olmstead Planning and Implementation: 90-Day Report* (Executive Office of Health and Human Services, 2025)[8]
- *Report of the Office of the Child Advocate Child Fatality Review Panel: A Review of Seven Fatalities and Twenty-Three Near Fatalities* (Office of the Child Advocate, 2025)[9]
- *Children's Behavioral Health Consent Decree Monitoring Report* (Innovations Institute, University of Connecticut School of Social Work, 2025)[10]

These reports are referenced periodically in this review, but readers are strongly encouraged to analyze them to identify additional opportunities for alignment and consistency.

Data Considerations and Interpretation

The findings in this report reflect the best information and understanding that the team had at the time of publication, recognizing that additional resources and information will be identified as the Implementation Plan is developed, the comprehensive needs assessment is conducted, and the Consent Decree is implemented.

While many stakeholders in Rhode Island may benefit from reviewing the report and its findings, the primary audience of this report is DCYF and the State of Rhode Island to inform the development of the Implementation Plan. Further, the findings and recommendations in this report reflect the opinions of the authors and do not necessarily reflect those of DCYF, the State, the Monitor, or DOJ.

As noted above, this review is not a comprehensive needs assessment and does not attempt to systematically quantify statewide service demand or capacity beyond the Consent Decree's Focus Population. Rather, it 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.

Findings in this report reflect a synthesis of available data and stakeholder input and should be interpreted in light of known data limitations. In several areas, information was insufficient to fully assess service availability, accessibility, quality, or effectiveness across all regions or populations. Where data were limited, this report identifies gaps and highlights areas for possible future analysis, data collection, or system monitoring to support Implementation Plan development and implementation.

The Consent Decree requires an assessment of the “capacity and sufficiency” of several types of services and interventions. For this review, 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). Given the breadth of these considerations, comprehensive information was not always available for every service type. Accordingly, this review describes what is known, identifies gaps, and offers planning considerations where additional information or system development may be required.

Findings were synthesized by integrating quantitative and descriptive data with qualitative input from stakeholders to identify recurring themes, system strengths, and implementation challenges. Emphasis was placed on areas most relevant to compliance with the Consent Decree and to informing feasible and sustainable system changes. This approach was intended to ensure that findings support practical planning and decision-making for Implementation Plan development. Recommendations are listed together in a table in the Appendix.

Anchoring the Findings

The following sections briefly explore national and state-specific data related to behavioral health service need and access to care and elevate some key findings from the *Baseline Data Report*.[1]

National Data

Nationally, an estimated 22% of the child population in the US experiences mental, emotional, or behavioral health challenges.[11] For decades, children and youth with complex behavioral health needs and their families have struggled to get access to timely, responsive, high quality, and effective treatment and interventions in their homes and communities,[12] with one study finding that half of the children in the US with a mental health disorder did not receive needed treatment.[13] Unmet behavioral health needs are associated with numerous poor outcomes.[14] A recent analysis of data from 2016-2019 found that “Black children, on average, have a higher probability of having unmet mental health needs than the average child living in any but three states in the US” (p.4) and there are significant geographic inequities across the country in access to mental health care, after controlling for sociodemographic factors including insurance type and family income.[15]

Families in the US have been experiencing increased financial burden and out-of-pocket costs for behavioral health care, with behavioral health spending on a child in the family found to be independently associated with high and extreme family financial burden.[13] In many states, services available through Medicaid are more robust than what are available through commercial or private insurance,[16] in part due to the mandates for coverage of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).[12] Families who are publicly insured are *less likely* to experience high or extreme financial burden compared to families with private insurance.[17]

When children and families are not able to access services through Medicaid due to being privately insured, they are more likely to become involved with more restrictive child- and family-serving systems, like child welfare and juvenile justice, in order to access services through those systems. Landmark reports in 2000[18] and 2003[19] found that families across the country were giving up custody of their children due to difficulty in accessing mental health care for them. Many states use strategies like voluntary placement agreements to reduce the use of custody relinquishment. Even the use of voluntary placement agreements can have negative outcomes, with youth being more likely to be placed in restrictive settings and experience multiple placement moves; the youth and their families are more likely to experience trauma, grief, and diminished decision-making authority, as well as challenges in exiting from care.[12]

Rhode Island Data

In 2019, Rhode Island ranked 19th in the country for the average length of stay for inpatient hospitalizations among children 0-17 for physical and behavioral health reasons (4.2 days).[20] Rhode Island ranked 33rd in the country for the percentage of children ages 12-17 who received needed mental health treatment or counseling in 2023-2024 (83.6%, which was close to the national average of 83.3%).[21] Children in Rhode Island were identified as having a slightly lower predicted probability of having an unmet need for mental health care than the national probability (19th lowest) and close to the national probability for difficulty in accessing mental health care.[15]

NHP[22] (the Medicaid managed care plan that covers children involved with DCYF) reported the following quality measures for children and youth enrolled in their plan in 2024:

- 49.82% of children newly prescribed ADHD medication had a follow-up care visit within 30 days of when the medication was first dispensed and 53.91% had at least three follow-up care visits within a 10-month period, two of which were within 270 days after the initiation phase ended.
- 58.39% of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication had documentation of psychosocial care as first-line treatment.

Additionally, in 2023, 59.7% of children enrolled in Medicaid or CHIP in Rhode Island ages 6-17 who were hospitalized for treatment of mental illness or intentional self-harm received a follow-up visit within 7 days of their discharge from the hospital; 77.5% received a follow-up visit within 30 days of discharge. Both of these figures are above the national median percentages of 44.8% and 70.0% respectively.[23] Similarly, in 2023, 25.3% of youth ages 13-17 who had an emergency department (ED) visit for substance use disorder (SUD) or drug overdose had a follow-up visit within 7 days; 49.3% had a visit within 30 days. Both of those are also higher than the national median values of 21.5% and 33% respectively.[24]

On December 1, 2025, there were 2,087 children open to DCYF. Most of those children were served by the Family Services Unit; 1,248 children were in out-of-home placement. Of the children in out-of-home placement, 25.5% were in residential interventions, which include group homes, semi-independent living, residential treatment centers, and assessment and stabilization centers (it does not include independent living, medical hospital, psychiatric hospital, or absent from care). On December 1, 2025, 30 children in DCYF out-of-home placement were in psychiatric hospitals, the highest number in the past year (although close to the number in hospitals on July 1, 2025). As of December 1, 2025, 70 of the 282 youth in residential interventions were placed out-of-state.[1]

Rhode Island's data suggests a mixed picture, where many figures are slightly better or near the national average or median. Children and families are slightly more likely to gain access to mental health care and more likely to have follow-up care after a hospitalization for treatment of mental illness or intentional self-harm than the national average. They are more likely to have follow up visits after an ED visit for SUD within 30 days. However, Rhode Island is close to the national median for rates of follow-up care after ADHD medication is dispensed and use of psychosocial care as a first-line treatment when prescribing antipsychotic medication. When examining Federal Fiscal Year 2024 data, Rhode Island had the 12th highest rate of children in foster care and the 20th highest rate of children entering foster care.[25]

Focus Population

This section summarizes baseline information about Rhode Island's Consent Decree's Focus Population, using data from the *Baseline Data Report*[1] to describe key characteristics and patterns of system involvement among children who are hospitalized at Bradley Hospital or at serious risk of psychiatric admission. This information provides context for understanding system demand and informs subsequent analysis of service capacity, crisis response, and transition planning.

Baseline Data Report Summary – Inpatient Group

Between January 7, 2024, and June 3, 2025, there were 149 children in the Inpatient Group, defined as having experienced at least one psychiatric admission to Bradley Hospital's acute inpatient unit during that time. Children admitted to Bradley Hospital were predominantly adolescents. Younger children under age 10 and young adults between the ages of 19 and 20 accounted for smaller proportions of admissions. Slightly more than half of admitted children (54%) were identified as male. Forty-three percent of admitted children were identified as white, and 42% were identified as Hispanic, with smaller proportions identified as Black or other racial groups. Most children (70%) resided in Providence County prior to admission, indicating a geographic concentration of inpatient admissions in the state's urban core.

All children in the Inpatient Group had an open DCYF case at the time of admission, with most involved through DCYF's Family Services Unit (FSU) rather than the voluntary Children's Behavioral Health (CBH) Family Navigation Unit (FNU) pathway. Most children (72%) experienced a single inpatient stay during the reporting period; however, over one in four had two or more admissions, reflecting a subset of youth with recurrent or unresolved acute behavioral health needs.

Hospital stays for children in the Focus Population were often lengthy. Among children who had been discharged at the time of reporting, the average length of stay was 38 days, with a median stay of 22 days. While approximately one-third of discharges occurred within two weeks, more than one-quarter involved stays of 45 days or longer. Children who remained hospitalized at the time of data extraction had even longer stays, with an average length of stay of 73 days, underscoring challenges related to discharge planning and access to appropriate step-down services.

Following discharge from Bradley Hospital, children transitioned to a range of living arrangements, often involving high-intensity or congregate care settings. The most common immediate discharge placements were residential facilities (31%), followed by a return to a parent's home (20%) and group homes (16%). Most children (90%) were discharged to placements within Rhode Island. During the follow-up period, a notable proportion remained in or later transitioned to institutional settings, including residential and psychiatric care. As of June 3, 2025, 13% of the Inpatient Group were residing in psychiatric hospitals, indicating continued reliance on institutional levels of care for some youth.

> "When families feel like they are white knuckling it and can't take it anymore, people think that the only option is residential. If everyone thought there was a full array of services, it would look different."

Baseline Data Report Summary – At-Risk Group

In addition to children who were admitted to Bradley Hospital, the Focus Population includes children and youth with open DCYF cases who are deemed to be at serious risk of admission to Bradley Hospital for acute inpatient treatment because they have had three or more ED visits within a 12-month period. For the Baseline Data Report, children met these criteria if they had three or more behavioral health-related ED visits within a twelve-month period between July 7, 2024, and June 3, 2025.

Using this definition, 45 children were identified in the At-Risk Group. This group was predominantly older adolescents and young adults, with 80% ages 16–21. Just over half (51%) were identified as male. Sixty percent were identified as white and 31% as Hispanic. Similar to the Inpatient Group, the At-Risk Group was geographically concentrated, with 73% residing in Providence County at the time of the index event. The majority of children in this group were involved with DCYF through the FSU rather than the voluntary FNU pathway.

Children in the At-Risk Group experienced frequent and repeated ED utilization for behavioral health reasons. Nearly two-thirds (64%) had four or more behavioral health-related ED visits during the reporting period.

Preliminary Observations

Numerous strengths

Interviews with stakeholders and document reviews identified numerous strengths. Many stakeholders reported that the current leadership at DCYF is engaged, communicative, and has shared values and priorities. Others observed that a “strength of the state is that DCYF is working really hard to show up in a way that counts for these young people,” although they went on to note that they are doing so “without the right tools in their toolbelt.” Other stakeholders described DCYF Primary Service Caseworkers as often having strong relationships with the youth they work with, and many individuals noticed increased engagement from DCYF workers and managers in recent years and months. Some stakeholders described a willingness to evolve on the part of both DCYF and Bradley Hospital, with one noting that Bradley Hospital is trying to think outside of the box and find creative approaches.

Many stakeholders described a strong core service array and noted that residential and community-based providers have worked hard to meet the needs of both DCYF and individual children and families. Numerous aspects of the service array were identified as strengths, including MRSS, and providers were seen as having deep expertise in working with children and families over numerous years. One stakeholder noted that there are a lot of clinicians and organizations that are good at delivering quality services for children on the ground.

The review team observed that there was a willingness by stakeholders across sectors to engage in interviews, share data, and provide observations about what is working and what could be improved. Many of the strategies being implemented across EOHHS, including with DCYF, and prioritized approaches are consistent across initiatives and plans, including the Olmstead Plan and Children’s System of Care.

Challenges

The system review identified a set of interconnected challenges that extend beyond the specific issues cited in the Consent Decree (e.g., children having very long lengths of stay in inpatient hospitalizations or experiencing multiple ED visits) and reflect deeper structural, systemic, operational, and family-centered barriers within Rhode Island’s children’s behavioral health system. These challenges affect how families access care, how services are coordinated and delivered, and how decisions are made across public agencies, providers, and the courts. Collectively, they contribute to confusion and stigma for families, fragmented accountability across systems, strained interagency relationships, risk-averse practices that can favor restrictive settings, and inconsistent elevation of youth and family voice. Addressing the challenges outlined below will improve the system for children and families, strengthening coordination, shared accountability, and create a clearer alignment among the policy, practice, and values of the system of care.

> “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.”

Specific challenges will be noted throughout in the report; below are some of the overarching challenges that emerged.

- **Access to children's behavioral health care can be confusing and stigmatizing**. As noted, DCYF is responsible for the children's behavioral health system, child protection and child welfare system, and juvenile probation and services.
    - Even when services can be provided through DCYF outside of the child protection system, it is not always clear to families that they are accessing voluntary services unrelated to the child welfare system. This is particularly challenging for families who have histories with the child protection system. In the first Compliance Report, the Court Monitor noted, "Although there is a different path between voluntary and nonvoluntary engagement with DCYF, the initial entry for children to access behavioral health care is through the Rhode Island's child protection organization. The need to enter through the child protection system is a barrier for children to access the clinical care necessary to address their behavioral health needs" (p.6).[10]
    - Some services have restrictions on them due to limited availability, and families may face barriers to accessing voluntary services if there is any court involvement, making it more likely for them to be involved with the formal child welfare system.
    - One stakeholder noted that families seeking residential treatment for their child without relinquishing custody encounter procedural barriers that can prolong hospitalizations. They observed that it "often keeps the kids in the hospital and in limbo for a long time. It is a significant pain point for the families, kids, and teams working with them."
- **There is fragmentation and a lack of coordination at the individual and system levels**. A foundational principle in systems of care[26] is that there must be a clear locus of accountability for services and outcomes with coordination across providers, settings, and domains. However, Rhode Island has structured the children's behavioral health system and agencies in a way that creates fragmentation and duplication of responsibilities, with everyone and no one being accountable for providing high quality, timely, responsive, and effective services and supports: "Rhode Island's behavioral health system is highly fragmented due to the involvement of many state agencies in behavioral health" (p.82).[4]
    - Within the children's behavioral health system, DCYF, BHDDH, Medicaid, the Rhode Island Department of Health (RIDOH), and NHP all have responsibilities associated with providers, payments, contracting, and oversight. This is in addition to the to-be-expected overlap of some prevention, early intervention, and behavioral health treatment that is provided through the educational system and other public child- and family-serving systems.

"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."

    - It can be confusing for workers, families, and providers to try to navigate to the "right" door to access behavioral health services and supports, even after a child or family has an open case with DCYF: "Services for people with disabilities operate in silos, leading to inefficiencies and gaps in care. There is no overarching statewide structure to ensure services are coordinated" (p.34).[7] Families do not always have access to or *know* what they may have access to in terms of a full array of services in the home and community.

"Rhode Island is too small to have lots of offices with expertise. We need to be nimble and work with each other."

    - During the system review process, it was challenging for the Innovations Institute team to identify which specific unit or division *within* DCYF was responsible for which function or activity, even *after* the units were explained in meetings and interviews and *after* reviewing reports and the organizational chart. This is, in part, due to functional names given to units and divisions that differ from their official titles. This was a common refrain heard from multiple stakeholders.

- **There is lack of trust across many public and private agencies, providers, and organizations**:
    - Multiple stakeholders reported a need for a “reset” on relationships, although some noted relationships have improved over the past year, particularly between DCYF and Bradley Hospital.

    - Some individuals noted historic and sometimes unproductive friction among Court Appointed Special Advocates (CASA), OCA, Bradley Hospital, and DCYF, hindering parties’ ability to achieve shared goals. They described their different roles and how different responsibilities and procedures can lead to some feeling like others are not responding with the necessary sense of urgency.

    - Stakeholders described needing to trust that DCYF and providers will offer the necessary services at the necessary intensity to support children after a hospitalization. They described concern among clinicians, team members, and even family members about what will happen when the child goes home. Some of that originates from situations when children come back into the hospital despite the services that were supposed to be in place in the community. Stakeholders explained that it is “painful to sit with the families who have been in the hospital multiple times and hear that nothing is improving. It is hard to not want to do something different. Everyone is well-intentioned and there are systemic gaps in care. There is not always consistency and it feels very [DCYF] worker-dependent.”

    - Some of the trust issues identified were about a seeming disconnect between the emphasis on reducing residential interventions and increasing home- and community-based services and the focus on developing new residential programs: "When you see that Rhode Island is investing $20-30 million in [the campus that held] St. Mary's, [you] feel despondent about whether families are going to actually get what they need or if we're going to keep warehousing them in different locations to see if that place will do a better job than the last place.”

    - The review team identified repeated conflict between DCYF and one union, which was identified as a barrier that can lead to disruption of work and the inability to focus on priority activities and initiatives.

- **There appears to be an aversion to perceived risk across systems and organizations, which exacerbates other challenges.**

    - There is a perception that children and youth are “safer” when they are in the hospital and that, when a youth is in the hospital, the workers and family feel like they are physically safe. However, one stakeholder explained that hospitalization may just shift the risk from the family, community, and providers onto the child who then has the burden of being off of their developmental trajectory. Another stakeholder commented that, when children are at Bradley, they “are well cared for and get good treatment but go to sleep every night behind a locked door. We are acutely aware of that.”

    - There is a significant concern about youth running away from homes and programs, but the response is frequently to move the youth farther from their homes and communities or into more restrictive settings rather than addressing the needs of the youth:

"We as a system need to do better to stop them from coming into care at all."

        - "We use physical solutions instead of programmatic solutions" and, instead of using creative clinical programming we "just keep ramping up the physical restrictions more and more."
        - "When kids are running away, we are then moving them to a more restrictive setting, which doesn't necessarily actually reduce future risk of running away. Moving a youth away from the community and natural supports won't necessarily minimize the risk of trafficking."
    - There is an emphasis on the use of traditional and medical models, which may be less nimble and may not be designed to specialize and meet the needs of youth and families within their homes and communities.

> "It is great to have these robust hospital-based services, but that means they are the biggest player on the stage."

- **There is a lack of meaningful family and youth engagement and voice at the service delivery and care planning level.**

    - Assessments, clinical records, treatment and discharge plans, and placement referral forms do not consistently elevate the youth and family's goals for themselves, their interests, or their strengths. This was identified in both record reviews and stakeholder interviews. Some stakeholders observed that it may feel like a false choice to ask for input from a youth or family member if there are no real options for them.

    - Families and youth do not always have a clear voice in Family Court. It was explained that youth may be encouraged to write a letter to the Court, but many stakeholders confirmed that it is less common to see youth in Court unless they are older adolescents.

- **The relationship between the Family Court and other partners was identified by multiple stakeholders across public and private agencies as an ongoing challenge.**

    - One stakeholder commented that sometimes "Family Court judges don't know what to do and end up ordering DCYF to place kids or for people to not be picked up or order a child who is inpatient to go take classes outside of the hospital setting." Even though they understood why the Court would issue these orders, they said that this makes it challenging for providers to do their jobs and for DCYF to ensure that children get what they need.

    - Another stakeholder reflected that it is a problem when the Court orders youth into long-term treatment if that is not the recommendation of DCYF and BHDDH based on the youth's assessment.

    - Some stakeholders felt that there is a belief in the Family Court that residential interventions are the be-all, end-all for children with mental health needs.

- **There are overarching challenges with the service array.**
    - There are gaps in the service array generally, with waitlists for some services and confusion regarding how to navigate to services. One stakeholder observed that there are essentially two different behavioral health service arrays (DCYF-contracted and through NHP). They noted that there are not enough effective resources and there is a need to combine them, expand access, and hold all providers to a consistent standard.

  - Providers and families are challenged by a lack of consistency and accountability across providers.
  - There is a lack of intensive interventions, residential and in the community, for specific populations of youth, including youth with aggressive behaviors and/or co-occurring I/DD or substance use treatment needs.

- **There are challenges with the placement referral process.**
  - Many stakeholders described a prioritized use of residential interventions, particularly for youth who are coming from the hospital, rather than consistently working to create solutions to support youth to return to a family setting.
  - The referral process is heavily focused on just finding a placement or a bed for a child, rather than the best fit when a child cannot be supported in a family setting.
  - Information included in the referral cover sheet frequently does not reflect the youth's goals, current treatment needs, or interests.
  - Although the placement referral process requires the supervisor to review the completed Placement Referral packet, multiple DCYF staff members said this does not happen routinely, which may impact the quality and consistency of information included in the referral forms.
  - Providers reported frequently receiving referrals for youth whose needs did not align with the populations of youth they are designed to serve. Some providers described that they would accept (or even feel some pressure to accept) emergency placements that impact the program's ability to deliver treatment interventions as intended within the milieu.
  - There is no aggregate tracking of referrals and reasons for acceptance or rejection. Unless a worker or supervisor enters information into RICHIST, there is no electronic information about which programs have been contacted about accepting a youth nor their reasons for any rejections.

- **Language used across systems is not always consistent with best practices and systems of care values.**
  - Reports, forms, assessments, and notes frequently refer to youth as AWOL. This term, which means "Absent Without Leave" or "Absent Without Official Leave," is a military term and not one that should be applied to children. Rhode Island is often using AWOL instead of "missing," which would be consistent with language in the Preventing Sex Trafficking and Strengthening Families Act (P.L. No. 113-183) and the 2023 U.S. Office of the Inspector General Report on improving reporting of children missing from foster care.[27] The urgency of a missing child is often lacking when a child or youth is considered AWOL. When the language shifts to "missing," it reminds all parties that the individual is a child who is not where they are expected to be and may be in a dangerous situation.
  - Youth and families often are referred to by their needs, diagnoses, history, or challenges, both verbally and in written materials. For example, during a call with providers, DCYF was struggling to identify a provider that would accept some youth with histories of aggressive behaviors. However, when DCYF started describing them based on their interests and preferences (including describing favorite foods and what they like to do in their free time) and not *only* by

their treatment needs, providers quickly responded and started problem-solving about how they might be able to accept the youth into their programs.

- Similarly, referrals and reports often described the living arrangement where a youth is recommended to go instead of describing a youth's treatment needs and the types of interventions and services they would benefit from. For example, a referral might say that the youth requires a residential intervention. However, it would be better to describe that the youth would benefit from a structured living environment that has 24/7 supervision and provides individual and group therapy focusing on addressing past trauma and challenges with attachments.
- In Court, families often were referred to by multiple parties as "mom" and "dad" and not by their names, which can result in less individualized and strengths-based approaches to care and treatment.

"...So many links
So much rust
So much damage
So much distrust...
People have suffered
Families broken
Services missing
Yet many words are spoken
It's time to put feet on plans
made for so long
It's time to correct things that
have gone so wrong...
When we think of the task
And what we must do
Remember the families
Are just like me and YOU!
Hold onto the hope
Don't put it rest
Remember their faces
Let's give it our best—"

Excerpt from *The Room* in Almeida, R. (2025). *Just another Tuesday.* Stillwater River Publications. p.140-141.

DCYF's Processes to Identify Children in the Focus Population (¶21(a))

Assessment of Processes to Identify Children in the Focus Population

Timely identification of children in the Focus Population is critical to supporting effective service planning and decision-making. DCYF staff may learn of a child's admission to Bradley Hospital from the family, residential service provider (if the child was residing out of home), or Bradley Hospital. Bradley Hospital screens for DCYF involvement during intake; however, screening practices may not consistently capture all forms of DCYF involvement. If a youth is entering Bradley Hospital from foster care or a residential setting, they will have the "blue form," which is the medical authorization for treatment. However, if they are coming from a home setting and there is some DCYF involvement, Bradley Hospital may not be aware of that involvement. Current Bradley Hospital's intake forms ask about guardianship and parental rights, but that is different from custody. DCYF may have temporary custody or "care, custody, and control" of the youth. At an arraignment, a child may be placed in the temporary custody of DCYF while remaining at home, resulting in shared custody between DCYF and the parent(s). This may not be clear when a child enters Bradly Hospital, and they may not know to notify DCYF.

Once DCYF staff identify a youth's admission to Bradley Hospital, they enter the information into RICHIST (DCYF's electronic health record), where it is reflected in internal dashboards used for leadership review and oversight. The CBH team at DCYF also maintains supplemental tracking to keep leadership informed. The newly established Transition Coordinators, who are part of the CBH team, are expected to further support timely child-level updates during hospitalization and discharge planning.

Similarly, DCYF staff must first become aware of a child's ED visit—typically through the family or another external source—before the visit can be documented. ED visits are entered into RICHIST with start and end dates, and utilization data are extracted weekly into spreadsheets that include both aggregate counts and individual-level information. These weekly reports are shared with DCYF FSU and CSBH administrators to monitor utilization and identify opportunities for intervention. Recently, DCYF established a process where youth with two or more ED visits are flagged to prompt focused review and intervention aimed at preventing a third ED visit. When these youth are identified, a facilitated case review is completed with the worker, supervisor, and senior case work supervisor, but not necessarily with a family or at a team meeting. The worker may bring options back to the family for their consideration.

The ED data are also aggregated into monthly trend reports to support system-level monitoring. Recent data indicate a decline in the number of youth with two or more and three or more ED visits since February 2025. The November 2025 Court Monitor's Report noted that "systems to automatically track this data are not currently in place but will be developed as part of the implementation Plan. In the interim, DCYF will track this data through internal reports." The report noted that the State is working on a complete accounting of the population and will be engaging in additional…data linking.[10]

Monitoring inpatient status and ED utilization relies on timely and accurate data entry into RICHIST; variability in the timing or completeness of entries can affect the reliability of reporting. The new data system replacing RICHIST will be implemented in fall 2027 and is expected to improve data management and reporting, but it will not, on its own, address gaps in identification that depend on timely communication and thorough intake practices. Information cannot be recorded if it is not known to DCYF staff, which further limits the completeness of tracking. Communication gaps between Bradley Hospital and DCYF staff may also delay identification of DCYF-involved children at admission.

Although NHP is responsible for paying for hospitalizations and ED visits for children enrolled in their plan, they no longer authorize care for in-network services: effective January 1, 2025, in-network behavioral health services no longer require prior authorization or continuing review, and providers are responsible for determining medical necessity. NHP runs weekly reports to identify enrolled children experiencing inpatient hospitalizations, but NHP's involvement varies by child depending on the services needed. The process may be slightly different for older youth if they are 18-21 years old and are seen in the ED or hospitalized but not involved with DCYF; in those instances, NHP may partner with the hospital and BHDDH to identify services in the community.

Recommendations to Strengthen Identification of 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:
    - 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.

DCYF's discharge and transition planning once a child in the Focus Population is admitted to Bradley Hospital (¶21(b))

Assessment of Discharge and Transition Planning from Bradley Hospital

When a child in the Focus Population is admitted to Bradley Hospital, the Consent Decree requires DCYF to ensure timely discharge to the most integrated setting appropriate to the child's needs, with necessary community-based services and supports in place. Discharge and transition planning is therefore a critical intervention point for preventing unnecessarily prolonged hospitalization and reducing reliance on institutional care.

Stakeholders described discharge planning for youth with prolonged hospital stays as highly resource-intensive and dependent on factors that extend beyond the control of hospital staff or individual workers. While Bradley Hospital conducts clinical assessments and determines medical readiness for discharge, successful transitions require coordinated action across DCYF, service providers, and other system partners to secure appropriate community-based services or residential placements. Stakeholders consistently noted that gaps in service availability, placement options, and system responsiveness create misalignment between clinical readiness and the system's ability to support discharge.

Within this context, stakeholders characterized discharge planning as driven by urgency and system constraints rather than early, coordinated decision-making. As a result, 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. These dynamics contribute to delays, repeated referral cycles, and prolonged hospitalization once children are clinically ready for discharge.

Stakeholders raised concerns about DCYF referral practices, including a tendency to "cast a wide net" when making referrals for placements or services in an effort to secure *any* available option. While this approach reflects pressure to move children out of the hospital, stakeholders noted that insufficiently individualized referrals often result in placement denials and repeated outreach to providers. As documented in prior reviews, these practices can prolong hospitalization rather than expedite transition.[9]

More specifically, the following factors were identified by stakeholders and from record reviews as impacting timely and effective discharge planning for DCYF-involved youth admitted to Bradley Hospital:

Service Array Availability, Confidence, and Utilization

- There is often a misalignment between a child's clinical readiness for discharge and the availability of appropriate community-based services, placements, and supports.
- There is a limited capacity of intensive community-based services and therapeutic foster care placements, particularly for youth with high acuity and/or co-occurring needs (including SUD and I/DD).
- Many stakeholders have concerns about the reliability of community-based services to manage risk, ensure safety, and prevent rehospitalization.
- NHP may be involved in discharge planning, but that depends on outreach to NHP and the preferred or anticipated living arrangement for the youth. If identified, some youth could be receiving services through the NHP complex case management program and, if the youth are not being discharged to a DCYF-contracted residential intervention, NHP can accept a referral and support the case management process.
- Youth with long lengths of stay in residential interventions often have worse outcomes, and their extended stays can limit access for other youth who could otherwise transition from the hospital into the residential intervention when it is the least restrictive and most appropriate setting.
- There are specific challenges in identifying appropriate community-based and residential interventions and services for some populations of youth, including:
    - Youth with co-occurring mental health and SUD treatment needs.
    - Youth with a history of concerning sexual behaviors.
    - Youth with current or history of high levels of aggressive behaviors.
    - Intensive residential interventions providing treatment services for adolescent females.

Discharge Planning Processes and Decision-Making

- Transition planning is not consistently initiated early in hospitalization.
- There is inconsistency in the approach to discharge planning and whether youth are "pushed out" right away or there is a decision to "wait until the next Court hearing."
- There is a lack of clarity about who is responsible to lead the discharge planning: the hospital or DCYF.

- There is a sense of reluctance by DCYF to begin discharge planning before clinical readiness is established, limiting opportunities to proactively address service, placement, or court-related barriers.

- There is no independent continuing review process for medical necessity. Although current processes are reported to be working well, they rely on hospitals to determine whether a youth continues to meet medical necessity. When a youth remains hospitalized after no longer meeting medical necessity, approval is required for administrative bed days, which are covered by NHP as part of their per-member-per-month rate.

- Multiple, parallel meetings are used to support discharge planning without a single forum responsible for resolving barriers, contributing to stalled decision-making when viable options are limited.

- There is limited and inconsistent inclusion of youth and family voice in discharge and transition planning, with key decisions about readiness, services, and placements frequently occurring without youth or caregiver participation, including meaningful interviews and opportunities to visit programs (in-person or virtually). Youth have told the Court Monitor that the hospitalization is very helpful for the first week or two but then, when they feel ready to go home, they "kept me there but didn't give me any new help."

- Internal DCYF structural complexity and handoffs across units (e.g., CBH, FSU) result in inconsistent approaches to service planning and unclear decision-making authority. Additionally, when a child is voluntarily in a hospital or residential setting, CBH facilitates access to the residential intervention and maintains monthly contact with the child but does not have any responsibility for creating or managing a treatment or service plan. When FSU is involved, they create and manage a treatment plan.

- Ongoing Court involvement often seems to constrain flexibility, with orders sometimes specifying placements or services misaligned with clinical needs or system availability. Additionally, there is a tension between individualized clinical recommendations and what can be operationalized within existing system constraints, resulting in discharge plans shaped by availability rather than need.

- There is a perception of a residential intervention as a more stable or defensible option, narrowing the range of discharge pathways considered even when community-based services may be clinically appropriate. Additionally, there is no external line of sight or clinical oversight for residential placements, and NHP is not involved in reviewing appropriateness of the DCYF-contracted residential interventions for individual youth against defined criteria.

- It is important for DCYF frontline staff to be aware of the roles and responsibilities of the NHP case managers. Sometimes there is a sense of pressure on NHP to create a service for a youth, but they may not be able to identify a provider who is willing to offer it.

DCYF Referral Practices and Information Quality

- DCYF's current placement-focused referral practices functionally prioritize securing any available option over identifying the most clinically appropriate, least restrictive services, even if that is not what is outlined in policy.

- The inconsistent quality, completeness, and timeliness of referral information limits providers' ability to assess fit and readiness (see notes above regarding the placement referral forms and process).

- There are differences in who is responsible for developing and submitting the referrals across DCYF and, at times, transitions among units within DCYF that can delay processes.

- Requirements for DCYF to provide comprehensive and historical assessments and medical records as part of the placement referral process can delay opportunities to share referrals in a timely manner.

Taken together, stakeholders emphasized that effective discharge and transition planning depends not only on hospital-based processes but also on the broader service system's ability to respond quickly, coordinate across agencies, and resolve barriers that emerge during hospitalization. Without these supports, discharge planning risks reinforcing the very institutional reliance the Consent Decree seeks to eliminate.

Transition Coordinator

The Consent Decree establishes a Transition Coordinator role as required in the Consent Decree to facilitate discharge planning, identify and address barriers to transition, and coordinate across systems during hospitalization. In response to the urgent needs of children experiencing extended lengths of stay at Bradley Hospital, DCYF initiated implementation of the Transition Coordinator Unit prior to the completion of the full Implementation Plan. This early action reflects a proactive commitment to improving transition outcomes while formal structures continue to be finalized.

At the time of this review, staff had been hired into Transition Coordinator positions, and substantial foundational work had been completed or initiated to support both unit implementation and leadership readiness. While some procedures, workflows, and role definitions remain under development, the stakeholders have reported early benefits from this participation, particularly improved communication, coordination, and information sharing. Additionally, documents are under development to support the implementation of these positions, including a DCYF Youth Transition Plan Tool and Instructions, a related Plan of Care, a revised Crisis and Safety Plan, and numerous tools and communications materials. These materials collectively support role clarity, practice consistency, and alignment with Consent Decree expectations, while also serving as practical tools for onboarding and cross-system communication. Additionally, the leadership of the transition coordinator unit completed the full track of the FOCUS Intermediate Care Coordinator Training Model, with transition coordinators scheduled to begin FOCUS training in early 2026. While these positions generally are seen as a positive development, particularly in strengthening communication with Bradley Hospital, formal workflows, procedures, and role definitions are still evolving and there are concerns about the role as an added layer rather than a facilitative role.

Several stakeholders noted early benefits associated with the Transition Coordinator supervisor's participation in weekly meetings at Bradley Hospital, particularly improvements in communication and information sharing. At the same time, stakeholders described ongoing uncertainty regarding the scope, authority, and integration of the Transition Coordinator role within the broader discharge and transition planning process. In some cases, the role was perceived as an additional layer rather than a central organizing function.

Recommendations Regarding 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.

DCYF's Service and Care Coordination for Children in the Focus Population(¶21(c))

Assessment of DCYF's Service and Care Coordination for Children in the Focus Population

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. In stakeholder interviews, most agreed that the absence of such a child- and family-driven team planning model represents a critical gap in the current system.

Existing Approaches

> "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."

DCYF case managers coordinate services for children involved in the child welfare system. This coordination includes placement planning, service referrals, and oversight tied to safety, permanency, and court requirements. NHP provides limited care management services focused on service authorization, utilization management, and limited coordination of covered behavioral health services. Additionally, many providers offer some form of case management as part of their service delivery.

Family Care Community Partnerships (FCCPs) are a DCYF-contracted service that offers voluntary, prevention-oriented, comprehensive supports to assist families with system navigation, early intervention, and stabilization for lower to moderate levels of need. DCYF has made sustained investments in FCCPs as its primary community-based prevention strategy, positioning FCCPs as an accessible entry point for families experiencing emerging behavioral, social, or system-related challenges.

FCCPs play an important role in crisis mitigation, connection to community resources, and support for families seeking to address concerns before deeper system involvement is required. According to DCYF's FCCP Annual Report covering Fiscal Years 2020 through 2022,[28] the median length of stay for families receiving FCCP services decreased from 88 to 78 days. The report also indicated that longer lengths of stay, referrals originating from DCYF, and families closing without meeting their goals were associated with a higher likelihood of subsequent DCYF involvement within 24 months. Importantly, FCCPs are designed as a prevention and early intervention resource and are not intended to provide the level of clinical intensity required by many children in the Focus Population, particularly those with high acuity, co-occurring behavioral health and substance use needs, or repeated crisis involvement.

Additionally, Certified Community Behavioral Health Clinics (CCBHCs, discussed more below), have a responsibility to provide care coordination. However, nationally and in Rhode Island, some CCHBCs are struggling to provide effective services to children and families, in part because of the requirements to provide all service lines across the entire lifespan.

These are just some of the approaches that exist to provide elements of coordination, but which are time-limited, program-specific, and governed by differing mandates and accountability structures. They do not offer consistent, intensive, cross-system care coordination for children with complex behavioral health needs.

System Challenges

DCYF and BHDDH operate largely separate and unaligned systems for children's mental health and SUD services, complicating planning for children with co-occurring needs and contributing to fragmented services, duplicative processes, and unclear accountability. In the absence of shared planning structures and clearly defined cross-system roles, families and providers are often left to navigate multiple systems independently, increasing the risk of service disruption and poor outcomes.

A lack of clarity about the children’s behavioral health service array access further limits effective coordination. As noted above, stakeholders described inconsistent understanding of available services, eligibility criteria, referral pathways, and points of access across agencies and providers. Families and caregivers may struggle to understand how to navigate the system, particularly when services are administered by multiple entities with differing rules and requirements. Providers also described confusion knowing how to identify appropriate and available options for children with complex needs. This was particularly true when there were providers experiencing workforce challenges, waitlists for existing services, or challenges in accessing services based on geography.

> “In terms of services, a lot of it has to do with knowing how to access them.”

For children in the Focus Population, inconsistent communication and information-sharing practices across agencies further compound these access challenges. Information related to clinical needs, service history, family circumstances, and legal requirements does not move consistently or in a standardized manner, contributing to delays in service initiation, repeated assessments, and confusion regarding roles and expectations. In some instances, adults are meeting and making decisions for a youth they may not have even met. Additionally, providers and families report that youth and families sometimes are offered the right services, but at what seems to be the wrong time—when the family is no able to engage or when multiple services are being offered simultaneously. This can result in families being less likely to engage and complete treatment. This contributes to frustration among youth, families, and providers.

> “The problem is there is lots of good care delivered at the wrong time, including when the youth aren't ready for the care.

For children in the Focus Population, stakeholders emphasized that youth and family voice is not consistently or meaningfully integrated into service planning and decision-making across systems. Current practices were described as falling short of a consistent, family-centered approach. Across settings, stakeholders described a broader pattern in which youth and families experience service planning and decision-making as something that happens *to* them rather than *with* them. Even when youth or caregivers articulate preferences, those perspectives may have limited influence on outcomes due to system constraints, timing, or the structure of decision-making forums. Over time, this dynamic can undermine engagement, trust, and shared ownership of decisions, particularly for youth who have experienced repeated system involvement.

Coordination of education needs and services for youth in or recommended for residential intervention can be complicated and further illustrates these challenges. When youth remain at Bradley Hospital, they received educational services from LearnWell, the contracted educational provider at Bradley Hospital, which coordinates with local education agencies to obtain assigned coursework. However, youth typically receive fewer than two hours per day of educational services because the hospital is not designed for long-term care and the primary goal while a youth is hospitalized is to stabilize them; one stakeholder noted that too much schoolwork while being in the hospital is not helpful because the youth is trying to prioritize feeling okay and may not be in the right headspace for learning. This becomes a significant issue the longer that youth are in the hospital. There is a need for educational goals and services to be prioritized and coordinated for youth in the Focus Population while at Bradley Hospital, particularly after their immediate needs have stabilized, as well as after they are discharged.

In addition to these system-wide challenges, stakeholders identified several ICC-specific considerations informed by prior implementation experiences and early planning efforts. Stakeholders noted that Rhode Island previously implemented Wraparound, but that the model was not sustained over time. This history continues to shape stakeholder perspectives and has contributed to caution regarding new care coordination initiatives. While there is general support for renewed investment in ICC, stakeholders raised concerns about how a new model would be structured, funded, and sustained. In particular, some questioned the viability of establishing an independent agency whose sole service stream would be ICC, citing risks related to financial sustainability, workforce stability, and integration with existing service systems. Other stakeholders observed that an independent, conflict-free care management entity (CME), one that does not provide any direct services, is the only viable option to implement and sustain ICC.

Planning Activities to Date

In August 2025, Innovations Institute and the National Wraparound Implementation Center (NWIC) presented on ICC models to the Rhode Island Governor's Office, EOHHS, BHDDH, and DCYF. An abbreviated version of this presentation was provided to the Rhode Island Coalition for Children and Families in December 2025. This presentation[29] summarized national best practices and research evidence regarding implementation of ICC using Wraparound, including the following key findings:

- Wraparound is an evidence-based model for care coordination that leverages child and family teams (CFT) to support youth with complex needs and their families, shown to demonstrate more positive effects in outcomes and with lower treatment costs compared to treatment as usual.[30]
-
- Well-implemented Wraparound reduces costs and improves outcomes but requires multiple areas of intentional and sustainable system support, including through workforce development, implementation oversight, financing and infrastructure, and continuous quality improvement.[29,30,31]

- The two primary approaches to implementing ICC with Wraparound across the country have been through standalone, conflict-free CMEs/care coordination entities or through a direct service agency.
    - While there are benefits to both approaches, research and field experience indicate that standalone, conflict-free CMEs yield stronger fidelity to Wraparound principles, higher family satisfaction, and improved long-term outcomes.[31]
    - Across both structures, Wraparound takes longer to implement than other cross-system interventions. However, it was faster when implemented through a CME than through a community mental health center or direct service agency. In fact, community mental health agencies took significantly longer to complete most stages of implementation and previous research found that implementation quality varies across these structures, with mean fidelity scores consistently higher in standalone CMEs.[31]

As noted above, the Transition Coordinators are being trained on FOCUS, an intermediate care coordination model to support the transition planning activities. This training and support is ongoing.

Additionally, during fall 2025, DCYF and partners participated in a site visit to New Jersey to learn more about their single point of access[vi] (an administrative service organization called PerformCare), independent care management organizations providing ICC with Wraparound, MRSS, and other aspects of the service array. New Jersey was selected because of its more than 20 years of experience implementing these structures with improved outcomes for children and families.[32]

[vi] A single point of access or single point of entry is a structure that serves as an entry point for triage, referrals, assessments, and access to services, which can include MRSS, ICC, and other services and supports.

New Jersey's system structures, along with the technical assistance provided by Innovations Institute regarding single points of access and CMEs, are consistent with the recommended Rhode Island Children's Behavioral Health System of Care depicted in the 2022 *Rhode Island Behavioral Health System of Care Plan for Children and Youth* (p.36; see Figure 2):[5]

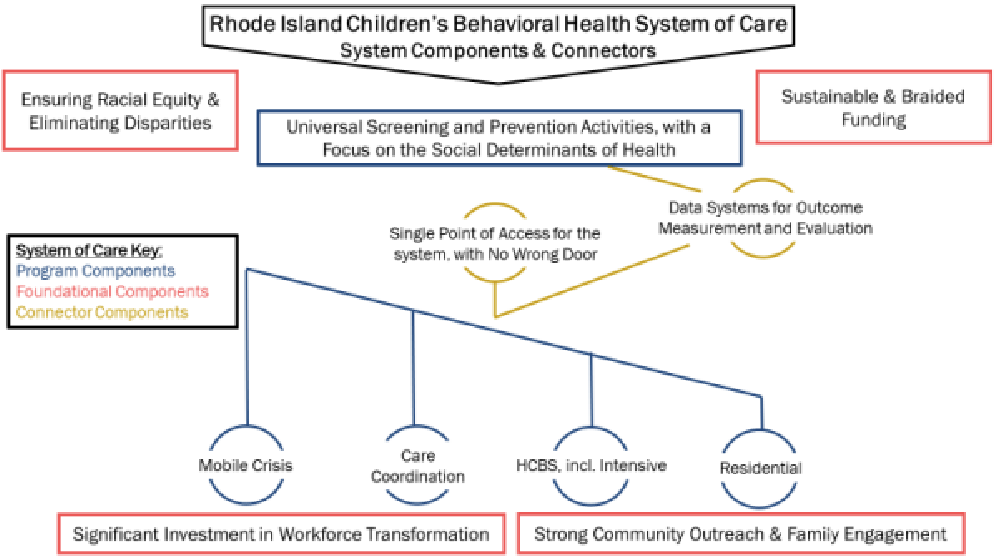

Figure 2: System of Care Visual Representation from the Rhode Island Behavioral Health System of Care for Children and Youth (Figure 17, p.36)

Recommendations for 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.[29]

- 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.

The capacity and sufficiency of Community-Based Services available to children in the Focus Population (¶21(d))

Assessment of the capacity and sufficiency of Community-Based Services

The Consent Decree places significant emphasis on the availability, sufficiency, and functioning of community-based behavioral health services as the primary mechanism for preventing unnecessary psychiatric hospitalization and supporting timely discharge for children in the Focus Population. For these children—many of whom have high acuity, co-occurring behavioral health and SUD needs, I/DD service needs, and involvement across multiple systems—the effectiveness of the service array is central to the State's ability to comply with the Decree's requirements and achieve durable community-based outcomes.

Rhode Island maintains a broad set of community-based services across multiple funding streams and agencies. The subsections below examine key components of the service continuum—including CCBHCs, intensive in-home services, SUD treatment, and other community-based supports—to identify strengths, gaps, and system-level constraints that affect the State's ability to functionally substitute community-based services for institutional care, as required by the Consent Decree. *(Note: MRSS and crisis services and therapeutic foster care are explored separately below.)*

The Consent Decree defines community-based services as "behavioral health services provided in a child's family home and in the community" (¶10, ¶63). These services are intended to prevent unnecessary psychiatric hospitalization, support timely discharge from inpatient care, and enable children to remain safely in their homes and communities. Community-based services identified in the Consent Decree include intensive in-home services, SUD treatment, crisis response and stabilization, respite, family peer support, and psychiatric services and medication management.

The Consent Decree outlines a series of requirements related to the availability, quality, and accessibility of community-based services for children in the Focus Population. The State is responsible for ensuring that children have timely access to services of sufficient intensity that are child- and family-centered, trauma-informed, and individualized to the strengths and needs of the child and family. Children with I/DD service needs must receive services from providers with personnel who are qualified and trained to work with this population. The State must also ensure that community-based services are available statewide, accessible during hours that meet the needs of children and families, and supported by transportation when services are not delivered in the home. In addition, the State is responsible for ensuring that families receive accurate, timely, and accessible information about available community-based services and how to access them.

Generally speaking, Rhode Island maintains a broad array of community-based behavioral health services for children, including services funded directly by DCYF as well as services supported through insurance. However, the breadth of services reflected in publicly available resource guides and service-related websites does not necessarily translate into predictable or timely access for children in the Focus Population. Limitations in available and centralized information, fragmented eligibility and referral pathways, and variability in service availability across funding streams complicate the ability for families and providers to identify appropriate services and access them when needs escalate, contributing to delays in service initiation and continued reliance on higher levels of care. These issues also make it challenging to assess the capacity and sufficient of the service array.

Across stakeholder interviews, several service array strengths were identified, including a network of innovative and long-standing providers. At the same time, stakeholders repeatedly noted that a number of service types are inadequate in terms of capacity and sufficiency, including adolescent SUD treatment (both outpatient and residential), services for children with co-occurring mental health and substance use treatment needs, services for children who experienced trafficking, youth with histories of concerning sexual behaviors, youth with current or histories of aggressive behaviors, and community-based services for children with I/DD. There were also some challenges with accessing services for youth and families who speak particular languages, including a shortage of clinicians and providers who speak Spanish and limited availability of interpreters for languages such as K’iche’, creating barriers to engagement, assessment, and effective service delivery for some families.

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are state-certified outpatient behavioral health providers required to deliver a comprehensive array of mental health and substance use services to all individuals, regardless of age or insurance status. In Rhode Island, eight regionally based CCBHCs collectively provide statewide coverage. Many of the core community-based services required under the Consent Decree are also required components of the CCBHC model. CCBHCs deliver services across clinic, home, and community settings, including 24/7 mobile crisis response; MRSS; outpatient mental health and substance use treatment; psychiatry and medication management; intensive community- and home-based services for children and transition-aged youth; care coordination and case management; and peer and family support services.[33]

Rhode Island launched full implementation of its CCBHC initiative in October 2024. All eight CCBHCs are long-standing community behavioral health providers, many of which delivered comparable services prior to certification. However, the CCBHC model represents a significant shift in payment structure, reporting expectations, and system role, including requirements to provide a series of services across the full lifespan. Stakeholders shared that Rhode Island is shifting its structure and payment for the provision of mobile crisis, and CCBHCs have been utilizing their rate to pay for all services except MRSS for children. (See below for more information on MRSS). While CCBHC-required service lines align with the Consent Decree, that does not mean that all CCBHCs will be implementing models aligned with the needs of the Focus Population nor that the services provided will be the most effective for that population. While this is a critical and growing part of Rhode Island's service array, more needs to be done to understand exactly how the services provided through the CCBHCs complement other services and supports.

Intensive In-Home Services

The Consent Decree identifies a broad array of in-home services, including in-home mental health services; in-home family stabilization and prevention; parent skill-building; youth support; in-home developmental disability services; foster and kinship home support; in-home individual and family therapy; behavioral services; and therapeutic mentoring. It requires the State to ensure that Intensive In-Home Services are available with sufficient capacity and intensity to meet each child's individualized needs, are delivered in the child's home or other community settings at times that are responsive to families, and are aligned with the child's service plan and discharge/transition needs to prevent unnecessary hospitalization and support timely step-down.

DCYF funds a wide continuum of home- and community-based services intended to stabilize children and families, prevent unnecessary placement or hospitalization, and support reunification, permanency, and successful transitions from higher levels of care. These services include intensive in-home clinical interventions, family stabilization and preservation services, crisis response and short-term stabilization, parent skill-building and caregiver supports, kinship and foster care stabilization services, supervised visitation, and transitional and aftercare supports for youth stepping down from congregate care or juvenile justice settings (See Table 1).

Per the Baseline Data Report, DCYF contracts for 65 home-based programs delivered by community providers statewide.[1] Services are provided in family homes, community settings, and foster homes, and many are delivered on a statewide basis. In 2024, DCYF reprocured its home-based services, resulting in an expanded number of contracted programs and increased authorized capacity, with some programs newly introduced and others discontinued or restructured to reflect evolving population needs.[1] The service array includes a subset of well-supported, evidence-based models that qualify under the Family First Prevention Services Act (FFPSA) framework (e.g., Intercept, Family Centered Treatment, Functional Family Therapy). Collectively, these services provide a strong foundation for preventing unnecessary out-of-home placement, supporting reunification, and stabilizing children with significant behavioral health needs in family settings. Service capacities have fluctuated over time due to changes in population needs, staffing availability, and ramp-up periods for newly awarded contracts.

The Baseline Data Report shows capacity, census, and utilization for DCYF-funded home-based services at several points in time, consistent with reporting requirements. For several programs, average census levels fall below contracted capacity, suggesting some services have the ability to absorb additional referrals (if well-matched to program criteria and timing). However, these data are not presented in a manner that enables clear assessment of whether in-home services are sufficient across the continuum. In particular, the data

- are not consistently aggregated by service type or level of intensity;
- do not distinguish between authorized and staffed capacity;
- do not capture referral-to-service timelines, waitlists, service intensity (e.g., hours per week), duration, treatment model fidelity, or outcomes; and
- do not clarify how eligibility criteria or referral practices may affect utilization patterns for specific service types.

As a result, while the Baseline Data Report provides important descriptive information about the home-based service array, additional data and analysis are needed to determine whether in-home services are available at sufficient scale, intensity, and timeliness to function as a reliable alternative to psychiatric hospitalization and to support timely discharge, as required by the Consent Decree. Many DCYF-funded in-home services are also oriented toward child welfare objectives—such as placement stability, reunification, and permanency—which may further shape utilization patterns and limit availability for some children in the Focus Population.

In addition to DCYF-funded services, children may access outpatient and community-based behavioral health services through insurance via CCBHCs, schools, and other providers. Navigating this broader service landscape is often challenging. Stakeholders described difficulty understanding what services exist, where they are available, who is eligible, and how to access them, with confusion regarding eligibility criteria, referral pathways, and points of access contributing to delays in service initiation. These access challenges are reflected in the *Children in Crisis Can't Wait* report, which identifies insufficient availability of services for children with acute behavioral health needs, long waitlists driven in part by workforce shortages, geographic barriers, policy and equity barriers, and frequent mismatches between children's level of need and the intensity of services available in the community.[6]

Stakeholders identified some specific services that they viewed as effective and valuable to the service array. In particular, several stakeholders highlighted the DCYF-funded Youth Villages Intercept program—particularly its 24/7 crisis response and intensive in-home support—as an effective model of community-based service delivery. Stakeholders also cited other DCYF-funded stabilization programs, including NAFI's Rapid Crisis Stabilization (RCS) and Tides Family Services' Preserving Family Networks (PFN), and emphasized the need to expand services with extended hours, rapid response, and sufficient intensity to better support families in managing crises at home.

Table 1: DCYF Home-Based Service Types and Programs

Service Type	Programs	
Mental Health and Behavioral Services	Brief Strategic Family Therapy (BSFT) Family Centered Treatment (FCT) Family Centered Treatment Recovery (FCT-SAR) Functional Family Therapy (FFT) Functional Family Therapy - Gang (FFT-G) Intensive Care Dialectical Behavior Therapy (IC-DBT) Intensive In-Home Child & Adolescent Psychiatric Services (IICAPS) Multisystemic Therapy (MST) Multisystemic Therapy - Problem Sexual Behavior (MST-PSB)	Parenting with Love and Limits (PLL) Preserving Families Network (PFN) Preserving Families Network Lite (PFN Lite) Rapid Crisis Stabilization (RCS) Supporting Teens and Adults At-Risk (STAAR) Teen Assertive Community Team (TACT) Trauma Systems Therapy - Community Based (TST-CB) Youth Advocate Program (YAP) Youth Villages - Intercept (YV Intercept)
Family Stabilization and Prevention Services	Believe in Making Results (BMR) Commercial Sexual Exploitation of Children Mentoring Program (CSEC) Community Health Team (CHT) Credible Messenger (CM) Enhanced Family Support Services (EFSS) Family Stabilization Program (FSP) Familias Unidas Family Preservation Program (FPP) Homebuilders Outreach Program Parent and Family Empowerment Program (PFEP)	Parents and Children Together (PACT) Reunification Services (RS) Strong African American Families (SAAF) Supporting Adoptive and Foster Families Everywhere (SAFFE) Supporting Teens and Adults At-Risk (STAR) Therapeutic Day Care Support (TDCS) Thriving Together (TT) Trauma Treatment, Evaluation, Assessment, and Management (TTEAM) Youth Transition Center (YTC)

Parent Skill Building Services	Best Start Caring Dads Parent Child Interactive Therapy (PCIT)	Positive Parenting Program (PPP) SafeCare Strengthening Families Together (SFT)
Kinship, Foster Care, and Adoption Services	Care Coordination Kinship Services (CCKS) Children's Mobile Crisis Response (CMCR-FC) Family Stabilization Program - Foster Kinship (FSP-FK) Foster Care Support Services (FCSS)	Functional Family Therapy - Therapeutic Case Management (FFT-TCM) Kinship CARES (KC) Safe Families (SAFE) Supporting Kinship Foster Families (SKFF)
Family Visitation	Family Time (FT) Family Visitation Center (FVC) Family Visitation Center Parents w/ Cognitive Delays (FVC-DD) Nurturing Early Connections (NEC)	Nurturing Early Connections Parents w/ Cognitive Delays (NEC-DD) Trauma Systems Therapy Family Coaching and Visitation (FCV) Visitation - Families Together
Aftercare and Transitional Services	Aftercare (Aftercare) Supportive Apartment Service Aftercare (SAS Aftercare)	Teen Focus (Teen Focus) Therapeutic Treatment Program Aftercare (TTP Aftercare)

Source: Rhode Island Department of Children, Youth, and Families. (2025). *Baseline data report*.[1]Error! Bookmark not defined.

Substance Use Disorder Treatment

SUD treatment for youth in Rhode Island is overseen and financed by multiple state agencies, with responsibilities distributed across behavioral health, Medicaid, public health, and child welfare systems. BHDDH serves as the lead agency for SUD system planning, licensing, and oversight, while Medicaid is the primary payer for most youth SUD services. RIDOH plays a public health role related to prevention, surveillance, and the State's opioid response.

DCYF does not serve as the lead agency for youth SUD services but plays a critical operational role as a referral source and payer of last resort for children involved with the agency. While DCYF does not provide SUD treatment directly, the agency funds a range of home-based and family-focused services that address substance use as a contributing factor to family instability and are often delivered alongside or in advance of formal SUD treatment. Stakeholders observed that, while it may be more straightforward with adults, youth with SUD treatment needs typically have mental health treatment needs, requiring planning and service delivery to be integrated. The OCA Child Fatality Review Panel Report[9] found that "the coordination between DCYF and BHDDH is critical to appropriate planning for youth and families whose needs include substance use treatment. DCYF's involvement in developing adolescent substance use treatment ensures that the approach is appropriate for this population" (p.53).

There is no single point of access for youth SUD services, and families and system partners must often navigate multiple agencies, funding streams, and eligibility requirements to secure care. Publicly available information, including BHDDH's online list of licensed substance use treatment providers,[34] does not clearly indicate whether programs serve adolescents, further hindering access and contributing to delays in service initiation.

Stakeholders consistently identified youth SUD treatment—both community-based and residential—as a significant gap in Rhode Island's behavioral health service continuum. Outpatient options for adolescents were described as limited, with a particular lack of developmentally appropriate, adolescent-specific programming. At the same time, BHDDH has supported implementation of a youth-focused substance use intervention—the Seven Challenges Program, a counseling model for youth and young adults ages 12–25 with substance use and co-occurring disorders that can be delivered in schools, homes, outpatient settings, community health sites, and group homes.[35] At the time of this review, Seven Challenges was implemented in Cranston, Coventry, and Providence.[36]

CCBHCs are also implementing Youth Assertive Community Treatment (ACT) for transition-aged youth.[37] However, stakeholders reported limited availability of recovery-oriented supports for adolescents, including ongoing recovery services and peer- and family-based supports. Engagement of adolescents in SUD treatment is also a challenge, particularly in the absence of developmentally tailored, youth-specific programming and recovery supports.

In-state residential SUD treatment capacity for youth is limited, which can create pressures on other systems and result in youth receiving treatment in settings that may not be most appropriate to their needs. The Bradley Center currently operates the State's only co-occurring disorders unit for children, with eight beds. BHDDH has recently procured additional residential capacity through two providers, including a 10-bed unit for males and a 6–8-bed unit for females, which are expected to become operational within the next year. Until these programs are fully implemented, limited in-state capacity continues to restrict access for youth with higher-acuity SUD treatment needs. It is also unclear how much capacity these programs will have to provide co-occurring mental health and SUD treatment services. The OCA's review of fatalities and near fatalities identified that Assessment and Stabilization Centers are used repeatedly as interim placements, with youth often cycling in and out of these centers, hospitals, and group homes.[9]

As a result of these capacity constraints, youth with significant substance use and co-occurring behavioral health needs are frequently referred to out-of-state residential placements. Stakeholders reported that out-of-state placement disrupts family and community connections, complicates care coordination, and creates challenges for discharge planning and continuity of care upon return to Rhode Island. Stakeholders also identified persistent system-level challenges affecting youth SUD service delivery, including waitlists, workforce shortages, and limited data on service utilization and outcomes. The lack of consistent, systemwide data limits the State's ability to assess service sufficiency, monitor outcomes, and strategically plan for expansion of youth substance use treatment services. Collectively, these factors constrain the effectiveness of SUD services as a component of the community-based behavioral health continuum and undermine the State's ability to prevent unnecessary psychiatric hospitalization and support timely, sustainable discharge for children in the Focus Population.

Other Community-Based Services

The following section outlines findings related to other key services: respite care, family peer support, psychiatric services and medication management, and other behavioral health services.

Respite. Respite services are intended to provide short-term relief to caregivers, support family stability, and prevent crisis escalation and placement disruption. Respite services were mentioned in a limited context during stakeholder discussions. Some stakeholders emphasized a broader need for respite as a support for families managing children with significant behavioral health needs, regardless of whether they are biological, relative, fictive kin, or other foster families. One noted that even a few hours of respite care can be helpful. Beyond these examples, stakeholders did not describe respite as a broadly available or consistently accessible support across the community-based service continuum.

Family Peer Support. Family peer support is widely recognized in children's behavioral health systems as an effective strategy to promote family engagement, improve system navigation, and support stabilization—particularly for families involved with multiple service systems or caring for children with complex needs. In Rhode Island, the Parent Support Network (PSN) currently provides supports to caregivers involved with DCYF; however, PSN is not presently funded to deliver family peer support services that are fully aligned with established best-practice models. In addition, while CCBHCs are required to provide peer support services, the scope, model, and consistency of family peer support delivery across CCBHCs are not clearly defined at the system level. While Peer Recovery Services are a Medicaid benefit for adults, Family Peer Support does not appear to be available as a Medicaid State Plan service for youth or their families.[38] The Monitor has identified family peer support as a needed component of the children's behavioral health continuum in Rhode Island. Targeted investment in family peer support would advance efforts to strengthen family voice in both service-level planning and broader system-level activities.

Psychiatric Services and Medication Management. Interviews with hospital-based providers highlighted challenges accessing timely outpatient psychiatric services and medication follow-up for children transitioning from the emergency department or inpatient psychiatric care to the community. Providers described reliance on short-term bridging models to ensure children are seen and medications are managed while awaiting longer-term outpatient appointments. Outpatient psychiatric services were described as difficult to access, particularly within the timeframe needed to support stabilization following discharge. DCYF contracts for a part-time psychiatrist who advises the Department, including reviewing clinical records and supporting medication management. Additional information and data are needed to fully assess the availability and timeliness of psychiatric services for children in the Focus Population, including an exploration of services available through the CCBHCs.

Other. Stakeholders also identified gaps in access to services for parents and caregivers, particularly SUD treatment, mental health services, and other supports that directly affect child safety and stability. When caregiver needs go unaddressed, children's risk of crisis, placement disruption, and hospitalization increases. The OCA's Fatality Review Panel Report identified multiple youth whose families had earlier involvement with DCYF and whose families had SUD treatment needs as well.[9] As noted above, additional cross-cutting concerns included limited language access, particularly for Spanish-speaking families and families requiring interpretation in less commonly supported languages, further constraining engagement and effective service delivery.

Recommendations regarding the capacity and sufficiency of Community-Based Services

Many other reports on Rhode Island's behavioral health system include detailed recommendations regarding service array needs, which are consistent with the findings of this report.[2,3,4,5,6,7,8,9,10] For the purpose of this review, we provide the following specific 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 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.

- 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. This could be aligned with a care pathways analysis and support ongoing service array development and planning.

- 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.

The capacity and sufficiency of mobile crisis response and crisis prevention, intervention, and stabilization services available to children in the Focus Population (¶21(e))

Assessment of the capacity and sufficiency of mobile crisis response and crisis prevention, intervention, and stabilization services

This section assesses the capacity and sufficiency of crisis response, prevention, intervention, and stabilization services available to children in the Focus Population, as defined in the Consent Decree. These services include crisis hotlines, mobile crisis response teams, and in-home crisis stabilization services, along with other community-based behavioral crisis and stabilization supports.

Rhode Island's children's crisis system is organized across multiple agencies and provider entities. Responsibility for crisis access, response, and stabilization is distributed across behavioral health authorities, Medicaid, and community providers, contributing to variability in access, coordination, and accountability. Medicaid is the primary payer for most children's crisis services, establishing coverage parameters, reimbursement rates, and service definitions. The availability and sustainability of crisis services are therefore closely tied to Medicaid policy and, for privately insured children, to the extent of commercial insurance coverage. Financing structures have shaped the scale and stability of community-based crisis services, particularly mobile crisis response and in-home stabilization.

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.

Crisis Hotlines and Telephonic Crisis Access

Rhode Island has multiple telephonic access points that families may use when a child is experiencing a behavioral health crisis. These access points serve different functions, including a statewide crisis hotline, navigation and referral services, provider-based crisis and emergency lines, and direct access lines for mobile crisis response. From a family perspective, these resources may all be experienced as "crisis numbers," despite being designed to play distinct roles across the crisis continuum.

Best practice in children's behavioral health crisis response emphasizes a "just go" approach, with a minimal threshold for in-person dispatches when "going" to do outreach is potentially needed. At the same time, some callers to 988 or other warmlines may be seeking connection to services and supports rather than experiencing an immediate behavioral health crisis. In those instances, call centers must be equipped to make warm handoffs and referrals to appropriate services and supports, including entities that will conduct comprehensive assessments, as needed. The call centers need to use developmentally appropriate and culturally relevant screening tools to inform this referral process and ensure timely access to the right level of support.

Crisis hotlines. Rhode Island participates in the national 988 Suicide and Crisis Lifeline, which serves as the State's primary statewide crisis hotline. The 988 Lifeline provides 24/7 telephonic access for individuals experiencing behavioral health crises, including children and youth. Calls are answered locally by trained crisis counselors at BH Link. Services are available in English and Spanish, with Language Line Solutions used to support communication in more than 250 additional languages.[39] When needed, 988 can connect callers to the regional CCBHC mobile crisis response teams.[40]

While 988 serves as a centralized access point, it is not child-specific. The effectiveness of 988 for children in the Focus Population therefore depends not only on call answer rates, but on the availability of trained staff, the use of clear decision-making criteria for dispatch, and the capacity of downstream mobile crisis and stabilization services. When those services are unavailable or delayed, hotline intervention alone is insufficient to prevent escalation to EDs or inpatient care.

Kids' Link RI operates as a 24/7 behavioral health navigation, referral, and triage service for children and youth in emotional crisis.[41] Through Kids' Link, callers are connected with clinicians who assess needs, provide guidance, and facilitate referrals to appropriate services, taking into account family language, culture, and potential barriers to access.[42] Kids' Link connects children and families with appointments for services within 5 days and can connect callers to children's mobile crisis resources when needed.[42] Kids' Link plays an important role in helping families navigate the system, particularly those unfamiliar with available behavioral health resources.

Demand for Kids' Link remains high. According to Rhode Island KIDS COUNT, call volumes increased substantially during the COVID-19 pandemic and remain elevated compared to pre-pandemic levels, reflecting persistent unmet need in the children's behavioral health system.[43, 44, 45]

Additional crisis and emergency phone lines. In addition to 988 and Kids' Link, Rhode Island's CCBHCs operate regional 24/7 crisis or emergency services phone lines, which provide crisis counseling and triage and may initiate in-person crisis response. These lines are provider- and region-specific and vary in structure and scope, contributing to differences in how children and families experience crisis access. CCBHCs are required to ensure crisis hotlines are accessible to callers who speak languages other than English.[46] Some community providers also operate 24/7 phone lines specifically for requesting mobile response and stabilization services. These lines function primarily as service activation points, rather than as comprehensive crisis hotlines.

System design and capacity considerations. From a system design and capacity perspective, the presence of multiple, parallel access points creates challenges for both families and system oversight, consistent with the discussion above regarding access and single points of entry. Families may be uncertain which number to call in a crisis, particularly when distinctions between lines are not clear or when services overlap. At the system level, the absence of a single, clearly designated access point for children's behavioral health crises makes it difficult to consistently track demand, monitor response timeliness, assess whether callers are successfully connected to appropriate in-person services, and identify points of failure in the crisis continuum.

During stakeholder interviews, one individual (not a direct service provider) identified the child abuse and neglect reporting hotline as the appropriate number to call during a behavioral health crisis, suggesting a lack of widespread understanding of 988 and other behavioral health crisis intervention services. Stakeholders also reported that families and providers are sometimes directed to call the child abuse and neglect reporting hotline as an access point for services and intervention, even when concerns are primarily behavioral health-related. This dynamic is reflected in the OCA Child Fatality Review Panel report, which describes a situation in which an 18-year old called mobile crisis following a suicide attempt: "The young adult called mobile crisis and was transported to the hospital requiring intubation. Initially, this information was provided to the DCYF casework supervisor by mother and mobile crisis. DCYF requested that mobile crisis contact the DCYF's Child Abuse Hotline" (p.40).[9]

Mobile Response and Stabilization Services (MRSS)

MRSS provides rapid, community-based response and intervention to help stabilize youth experiencing behavioral health challenges and prevent further escalation of harm. Key features of MRSS include mobile rapid response, 24/7 availability, mobile support, assessment and referral, short-term stabilization, collaboration with other providers, and an individualized and family-centered approach.[47,48]

This child- and family-specific model is important because recent reports, guidelines, and white papers have been clear: children and youth require a different approach to crisis response and stabilization than what is available through the adult crisis response system. A 2022 paper observed that "amending or attempting to retrofit an adult crisis response system to serve the needs of youth and families is insufficient."[49] MRSS is a critical component of Rhode Island's crisis continuum and is particularly important for children in the Focus Population, for whom delays in response or reliance on emergency departments can increase risk and disrupt care.

Rhode Island began piloting MRSS in 2020 as part of a broader statewide behavioral health system review and a Centers for Medicare & Medicaid Services (CMS)-funded initiative to strengthen the SUD and crisis response system across the life course. The grant supported the development of both CCBHCs and MRSS. With the launch of CCBHCs in October 2024, MRSS was initially folded into the CCBHC structure, reflecting an early policy decision to align children's mobile crisis services with the new CCBHC delivery system. However, State leaders subsequently determined that MRSS should operate as a distinct, standalone service model, resulting in plans to formally separate MRSS from the CCBHC framework through a forthcoming Medicaid State Plan Amendment (SPA).

MRSS is currently available statewide to children and youth under age 21 and is delivered by a small number of community providers, including Family Service of Rhode Island (FSRI), Tides Family Services, and Newport Mental Health. FSRI and Tides also operate as Designated Collaborating Organizations (DCOs) within the CCBHC network. MRSS providers operate within designated geographic catchment areas and use warm handoffs when children require follow-up services outside the immediate response.

Available outcome data suggest that MRSS has been effective in diverting children from higher levels of care. According to DCYF's 2024 Annual Report, MRSS served more than 1,000 children and families statewide and prevented psychiatric hospitalization in approximately 92 percent of cases, with most encounters avoiding emergency department or law enforcement involvement.[50, 51] Providers and State partners consistently identified MRSS as a strength of Rhode Island's crisis system and a critical alternative to ED use for children and families in crisis.

At the same time, stakeholders identified financing and sustainability as persistent challenges. MRSS has largely been supported through a "firehouse" payment model, with providers paid upfront to maintain readiness to serve a projected volume of children. Initial funding relied on federal grant dollars and ARPA funds. The CCBHC prospective payment system (PPS) rate does not include children's MRSS, and Medicaid reimbursement has not fully covered the cost of service delivery. Although the model assumes that increased service utilization within CCBHCs may offset MRSS costs over time, providers reported ongoing financial strain. Providers have also reported operating under financial strain in the absence of consistent commercial insurance reimbursement.[52,53]

In response to these gaps, the State allocated approximately $900,000 in FY 2026 to support MRSS services for uninsured and underinsured children,[54] distributed directly to MRSS providers based on prior service volume. More recently, legislation effective January 1, 2026, requires commercial insurers to cover youth mobile crisis response and stabilization services.[55] At the time of this review, at least one major insurer had negotiated contracts in place, and providers expressed cautious optimism that commercial coverage would improve sustainability.

The State is planning to formally pull MRSS out of the CCBHC structure effective October 1, 2026, through a Medicaid SPA currently under development. Under this model, MRSS will operate independently of CCBHC PPS financing, with DCYF serving as the licensing and oversight agency responsible for quality monitoring and compliance. Non-financial DCO arrangements are expected to continue during the transition, though roles and accountability are still being clarified.

Stakeholders also identified MRSS data collection and fidelity monitoring as ongoing gaps. MRSS utilization and service data are currently tracked through spreadsheets, with efforts underway to develop a centralized dashboard. Stakeholders noted challenges assessing fidelity to evidence-informed MRSS models and emphasized the importance of this information for ensuring quality and consistency across providers.

Other Crisis Services: Emergency Department and Hospital-Based Care

Several Rhode Island hospitals operate programs that support children and youth experiencing a behavioral health crisis. Most of these programs are part of Brown University Health, including Rhode Island Hospital, Bradley Hospital, Hasbro Children's Hospital, and Newport Hospital.[56]

Hasbro Children's Hospital maintains a Psychiatric Emergency Services department that operates 24 hours a day, seven days a week, and provides emergency psychiatric evaluations, crisis management, and linkage to treatment, and has a small number of inpatient hospital beds for children with medical and psychiatric needs.[57] Hasbro also operates the Psychiatry Access, Continuity, and Evaluation (PACE) Clinic, which offers short-term outpatient psychiatric services for children awaiting entry into longer-term treatment programs.[57]

Bradley Hospital operates an Access Center, staffed by clinicians who conduct evaluations and connect children to appropriate services.[58] Bradley also operates an Outpatient Crisis Clinic for children without an existing mental health provider who have an urgent need to be seen for a psychiatric evaluation or require stabilization.[59] Bradley Hospital serves as the State's primary provider of inpatient psychiatric care for children, particularly younger children. Additional inpatient capacity is provided through Bradley Hospital's inpatient psychiatric unit (19 beds) within the Center for Autism and Developmental Disabilities (CADD), which serves children with autism spectrum disorder and other developmental disabilities requiring psychiatric stabilization.

Newport Hospital is scheduled to open an eight-bed Adolescent Behavioral Health Unit in early 2026 to serve youth ages 12 to 18, providing short-term stabilization, assessment, and treatment, with an estimated annual capacity of approximately 240 youth and families.[60]

Butler Hospital operates an inpatient psychiatric unit for adolescents, contributing short-term acute capacity for older youth.

Recommendations regarding the capacity and sufficiency of mobile crisis response and crisis prevention, intervention, and stabilization services

- 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.

The capacity and sufficiency of Therapeutic Foster Care for children in the Focus Population (¶21(f))

Assessment of the capacity and sufficiency of Therapeutic Foster Care (TFC)

Therapeutic Foster Care (TFC) is a family-based, community placement for children with significant behavioral health needs who cannot safely remain at home and who might otherwise enter congregate care. TFC operates within a public–private foster care system in which DCYF's Division of Licensing and Resource Families oversees recruitment, licensing, and support of foster families, while contracted private foster care agencies partner with DCYF to recruit and support foster families providing enhanced services and supports. For children in the Focus Population, TFC is a key community-based alternative to residential treatment and may serve as step-down care from inpatient or residential settings.

The Consent Decree requires the State to ensure a sufficient supply of TFC placements for all children in the Focus Population who need them, supported by an active recruitment plan and tracking of access barriers (¶64–65). The State must also ensure that TFC families receive adequate services, supports, and reimbursement to maintain placements and participate in discharge and transition planning from inpatient settings (¶66–67).

Capacity and Availability

According to the Baseline Data Report, as of April 2025, DCYF contracted with nine provider agencies operating ten TFC programs, encompassing 193 licensed TFC homes with a total capacity of 257 placements.[1]**Error! Bookmark not defined.** At that time, approximately 53% of capacity was utilized. The report notes, however, that these figures may overstate actual placement availability because licensed capacity reflects placement configurations rather than homes able to accept additional children.[1]

TFC capacity has declined over time. The number of licensed TFC homes decreased from 234 in January 2024 to 193 in April 2025, following licensing reviews intended to better align approved homes with children's needs, alongside limited success in recruiting new families.[1] Providers reported that this decline has been compounded by the loss of foster parents since the COVID-19 pandemic and by competition among the nine TFC provider agencies operating statewide, all recruiting from a limited pool of foster families.

Per descriptions in the DCYF Resource Guide, most TFC programs serve children across the full age range of the Focus Population. A small subset of programs focus on particular age ranges (e.g., children under ten). While services are broadly available statewide, no data were available on the geographic distribution of TFC homes. All programs provide services in English, most in Spanish, and some in additional languages;

however, the number of foster families with non-English language capacity is not clear.[61] While TFC programs differ in clinical orientation, target populations, and support intensity, these distinctions are inconsistently specified in the DCYF Resource Guide and are not presented in a way that reliably supports systematic matching or differentiation across programs.

Recruitment and Retention

Providers identified recruitment and retention of TFC families as a primary constraint on capacity and placement stability. Recruitment and preparation of families able to serve youth with higher-acuity behavioral health needs can take six to eight months, limiting the system's ability to respond to urgent step-down needs from hospitals or residential programs. Some providers reported that licensing and training bottlenecks at the state level further delay the availability of newly recruited families, even when agencies have identified appropriate candidates. At the same time, the State identified examples of how these concerns have been addressed, leaving it unclear as to the extent of this as a challenge.

These challenges are longstanding and have been documented in prior OCA Monitoring Team Reports under the *Andrew C. v. McKee* settlement. Historical data indicate a limited pool of families willing and able to care for children with significant behavioral health needs, contributing to persistent shortages of placements for children with the highest acuity.[62]

Statewide recruitment data also reflect these concerns. In SFY 2023-2024, DCYF set a goal of recruiting 125 new non-relative foster families but licensed 52, retaining 49.[63] While recruitment targets for families open to serving children with mental health needs were exceeded, recruitment of families able to serve adolescents fell short of targets, reinforcing provider concerns that overall recruitment numbers do not translate into sufficient TFC capacity for the Focus Population.

Matching and Referrals

Providers emphasized that TFC sufficiency is not solely a function of the number of licensed homes, but also of match quality and system coordination. For example, in the past, up to 68% of TFC placements were being utilized for children from low level of need (LON) tiers, leaving limited placements available for children with higher LON.[64] Providers also described inconsistent referral practices, including referrals that are not aligned with the child's clinical needs or with the capabilities of available foster families. In some cases, referrals appear driven by placement availability rather than by clinical fit, undermining placement stability and the effective use of TFC.

Providers also noted that while individual agencies have developed areas of expertise (e.g., female youth, higher-acuity behavioral needs), increased system centralization and standardization have reduced flexibility for specialization and intentional matching. This has limited the ability of the TFC system to function as a differentiated and responsive level of care within the broader continuum.

Financing and Sustainability

Providers reported that census-driven financing models do not adequately cover the upfront costs of recruiting, training, and supporting therapeutic foster families, undermining program sustainability. Providers noted that financial pressures have contributed to program closures and may further constrain capacity for higher-acuity youth under standardized Medicaid rate approaches.

DCYF concurred that there are challenges with the existing system. They are looking to a collective approach with the providers to implement strategies to address these problems. While DCYF concurred about challenges with recruitment, lack of ability to specialize, and challenges with training, there is also a frustration from an apparent disconnect or mixed messaging between leadership and staff at provider agencies. DCYF believes there is shared responsibility for some of the challenges and more remains to be done and has committed to ongoing meetings with the providers.

Recommendations regarding the capacity and sufficiency of Therapeutic Foster Care

Although Rhode Island maintains a network of TFC providers, current TFC capacity and functioning are insufficient to consistently meet the needs of children in the Focus Population. Declining numbers of licensed homes, inconsistent referral and matching practices, and financing structures that limit program sustainability constrain the effective use of TFC.

- 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, existing Medicaid-funded HCBS waivers, state plan policies and reimbursement structures and payment methodologies to determine what, if any, changes may be needed to assure the State's compliance with this Consent Decree (¶21(g))

Assessment of policies, procedures, structures, and changes needed

Much of the information related to these topics has been discussed throughout this review, including in the overarching themes and findings. There are some additional findings that were identified in the course of conducting the review:

- 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. It was noted that there was a significant effort in the past year to prepare for children's services to go inside the Managed Care Organization (MCO) plans so they could manage plans, utilization, and quality, but those services are going to stay outside the plan in a fee-for-service model. Providers will have to be Medicaid eligible, but DCYF will continue to manage the services.
    - Some concerns about the changes relate to the sufficiency of the rates and whether:
        - the rates are based on child and family service provision versus adult models of care;
        - the utilization rates used to calculate the reimbursement rates are realistic; and
        - the rates are sufficient to cover specialization of care and necessary recruitment and retention of the workforce, including for in-home services.

    - Some concerns relate to changes in oversight and the roles and responsibilities of different agencies. There is a fear that the move to Medicaid reimbursement will result in more generic and less intensive services because the services are contracted individually.

- Although Rhode Island has developed a relatively strong and evolving data infrastructure to support identification and monitoring of children in the Focus Population and related services, important gaps limit the effectiveness of the State's data infrastructure for comprehensive oversight and real-time coordination.
    - Data sharing across EOHHS entities, including BHDDH and RIDOH, is not yet fully institutionalized, constraining routine cross-system analysis.
    - Service-level data for community-based programs are fragmented across multiple systems and reporting processes, limiting visibility into service access, continuity, and outcomes across the full continuum of care.
    - In addition, stakeholders identified limited staffing and analytic resources to support ongoing reporting, ad hoc analysis, and data visualization, raising concerns about the State's capacity to expand data use to meet evolving Consent Decree monitoring needs.

- As discussed above, there are challenges with interagency collaboration across the State. Some recurring recommendations included:
    - Better coordination between DCYF and BHDDH (with many suggesting that adolescent SUD treatment services move within DCYF);
    - More presence of Medicaid and BHDDH in the implementation of the Consent Decree; and
    - A stronger role for the Children's Cabinet.

Recommendations regarding policies, procedures, structures, and changes needed

- 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. [26]

> "The increasing specialization of government services has led to silos and disconnected services that can be inefficient or ineffective. Moreover, the distribution of responsibility and the specialization within agencies often means that no one entity is responsible for listening to and holistically responding to the needs and aspirations of children and families, the intended beneficiaries of the public investments." The Aspen Institute & The Forum for Youth Investment. (2022). *Strong and sustainable children's cabinets: A discussion for state leaders.* https://forumfyi.org/knowledge-center/strong-and-sustainable-childrens-cabinets-a-discussion-guide-for-state-leaders/

- 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.

- 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.

Conclusion

Magic Wand

As part of this review, stakeholders were given opportunities to answer a "magic wand" question, exploring what they would do to support the Focus Population if they did not have constraints of time, resources, or other barriers. This enabled them to share their goals and priorities for the Focus Population, unencumbered by the challenges that often constrain ideas.

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

Responses focused on themes related to communication, trust, coordination, access, and the service array. Below are some responses from a range of stakeholders in the form of direct quotes or summary statements:

Communication, Trust, Coordination, and Access

- "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."

- "Put the people doing this work [with children at Bradley Hospital] on a daily basis in a room and have a facilitated conversation--talk through what needs to happen. Familiarity and talking it through would make a difference. Identify common ground and develop trust and respect. Work together to establish roles."

- "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 are expecting a lot from our frontline staff for coordination of care, and it does a number on our youth. Frontline staff do an excellent job, but it is so associated with DCYF that parents and youth have a hard time building that trust. Having someone who stays involved, who knows the family's history, who can help prevent the need to repeat everything that has happened to the family is really important. Youth sometimes feel like so many people are involved and making decisions who don't know their families and situation. It could help them to feel more secure to have a consistent person."

- "Have a very skilled children's behavioral health/system of care director that sits side-by-side with juvenile services and child protection with equal authority and resources. Pull all children's behavioral health staff and assess if they can do this work and then move them into that department. Have clarity and firewalls with child protection and permanency."

Additional suggestions included:

- Embedding as much of this work as possible into a Medicaid SPA using a public health approach, including children who do not meet Medicaid eligibility. Provide all youth regardless of insurance with access to certain services and supports and create presumptive eligibility for Medicaid through MRSS and ICC so there are no delays in getting care.

- Create a Single Point of Access separate from DCYF to remove the stigma from accessing children's behavioral health services.

- Move BHDDH services for I/DD and adolescent SUD into a new division at the State level.

- Implement a harm reduction model for children more likely to be missing from care.

Service Array

- “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.”

- “Actually invest in families and allow them to care for their children—that is cheaper and least restrictive. It could mean paying a parent to come to training for a couple of weeks to learn specific skills to support their child. There is a population of families who could benefit from this.”

- “I want to see an independent care management entity providing intensive care coordination with Wraparound.”

- “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.”

- “Whatever we can do to close the door to the hospital is important. Once they are in the hospital, we need to go back to the model that youth go and get stabilized and get to walk out the door.”

- “Rhode Island needs a truly robust pool of foster parents who will take kids, including teens, emergency placements, youth who identify as LGBTQIA, experiencing substance-related issues that can be addressed in the community, other needs.”

- “Resources should follow the child.”

- “Implement multi-year budgets: budgeting is year-to-year and then there is a line item that is cut or not. Governors tell their staff to cut by 7% and then the lines are cut while expenses are going up.”

Additional suggestions included:

- Creating TFC with professional homes and clinical teams that can even support sibling groups.
- Increasing capacity for in-state community-based resources.
- Implementing MRSS fully and statewide, beyond what is available currently.
- Implement ICC using Wraparound, provided by an independent, conflict-free care management entity that is formed in Rhode Island with a Board that includes caregivers, providers, and community members.

Final Reflections

As required by the Children’s Behavioral Health Consent Decree, this system review presents the Innovations Institute’s preliminary observations and recommendations to inform DCYF and the State’s development of a comprehensive implementation plan. Rhode Island’s children’s behavioral health stakeholders provided thoughtful contributions to and partnership in the completion of this review. The compiled analyses, recommendations, and magic wand wishes are lengthy, and the efforts required are significant. However, they are consistent with many of the reports that have predated the Consent Decree and with several initiatives currently underway.

The strengths evidenced, resources provided, and interviews and focus group discussions make clear one additional observation: that the people of Rhode Island, at all levels and in all capacities, care deeply about the state's most vulnerable children and are embracing the visioning, collaboration, and hard work necessary to move the state toward a well-appointed, well-functioning, easily accessible, and sustainable service system that meets the individual needs of its children and families.

Appendices

Appendix 1: Interviews and Focus Groups

Rhode Island Consent Decree System Review – Interview, Focus Group, and Site Visit Participants

Representatives from the following organizations and committees participated in interviews, conducted either individually or in groups, to inform the system review. Interviews took place virtually or in-person between March 2025 and December 2025, with the majority conducted in December. Some stakeholders participated in multiple meetings and several interviews included more than one individual from an organization. Several interviews were conducted as part of site visits, which included a comprehensive overview of services and a tour of the facility. Site visits occurred in March, May, October, and December 2025. In addition, Family Court proceedings were observed.

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*

Appendix 2: Semi-Structured Interview/Focus Group Prompts

The following questions and prompts were used to guide interview and focus group discussions with key Rhode Island stakeholders, including state agencies, child advocates, hospital and residential facility staff, and youth and families with lived experience.

The script and prompt below are generic questions; all interviews were customized to the specific individuals participating.

Introductory Script

Welcome and thank you for letting us join your meeting today.

Before we begin, we would like to obtain your permission to record the meeting, for note-taking purposes only, to ensure we do not miss anything. We will not share the recording with anyone outside of our Consent Decree consulting team. We will also capture all comments shared in writing through the Zoom chat function. The recording will be destroyed after notes are verified and no later than one year.

Are you comfortable with us recording this meeting?

Purpose/Background

As you know, DCYF is required under Paragraph 21 of the Consent Decree to engage an independent entity to conduct a comprehensive Children's Behavioral Health System Review, and DCYF has contracted with us at the Innovations Institute to complete this review. As a reminder, our team is separate from the Court Monitoring team at Innovations, who will not have access to the recording or notes.

This assessment focuses specifically on how the children's behavioral health system functions *for the Consent Decree's Focus Population*. The **Focus Population** includes children and youth who are admitted to Bradley Hospital for psychiatric inpatient care or at risk of psychiatric hospitalization because of significant behavioral health needs. The goal of the system review is to assess relevant processes and the capacity, sufficiency, and coordination of services intended to meet the needs of this Focus Population—particularly services designed to prevent unnecessary psychiatric admissions and support timely, successful transitions back to the community.

Our role is to understand how the system is currently operating, identify strengths and gaps, and inform recommendations that will be incorporated into DCYF's required **Implementation Plan**. We are speaking with a broad range of stakeholders across Rhode Island to gather insights and context about the system—not about individual children or cases.

Housekeeping

Before we start, I want to cover a few housekeeping items:

Please note that your participation is completely voluntary. If you decide you do not want to participate or want to leave this meeting early, just let us know. Your relationship with us or other stakeholders will not be impacted. We would like to hear your honest input, and since there are no right or wrong answers to these questions, we encourage you to speak openly and honestly. You can choose not to respond to a specific question, and you can also end your participation in the discussion at any time.

We will summarize themes across interviews. While we will include your organization in a list of participants, no comments will be attributed to individuals.

Finally, the information you provide today will only be used for the purposes of this project, but we may have to share information if it is required by law. As a reminder, please do not disclose any identifying information about any participants (parents/caregivers and children/youth).

As we proceed, please let us know if something you tell us is off the record.

Do you have any questions before we begin?

Interview Guide

Interviewee/Agency

1. Please introduce yourself and share your role/and background as it relates to implementing, designing, and/or providing services for children in the Consent Decree Focus Population.

General

2. What is working well with respect to children who are served at Bradley and are involved with DCYF? Where are there challenges? Why and what do you think could be done to support? *(Probe re: services, family and youth engagement, training/expertise, external resources, communication, etc.)*

3. Are there specific policies, procedures, or rules that are confusing or seem to make it harder to support the youth in the Focus Population? Are there any that you wish would exist to help you better support these youth?

4. When you think about the service needs of youth in the Focus Population, how well do you think the existing services match the needs?
    a. In-home and community-based
    b. Residential (including TFC)
    c. Crisis Response

5. Are there services that exist on paper but are hard to access? Are there services that are technically available but don't provide the quality or level of support you think is needed?

6. Where are there specific gaps in services for the Focus Population—any particular geographic areas, demographic or clinical characteristics, etc.?

7. If you were in charge, and could make any changes at all to improve the provision of behavioral health care for youth in the Focus Population without regard to resources, time, or other constraints, what would you do? (Magic Wand)

Appendix 3: Documents Reviewed

The following reports, procedures, policies, and other documents were reviewed to inform the observations and recommendations within the Rhode Island Children's Behavioral Health System Review. If a link is not provided, it is because the reviewers were unable to locate a publicly accessible version of the document.

Table 2: Documents Reviewed

Report Name	Year	Summary	Link (if available)
DCYF Reports			
United States v. State of Rhode Island Civil Action No. 24-cv-00531 Children's Behavioral Health Consent Decree Baseline Data Report	2025	This is the required Consent Decree Baseline Data Report that includes information on the Focus Population and the behavioral health service array. The report serves two primary purposes: (1) to inform the development of the State's Implementation Plan, which will guide efforts to achieve compliance with the Consent Decree's requirements; and (2) to support the Monitor's compliance reviews, which will assess the State's progress in meeting the Decree's requirements.	https://dcyf.ri.gov/media/4541/download?language=en
FCCP Annual Report: Opening to DCYF within 24 Months, Entry Cohort FY 20 – 22.	2025	The report examines the percentage of children receiving at least one day of Family Care Community Partnership (FCCP) services in FY 2020, 2021, and 2022 and later opened to DCYF within 24 months.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2025-07/FCCP%20Annual%20Report%20FY%2020%20-%20FY%2022%2021JUL25%20v1.0%20FINAL_0.pdf
Safety Report (October 1, 2021 – September 30, 2024).	2025	The Safety Report presents findings from a qualitative review of case records involving maltreatment in foster care and was developed to support collaboration among agencies working to promote child and family safety and well-being.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2025-04/Annual%20Safety%20Report%20FFY24.pdf
Strategic Metrics Dashboard December 18, 2025	2025	The Dashboard provides data on metrics including CPS reports, screenings, and investigations; family services; juvenile corrections; out-of-home placements; and Voluntary Extension of Care participation.	https://dcyf.ri.gov/media/4821/download?language=en
DCYF Annual Report	2024	DCYF's 2024 Annual Report reflects the state and agency's accomplishments during the year, the agency's focus on family-based solutions, youth and family engagement, partnerships with other agencies and service providers, and the launch of DCYF's 2025 strategic plan.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2025-02/2024%20Annual%20Report%20PDF_0.pdf
DCYF Interim Comprehensive Needs Assessment	2024	The document provides a high-level overview of completed and ongoing assessments, data, surveys, reports, presentations, and other related documents that give comprehensive information on the needs of Rhode Island's children and families.	[Note: this was an internal document prepared to inform the accreditation process.]
Removals Brief: Entry Cohort of Children in Foster Care (FFY22 – FFY24).	2024	The brief provides a data-driven overview of trends among children entering out-of-home care in Rhode Island in FFY24, including removal rates, age distribution, racial and ethnic disproportionality, reasons for removal, and first-placement settings.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2024-12/FFY%2024%20Removals%20v1.0%2011DEC24%20Final.pdf
Rhode Island Child and Family Service Plan 2025-2029	2024	The plan, required of all states every five years under Title IV-B, includes updates on Rhode Island's child and family outcomes, service planning, and interagency structures.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2025-06/2025-2029%20RI%20DCYF%20Child%20and%20Family%20Services%20Plan%20.pdf

Report Name	Year	Summary	Link (if available)
DCYF Annual Report	2023	DCYF's 2023 Annual Report reflects the state and agency's interest in increasing the capacity of and array of children's behavioral health services through funding allocations for psychiatric residential treatment facilities and residential treatment facilities for adolescent girls, the implementation of CCBHCs, and the development of a stronger continuum of care.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2024-03/2023%20Annual%20Report%20Final%203.7.2024.pdf
Community-Based Services Contracted & Funded by RI DCYF: July 1, 2020 – June 30, 2021 (SFY21) Entry Cohort.	2022	The report provides preliminary data on the profile of children, youth, and families involved with RI DCYF (assigned to RI DCYF family service or juvenile probation caseworker) as well those who received RI DCYF funded community based contracted services between July 1, 2020 – June 30, 2021 (FY21)	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2022-12/Community%20Based%20Programs%202022%20FY21%20Entry%20Cohort%20v3.pdf
Title IV-E Prevention Services Plan: FFY2022-FFY2026	2021	Provides the State of Rhode Island's Title IV-E Prevention Plan to set a basic operational foundation and expand existing prevention services, including defining candidates for prevention services and eligible prevention services.	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2022-10/RI%20DCYF%20FF%20Prevention%20Plan%20FINAL_10.2022.pdf
Community-Based Services Contracted & Funded by RI DCYF: July 1, 2018 – June 30, 2019 (SFY19) Entry Cohort.	2021	The report provides preliminary data on the profile of children, youth, and families involved with RI DCYF (assigned to RI DCYF family service or juvenile probation caseworker) as well as those receiving RI DCYF contracted community based contracted services during July 1, 2018 – June 30, 2019 (FY21).	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/2022-12/Community%20Based%20Programs%202022%20FY21%20Entry%20Cohort%20v3.pdf
Race Equity Plan	2021	The Race Equity Plan highlights DCYF's planned efforts to reduce and ultimately eliminate the disproportionalities and disparate outcomes based on race and ethnicity found within the state's child welfare, children's behavioral health, and juvenile justice.	
Community-Contracted Services Funded by RI DCYF: July 1, 2017 – June 30, 2018 (SFY18) Entry Cohort.	2020	This report provides a preliminary surveillance on the profile of children, youth, and families involved with RI DCYF (assigned to RI DCYF family service or juvenile probation caseworker) as well as those who received RI DCYF funded community-based contracted services during July 1, 2017 – June 30, 2018 (FY18).	https://dcyf.ri.gov/sites/g/files/xkgbur416/files/documents/data-evaluation/community-based-programs-2020-fy18-entry-cohort.pdf
DCYF Departmental Operating Procedures and Policies			
Emergency Department Visits- Facilitated Case Reviews	2025	The policy formalizes DCYF's protocol for identifying and responding to children and youth who experience repeated Emergency Department visits for behavioral health reasons, in alignment with the requirements of the DOJ Children's Behavioral Health Consent Decree.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Assessing Reports of Child Abuse and Neglect and Child Safety Determinations (500.0025)	2024	The DOP contains general directives for handling all CPS assessments and designates tasks to be completed by the child protective investigator (CPI) using validated screening tools and best practices.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Family Time (700.0030)	2024	The DOP establishes clear policy and procedural guidance for maintaining and strengthening family relationships when a child is removed from their home and placed in out-of-home care. The document outlines how family time should be initiated promptly after removal and maintained in a regular, frequent, and progressive manner.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures

Report Name	Year	Summary	Link (if available)
Ongoing Engagement with Families Open to the Family Services Unit or Juvenile Probation. (700.0090)	2024	The DOP ensures that children and families involved with the DCYF receive consistent, purposeful, and documented contact with their assigned primary service worker to safeguard child safety, promote permanency, and support overall well-being.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Placement Determinations, Referrals, and Transitions. (700.0170)	2024	The DOP describes how DCYF initiates and manages referrals for out-of-home placement when a safety assessment indicates a child cannot safely remain with a primary caregiver or an alternative caregiver.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Screen-Outs Requiring a Response (500.0015)	2024	The DOP outlines DCYF's standardized response to Child Protective Services (CPS) Hotline reports that do not meet the statutory criteria for an abuse or neglect investigation but nevertheless present a valid concern regarding a child's well-being.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Youth Transition Planning and Support. (700.0115)	2024	The DOP describes DCYF's expectation for collaborative effort between Primary Service Workers and youth aged 14 and older in out-of-home placements to implement the guidance and community-based supports necessary for the youth's successful transition to adulthood.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Level of Need Assessment (LON) (700.0240)	2022	The DOP outlines the purpose of the LON and describes the procedure for assessing each child in out-of-home care by using a standardized assessment known as the Level of Need (LON) There are two versions of the LON assessment, one for children birth to age four and one for children ages five and up.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Education Stability. (700.0075)	2021	The DOP establishes the agency's policies and procedures for ensuring educational stability and access to a free and appropriate public education for children placed in out-of-home care.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Notification to School Districts when a Child is Admitted to Bradley Hospital. (700.0195)	2021	The DOP outlines DCYF's requirements in support of its commitment that every child admitted to Bradley Hospital and in the care of DCYF receive education programming as required by federal IDEA legislation.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Voluntary Placement	2019	This DOP outlines the policies and procedures for DCYF to enter into a Voluntary Placement if a child would benefit from foster care or residential treatment services without the family relinquishing custody.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Children's Behavioral Healthcare Coordination. (100.0330)	2019	The DOP outlines the procedures for families to access Children's Behavioral Health (CBH) services through DCYF for youth with Serious Emotional Disturbance (SED) or Intellectual/Developmental Disabilities (IDD) who present with significant functional impairments.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Comprehensive Assessment and Service Planning (700.0075)	2019	The purpose of this proposal is to outline the Department's process for comprehensive assessments and service planning for each child and family, referencing applicable policies and laws.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures

Report Name	Year	Summary	Link (if available)
Placement Referrals (700.0170)	2019	The DOP delineates the process for Department of Children, Youth and Families (hereinafter, the Department) and contracted provider staff to initiate referrals for out -of-home placement. Placement with kin must be continuously pursued for every child placed out of home, in compliance with DOP: 700.0035, Kinship Care.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Ongoing Family Functioning Assessment Intervention Manual	2019	Manual produced by ACTION for Child Protection for the implementation and use of the Ongoing Family Functioning Assessment.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
Mental Health Evaluation and Counseling Services. (700.0010)	2011	This policy and procedural document describes DCYF's policies enabling access to mental health evaluation and counseling services within and outside (through partners) of the agency.	https://dcyf.ri.gov/about-us/dcyf-policies-operating-procedures
EOHHS Reports			
Integration for All: Rhode Island Olmstead Plan 2025-2030	2025	This working draft released for community review outlines Rhode Island's Olmstead Planning Process and includes relevant background information, planning and writing methods, the current state of disabilities in Rhode Island, and the state's implementation plan.	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-02/Integration%20for%20All%201.0%20-%202.17.pdf
Olmstead Planning and Implementation 90-Day Report	2025	This report provides an overview of Rhode Island's Olmstead plan and early progress toward the plan's implementation.	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-10/Olmstead%2090%20Day%20Report%20%28FINAL%209.30.2025%29.pdf
Rhode Island Behavioral Health System of Care Plan for Children and Youth	2022	This document provides background data and information and Rhode Island's youth behavioral health crisis and describes specific goals and objects to frame a coordinated System of Care.	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-03/RI%20Behavioral%20Health%20System%20of%20Care%20Plan%20for%20Children%20and%20Youth.pdf
Office of the Child Advocate Reports			
Report of the Office of the Child Advocate Child Fatality Review Panel: A Review of Sevent Fatalities and Twenty-Three Near Fatalities	2025	This report identifies systemic strengths and weaknesses within Rhode Island's child welfare, children's behavioral health and juvenile justice systems, with a key focus on improving policies and procedures to support organizations serving children in Rhode Island.	https://childadvocate.ri.gov/media/386/download?language=en
DCYF and St. Mary's Home for Children Investigative Report	2023	This report contains the OCA's findings after its investigation into all units at the St. Mary's Home for Children in North Providence, Rhode Island.	https://childadvocate.ri.gov/media/341/download?language=en
Andrew C. v. McKee Monitoring Team Reports.	2018-2024	As part of the settlement agreement in *Andrew C v. McKee,* the OCA and an external data validator conducted data reviews and provided these bi-annual and supplemental reports to ascertain DCYF's compliance with the settlement agreement requirements.	https://childadvocate.ri.gov/reports
Site Review and Investigation of Blackstone Valley Youth and Family Collaborative	2018	This report contains a summary of the OCA's findings and recommendations after its visit to Blackstone Valley Youth & Family Collaborative.	https://childadvocate.ri.gov/media/156/download?language=en

Report Name	Year	Summary	Link (if available)
Other Reports			
Quality of clinical care: Medicaid HEDIS® measurement year 2024 results [Author: Neighborhood Health Plan of Rhode Island]	2025	This report provides the HEDIS clinical performance measures and Quality Compass benchmark ratings for measurement year 2024.	https://www.nhpri.org/blobnhpri08e0944faa/wp-content/uploads/2025/12/HEDIS-CY-2024-Website-PDF-10232025.pdf
Rhode Island Children's Behavioral Health Consent Decree Monitoring Report. [Author: Elizabeth Manley, Innovations Institute, UConn School of Social Work]	2025	This Monitoring Report was submitted in accordance with the requirements of the Consent Decree and provided an assessment of progress that RI EOHHS, DCYF and BHDDH made regarding required activities within the Monitoring Plan as consistent with the Consent Decree.	https://dcyf.ri.gov/media/4831/download?language=en
Rhode Island Behavioral Health System Review Technical Assistance (Final Report). [Author: Faulkner Consulting Group and Health Management Associates]	2021	The document describes the results of a study of the health of Rhode Island's Behavioral Health System and includes core indicators, key findings, and policy proposals.	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-05/bh-study-full-report-final.pdf
Mental Health Hearings Findings and Recommendations. [Author: Rhode Island Senate Health and Human Services Committee]	2017	This report compiles hearing testimony and identified issues and recommendations stemming from the Rhode Island Senate's Health and Human Services Committee's hearings to assess the state of mental health services within the state.	https://www.rilegislature.gov/Reports/FINAL%20Senate%20HHS%20Mental%20Health%20Report%202017.pdf
Rhode Island Behavioral Health Project Final Report [Author: Truven Health Analytics]	2015	Compiled through the collaborative efforts of the Rhode Island Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH); Department of Health; and the Office of the Insurance Commissioner (OHIC), this summary report recommends practices, policies, and system structures to further the goal of providing accessible, high quality, and affordable behavioral health care across the lifespan using a population health approach.	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-06/Truven_Rhode_Island_Behavioral_Health_Final_Report_9-15-2015.pdf

Note: Various websites were also reviewed, including the State of Rhode Island EOHHS webpages for Providers and Partners (including Medicaid Managed Care, Fee Schedules, and Provider Manuals).

Appendix 4: Table of Recommendations

Area	Recommendation
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.
	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: • 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.
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.
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.
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.
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.
Capacity and sufficiency of Therapeutic Foster	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.

Care for Children 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.
Policies, procedures, mechanisms for data collection and coordination, Medicaid policies and reimbursement structures, and changes needed to support the Children in the Focus Population	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.
	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.

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