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SUBJECT Complex Needs Planning for Children, Youth, and Young Adults Through Age 21		BY  Valerie A. Arkoosh, MD, MHP, Secretary Department of Human Services

PURPOSE:

The purpose of this bulletin is to update guidance provided in *14-Bul-110 Complex Case Planning for Children and Youth Under Age 21*. This guidance clarifies the referral process, roles and responsibilities, offers the availability of technical assistance, and describes the benefit of technical assistance to the agencies in the human services systems that support children, youth, young adults through age 21 (youth with complex needs) and their families and/or caregivers.

SCOPE:

This bulletin applies to child-serving private, county and state agencies, family and youth advocacy organizations, and both physical and behavioral health managed care organizations involved in complex needs planning for youth. Applicable agencies and organizations include, but are not limited to:

- County Chief Juvenile Probation Officers
- County Children and Youth Social Service Agencies
- Private Children and Youth Social Service Agencies S
- County Mental Health/Intellectual Disabilities/Developmental Disabilities Agencies
- County Child and Adolescent Service System Program (CASSP) Coordinators
- County System of Care (SOC) Coordinators
- County Children’s Behavioral Health Specialists
- Human Services Administrators
- Juvenile Court Judges’ Commission
- Administrative Office of Pennsylvania Courts
- Office of Developmental Programs Supports Coordination Organizations/Targeted Support Management
- Behavioral Health Managed Care Organizations (BHMCOs)
- Physical Health Managed Care Organizations (PHMCOs)
- Family and Youth Advocacy Organizations
- Early Intervention Service Coordination Entities
- Early Learning Resource Centers

BACKGROUND:

To meet the needs of youth with complex needs and their families and/or caregivers, clear structures are necessary at the county, regional, and state levels so that resources, expertise and collaboration are maximized. A comprehensive and effective system of care recognizes that the complex needs and social histories of some youth require service from multiple systems that are highly coordinated and flexible.

The Department of Human Services (“Department”) recognized the need to build a coordinated response to support county planning teams in their efforts to improve outcomes for youth with complex needs and their families and/or

caregivers. On October 2, 2020, the Department issued 14-Bul-109 Complex Case Planning for Children and Youth Under Age 21. The Department issued 14-Bul-110, **Complex Case Planning for Children and Youth Under Age 21**, on April 6, 2021, which replaced 14-Bul-109 to provide updated guidance.

The Department is issuing this bulletin to provide further guidance and clarification regarding complex needs planning, this includes more clearly describing the population that is the subject of this bulletin, providing clear instructions for when and how to submit a referral, defining the technical assistance available through complex needs planning, revising the referral form, simplifying the language describing complex needs planning and the referral process, and redefining who may submit a referral. Additionally, while the Department recognizes that there is, at times, overlap with children with medically complex conditions, this bulletin focuses on children with complex behavioral needs. This bulletin replaces #14-Bul-110.

DISCUSSION:

Service Planning

Pennsylvania has a wide array of services and supports for youth and their families and/or caregiver(s) that are accessed at the county level. These supports include not only behavioral, developmental and physical health professionals and provider agencies, but also educational, social, religious, and cultural organizations and other natural community support networks.

Services should be planned to meet the individual needs of the youth and the family and/or caregiver(s). This individualized service planning process should align with both [Child and Adolescent Service System Program \(CASSP\)](#) principles and [System of Care](#) core values and guiding principles. This service planning approach includes collaboration across child-serving systems to improve behavioral health and related outcomes for youth and their families and/or caregiver(s).

Service planning for each youth should start where the family and/or caregiver(s) and youth are located, at the local level. Whenever possible, services should be delivered in the youth's home community, drawing on formal and informal resources and supports to promote the youth's successful participation in the community. Services should be the least restrictive and intrusive available to meet the needs of the youth and family and/or caregiver(s) and include discussions addressing permanency and concurrent planning for the youth.

These services should be developmentally appropriate and child specific, they should consider the youth's family and community structure, build on the strengths of the youth and family and/or caregiver(s) to meet the developmental, social, cultural, physical and behavioral health needs of the child. Representatives from all child-serving systems should collaborate with the family and/or caregiver(s) and involve the youth as much as developmentally appropriate when defining goals for the youth, developing a service plan, developing the necessary resources to implement the plan, providing appropriate support to the youth and family and/or caregiver(s), and evaluating progress. Service planning is not a static activity, rather, it is an ongoing process as needs, goals, and circumstances change.

While the needs of most youth and families can be met through the county service planning process described above, there may be youth whose needs involve complexities or challenges warrant additional technical assistance.

Complex Needs Planning

Complex needs planning is a process to support efforts to improve outcomes for youth with complex needs and their families and/or caregiver(s). Understanding that each youth with complex needs and their families are unique, there are several characteristics that differentiate the population that is the focus of this Bulletin and can be used to identify a youth with complex needs. The following are the most frequently encountered characteristics of youth with complex needs; often, the combinations and acuity of these characteristics vary significantly:

- Complex trauma including abuse, neglect, developmental and institutional trauma;

- Multiple and complex diagnoses across the developmental, physical, behavioral and /or mental health domains;
- Complex communication needs;
- Inconsistent presentation of behaviors and symptoms across settings;
- Diagnostic overshadowing due to an intellectual disability and/or autism diagnosis;
- Lack of diagnostic clarity;
- Disrupted education;
- Limited, strained, or no natural supports;
- Multiple system involvement, including justice systems; or
- An extensive history of out-of-home care, including multiple disrupted placements.

When considering a specific youth, not all of the characteristics listed above are required, though it is often a combination of several and sometimes all of these characteristics. Additionally, a youth may not have emergent acuity but could still be considered as having complex needs.

Because these youth present with such varied characteristics and needs, they often require support from many different systems, such as mental/behavioral health, intellectual disabilities and autism, child welfare, education, juvenile justice, and physical health. Complex needs planning is a multi-agency effort spanning multiple child-serving systems and multiple disciplines, all of which requires significant coordination, communication, and shared goals. County planning teams often experience many different challenges in their efforts to support youth with complex needs and their families. County planning teams frequently have questions regarding licensed settings, funding, clinical or medical resources, best practices, and successful strategies from other areas of the Commonwealth.

Referrals to the DHS Complex Needs Planning Team

To effectively and efficiently support county planning teams, the Department established a referral process for counties to request technical assistance from the DHS Complex Needs Planning Team. The Department’s technical assistance includes guidance related to licensed settings, funding, clinical and medical resources, and successful strategies from other counties and regions in the Commonwealth. The technical assistance is tiered and consists of regional and statewide teams joining the county planning team meetings.

By referring to the DHS Complex Needs Planning Team, county planning teams will gain access to subject matter experts and clinicians within the Department. Generally, the role of these subject matter experts and clinicians is to support the county planning team by providing technical assistance and guidance, including supporting the county planning team’s development of a comprehensive plan if the county planning team requests this support.

The criteria for when a county should make a referral is provided in further detail in the section below: “When to Submit a Referral”. When the referral criteria are met, a county planning team may make a referral to the DHS Complex Needs Planning Team. After the DHS Complex Needs Planning Team reviews the referral and depending on the situation, the county may be asked to invite the DHS Regional Offices or invite the Regional Offices and the Statewide Office to the existing county planning call. The complex needs planning process starts with the county team and counties will continue to maintain leadership over the planning process for the duration of the process and the Department’s participation.

PROCEDURE:

When to Submit a Referral

A county planning team can choose to submit a referral to the DHS Complex Needs Planning Team when all of the following apply:

- The county is supporting a youth with complex needs as described in this bulletin,
- That youth is 21 years old or younger,

- The county office submitting the referral represents one of the following: County Mental Health, County Intellectual Disability (or Developmental) and Autism, County Juvenile Probation, or County Children, Youth, and Families,
- The county has organized all relevant system partners at the local level and as appropriate, available family, caregivers, and/or the youth in planning efforts, **AND**
- The situation involves complexities or challenges that may need additional technical assistance. Ideally, referrals should be made as soon as the county planning team recognizes that the current situation is not resolvable with current planning efforts.

Please see Attachment A – When to Submit a Referral for further detail. **Note** – before submitting a referral, the Commonwealth of Pennsylvania’s Authorization to Use or Disclose Personal Information form must be completed (Attachment D).

How to Submit a Referral

To request assistance from the Department, please see Attachment B – How to Submit a Referral. In addition to the guidance described in Attachment B, documentation is expected and needed to support a complete understanding of the youth and family. Supporting documentation may include, but is not limited to:

- Psychiatric Evaluation
- Psychological Evaluation/Testing
- Individual Support Plan (ISP)
- Behavior Support Plan (BSP)
- Treatment Plan
- Functional Behavior Assessment (FBA)
- Individualized Education Plan (IEP)
- Clinical notes
- Permanency Plan
- List of resources attempted/referrals, including denial reasons
- Medication List
- Timeline of Events (trauma, loss, placement history, legal events)
- Other Pertinent Information

The Department recognizes that there may be organizations outside of county government that have identified a youth with complex needs who may benefit from the support of the DHS Complex Needs Planning Team. Such organizations should contact the relevant county agencies and inquire about planning efforts and discuss whether a referral to the DHS Complex Needs Planning Team is appropriate. At that time, the county can determine if they would like to move forward with a referral to the DHS Complex Needs Planning Team. If those organizations still have questions, they may contact the complex needs planning resource account at RA-PWCMPLEXCASEREFS@pa.gov. The DHS Complex Needs Planning Team will contact the county to offer a consultation or to consider submitting a referral, if appropriate.

Referral Review

The DHS Complex Needs Planning Team will review the referral and supporting documentation. Every effort will be made to prioritize and respond to referrals from counties and other queries within 10 business days upon receipt of requested information. This review includes the youth’s:

- Referral form;
- Submitted documentation;
- Current treatment needs;
- Current in- or out-of-home care needs;
- Current educational needs;

- Current recommendations to support the child and family;
- Past and current efforts to resolve concerns including behavioral health supports, intellectual disability/autism supports, educational supports, and social determinates of health.

Upon review by the DHS Complex Needs Planning Team, a primary program office will be identified. The primary program office will be the Office of Children Youth and Families (OCYF), Office of Developmental Programs (ODP), or Office of Mental Health and Substance Abuse Services (OMHSAS). The primary office is responsible for ensuring information is provided back to the DHS Complex Needs Planning Team and will serve as the main point of contact for the lead of the County Planning Team. The DHS Complex Needs Planning Team will contact the referring county to discuss appropriate Department team members to involve in complex needs planning.

Although there are pre-screen questions in the referral form, there may be an occasion where a referral is not appropriate. In those situations, the DHS Complex Needs Planning Team will contact the referring county to discuss the referral in more depth.

Ongoing Engagement and Available Support

The Department will begin to provide technical assistance to the County Planning Team and engage with existing planning meetings and other activities as appropriate. While the Department will be involved with complex needs planning, the county will maintain responsibility for scheduling, coordinating and facilitating complex needs planning meetings.

Regional Supports

The Regional DHS Complex Needs Planning Team (Regional Team) consists of subject matter experts and clinicians from a variety of fields and disciplines, who work within OMHSAS, OCYF and ODP.

The Regional Team will provide technical assistance to support the county's efforts to meet the complex needs of the youth with reasonable promptness, including as needed, the development of a comprehensive plan. In addition to the technical assistance, the Regional Team has existing relationships with other counties and providers in the region, which may be helpful toward finding a solution. Their technical assistance will occur through the Regional Team's participation in existing county planning meetings. The county will continue to coordinate, facilitate, and attend planning meetings, including adding any remaining regional offices to their existing complex needs planning meetings.

Statewide Supports

The Statewide DHS Complex Needs Planning Team (Statewide Team) includes additional subject matter experts and clinicians from OCYF, OMHSAS, ODP, and the Complex Needs Planning Leadership Team. In addition to the technical assistance and continued support in developing a comprehensive plan as needed, this team also brings a statewide perspective, is able to support county and regional office efforts to facilitate difficult or challenging planning meetings, has access to DHS leadership and can support communications with other branches of government, and is able to connect with other state and some federal agencies, if such outreach is required.

The role of the Statewide Team is to support the current county and regional planning team. This will occur through participation in existing meetings and the provision of technical assistance. The county will continue to coordinate, attend and facilitate complex needs planning meetings, engage in planning efforts and follow up action steps, and collaboratively work across child serving systems.

Resources

In addition to the support identified above, the Department has some suggested resources available. The suggested resources may be used by county complex needs planning teams to support their planning and facilitation efforts. Some

examples include agenda templates, case conceptualization forms, service planning tools, communication profiles, and more. These suggested resources can be found on the Department website.

Referral Closure

Referral closures may be initiated by the county or DHS Complex Needs Planning Team. A referral may be closed, and the DHS Complex Needs Planning Team will stop participating in planning meetings and providing technical assistance when:

- A county determines that support from the DHS Complex Needs Planning Team is no longer needed.
- The referral reason and/or crisis has resolved and there is a reasonable expectation that the youth with complex needs and family/caregiver(s) will remain stable.
- A comprehensive plan has been developed and continues to be implemented including coordinated treatment.
- New resources have been identified and accessed.
- Placement has been identified, and the transition has occurred.
- The County Planning Team has been successful with complex needs planning, meeting facilitation, and continues to work toward its identified goal.
- The young adult has turned 21 years of age and fully transitioned to the adult serving system.
- The youth with complex needs, family, and/or caregiver(s) choose to withdraw.

The closure process is gradual, support from the DHS Complex Needs Planning Team will fade with time. The DHS Complex Needs Planning Team will work with the county planning team to determine the duration of the closure process, but at a minimum, DHS will contact the county to receive updates once per month for three months. If at the third check-in, the county planning team feels confident that the youth's needs are met, the DHS Complex Needs Planning Team will end its outreach and close the referral. If, during the closure process, a county planning team identifies the need for additional support for the youth, the DHS Complex Needs Planning Team can rejoin county planning meetings and technical assistance will resume.

Reengagement

Following a closed referral, the county may re-engage the DHS Complex Needs Planning Team for technical assistance. If support from the DHS Complex Needs Planning Team is needed and it has been less than 6 months since the last status update, the county should email RA-PWCMPLEXCASEREFS@pa.gov. If it has been more than 6 months since the last status update, the county should submit a new Complex Needs Planning Referral Form with updated supporting documentation.

OBSOLETE BULLETIN:

14-Bul-110, Complex Case Planning for Children and Youth Under Age 21

ATTACHMENTS:

[Attachment A – When to Submit a Referral](#)

[Attachment B – How to Submit a Referral](#)

[Attachment C – Complex Needs Planning Referral Form Sample](#)

[Attachment D – Commonwealth of Pennsylvania, Department of Human Services – Authorization for Use of Disclosure of Personal Information](#)