



Louisiana Department of
EDUCATION



Louisiana Coordinated System of Care

MEMO

To: Planning Group

From: Leadership Team

Date: June 8, 2010

We are writing to communicate our acceptance of the Planning Group's Ideal Service Array Recommendations and to thank the group for such a thoughtful and thorough submission. We appreciate that your work spans the CSoc practice model, the service array, evidence-based and promising practices, and financing and quality management. We look forward to considering these recommendations into our deliberations regarding how to best implement Louisiana's CSoc.

As you know, we have contracted with Mercer to conduct a cross-system analysis of current services and funding sources to identify the state general funds currently in use that Louisiana can better leverage to generate federal funding. The analysis will also identify current resources that could potentially be better allocated to more effective services when at-risk children/youth currently served in out-of-home placements begin the transition to home- and school-based interventions.

This analysis will be complete in August and at that time we will be better able to make a determination of the resources available to support CSoc implementation as well as the changes in the authorities needed to obtain federal dollars as a match to state general funds. One of our primary goals is to replace state general funding for at-risk children with federal funds, so the State can expand the funding base for children's programs while reducing overall state general fund expenditures. As we consider our financing options, we will better understand the array of services that can be implemented through the CSoc.

Please thank the Ideal Service Array workgroup on our behalf. And we also thank all of you as members of the Planning Group for your hard work and commitment to the CSoc and to Louisiana's at risk children.

Louisiana Comprehensive System of Care
Ideal Service Array Workgroup

Ideal Service Array Workgroup Recommendations
Approved by Planning Group for submission to Leadership Team

May 26, 2010

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1. Louisiana Comprehensive System of Care (CSoC) goals, values and principles, and population of focus

The State of Louisiana is undertaking the development of a Coordinated System of Care (CSoC) for Louisiana's at risk children and youth with significant behavioral health challenges or co-occurring disorders. In the initial planning retreat, over forty agency and stakeholder leaders agreed to the following goals, values and population of focus for the CSoC.

Goals of System of Care implementation

- Reduction in the current number and future admissions of children and youth with significant behavioral health challenges or co-occurring disorders in out-of-home placements
- Reduction of the State's cost of providing services by leveraging Medicaid and other funding sources, as well as increasing service effectiveness and efficiency and reducing duplication across agencies
- Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care

CSOC values and principles

- Family-driven and youth-guided
- Home- and community-based
- Strength-based and individualized
- Culturally and linguistically competent
- Integrated across systems
- Connected to natural helping networks
- Data-driven, outcomes oriented

Population of focus

- Louisiana's CSoC will initially serve children and youth that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement.
- Out-of-home placements are defined as the following: detention, secure care facilities, psychiatric hospitals, residential treatment facilities, developmental disabilities facilities, addiction facilities, alternative schools, homeless as identified by DOE and foster care.

2. Practice model and service array

Purpose of this paper

This “working” document summarizes the discussion of the Ideal Service Array (ISA) Workgroup on the practice model and ideal services array for serving children, youth and their families through the CSoC.

- The practice model is the approach to implementation of a family-driven, youth-guided CSoC that emphasizes the values and principles adopted by Louisiana and its stakeholders described earlier in this document.
- The service array is the desired service categories that would be available statewide. Within each of these service categories, there is an array of “ideal” services that consist of evidence based and promising practices, basic behavioral health services, and other educational, rehabilitation, vocational and social services, as well as natural supports that may be offered to children, youth and their families.

The ISA Workgroup considers this a working document that outlines recommendations to guide the implementation of CSoC. The “ideal” services identified in this paper are examples of evidence-based and promising practices that may be funded through a various sources from Louisiana’s child serving agencies. The Workgroup supports continuous stakeholder involvement in refining the CSoC model and its recommendations. For the purposes of this paper, the term “behavioral health” covers both mental health and substance use.

Family-driven practice model

The ISA workgroup proposes a family-driven practice model to guide its CSoC. This model centers on basic principles of empowering families by relying on family choice or decision-making and emphasizes the strengths and capabilities of families; involves parents and their children in collaborative partnerships with professionals; maintains children and youth in their own homes whenever possible; addresses the uniqueness or culture of the family and follows principles of normalization, emphasizing the use of natural supports.

Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes: choosing culturally and linguistically competent supports, services, and providers; setting goals; designing,

implementing and evaluating programs; monitoring outcomes; and partnering in funding decisions. The Guiding Principles of Family-Driven Care are: 1) Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes; 2) Families and youth are given accurate, understandable, and complete information necessary to set goals and to make informed decisions and choices about the right services and supports for individual children and their families; 3) All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute decision makers at any time; 4) Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice; 5) Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and advocate for families and youth to have choices; 6) Providers take the initiative to change policy and practice from provider-driven to family-driven; 7) Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families and where family and youth organizations are funded and sustained; 8) Community attitude change efforts focus on removing barriers and discrimination created by stigma; 9) Communities and private agencies embrace, value and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities; 10) Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes so that the needs of the diverse populations are appropriately addressed.

Thus, a family-driven practice model across disciplines and settings views the family unit as the center and organizes assistance in a collaborative fashion in accordance with each individual family's wishes, strengths and needs. Family-driven delivery systems often rely on a Wraparound planning model where a team that includes the family, child, natural supports, agencies and community services work together in partnership on an individualized service planning process and provide necessary supports throughout treatment. The National Wraparound Initiative outlines standards for implementing effective wraparound planning and outlines ten principles:¹

¹ Bruns, E.J., Walker, J.S., Adams, J., Miles, P. , Osher, T.W., Rast, J., VanDenBerg, J.D. & National Wraparound Initiative Advisory Group (2004). *Ten Principles of the Wraparound Process*. Portland, OR: National Wraparound Initiative, Research and Training Center on Family Support and Children's Mental Health, Portland State University.

1. **Family voice and choice** – Families must be full and active partners in every level of the wraparound process, exercising both voice and choice.
2. **Team-based** – The Wraparound approach must be a team-based process involving the family, child, natural supports, agencies and community services working together to develop, implement and evaluate the individualized service plan.
3. **Natural supports** – Wraparound plans must include a balance of formal services and informal community and family resources.
4. **Collaboration** – The plan should be developed and implemented based on an interagency, community-based collaborative process.
5. **Community-based** – Wraparound must be based in the community.
6. **Cultural competence** – The process must be culturally competent, building on the unique values, preferences and strengths of children and families and their communities.
7. **Individualized** – Services and supports must be individualized and meet the needs of children and families across life domains to promote success, safety and permanence in home, school and community.
8. **Strengths-based** – Services and supports must identify and build upon the strengths of the child and family.
9. **Persistence** – An unconditional commitment to serve children and families is essential.
10. **Outcome-based** – Outcomes must be determined and measured for the system, for the program and for the individual child and family.

Recommendation #1: Family-Driven Practice Model. The ISA workgroup recommends the adoption of the Family-Driven Practice Model and statewide implementation of Wraparound planning, based on the principles of the National Wraparound Initiative. The Workgroup especially wants to emphasize the importance of providing family-driven and youth guided services in natural settings – homes, schools and in the community – instead of relying on out-of home placements in residential treatment, group homes, and psychiatric hospitals or other institutions and use of long-term day treatment programs.

System of care services

Family-driven systems of care (SoC) incorporate a wide range of services and supports that are organized into a coordinated network, are culturally competent and build meaningful partnerships with families at service delivery and policy levels. The goal is to improve outcomes for safety, permanency and well being by keeping children at home safely, increasing kinship care, maintaining community and school times and achieving timely permanency.²

The original service categories for SoC were developed by Pires et al, as listed below:

- Assessment and diagnosis
- Outpatient psychotherapy
- Medical management
- Home-based services
- Day treatment/partial hospitalization
- Crisis services
- Behavioral aide services
- Therapeutic foster care
- Therapeutic group homes
- Residential treatment centers
- Crisis residential services
- Inpatient hospital services
- Case management services
- School-based services
- Respite services
- Wraparound services
- Family support/education
- Transportation
- Mental health consultation
- Other, specify

From Pires, S.A. Building Systems of Care: A Primer, p. 40, Benefit Design/Service Array; Stroul, B.A., Pires, S.A., Armstrong, M.I. (2001). *Health care reform tracking project: Tracking state managed care reforms as they affect children and adolescents with behavioral health disorders and their families – 2000 State Survey*. Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health, Department of Child and Family Studies, Division of State and Local Support.

Since these key services were identified by Pires et al in 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a Child Mental Health Initiative, System of Care Request for Applications (RFA) in 2009 that identifies a “minimum required” set of services for a SoC, as well as other services essential to a SoC, both

² State of Kansas definition.

behavioral health services and non-behavioral health services.³ The SAMHSA services are based on the Pires et al categories and are representative of SoC services throughout the United States.

SoC behavioral health services (SAMHSA Child Mental Health Initiative)

- Screening to determine whether a child is eligible for services
- Diagnostic and evaluation services
- Cross-system care management processes
- Individualized service plan development, inclusive of caregivers
- Community-based services provided in a clinic, office, family's home, school, primary health or behavioral health clinic or other appropriate location, including individual, group and family counseling services, professional consultation and review and medication management
- Emergency services, available 24 hours a day, 7 days a week, including mobile crisis outreach and crisis intervention
- Intensive home-based services available 24 hours a day, 7 days a week
- Intensive day treatment services
- Respite care
- Therapeutic foster care
- Family advocacy and peer support services delivered by trained parent/family advocates including educational advocacy
- Training in all aspects of system of care development and implementation, including evidence-based, practice-based or community-defined interventions
- Therapeutic recreational activities

³ Short Title: Child Mental Health Initiative (CMHI). Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Cooperative Agreements for Comprehensive Community Mental Health Services for Children and Their Families Program. Request for Applications (RFA) No. SM-10-005. Catalogue of Federal Domestic Assistance (CFDA) No.: 93.104

- Mental health services (other than residential or inpatient facilities with ten or more beds) that are determined by the individualized care team to be necessary and appropriate and to meet a critical need of the child or the child's family related to the child's mental health needs
- Customized suicide prevention and intervention approaches to promote protective factors and intervene, as needed, to address the needs of children who have been identified as at risk for suicide (e.g., previous suicide attempts, suicidal ideation, etc.)
- Customized suicide prevention interventions, which identify children and youth at risk for suicide, including those who need immediate crisis services because of an imminent threat or active suicidal behavior.
- Educational services, especially for children and youth who need special education programs
- Health services, especially for children and youth with co-occurring chronic illnesses
- Out-of-home services, such as acute inpatient and residential, when clinically necessary
- Vocational counseling and rehabilitation and transition services offered under IDEA for those children 14 years or older who require them
- Protection and advocacy, including informational materials for children with a serious emotional disturbance and their families

The ISA Workgroup recommends inclusion of substance use treatment and prevention as required services in Louisiana's CSoC due to the high prevalence of co-occurring mental health and substance use conditions in youth. Furthermore, for children and youth with Autism Spectrum Disorders and developmental disabilities that meet the target population of the CSoC, scientifically based treatment and promising practices should be available. The Workgroup also emphasized the importance of offering recreation services and providing transportation to services.

Recommendation #2: CSoC service array: The ISA Workgroup recommends statewide adoption of the service categories outlined in the Child Mental Health Initiative (SAMHSA RFA) for the Louisiana CSoC. Furthermore, the Workgroup recommends provision of substance use treatment and prevention as required services. For children and youth with Autism Spectrum Disorders and other developmental disabilities that meet the target population of the CSoC, the Workgroup recommends provision of scientifically based treatment (e.g. ABA) and promising practices as clinically necessary and specified in the individual service plan. Other services and supports should also include therapeutic recreation services and transportation. Examples of the types of services for each of the Child Mental Health Initiative categories are listed later in this report. Additional work on defining specific service definitions based upon a review of current definitions in use (e.g., State Medicaid plan, other state definitions) and EBP and promising practices will be a necessary next step in the CSoC implementation process.

Evidence-based and promising practices

To support high quality services, the ISA Workgroup discussed the importance of providing evidence-based and promising practices that demonstrate high fidelity to the practice model. Evidence-based practices (EBP) are services that emerged from research studies with proven positive outcomes. Promising practices are services where positive outcomes exist but not at the level of research “evidence.” Fidelity means following the guidelines and standards for delivering the service to ensure the positive outcomes achieved in the research model are achieved. The Workgroup also recognizes there are other basic mental health services that may be helpful to children/youth or families that are not evidence-based or promising practices but demonstrate good outcomes as reported through standardized data collection processes. Furthermore, “practice-based research” that links academic research and practitioners to develop and implement effective practices is an important component of a SoC service array. The ISA Workgroup also recommended instituting standardized data collection and reporting methodologies for all services provided in the CSoC to track the services that have the best outcomes.

It is important to note that EBPs are diagnosis- and age-specific, meaning that research determined these services work for children and youth from defined age groups with specific diagnoses. For example, young children with conduct disorders and their parents may benefit from Parent Child Interaction Therapy (PCIT); youth with conduct disorders and involvement in the juvenile justice system may benefit from Multisystemic Therapy (MST) and Functional Family Therapy (FFT) (See definitions on the following pages). But, not all children benefit from every EBP. A problem that occurs during the implementation of EBPs is applying the same EBP to all children and youth, rather than conducting a thorough assessment and matching the service to the child’s/youth’s and family’s needs. Thus, different regions across Louisiana may elect to develop EBPs or promising practices that are tailored to children and families of specific ages, racial, ethnic, linguistic or cultural backgrounds based upon their population demographics.

Pires (2002, p. 46) discusses several considerations regarding evidence based practice that are relevant to Louisiana’s CSoC.⁴ She discusses the importance of:

- Studying interventions in the context of the existing service system and the diversity of the population;

⁴ Pires, S.A. Building Systems of Care: A Primer, p.43-46, Evidence-Based Practices, for National Technical Assistance Center for Children’s Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center; Supported by Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

- Using common sense and experience to select services when an evidence based practice does not exist;
- Identifying unique and creative practices that are candidates for development of an evidence base;
- Not allowing innovation to be stifled by the desire to use only proven interventions;
- Incorporating EBPs into SoC when there is data and supporting the use of effective clinical practice through training;
- Broadening the concept of EBPs to include processes that cross clinical interventions such as wraparound;
- Defining what constitutes “evidence” and the research methods considered acceptable for providing evidence and to ensure relevance to the CSoC; and
- Understanding that the concepts of EBPs go hand in glove with SoC.

For these reasons, the ISA workgroup recommends that Louisiana expedite the implementation of EBPs that have been tested on a broad population base and promising practices that have been shown to prevent out-of-home placements and/or enabling children and youth to leave out-of-home placements and to succeed at home, in school, and in the community.

Recommendation #3: Reliance on evidence-based and promising practices. To help families begin to transition their children and youth currently in residential treatment and other out-of-home placements, the ISA Workgroup recommends targeting specific EBPs and promising practices for expedited statewide implementation, such as **HOMEBUILDERS®**, Functional Family Therapy (FFT) and Multisystemic Therapy (MST) or other services that demonstrate good outcomes. Specific practices should be selected based upon further analysis of the ages and needs of children and youth currently in out-of-home placements.

Financing the ideal service array

To support the development of EBPs and promising practices, the ISA Workgroup discussed the need for flexible funding arrangements that will pay for the “ideal services array.” Strategies to finance services will require careful analysis of current funding. The potential to leverage Medicaid funds exists to pay for allowable services for eligible recipients. This strategy could free up state dollars to support a wider array of services for children and youth not eligible for Medicaid. The Workgroup also noted that payments for services will need to be structured to provide incentives for delivery of EBP and promising practices that have proven outcomes.

Recommendation #4: Financing the ideal service array. The ISA Workgroup recommends that Louisiana institute flexible financing that allows provision of EBPs and promising practices through careful analysis and leveraging of state and Medicaid funds. The financing structure should offer enhanced funding for specific EBPs and promising practices

that have been shown to be effective at preventing out-of-home placements and/or enabling children and youth to leave out-of-home placements and to succeed at home, in school, and in the community. Providers of such services must demonstrate fidelity to the particular EBP or promising practice to be considered qualified or participating EBP or promising practice providers. This approach will allow the flexibility to finance proven practices while requiring the practice to meet defined quality standards.

Implementing the ideal service array

Implementation of EBPs and promising practices takes time, training and staff that are committed to learning the practice and willing and able to participate in supervision and training activities that promote fidelity to the practice standards. Significant attention to workforce development and training will be necessary. It is essential to design a workforce development and training plan that addresses training and certification in EBPs or promising practices, as well as ongoing clinical supervision. Options include developing training institutes, centers of excellence and academic partnerships to achieve these goals.^{5, 6} The Workgroup noted that it will be important to build provider capacity concurrently with the delivery of CSoC services. Furthermore, the Workgroup recommended that EBPs be promoted and encouraged through the establishment of provider incentives, adequate rates, and access to necessary training, so as to promote greater statewide availability of evidence-based and promising practices.

Recommendation #5: Implementing EBPs and promising practices. The ISA Workgroup recommends preparation of a workforce development and training plan for CSoC implementation. The training plan should address the fundamental principles and requirements for the CSoC, desired EBPs and promising practices. The Workgroup recommends establishing training institutes, centers of excellence or other training and technical assistance centers to assist regions and providers. If the CSoC utilizes a statewide management organization for administration of the CSoC, training and technical assistance could be provided by this entity.

Recommendation #6: Implementing a Quality Management and service outcomes approach. The ISA Workgroup recommends development of a quality management plan for the CSoC that includes tracking of service outcomes.

⁵ Please see: Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). "Implementation Research: A Synthesis of the Literature." Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

⁶ See also the National Implementation Research Network's website. <http://www.fpg.unc.edu/~nirn/reviews/index.cfm>

3. Summary of recommendations

Recommendation #1: Family-Driven Practice Model. The ISA workgroup recommends the adoption of the Family-Driven Practice Model and statewide implementation of Wraparound planning, based on the principles of the National Wraparound Initiative. The Workgroup especially wants to emphasize the importance of providing family-driven services in natural settings – homes, schools and in the community – instead of relying on out-of-home placements in residential treatment, group homes, and psychiatric hospitals or other institutions and long-term day treatment programs.

Recommendation #2: CSoC service array: The ISA Workgroup recommends statewide adoption of the service categories outlined in the Child Mental Health Initiative (SAMHSA RFA) for the Louisiana CSoC. Furthermore, the Workgroup recommends provision of substance use treatment and prevention as required services. For children and youth with Autism Spectrum Disorders and other developmental disabilities that meet the target population of the CSoC, the Workgroup recommends provision of scientifically based treatment and promising practices as clinically necessary and specified in the individual service plan. Other services and supports should also include therapeutic recreation services and transportation. Examples of the types of services for each of the Child Mental Health Initiative categories are listed later in this report. Additional work on defining specific service definitions based upon a review of current definitions in use (e.g., State Medicaid plan, other state definitions) and EBP and promising practices will be a necessary next step in the CSoC implementation process.

Recommendation #3: Reliance on evidence-based and promising practices. To help families begin to transition their children and youth currently in residential treatment and other out-of-home placements, the ISA Workgroup recommends targeting specific EBPs and promising practices for expedited statewide implementation, such as **HOMEBUILDERS®**, Functional Family Therapy (FFT) and Multisystemic Therapy (MST) or other services that demonstrate good outcomes. Specific practices should be selected based upon further analysis of the ages and needs of children and youth currently in out-of-home placements.

Recommendation #4: Financing the ideal service array. The ISA Workgroup recommends that Louisiana institute flexible financing that allows provision of EBPs and promising practices through careful analysis and leveraging of state and Medicaid funds. The financing structure should offer enhanced funding for specific EBPs and promising practices that have been shown to be effective at preventing out-of-home placements and/or enabling children and youth to leave out-of-home placements and to succeed at home, in school, and in the community. Providers of such services must demonstrate fidelity to the particular EBP or promising practice to be considered qualified or participating EBP or

promising practice providers. This approach will ensure the flexibility to finance proven practices while requiring the practice to meet defined quality standards.

Recommendation #5: Implementing EBPs and promising practices. The ISA Workgroup recommends preparation of a workforce development and training plan for CSoC implementation. The training plan should address the fundamental principles and requirements for the CSoC, desired EBPs and promising practices. The Workgroup recommends establishing training institutes, centers of excellence or other training and technical assistance centers to assist regions and providers. If the CSoC utilizes a statewide management organization for administration of the CSoC, training and technical assistance could be provided by this entity.

Recommendation #6: Implementing a Quality Management and service outcomes approach. The ISA Workgroup recommends development of a quality management plan for the CSoC that includes tracking of service outcomes.

The next section of this paper outlines service categories and examples of services in an ideal service array.

4. Ideal service array

The table below lists service categories identified in the SAMHSA Child Mental Health Initiative RFA for a SoC in the left column and sample services (and definitions) in an ideal service array. The ISA Workgroup members provided examples of services in each category that are representative of the array of services essential to a CSoC. While it is not feasible to list every service that a child, youth and their family might need, the services listed are representative of an ideal array for each service category.

Category of service	Service array examples
Screening to determine whether a child is eligible for services.	“Screening is the first step of an ongoing process to determine a child’s need for services” (Pires, 2002, p. 53). Screening for CSoC may involve use of a standardized tool such as the Child and Adolescent Needs and Strengths assessment (CANS)
Diagnostic and evaluation services	Assessment and diagnosis is gathering and assessment of historical and current information, which includes face-to-face contact with the person and/or the person’s family or other informants or groups of persons resulting in a written summary report and recommendations. (Arizona Department of

Category of service	Service array examples
	<p>Health Services, Division of Behavioral Health Services Guide)</p> <p>Evaluation is often discipline-specific (e.g., psychological testing, neuropsychological testing) and is conducted by individuals trained and certified in a specific discipline. It provides a closer, more intensive study in a particular area to provide additional data and recommendations to the assessment and care-planning process (Building Systems of Care: A Primer, p.53).⁷ The intent of assessment and diagnosis category is to allow for the type of assessments and evaluations that address the specific needs of children and youth. In SoC, assessment and evaluation should be strength-based (Pires 2002, p. 53).</p>
Cross-system care management processes	<p>Care management, or care coordination services, tailored to the needs of individual children and youth are required for all children and adolescents who are offered access to the services provided under this cooperative agreement. Care management represents the procedures that a trained service provider uses to access and coordinate multi-agency services for a child with a serious emotional disturbance and the child’s family. For the Louisiana CSoC, Wraparound planning will be the primary method for cross-system care management. (Child Mental Health Initiative)</p>
Individualized service plan development inclusive of caregivers	<p>Each child or adolescent served within the system of care funded under this program must have an individualized care plan developed by an interagency team, with leadership from the child’s parents or legally responsible adult and the child or youth. The individualized care plan refers to the procedures and activities that are appropriately scheduled and used</p>

⁷ Pires, Sheila A. Building Systems of Care, A Primer. (2002). Human Services Collaborative, National Technical Assistance Center for children’s Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. Supported by Child, Adolescent and Family Branch, Center for Mental Health Services, Substance abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Category of service	Service array examples
	<p>to deliver services, treatments and supports to a child and the child’s family. These procedures and activities must fit the unique needs of the child and the child’s family and build on child and family strengths. The group that assists the care manager, family member and child to implement the individualized care plan is the individualized care team. Team members are identified in partnership with the individual child and family and comprised of representatives from agencies that provide services to the child and the family, as well as other significant individuals in the community who relate closely to the child and family. (Child Mental Health Initiative) For Louisiana’s CSoC, wraparound planning and use of child and family teams will be utilized for developing the individualized service plan. The ISA Workgroup recommends using the Wraparound model for individualized service plan development.</p>
<p>Community-based services provided in a clinic, office, family’s home, school, primary health or behavioral health clinic or other appropriate location, including individual, group and family counseling services, professional consultation and review and medication management</p>	<p>Behavioral health counseling and psychotherapy is an interactive therapy designed to elicit or clarify presenting and historical information, identify strengths and stressors, and affirm resourcefulness and help seeking, provide support, education or understanding for the person, group or family to resolve or manage the stressors and prevent, resolve or manage similar future stressors. Services may be provided to an individual, a group of persons, a family or multiple families. (Adapted from Arizona Department of Health Services, Division of Behavioral Health Services Guide and Building Systems of Care: A Primer, p. 55). The ISA Workgroup recommends that a range of licensed and certified practitioners (e.g., licensed clinical social workers, licensed professional counselors, licensed marriage and family counselors, and certified addictions counselors), in addition to psychiatrists and psychologists provide these services. The ISA Workgroup also recommends establishing qualifications and certification requirements for peer and family support specialists, and qualifications for paraprofessionals that work under the direction of licensed professionals.</p> <p>Goal is to shape outpatient services to individual child and family strengths</p>

Category of service	Service array examples
	<p>and needs using EBPs treatment protocols. Examples may include, but are not limited to: Brief solution-focused therapy and Stages of Change/ Motivational Interviewing; Aggression Replacement Therapy (ART), offered in outpatient clinics or day treatment settings for children exhibiting significant aggression; dialectical behavior therapy (DBT), group therapy offered in outpatient clinics to adolescents with borderline personality features; child-parent psychotherapy (CPP), a trauma-focused treatment, offered in-home for approximately one year to young children and non-offending caregivers who have experienced domestic violence; parent child interaction therapy (PCIT): an empirically supported treatment for conduct-disordered young children that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns; brief strategic family therapy (BSFT): offered in outpatient clinics to improve child behavior and family relationships; ASAM outpatient land intensive outpatient substance use treatment consistent with the American Society of Addiction Medicine (ASAM) level of care and other substance use treatment models, such as Seven Challenges Model for adolescents with co-occurring disorders, an individualized program that incorporates a cognitive/emotional decision-making model, and Adolescent Community Reinforcement Approach (ACRA) to promote abstinence from marijuana, drugs and alcohol in the intensive outpatient level of care.</p> <p>School-based services identify and intervene at early points in emotional disturbances and assist parents, teachers and counselors in developing comprehensive strategies for resolving these disturbances. Services include: individual, family and group counseling, crisis intervention, psychiatric consultation, consultations with school staff, staff development workshops, parent/support workshops, after-school programs, violence and substance use prevention programs, in-school suspension counseling, gang awareness and interventions, positive behavioral interventions and supports and juvenile arbitration. (South Carolina Department of Mental Health)</p>

Category of service	Service array examples
	<p>http://www.state.sc.us/dmh/schoolbased/about.htm</p> <p>Medical services are provided by or ordered by a licensed physician, nurse practitioner, physician assistant or nurse to reduce a person’s symptoms and improve or maintain functioning. These services have been further grouped into the following four subcategories: 1) medication, 2) laboratory, radiology and medical imaging and 3) medical management (including medication management). (Arizona Department of Health Services, Division of Behavioral Health Services Guide)</p> <p>A Behavioral Health Aide (BHA) is a non-professional counselor, health educator, and advocate to help address community behavioral health needs which include alcohol, drug, and tobacco abuse and mental health disorders such as grief, depression, suicide, and related issues. BHAs seek to achieve balance in the community by bringing solutions and sensitivity to cultural needs. BHAs work under the supervision of a behavioral health professional. (Compiled from several sources.)</p> <p>Personal care attendant to provide support to children/youth in their homes and natural settings.</p> <p>Ambulatory detoxification in the clinic setting, which requires a medical team consisting of physician, nursing and addiction counseling staff.</p> <p>Telepsychiatry, covering a range of outpatient treatment and medical management services provided in schools and homes to reach children, youth and families in remote settings.</p>
Emergency services, available 24 hours a day, 7 days a week, including mobile crisis outreach and crisis intervention	Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated or potentially deleterious behavioral health condition, episode or behavior. Crisis intervention services

Category of service	Service array examples
	<p>are provided in a variety of settings, including but not limited to, a person's place of residence, other community sites and licensed facilities or over the telephone. These intensive and time-limited services may include screening, (e.g., triage and arranging for the provision of additional crisis services) assessment, evaluation or counseling to stabilize the situation, medication stabilization and monitoring, observation and/or follow-up to ensure stabilization and/or other therapeutic and supportive services to prevent, reduce or eliminate a crisis situation. (Arizona Department of Health Services Division of Behavioral Health Services Guide.) For CSoC, crisis services should include:</p> <ul style="list-style-type: none"> ▪ Consultation ▪ 24/7 telephone crisis, with access to professionals for the purpose of identifying crisis resolution including linkage to other necessary services ▪ 24/7 face-to-face mobile crisis available in homes and schools ▪ Family/peer support services ▪ Warm lines, with access to family/peer support specialists ▪ In-home crisis respite ▪ Out-of-home crisis respite, with intensive staffing and behavioral health and medication management. ▪ Telepsychiatry crisis services, such as access to psychiatrists from emergency rooms or crisis respite facilities ▪ Transportation to crisis facilities or emergency rooms
<p>Intensive home-based services available 24 hours a day, 7 days a week</p>	<p>The ISA Workgroup recommends implementation of various EBPs and promising intensive home-based service models. Examples of evidence-based intensive home-based services include:</p> <p>HOMEBUILDERS® provides intensive, in-home crisis intervention, counseling and life-skills education for families who have children at imminent risk of placement in state-funded care. It is the oldest and best documented Intensive Family Preservation Services (IFPS) program in the United States. HOMEBUILDERS® goal is to prevent the unnecessary out-</p>

Category of service	Service array examples
	<p>of-home placement of children through intensive, on-site intervention and to teach families new problem-solving skills to prevent future crises.</p> <p>The HOMEBUILDERS® program accepts families in which one or more children are in imminent danger of being placed in foster, group or institutional care. HOMEBUILDERS® is also used for families whose children are being returned from out-of-home care and for difficult post-adoption situations. See http://www.institutefamily.org/</p> <p>Functional Family Therapy (FFT) was developed by Thomas Sexton (2004) and his colleagues. It is a research-based family program for at risk adolescents and their families, targeting youth between the ages of 11-18 and has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (service delivery, supervision and organizational support) and quality assurance and improvement.</p> <p>FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on risk and protective factors. Intervention incorporates community resources for maintaining, generalizing and supporting family change (Rowland et al., 2001). FFT should be included in the system of care as a moderate-intensity family-based treatment for youth with moderate to severe behavioral problems, involving disruptive and oppositional behavior, as well as some with willful misconduct and lower level delinquency. FFT is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity. Sexton, Thomas L. <i>Implementing Functional</i></p>

Category of service	Service array examples
	<p><i>Therapy: Practical, Theoretical, and Empirical Findings.</i> 17th Annual RTC Conference, Tampa FL. March 1, 2004.</p> <p>Multisystemic Therapy (MST) is an intensive home-based service model provided to families in their natural environment, at times convenient to the family. MST is intensive and comprehensive, with low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory, where behavior is multi-determined and best understood in the naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of youth anti-social behavior (Weiss et al., 2004). At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and a reduction in association with "deviant" peers, primarily through parental mediation (Huey et al., 2004). Findings revealed that the successful implementation of MST leads to improved family functioning and indirectly to a decrease in peer affiliation and youth delinquency. Studies have also found that therapists who are directive without first gaining the trust and support of family members may be less effective or even detrimental. This finding fits with increasing evidence that suggests that an initial focus on collaborative, relationship building elements is necessary before the more active components of MST can be effectively applied. MST is widely implemented in many states, including Connecticut, Ohio, Colorado, Washington, Hawaii and Tennessee.</p> <p>Weiss, Bahr, Catron, Tom, Han, Susan, Harris, Vicki, Caron, Annalise, Ngo, Vicky. An Independent Evaluation of Multisystemic Therapy (MST). Center for Psychotherapy Research & Policy, Vanderbilt University.</p>

Category of service	Service array examples
	<p>Other outpatient treatment practices such as DBT and CBT, therapeutic behavioral health aides, can be provided in the home on an intensive basis to address specific needs as identified in the wraparound planning process.</p>
Intensive day treatment services	<p>Intensive therapeutic day treatment: A short-term, time limited intensive program of active treatment with regularly scheduled hours meant to assist the child/youth to recover and return to school or employment. Services may include individual, group and/or family counseling and therapy, including substance use treatment, skills training and development, behavioral health prevention/promotion, medication training and support, ongoing support to return to school or employment, family support, medication monitoring, self-help/peer services and/or medical monitoring. (Adapted from the Arizona Department of Health Services Division of Behavioral Health Services Guide.)</p>
Respite care	<p>Respite services involve the supervision and/or care of persons residing at home in order to provide an interval of rest and/or relief to the person and/or their primary care givers and may include a range of activities to meet the social, emotional and physical needs of the person during the respite period. These services may be provided on a short-term basis (i.e., few hours during the day) or for longer periods of time involving overnight stays. Respite services can be planned or unplanned. If unplanned respite is needed, the appropriate agency personnel will assess the situation. (Arizona Department of Health Services, Division of Behavioral Health Services Guide)</p>
Therapeutic foster care	<p>MTFC is a type of therapeutic foster care provided to children living with foster parents or for families who require an intensive period of treatment before reunification. This approach is well described in literature</p>

Category of service	Service array examples
	<p>disseminated by the developers of MTFC (TFC Consultants, Inc., 2006) with a primary goal to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents who are in need of out-of-home placement. Youth come to MTFC via referrals from the juvenile justice, foster care and mental health systems. MTFC treatment goals are accomplished by providing close supervision, fair and consistent limits, predictable consequences for rule breaking, a supportive relationship with at least one mentoring adult and reduced exposure to peers with similar problems. Intervention is multifaceted and occurs in multiple settings. Components include:</p> <ul style="list-style-type: none"> ▪ Behavioral parent training and support for MTFC foster parents ▪ Family therapy for biological parents (or other aftercare resources) ▪ Skills training for youth ▪ Supportive therapy for youth ▪ School-based behavioral interventions and academic support ▪ Psychiatric consultation and medication management, when needed. <p>There are three versions of MTFC designed to be implemented with specific ages. Each version has been subjected to evaluation and found to be efficacious. FFT should be included in the SOC as a service option for children and families for whom a temporary out-of-home placement is necessary or as a transition between more restrictive out-of-home settings and a return to the community. MTFC website. MTFC Program Overview. http://www.mtfc.com/overview.html</p>
<p>Family advocacy and peer support, including educational advocacy services delivered by trained parent/family advocates</p>	<p>Family support is defined here as the assistance given to families to cope with the extra stresses that accompany caring for a child with emotional disabilities. In addition to the stress of raising a child with an emotional disability, families often face other difficulties, such as poverty, joblessness, substance abuse and victimization. Family support often helps keep families</p>

Category of service	Service array examples
	<p>together by assisting them with the practicalities of living and by attending to the needs of all family members (Will, 1998). The main goal of family support services is to strengthen adults in their roles as parents, nurturers and providers (Weissbourd & Kagan, 1989) (U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.)</p>
<p>Training in all aspects of system of care development and implementation, including evidence-based, practice-based or community-defined interventions</p>	<p>Statewide management organization (if this administrative structure is selected); care management organizations; agency specific training; Centers of Excellence, training institutes, technical assistance and consultation.</p>
<p>Therapeutic recreational activities</p>	<p>Therapeutic recreation services have been recognized as an alternative/additional modality that may impact troubled and otherwise hard-to-reach youth. Social and peer skills may be improved through athletics and team sports. Self-esteem and self-confidence may be improved through music and art. With these same interventions and the addition of dance, dramatics, and other creative arts, youth may be assisted in expressing feelings of anger, sadness, isolation and hopelessness so that they may then deal with these feelings as they mature and develop. Cognitive, decision-making and problem-solving skills may be developed through cooperative games, initiatives and team-building activities. Youth may be educated on the role of leisure time and leisure/recreation resources in their community, so that a functional leisure lifestyle may be developed, as opposed to youth who, being faced with idle time and not knowing how or having the skills to use this time, would vandalize, rob, steal and/or use substances. (http://www.liveoakchicago.com/publication6.php)</p>

Category of service	Service array examples
<p>Behavioral health services (other than residential or inpatient facilities with ten or more beds) that are determined by the individualized care team to be necessary and appropriate and to meet a critical need of the child or the child's family related to the child's behavioral health needs</p>	<p>Partial Hospital Placement (PHP) consistent with the ASAM level of care definition for treatment of substance use conditions as a cost-effective model for increasing contact hours within the community setting, while engaging the adolescent and family in treatment.</p> <p>Partial Hospital – Time limited intensive outpatient step down from inpatient psychiatric hospital services.</p>
<p>Customized suicide prevention and intervention approaches to promote protective factors and intervene as needed to address the needs of children who have been identified as at risk for suicide (e.g., previous suicide attempts, suicidal ideation, etc.)</p>	<p>Peer support programs such as Link-Up (Minnesota) that target prevention at junior and senior high school students identified as at risk on the basis of prior problems of absenteeism, marginal academic performance, and personal problems identified by school staff. The program involves a series of small group sessions in which participants are taught to give each other support by listening and providing friendship. The Youth Suicide Prevention Project (Washington) is a peer support program for youth who have made a prior suicide attempt. The program offers weekly group meetings that give participants an opportunity to develop peer support and improve coping skills. The groups are designed to reduce the alienation and isolation felt by participants.</p>
<p>Customized suicide prevention interventions, which identify children and youth at risk for suicide, including those who need immediate crisis services because of an imminent threat or active suicidal behavior.</p>	<p>Wraparound Milwaukee's Mobile Urgent Treatment Team is staffed by a team consisting of psychologists, social workers, nurses, case manager and consulting physician, the Mobile Urgent Treatment Team provides crisis intervention services on a 24 hour basis to families.</p> <p>School and Community Gatekeeper programs provide training and support to individuals within the community and school who are in a position to observe "high-risk" behaviors and take action. The goal of these programs is to equip community members with basic suicide prevention education and</p>

Category of service	Service array examples
	intervention skills.
Educational services, especially for children and youth who need special education programs	<p>Coordinated School Health and Comprehensive Learning Supports</p> <p>School-Wide Positive Behavioral Interventions & Supports is an evidence-based decision making framework that guides selection, integration, and implementation of the best evidence-based academic and behavioral practices for improving important academic and behavior outcomes for all students.</p> <p>Project ACHIEVE is a whole school improvement process that emphasizes teacher development and ongoing technical consultation. The professional development process focuses on teaching staff (a) research-based information and effective instructional and educational practices that (b) translate into skills that are implemented in school and classroom to support student success.</p>
Health services, especially for children and youth with co-occurring chronic illnesses	Assessment during wraparound planning process and referral to appropriate health care providers; assignment of a health care home; ongoing collaboration with health care providers to monitor health status.
<p>Out-of-home services, such as acute inpatient and residential, only when clinically necessary, i.e. when intensive services in less restrictive settings are not appropriate.</p> <p>Inpatient and residential treatment should not be substituted for services in less intensive settings because such services are not available, unless clinically necessary.</p>	<p>Residential treatment: Inpatient psychiatric treatment under the direction of a psychiatrist, which includes an integrated residential program of therapies, activities and experiences provided to persons who are under 21 years of age and have severe or acute behavioral health symptoms, as close to the family's home as possible. There are two types of residential treatment centers:</p> <ul style="list-style-type: none"> ▪ Secure – a residential treatment center which generally employs security guards and uses monitoring equipment and alarms. ▪ Non-secure – an unlocked residential treatment center setting. <p>(Arizona Department of Health Services, Division of Behavioral Health Services Guide.)</p>

Category of service	Service array examples
	For the CSoC, the residential services continuum could include gender-responsive services, programs for co-occurring developmental disabilities/co-occurring mental health and substance use disorders, array of sub-acute stabilization/medium-term family-oriented/longer-term restrictive residential services/sex offending youth/ ASAM residential levels of care for substance use treatment.
Vocational counseling and rehabilitation and transition services offered under IDEA, for those children 14 years or older who require them	<p>Preparing Adolescents for Young Adulthood (PAYA) is an independent living preparation curriculum designed to be used with the Casey Life Skills tools, a promising practice provided by Casey Family Programs. Both the validity and reliability for Casey Life Skills are strong.</p> <p>In addition to specific programs, several successful SOC have focused on transition-age youth:</p> <ul style="list-style-type: none"> ▪ Partnership for Youth Transition Program – Allegheny County, PA ▪ Odyssey Program – Maine ▪ Options Program – Clark County, WA ▪ Pride-4 – PACT 4 Families Collaborative, MN
Protection and advocacy, including informational materials for children with a serious emotional disturbance and their families	Access to protection and advocacy advocates; distribution of human rights and rights, complaints, grievances and appeals; youth peer and family peer support/advocacy services.

Category of service	Service array examples
Other supports	Intrinsic and extrinsic reinforcements ⁸ , motivational interventions and items such as a radio, makeup, clothing, punching bag, skateboard, trips, activities, photographs for teen magazine, etc. Transportation: transportation to and from services and supports. Other services and supports that may be useful to include: <ul style="list-style-type: none"> ▪ After school programs – no cost to families ▪ Enrichment programs – no cost to families ▪ Independent living skills/social skills training ▪ Family resource centers ▪ Toys provided to parents to assist with developmental issues

⁸Extrinsic reinforcements: Lourie, I., Katz-Leavy, J & Stroul, B. (1996). Individualized services in a system of care. In B. Stroul (Ed), *Children’s mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brookes, Publishing Co.