

**Fairfax County, Virginia**

**System of Care  
Services Committee  
Final Report and  
Recommendations**

**November 2009**

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## Background

### Services for At-Risk Youth and their Families in Virginia

In November 2008, a System of Care initiative was undertaken by Fairfax county government, the public schools and the provider community to address the growth in expenditures for services and supports associated with the Comprehensive Services Act for At Risk Youth (CSA). CSA was established by the Virginia General Assembly in 1992 to support services and programs to children at risk or experiencing emotional or behavioral problems. This funding stream is one component of several supports available to serve youth and families, and is generally concentrated in service delivery to the highest need youth in communities.

As illustrated in the following chart, after several years of static growth, CSA expenditures had increased by over 25% between FY 2006 and FY 2008, and were expected to continue to rise. Due to practice adjustments in both placement decisions by the Family Planning and Assessment Teams approving residential placements, combined with departmental initiatives in the child placing agencies, a reduction in expenditures was realized between 2008 and 2009, thereby providing slight budgetary relief:

<b>CSA Expenditures for Fairfax Falls Church</b>		
Fiscal Year	\$ amount	% Change (1yr)
2006	\$ 32 million	----
2007	\$ 36 million	12%
2008	\$ 40 million	11%
2009	\$ 39 million	-2.4%

Concurrent to the experienced expenditure increases at the local level, State officials conducted a state-wide analysis of the CSA program and the funding sources and placement practices associated with the cost of care for children deemed at risk of emotional or behavioral problems. State officials noted the following:

- Virginia had too many children in residential care
- Some children were placed in more restrictive, intensive settings than necessary
- Children were staying in residential care too long
- Very few (5%) foster care children were placed with families and relatives
- Too many children aged out of foster care without achieving permanency

Further, state-wide CSA caseloads continued to grow, reflecting corresponding increasing costs:

- State-wide, youth served through CSA increased by 7.8% in FY 07 over FY 06; costs increased 16%

- State-wide CSA costs increased an average of 8% per year from FY 00 to 06
- Residential costs were 42.4% of all CSA state pool expenditures in FY 07

**In response to these identified challenges, the state created a two part strategy to contain costs:**

- Incentives – Established a new match rate that provided more state funds and lower local costs when localities provide community-based services in the family’s home or in a familial-like setting.
- Disincentives – Established a higher local cost for using residentially-based and group home-based treatment services so it is used only when children need this level of intensive care.

### Changes to Match Rate

Implementation timeframe	Family Foster Homes	Community Based Services	Residential Services
July 08- Dec 08	25% decrease in base rate	50% decrease in base rate	24% increase in base rate
Jan 09- June 10	Maintain 25% decrease	55% decrease in base rate	40% increase in base rate
July 2010 onward	Maintain 25% increase	Maintain 55% decrease	55% increase in base rate

Assuming a contract rate increase of 4% per year through FY 09-10, it was estimated that the proposed match rate change would result in a net revenue loss to Fairfax County of approximately \$1,728,487 in FY 2009.

The State was also engaged in a multi-year strategy, launched in November 2007, to establish a Children’s Services Transformation initiative. Led by the First Lady of Virginia, Anne Holton, thirteen localities were invited to serve on the Council on Reform (CORE), Fairfax County being one of those localities. In partnership with state agencies and community partners, this group was tasked with the following:

- ✦ Adoption of a statewide philosophy that supports family-focused, child-centered, community-based care with a focus on permanence for all children.
- ✦ Establishment of a state-level practice and uniform training program for resource families and staff in localities.
- ✦ Creation and implementation of strategies to increase availability and utilization of relative care and non-relative foster and adoptive placements to ensure that children can be placed in the most family like setting that meets their needs.
- ✦ Creation of a performance monitoring/quality assurance system to identify and measure outcomes, monitor quality of practice and improve accountability.

Additional activities were undertaken at the state and local levels, including implementation of reforms for improved access to mental health services for children, adolescents and their families, implementation of a Children's Mental Health Initiative to provide school-based mental health services, and establishment of three teaching Centers of Excellence.

To address the growth in local expenditures, and in light of state and national efforts to reform children's services, Fairfax County Deputy County Executive Verdia Haywood moved to create a local initiative for establishment of a system of care approach in children's services.

The initiative was guided by a community System of Care Reform group, comprised of public agencies/departments charged with meeting the needs of at-risk youth and families. Staffs from Fairfax County Public Schools, members of the private provider community representative of the continuum of care for youth and families, family representatives and county departments were convened over a series of months to plan for new strategies. Leadership identified the following areas of work to be completed:

- ▲ Adopt values and principles to serve the target population across all stakeholders, including cultural competence and family and youth engagement.
- ▲ Establish outcomes to be achieved.
- ▲ Identify performance indicators to measure progress toward achieving outcomes.
- ▲ Improve use of information technology to support quality services.
- ▲ Provide greater opportunity for family and youth voice in the development of policy and practice.
- ▲ Develop and promote practice models that empower families and engage youth in planning their own services, treatment and responsibility for the outcome.

The following goals and guiding principles were adopted by the group in December 2008:

### **Goals of the System of Care Reform Initiative**

- **Reduce the number of Fairfax-Falls Church children in long-term residential and group home placements by 33% between January 1, 2009 and January 1, 2010 by creating sustainable community-based services and individualized services planning (Defined as: point in time count of youth in residential and group home placements).**
- **Limit lengths of stay in residential/group home placements to an average of 6-9 months or less for children with serious emotional disturbances**
- **Limit FY 2009 and FY 2010 expenditures to FY 2008 actual expenditures by:**
  - **Maximizing use Medicaid, Title IV-E and other revenue sources to offset county costs for residential and community services; and**
  - **Implementing approved cost containment measures to reduce use of residential placements**

### **System Change Goals**

- Develop a seamless, improved and cost-effective system of care service approach for all youth by creating and implementing new community based resources in Fairfax-Falls Church and immediate region
- Create a comprehensive system of care for children with developmental or intellectual disabilities, including pervasive developmental disorders such as autism, supported by alternative revenue sources including Medicaid and third party funding

### **Measuring System Change**

- Serve 90% or more of children in CSA in the community annually (defined as no placements in out-of county congregate care).
- Reduce the total county-funded residential treatment bed days through focus on the appropriate development and use of in- community treatment and services and improvement of treatment and transition options when residential placements are used.

Philosophy: *The most important community responsibility is the well-being of children.* Children belong with families who nurture and protect them, children deserve healthy relationships, and families deserve to live in safe environments.

### **Values Supporting the SOC Reform Group**

- Services are supportive to children and their families, providing them with the opportunity to succeed in the community to the fullest extent possible;
- Needs of children and families will be met in the least restrictive way, with families fully participating in the decision making process;
- The family unit will remain intact whenever possible, and issues are to be addressed in the context of the family unit;
- Services will be community-based whenever possible, and children will be placed outside of the community only when absolutely necessary; all agencies providing services will work together, cooperatively, with each other and with the family, to gain maximum benefit from the available resources.

### **Guiding Principles of Service Delivery**

- *Services are flexible and comprehensive* to meet the individual needs of children and families;
- *Services are easily accessible* to residents of the community, regardless of where they live, their native language or culture, their level of income, or their level of functioning;
- *Services are integrated into the community*, in the neighborhoods where the people who need them live;
- *Services are family driven and child focused* to promote the well-being of the child and community;
- *Services are responsive* to people and adaptable to their changing needs;
- *Services are provided through collaborative and cooperative partnerships* between people living in their community and public and private organizations.
- *Services are provided in a seamless manner* where the needs of children and families are met by both public and private providers in a coordinated and planful manner throughout the service delivery and treatment process.

To accomplish the system change goals, consistent with these stated guiding principles, the following design and implementation committees were created:

**SOC Sponsor Group** – to oversee public agency participation and project management

**Services Committee** – to create methods and recommendations for:

- *Screening, Assessment and Evaluation*
- *Care Coordination/Case Management*
- *Home and Community-Based Services*

**Developmental Disabilities Committee** – to create a comprehensive system of care for children with developmental or intellectual disabilities including pervasive developmental disorders such as autism, supported by alternative revenue sources including Medicaid and third party funding

**Family and Youth Advocacy/Engagement Committee** – to design and implement a formal system of engagement of families and youth in system of care efforts in order to promote family and youth involvement at all levels in the planning and delivery of SOC services

**Financing and Administrative Implementation Committee** – to develop an inter-agency strategy for maximizing use of County dollars to leverage Medicaid, Title IV-E, CSA, other state and federal funding and private resources to maintain and enhance the community-based system of care.

This report incorporates work from the Services Committee, to respond to the deliverables and tasks assigned to committee members:

### **SOC Services Committee Deliverables**

**The Services Committee was tasked with the following:**

1. Develop a screening tool to identify children and youth eligible for referral to the System of Care (SOC) process that can be used by staff performing a variety of roles across the child serving system
2. Develop a protocol using the Child and Adolescent Needs and Strengths assessment instrument (CANS) and other objective behavioral criteria for functionally assessing the strengths and needs of children and youth identified by the screening tool as being eligible for the SOC process
3. With inter-agency support, develop a framework for Community Services Board (CSB) implementation of an intensive care coordination (ICC) function, based on wraparound fidelity standards, for children and youth identified at risk of residential/group home placement through a standard screening and assessment process. ICC includes the development of individualized service plans and implementation of community-based services to safely address risk factors and meet youth and family needs in their own community. It is to be Comprehensive Services Act (CSA) funded and accessed through Family Assessment and Planning Team (FAPT), with Community Policy and Management Team (CPMT) oversight.
4. Identify and recommend evidence-based and other best practices for implementation in calendar year 2009 in order to prevent or reduce length of stay in residential/group home care, along with suggested implementation strategies.
5. Assigned to Services Committee from SOC Reform Group (June 2009): recommendations for implementation of family engagement practices and models
6. Service gaps in community-based care and recommendations on areas that need to be prioritized to provide a comprehensive community-based continuum of supports and services, to allow for transition from residential placements sooner and prevent costly

out of county and out of home placements wherever possible. Particular emphasis on the needed exceptions to CSA cost containment limits in order to purchase services, supports and treatments in order to prevent residential placements.

7. Systems barriers that adversely affect services provision for families and youth.

### **SOC Services Committee framework**

#### **Work Processes of Services Committee**

The Systems of Care Services committee work began work on three areas:

- ***Screening, Assessment and Evaluation***
- ***Care Coordination/Case Management***
- ***Home and Community-Based Services***

#### **Tasks**

1. Identify the common behaviors/conditions that have a significant presence in current CSA referred children and their families
2. Identify risk factors contributing to children requiring restrictive levels of care
3. Clarify the respective roles of the public and private sectors in screening, assessment and evaluation
4. Research and report on the referral sources and timing of referrals to CSA. When are these children identified and by whom?
5. In coordination with the Developmental Disabilities Committee, identify differences in referrals for children with developmental disabilities (especially those with autism diagnosis)
6. Develop and implement standard screening, assessment and evaluation tools across all referring programs and providers
7. Develop strategies for outreach, training and education on the systems of care screening and assessment tools for staff across departments and in the school system Implement “intensive care coordination” to work with children in or at risk of residential placements – based on “wraparound” principles and program components
  - Identify criteria for qualification for intensive care coordination
  - Establish common outcome measures/indicators for each child placement
  - Distinguish *case management* from *care coordination*. Define who is responsible for each, if both are needed
  - Decide how case management is conducted and by whom
8. Identify the respective roles of the public and private sectors in providing care coordination and case management
9. Once a child is in residential care, develop process for staff to complete a step down protocol from residential settings to home/community settings (review other models/best practice, including adult model for step down, PACT program) (incorporate transition planning, process planning, documentation and service delivery)
10. Establish protocols for information sharing - identify existing barriers and resolve legal/public concerns based on national practices and protocols

11. Explore how ICC and other case management strategies can be brought to scale in a manner congruent with the Child Specific Team (CST) concept and practice
12. Develop a plan for incorporating the contribution of both formal and informal community support networks into the treatment planning process, including school resource officers, teachers, social workers, faith community members, volunteer mentors, athletic services providers, and other service providers from the public and private sectors
13. Develop a protocol for youth and families leaving ICC and transitioning back to agency/program-based case management services
14. Develop strategies for outreach, training and education on the systems of care intensive care coordination model for staff across departments and in the school system
15. Review evidence-based and other best practices for therapy/treatment for common profiles of presenting behaviors for CSA referred children
16. Review the existing treatment service capacity and formats available. Identify the resources that can be utilized at the community and school level for these children identified at risk
17. Identify the system barriers and challenges that result in out of home placements
18. Identify what best practices are not available in the community and in private/public residential settings (gap analysis)
19. In coordination with the Developmental Disabilities Committee, identify differences in services for children with developmental disabilities (especially those with autism diagnosis)
20. Review current caseload of residentially placed children studied by Dr. Lyons:
  - Identify gaps in services that caused the placement for the 25% of children that did not meet CANS criteria for residential care (What were the presenting conditions? What were the decision factors?)
  - Identify reasons for coming into CSA service structure – what were contributing factors: juvenile delinquency/behavioral issues, etc.
  - Identify the common elements for the 75% that went into residential care
  - Identify the reasons for those who stayed in care beyond the best practice six to nine month length of stay
21. Identify services needed and the respective roles of the public and private sectors in providing treatment services
22. Recommend service approaches that need to be developed in the community for:
  - children transitioning from residential placements back to the community
  - children who could be diverted from private residential placements to community settings
23. Recommend models for purchased treatment services when residential placements are required
24. Recommend strategies for effective evaluation of quality of the care and treatment effectiveness for children receiving intensive services or residentially placed
25. Develop strategies for outreach, training and education on the systems of care home and community-based services for staff across departments and in the school system

## Services Committee Membership and Activities

The Services Committee was created with representation from the following areas:

- County schools
- County departments
- Private service providers
- Family representatives

Initial work included a data review of current children in residential care. At the initiation of the project, analysis of the existing placements of children in residential settings identified the following:

<i>Child placements by mandate type</i> (point in time count as of 4/1/09)	
Foster Care/ Adoption	91
Schools	39
Foster Care Prevention	16
Non-mandated	13
<b>Total</b>	<b>159</b>

<i>Average length of stay # days</i> (point in time count as of 4/1/09)	
Children with developmental disabilities	690 days
Children with emotional and behavioral problems	295 days

<i>Placements in state vs. out of state</i> (as of 4/1/09)	
In state residential or group home facilities	132
Out of state residential facilities	27
<b>Total</b>	<b>159</b>

Presentations were provided by experts in wraparound services and utilization review. Members attended training from John Lyons on use of the Child and Adolescent Needs and Strengths tool. Additional reports included the analysis of children placed in residential care, An Analysis of the Needs and Strengths of Children and Youth Living in Fairfax County, Virginia Served in Residential Treatment (John S Lyons, Ph.D., and Alison Schneider, Northwestern University, August 2008), a Fairfax County Court Liaison Study, an internal report from the Department of Family Services on Youth In Residential Care, and a review of children in residential care requested by the SOC Finance and Administration Committee.

A review of youth currently funded through CSA and in residential settings identified characteristics and common needs, as summarized below:

<b>Youth in Residential Placements – Situations, Conditions and/or Behaviors Affecting Families and Children</b>	
<b>Youth with significant mental health concerns resulting from or exacerbated by traumatic experiences</b>	<b>Caregivers/family members needing specialized parenting skill development and/or capacity-building within families</b>
<b>Youth with developmental disabilities</b>	<b>Youth with symptoms of emergent mental illness</b>
<b>Youth deemed “CHINS” – child in need of services</b>	<b>Caregivers/family members with trauma history (such as loss, domestic violence)</b>
<b>Youth with delinquency issues and co-occurring substance abuse/mental health issues</b>	<b>Youth displaying “out of control” behaviors resulting from chronic neglect or under-socialization</b>
<b>Youth who engage in verbal and physical aggression who have made serious threats to harm others</b>	<b>Youth whose behavior is self-destructive and/or self-injurious, such as:</b> <ul style="list-style-type: none"> <li>• <b>Runaway with risk behavior</b></li> <li>• <b>Substance abuse</b></li> <li>• <b>Sexual behavior</b></li> </ul>

### **Common Characteristics and Needs for Youth in Residential Placements**

To further define effective treatment, case management, care coordination and other needed supports for these children and profiles of like conditions or behaviors, the members of the Services Committee divided into three groups to assess common characteristics as well as dissimilar needs.

#### **Process**

The Services Committee members used a group decision tool, ThinkTank, to process group research and information. They created a shared web collaborative for document sharing, electronic messages (yahoo group – FFX Systems of Care). Services committee members (18) met for total of 18 meetings and collective work in excess of 90 hours.

### **Analysis of Children in Residential Care**

- Characteristics- unique issues and presenting behaviors within the subgroup assigned to them
- Triggers for residential placement
- Desired outcomes for youth
- Identification and Screening criteria
- Effective community-based service approaches
- Transitions
- Systems and Process issues

For each of the profiles, the Committee turned to review of various strategies on aspects of care coordination, screening and assessment, evaluation tools/strategies, gaps in existing community and home based services. In April, the group formed three subcommittees on:

- Intensive Care Coordination
- Service Gaps
- Evidence-Based Practices

Each subcommittee reviewed best practice information on wraparound services and intensive care coordination, and systems of care approaches across the country. Each considered aspects of care coordination for the identified groupings of behaviors and conditions that appear to be common with children who are placed residentially. The committees also reviewed existing screening and assessment tools in use in various disciplines, some currently utilized in existing programs in the county or encouraged by state agencies. Other known screening and/or assessment strategies in use in other jurisdictions throughout the country, tools with potential for adaptation, and evaluation strategies in local existing community and home-based services were also reviewed.

As a result of this research, discussion and analysis, the committee completed all aspects of its committee responsibilities and reports the analysis and recommendations in the following report sections.

## Services Committee Deliverables

### **Deliverable A. Proposed Screening Tool for Identifying Children At- risk of Residential and/or Group Home Care**

#### Screening process for youth at risk of residential or group home care:

It is not required that children at risk for residential/group home placement be screened for ICC. It is, however, a legal requirement that prior to placing a child outside Fairfax County or the cities of Fairfax and Falls Church FAPT must explore all appropriate community services for the child and document that no appropriate placement is available in the locality. ICC using a wraparound approach is a best practice in coordinating community services for youth at-risk of residential placement.

The screening process is completed by a public agency staff person otherwise eligible to refer and manage CSA cases. To meet screening criteria for ICC at least one of the significant incidents listed in section 1 below must have occurred within the past 60 days, **and** the youth must have serious behavioral/emotional needs and/or risk behaviors, as identified in section 2.

#### **1. Significant incidents**

- Relief of custody petition/ request
- Second Juvenile Detention Center (JDC) or Less Secure placement
- Psychiatric hospitalization
- Leland placement
- Entry into foster care or notice to Department of Family Services (DFS) thereof
- Threatened foster home disruption
- Recommended for homebound instructional services due to severe, disabling anxiety or depression
- Consideration of more restrictive setting for special education student who is not adjusting to current setting
- Ten days of suspension within a school
- Ten unexcused absences within a school year
- Recommendation for expulsion
- Sexually aggressive/reactive behavior
- Pattern of running away accompanied by risk behaviors; most recent incident of runaway within 60 days
- Behavior requiring 911 involvement

## 2. Child Behavioral/Emotional Needs and Risk Behaviors Screening

Two CANS dimensions – Child Behavioral/Emotional Needs and Risk Behaviors - will be used to screen youth for ICC. Case managers will rate youth on these two dimensions to determine if the youth might benefit from and qualify for ICC. Youth who meet the screening criteria can be referred to CSA UR staff.

CANS screening criteria:

- A “3” on any Risk Behavior OR
- A total of 6 or greater when all 2’s and 3’s are added for Behavioral/ Emotional Needs and Risk Behaviors

<b>CHILD BEHAVIORAL/ EMOTIONAL NEEDS</b>				
0 = No evidence of problems		3 = Causing severe, dangerous problems		
1 = History, Watch/Prevent		2 = Causing problems consistent with diagnosable disorder		
	0	1	2	3
Psychosis				
Impulse / Hyper				
Depression				
Anxiety				
Oppositional				
Conduct				
Adjustment to Trauma				
Anger Control				
Substance Use				
Eating Disturbance				

<b>CHILD RISK BEHAVIORS</b>				
0 = No evidence of problems		2 = Recent, Act		
1 = History, Watch/Prevent		3 = Acute, Act Immediately		
	0	1	2	3
Suicide Risk				
Self-Mutilation				
Other Self-Harm				
Danger to Others				
Sexual Aggression				
Runaway				
Delinquent Behavior				
Fire setting				
Social Behavior				
Sexual Reactive Behavior				
Bullying				

### Screening process for youth in residential/group home care:

The FAPT is legally required to implement a plan for returning the youth to his home, relative's home, family-like setting, or community at the earliest appropriate time that addresses his needs, including identification of public or private community-based services to support the youth and his family during transition to community-based care. The FAPT will screen all youth in residential/group home placements for ICC no later than six months after placement, and every 3 months thereafter, to coincide with the quarterly FAPT review. FAPT will authorize the 14 day ICC assessment for those youth who meet the screening criteria.

### **Deliverable B. Proposed ICC Assessment Process**

Based on background information provided by the case manager, UR staff determines whether screening criteria were met and can provide emergency approval for a 14 day assessment conducted by an intensive care coordinator. CANS scores and background information will be used jointly by UR to decide on the initial referral.

**Residential prevention:** If the number of valid referrals exceeds ICC capacity, youth with significantly higher total scores on the CANS Behavioral/ Emotional Needs and Risk Behaviors (see screening criteria above) will have priority for approval.

**Youth in residential:** If the number of valid referrals exceeds ICC capacity, significantly lower total scores on the CANS Behavioral/ Emotional Needs and Risk Behaviors, and longer length of stay, shall be factors to be considered in prioritizing youth for approval.

The 14 day ICC assessment will include the comprehensive CANS as well additional assessment to include strengths and needs assessments of the youth, family, extended family and the community, often involving several sessions over one to two weeks, to assess their appropriateness and willingness to utilize the service. An initial crisis/safety plan should also be developed if critical risk factors are present. The results of the ICC assessment will be shared with the case manager and UR for determination about additional ICC services.

Youth who are screened out by UR for the ICC assessment may be referred to the CST coordinator for the standard CST assessment and planning process. Youth who receive the 14 day assessment and are not recommended for additional ICC will be referred back to their agency case manager and supervisor for follow up by the standard CST process. The CST may only refer a case back for re-screening or assessment if they identify significant new information that had not been previously considered. It is expected that CSTs incorporate wraparound principles and practices in developing and implementing community-based plans.

## **Deliverable C. Proposed ICC Implementation Framework**

### **Intensive Care Coordination Definition**

1. ICC is a system-wide team-based process.
2. The team is fully family led.
3. ICC does not supplant or override the legally mandated service agency roles.
4. The ICC process develops community-based service strategies which integrate the needs of the child and the family and the requirements of the mandated child serving agencies.
5. The role of the ICC team is to maintain (or return) the child in the community and to divert long-term residential placement through use of wraparound principles, philosophy and coordinated community-based service provision and creative use of family/child strengths, resources and non-traditional agency supports.
6. The intensive care coordinator will do the extensive legwork necessary to assess, negotiate, facilitate and monitor the service plan among all parties, which should be an enormous support to agency case managers of high risk children, youth and families.

### **ICC Outcome Targets**

#### **Process Outcomes**

1. At least 90% of initial ICC assessments are completed within 14 days of referral and include the comprehensive CANS as well additional assessment to include strengths and needs assessments of the youth, family, extended family and the community
2. For 100% of referrals with critical risk factors (CANS risk behaviors rated “3”), an initial crisis/safety plan is developed as soon as possible but always within 14 days of referral
3. 100% of youth in the community have a crisis/safety plan developed within 14 days of FAPT ICC approval, or of community placement for youth stepping down
4. 90% of participating families have an individualized care plan developed within 30 days of FAPT ICC approval
5. 90% of ICC child and family teams include at least one extended family member or other informal support person, i.e. a friend or neighbor, with a best practice goal of teams comprising at least 50% extended family/informal supports.
6. 90% of care plans include at least one informal service or support

#### **Functional Outcomes**

1. Six months after ICC initiation a significant decrease in CANS Child Behavioral/Emotional needs and risk factors rated “two” or “three” at initial screening. These needs and risk factors are presented in the screening section above, and represent the conditions and behaviors that place youth at highest risk of residential placement.
2. Maintenance of lower ratings when measured 12 months after ICC initiation

### **Restrictiveness of Placement Outcomes**

1. At least 80% of children served in ICC to prevent residential are in the community at six months and twelve months after ICC initiation
2. At least 80% of children served in ICC to step down from residential are in the community three months after ICC initiation
3. Of the children returned to the community from residential within three months, at least 80% are in the community six months after leaving residential

### **Systems Outcomes**

Creation of collection, analysis and reporting methodologies are recommended prior to implementation of intensive care coordination. *Initial recommendations for client outcomes for children and their families from a systems perspective are outlined on page 45.*

### **Training Plan**

1. Prior to initial implementation all intensive care coordinators shall participate in 12 hours of introductory wraparound training. This training will also be required of case managers who would potentially refer ICC cases and public staff with similar coordination/facilitation roles with children, and open to other public and private human services professionals as appropriate, and families. In the first year after ICC implementation, introductory wraparound training will be conducted at least twice, thereafter at least annually.
2. Intensive care coordinators shall participate in an additional 12 hours of intermediate wraparound training during their first year of employment. This training would also be open to public and private staff with similar coordination/facilitation roles with children, youth and families, as appropriate. Intermediate wraparound training shall be conducted at least annually.
3. Intensive care coordinators shall participate in at least 20 hours of wraparound coaching/consultation annually. During the first year after ICC implementation the coaching /consultation shall be conducted by a consultant with demonstrated experience and expertise in wraparound care coordination. In the second year and after, coaching may be conducted internally if the necessary expertise and experience is available.

Note: It is intended that all intensive care coordinators be provided training and coaching from the same trainers using the same model, in a group process that develops cohesion and supports fidelity.

### **Wraparound Fidelity**

Fidelity measurement is a core implementation support to evidence-based practices. A fidelity measurement system is necessary to support program improvement through illuminating areas of relative strength and weakness with respect to adherence to the prescribed activities of the wraparound process and the 10 principles of wraparound. This information can be used to guide program planning, training, and quality assurance.

The most commonly used wraparound fidelity process is The Wraparound Fidelity Assessment System (WFAS), a multi-method approach to assessing the quality of individualized care planning and management for children and youth with complex needs and their families. WFAS instruments include interviews with multiple stakeholders, including the family, a team observation measure, a document review form, and an instrument to assess the level of system support for wraparound. The instruments that comprise the WFAS can be used individually or, to provide a more comprehensive assessment, in combination with one another. The WFAS provides a method for conducting fidelity measurement for the wraparound process, as specified by the National Wraparound Initiative.

It is recommended that a wraparound fidelity process be consistently applied to intensive care coordination interventions funded through CSA, and that the Services Committee research the WFAS and other fidelity monitoring systems and by September recommend to CPMT a system and process. All ICC providers would be required to participate in CPMT-approved training, coaching and fidelity monitoring. Providers could build into their rates the cost of acquiring training, coaching and fidelity monitoring, and of their staff's participation.

#### **FAPT Review and Approval Process**

**FAPT type:** Case managers for those youth who are recommended for ICC will prepare the IFSP for FAPT requesting ICC. FAPT review is "paper."

**Approval period:** Initial approval for six months, with possible renewals in three month intervals, not to exceed a total intervention of fifteen months.

**Copayment:** No co-pay is assessed for the ICC service but any additional services funded by CSA are subject to the appropriate co-pay process.

**Access to funding:** Youth must be eligible for CSA and/or MHI funding. While it is anticipated that most youth needing ICC will qualify for mandated CSA funding, it may be necessary to reserve CSA non-mandated, MHI-state and/or MHI-local funding for those who are not.

**Monitoring purchase of services:** While the intensive care coordinator is responsible for coordinating services within a wraparound approach, the public agency case manager maintains formal responsibility for monitoring provision of all CSA-funded services, including ICC. The intensive case coordinator will support and assist the case manager in monitoring purchased services.

**Transition out of ICC:** Many children transitioning out of ICC would continue with public agency case management, within a CST or other team process, using wraparound principles and practices. Some children will transition to private services and/or informal supports and no longer need public agency case management.

#### **Caseload and Projected Level of Need**

With most ICC interventions expected to last between six to twelve months, an average coordinator caseload would be six to twelve, depending on the pace of cases transitioning out of ICC, which is consistent with state caseload guidelines of seven to twelve. Intensive

care coordinators can accept an average of one new referral each month on an ongoing basis, consistent with seasonal variation in referral numbers.

Based on the current average of 8 youth per month currently entering residential/group home care, and approximately 110 youth currently in care more than six months, ICC should have a capacity to serve approximately 206 youth and families on an ongoing basis. That translates to a need for 20 intensive care coordinators. Estimating demand for a new service such as ICC is an inexact process. These preliminary estimates will be fine-tuned as additional data from the ICC screening process becomes available.

### **ICC Provider**

The primary ICC provider agency should not be a public agency with a legal mandate to provide particular services to children and families, in order to support the goal to develop comprehensive plans that address child and family needs across all domains. The ICC primary provider agency should not be a private provider of CSA-purchased services, in order to avoid an appearance of conflict of interest in recommending such services. It is recognized that in a community as large and diverse as Fairfax-Falls Church, there may be need for ICC to be provided by such agencies for special populations as necessary, but that should be on an exception basis.

Once an ICC intervention has begun, that provider agency is to continue providing ICC for the FAPT-approved six to twelve month intervention period, regardless of changes in the circumstances of the child and family, unless directed to desist by the public agency case manager or FAPT as specified in the conditions of the provider's CSA contract.

### **Service Planning and Coordination**

Service planning and coordination activities shall include:

1. **Development of an individualized care plan:** A child and family team develops a plan which fits the unique needs of the child and family. The intensive care coordinator, in consultation with the public agency case manager, assists the family in selecting team members, and facilitates the team coming together. Teams are comprised of the child and family, extended family, representatives of child-serving agencies that provide services to the child and family, and others who are important in the family's life or know and can access potential resources. Essential elements of the plan are: a) description of the need for services; b) development of objectives that meet the needs of the child/family and build on their strengths and culture; c) develop a methodology for meeting objectives that would typically involve both formal services and informal supports; and d) provision of non-mental health services as appropriate.
2. **Implementation of the individualized care plan:** The ICC coordinates the efforts of the child, family and other members of the team in implementing the plan, through ongoing team meetings and communication with individual team members. Such communication would include home visits, and site visits to providers.

3. **Development and implementation of a crisis plan:** With the team the ICC develops a crisis plan which anticipates the most likely at-risk behaviors and develops plans to prevent, and if necessary effectively respond to them. CSB Emergency Services and other existing county after-hours services will be available to assist in the development and implementation of crisis plans.

### **Intensive Care Coordinator Responsibilities**

The ICC process is facilitated by a coordinator, who:

- a) Serves as an advocate for the family to develop and achieve their plan goals
- b) Facilitates the care coordination team in preparing and executing a realistic care plan that best meets the child and family needs to prevent long-term residential placement
- c) Works with the family and others identified by the family and all services providers to develop plans based on the strengths and needs of the families
- d) Is deeply involved and engaged with the family/caregiver, service providers, and others in the child's constellation of support
- e) Supports family in assessing strengths, needs, and family resources, capacities and desires
- f) Assists families/caregivers in understanding what is and is not possible, based on their current system involvement, and works with the family to build on strengths and needs within the context of that reality
- g) Offers knowledge and strong "people skills"
- h) Works with the family and providers to facilitate a comprehensive consensus based plan that; builds on family and child strengths, assets, resources and natural community supports as well as formal community-based services; plans for the safety of the child, the family and the community; and includes contingencies/alternatives in advance of potential crises.
- i) Assures that all involved in the plan are aware, understand and are in agreement on respective roles and accountability
- j) Develops a team plan that is a "living plan" intended to be reshaped as circumstances change and focused on how to best meet the needs of the child and family in the community

### **Role of the Public Agency Case Manager versus Intensive Care Coordinator**

#### **Public agency case manager:**

##### **Knowledge and expertise:**

- a) Subject area expert on practice and policy in her field of child and family services
- b) Trained in and responsible for the legal requirements associated with her field of child services and its service system
- c) Familiar with ethical issues relating to serving children and families in her field of child and family services and its service system
- d) Knowledgeable of public and private resources for addressing child and family issues relating to her field of child and family services and its service system

- e) Ability to engage children, youth and families from a strength-based perspective
- f) Ability to view the strengths and needs of children and families comprehensively and from a developmental perspective over time.

Participation in the ICC process:

- a) Responsible for applying her knowledge and expertise for the benefit of the child and family through participating in the wraparound team process
- b) Responsible for ensuring that the service plan developed through the ICC process is congruent with the requirements of her child-serving system through participating in the wraparound team process and liaison as appropriate with others in her agency and system
- c) Responsible for participating positively in the wraparound team process, including raising issues of concern in a manner that is respectful of the family and other team members and supports the efforts of the team to develop and implement a plan that meets needs identified by the family and appropriately addresses requirements of involved systems

Meeting system requirements:

- a) Responsible for documentation and reporting requirements associated with her child-serving system
- b) Responsible for the referral process to CSA, managing the FAPT review process, and monitoring the purchase of services
- c) Responsible for supporting the quality of the ICC intervention through participating in the fidelity monitoring process
- d) Attend all FAPT meetings with the exception of paper reviews

**Intensive care coordinator:**

Knowledge and expertise:

- a) General knowledge of practice and policy issues within the four public child-serving systems: education, child welfare, juvenile justice and behavioral health
- b) Knowledge of the behavioral/emotional needs and risk behaviors that place children at risk of residential placement and the services and treatments that may be effective in addressing them
- c) Expertise in crisis/safety planning for youth with behaviors that place themselves or others at risk
- d) Ability to engage children, youth and families from a strength-based perspective
- e) Ability to facilitate a team-based process involving children/youth, family members, informal supports and child-serving professionals
- f) Communication and mediation skills, in group and one on one settings, to support the development of consensus and follow-through among all parties
- g) Ability to view the strengths and needs of children and families comprehensively and from a developmental perspective over time.

Participation in the ICC process:

- a) Conducts an initial assessment to include a comprehensive CANS as well additional assessment to include strengths and needs assessments of the youth, family,

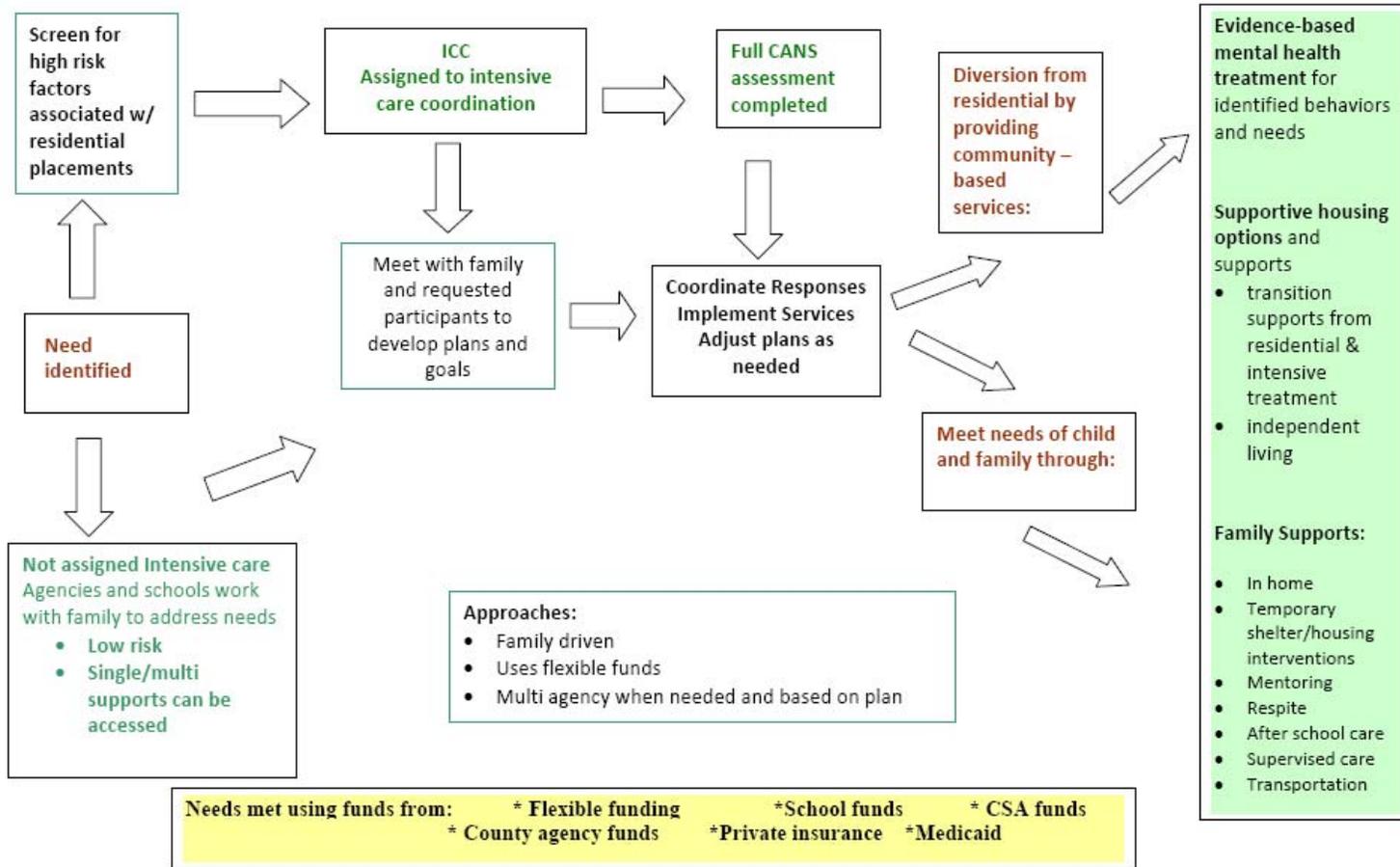
extended family and the community, often involving several sessions over one to two weeks

- b) In consultation with the public agency case manager, assists the family in selecting team members, and facilitates the team coming together.
- c) With the team, develops and implements a crisis plan which anticipates the most likely at-risk behaviors and develops plans to prevent, and if necessary effectively respond to them
- d) Facilitates the care coordination team in preparing and executing a realistic care plan that best meets the child and family needs to prevent long-term residential placement and return youth to the community. Does the extensive leg work necessary to assess, negotiate, facilitate and monitor the service plan among all parties
- e) Coordinates the efforts of the child, family and other members of the team in implementing the plan, through ongoing team meetings and communication with individual team members. Such communication would include home visits, and site visits to providers.
- f) Assists families/caregivers in understanding what is and is not possible, based on their current system involvement, and works with the family to build on strengths and needs within the context of that reality
- g) Assures that all involved in the plan are aware, understand and are in agreement on respective roles and accountability

Meeting system requirements:

- a) Conducts initial assessments of strengths and needs within the required 14 day period and produces written summaries that effectively communicate information necessary for case manager, FAPT and utilization review requirements
- b) Produce written service plans that are accurate, faithful to team decisions, and easily understood by all parties
- c) Produce service plans and progress reports that meet FAPT requirements and support the case manager's need for documentation
- d) Achieve and maintain CANS certification, and complete CANS comprehensive and re-assessments on a timely basis, in conjunction with the case manager
- e) Participate in program evaluation and ICC fidelity activities as required
- f) Produce and submit on a timely basis documentation of activities required for CSA-reimbursement
- g) Support the case manager in monitoring purchase of services as appropriate
- h) Attend all FAPT meetings with the exception of paper reviews

**System of Care Response to Children At-Risk of Behavioral or Emotional Problems  
Using All Community Resources to Respond in Community Settings with Existing Services**



## **Deliverable D: Family Engagement Approaches and Recommendations**

The Services Committee was tasked with review of specific program models implemented in the Department of Family Services and mandated by the State Department of Social Services as a component of services offered to families served through child welfare programs. Typically two models, the Family Engagement model, and Family Team Meetings, are provided for children placed in foster care and are used for transitions between family care, group or residential treatment settings and in permanency planning for a child, through transition to adulthood. The Services Committee was tasked by the SOC sponsor group with recommending strategies which support both the philosophy and approaches of family driven services and integration into a comprehensive array of services and supports for at risk youth.

<b><i>F a m i l y  D r i v e n</i></b> <b><i>a p p r o a c h</i></b>	<p><i>Recognition that.....</i></p> <ul style="list-style-type: none"><li>■ <b>All families have strengths</b></li><li>■ <b>Families are the experts on themselves</b></li><li>■ <b>Families deserve to be treated with dignity and respect</b></li><li>■ <b>Families can make well-informed decisions about keeping their children safe when supported</b></li><li>■ <b>Outcomes improve when families are involved in decision-making</b></li><li>■ <b>A team is often more capable of creative and high-quality decision-making than an individual</b></li></ul>
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## **Overview of Family Engagement Model and Family Team Meetings Used in Foster Care and Permanency Planning**

Purpose -A family team, including professional supports develops ideas and makes decisions for the child throughout the life of our work with the family

Structure- A meeting facilitated by a trained individual that is not the social worker for the child or family. Typically, *the facilitator* is a:

- Neutral party
- Full-time agency facilitator, that does not carry a caseload

*A team meeting* typically includes:

- Parents
- Child (as appropriate)
- Relatives
- Friends or relevant supports identified by the family
- Caregivers for the child
- Relevant Professionals involved with the family
- Relevant community partners

*Family Group Conferences* – are typically –

- Reconvened each quarter
- Used for follow up after a Family Team Meeting
- Supports family stabilization- to make decisions that create safety, permanency and well being for children, such as....
  - When child is transitioning from out of home placement back to family/community
  - For permanency plans for children aging out of out of home placement
  - For long term placement plan necessitated by caregiver health issues – such as chronic and/or terminal illness or severe physical or mental health issues affecting their lives
  - Prior to changes in where a child lives or where they are placed
  - Prior to formal foster care plan changes
  - At the request of the parent, foster parent, or social worker

Process/Strategies -

- Family Driven
- Family private time is built into process
- Broad family participation - widens the family/fictive circle - family often travel from out of state to participate
- Family traditions are incorporated into the process
- Usually held on weekends – always at the convenience of the family
- 4 – 8 hours in duration
- Requires 35 hours preparation time on average on part of supporting staff

***Benefits of Family Engagement models***

- Shared decision-making
- Increased family ownership
- Prevents children from out of home placement
- More relative and community placements

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**Screening and Referral Criteria Recommendations for Access to Family Group Conferencing and Family Team Meetings**

Upon review of the presentations from DFS on the models, the Services Committee developed the following recommendation for criterion to make referrals to Family Group Conferencing and Family Team Meetings to make the services more available to a broader population of at risk children than existing practice:

**Screening and Referral Criteria**

- Situations in which the family is “done” with child – caregivers demonstrate coping problems, feel loss of control/have no confidence in ability to parent, etc.
- Transition periods in living arrangements and/treatment, particularly:
  - i. Independent living transition
  - ii. Residential treatment
  - iii. Permanency planning goal is adoption or permanent foster care
  - iv. Situations in which family is engaged in plan but the plan is not being executed/the plans to return a child home are devolving

**Screening Process: Family Group Conferencing and Family Team Meetings**  
*Approved by SOC Services Committee 9/21/09*

**For children in DFS custody:** FTM and FGC are considered standard foster care services and the standard FAPT approval process for children in foster care applies.

**For children not in DFS custody but at risk of foster care and involved with DFS through Court Liaison, CPS or Family Preservation:** Using the "planned permanency caregiver strengths and needs" CANS domain, any child who's caregiver(s) rate a 6 or above (not counting one's) may access CSA funding on an emergency basis to allow a family team meeting to take place pre-FAPT. FAPT authorization is required prior to a family group conference.

**For children not in DFS custody but identified as potentially benefiting from the family engagement process:** FAPT authorization is required prior to CSA funded family team meeting or family group conferences.

<b>PLANNED PERMANENCY CAREGIVER STRENGTHS AND NEEDS</b>				
0 = No evidence of problems		2 = Moderate Needs		
1 = Minimal Needs		3 = Severe Needs		
<input type="checkbox"/> Not applicable – No caregiver identified				
	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
Supervision				
Involvement with Care				
Knowledge				
Organization				
Social Resources				
Residential Stability				
Physical Health				
Mental Health				
Substance Use				
Developmental				
Accessibility to Care				
Family Stress				
Self Care/Daily Living				
Employment				
Education				
Legal				
Financial Resources				
Transportation				
Safety				

### **Process Recommendations for Family Engagement Strategies**

The Services Committee further recommends:

1. A family's participation in Intensive Care Coordination would not preclude use of family group conferencing or team meetings as needed.
2. Access to the Family conferencing and meeting models would be provided through FAPT approval. FAPT approval is required for use of DFS FGC/FTM services.
3. If insufficient resources exist to provide this service, priority to be given to requests for children already receiving Intensive Care Coordination supports as these cases are at the most at-risk for out of home care.
4. A process to expedite FAPT review and approval of requests for FGC/FTM services is needed.
5. A work group to identify expected outcomes for both systems and individual client specific perspectives for family group conferencing and team meeting services. In light of competing demands for services development to address systems barriers and services gaps, this will allow ability to measure the effects and successful contribution to reduced costs, return on investment and positive program and individual client outcomes.
6. To expand capacity of service provision, training should be provided to each child serving agency and the public schools. This will allow a broadened exposure to the principles and philosophical approach imbedded in the practice of family engagement.

## **Deliverable E: Service Gaps**

The Services Committee reviewed resource documentation on the Fairfax-Falls Church CSA annual gap analysis of services provision in community settings. The committee also provided research and analysis on the various strategies to address the clinical and behavioral profiles of the children currently in residential care. Indications of broad service needs across the system were identified. They include:

### **SERVICE GAPS**

- Coordinated care – need for additional multi-disciplinary, skilled coordination and care management for children at high risk
- Educational, vocational supports – particularly for older teens
- Supervised recreation and socialization opportunities for all age groups
- Transportation to services – continue to be a barrier for all families, particularly when travelling long distances outside of the jurisdiction
- Development of a network of skilled, nurturing caregivers who are provided regular and consistent supports through respite opportunities and assistance in a crisis
- Safe, structured places to live for children
- Improvements in the approach to therapeutic services in community settings, particularly in the standards for provision of therapeutic foster care and the provision of services with demonstrated outcomes.

Based on the profiles of children who ultimately were placed in residential or congregate settings for treatment and special education services, the workgroups held several sessions to analyze the various behaviors and conditions that contributed to the need for more restrictive, structured therapeutic interventions in residential settings. These contributing factors, and issues within families, require specific development of new resources in the community to provide similar intensity and longer duration of supports to allow both the return of children from those settings, as well as the diversion of the initial placement altogether, whenever possible.

Three workgroups were formed to review the identified gaps by the types of profiles of children in residential care. The work was compiled and common elements were identified. The top nine needs are incorporated as final recommendations from the Services committee.

# System of Care Service Gaps

## Profiles of at risk children:

- CHINS/Delinquent
- Co-occurring substance abuse/mental health
- MH/Trauma
- Neglected/Under-socialized/ "Out of control"
- Youth with Developmental Disabilities

## Clinical Needs:

- Trauma history
- Aggression/ harm to others
  - Sexual behavior
- Self-injury/ harm to self
  - Runaway with risk behavior
  - Substance abuse
  - Sexual behavior
- Enhanced parenting skills and/or capacity



## Crisis Interventions:

- Mobile crisis response for youth
- Intensive outpatient services
- Intensive home-based intervention
- Day treatment
- Partial hospitalization program
- Acute psychiatric hospitalization

## In community home settings for special populations – new and expanded resources needed:

- Adolescents with chronic emotional/behavioral problems
- Adolescent sex offenders
- Adolescents with chronic & severe substance abuse and co-occurring mental health needs
- Adolescent mothers with chronic emotional/behavioral problems
- Youth transitioning into adult services (e.g., apartment program)
- Children needing therapeutic foster homes

### ***1. Increase case management capacity***

- Intensive Care Coordination is appropriate for any youth at risk of residential treatment placement
- Appropriate, high quality case management is needed for youth who don't qualify for intensive care coordination through the assessment process
- "hot potato" cases – those that are between system eligibility requirements or cases that are multi-agency/system in nature -require additional trained, available case management services

### ***2. Increase number of child and adolescent psychiatrists***

- Additional Medicaid providers are needed
- Providers who serve special populations - examples include services to those with developmental disabilities, experiencing trauma, and child with co-occurring mental health and substance abuse issues

### ***3. Supervised activities and customized programming for special populations\* of at-risk youth***

- After-school, holidays, summer recreation, socialization, and normalized developmental experiences
- Supervised vocational training and experiences, job coaches\*\*

*\* Consistent with recommendations, 2/24/2005 final report of Northern Virginia Regional Workgroup on Gaps and Barriers in Services for Sexually Abusive Youth*

*\*\*Consistent with recommendations, 10/12/2007 presentation to CPMT, Ensuring Effective Transitions for Youth*

#### ***4. Transportation***

- Access to community services and supports is critical to the success of community-based care plans

#### ***5. Support to Families to Meet Basic Needs***

- Basic goods and supports (e.g., registration fees, sports equipment, camps, utility payment, transportation, food, clothing, copayments for meds, incentives for meeting goals, etc.) funded through:
  - *Coordinated charitable giving*
  - *flexible public funds*

#### ***6. In-community crisis supports, including:***

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>● Mobile crisis response for youth</li><li>● Crisis out-of-home, community settings/Crisis residential settings (for young children)</li><li>● Intensive outpatient services</li></ul> | <ul style="list-style-type: none"><li>● Intensive home-based intervention</li><li>● Day treatment</li><li>● Partial hospitalization program</li><li>● Acute psychiatric hospitalization</li></ul> |
|--|---|

### ***7. Respite for caregivers***

- Capacity for special populations
- In-home and out of home
- Planned and crisis
- Daily, hourly, overnight

### ***8. In-community home settings for the following special populations:***

- Adolescents with chronic emotional/behavioral problems who have gained maximum benefit from treatment but continue to require ongoing structure and supports
- Adolescent sex offenders\*
- Adolescents with chronic/severe substance abuse and co-occurring mental health needs (trauma, conduct disorder)
- Adolescent mothers with chronic emotional/ behavioral problems (with custody of their infants/ toddlers) who require ongoing structure and supports
- Youth transitioning into adult services\*\* (e.g., apartment program)

*\* Consistent with recommendations, 2/24/2005 final report of Northern Virginia Regional Workgroup on Gaps and Barriers in Services for Sexually Abusive Youth*

*\*\*Consistent with recommendations, 10/12/2007 presentation to CPMT, Ensuring Effective Transitions for Youth*

### ***9. Linguistic and cultural competence***

- Expertise exists in the community that is not accessed
- Ongoing commitment needed for continued improvement of competencies throughout the system

### **Access Recommendations**

#### ***Short term implementation strategies within 6-12 months:***

1. To facilitate access to enhanced services, supports and treatments to build capacity for access to services in the community, and ultimately to prevent residential and group home placements, the Services Committee recommends that the following funding authorization levels be approved for referred families/children (see below for recommended criteria). These broad spending guidelines would relieve case managers of asking for approvals from Family Assessment Planning Teams for basic services and provide relief from administrative processes that are identified by case workers as cumbersome, time consuming and paper driven. ***These recommendations would reflect exceptions to CSA cost containment limits currently in place:***

- ***Respite for caregivers***- up to \$15,000 annually
- ***Crisis intervention*** for young children and special populations - up to \$25,000 annually
- ***Supervised activities*** for special populations for non-school time - up to \$10,000 annually
- ***Evidence-based treatment*** - up to \$15,000 annually
- ***Transportation*** - up to \$3,000 annually.
- ***Basic needs/flexible funds*** - up to \$2,000 annually

*An annual maximum of \$50,000 per family/child from any combination of these services, without additional approvals, is recommended.*

2. CPMT adoption of recommended exceptions to cost containment limits for cases assigned intensive care coordination.
3. Provision of mobile crisis response and psychiatric services/evaluation, funded through CSA, for children and families assigned ICC.
4. Provision of transportation services through DFS case assistants for children/families assigned to Intensive Care Coordination. Finance expansion through use of CSA funds.

**Eligibility for funding flexibility:**

- Initial eligibility recommended for families participating in intensive care coordination efforts.
- Subject to funds availability, expand eligibility for the higher cap levels for flexible funds to include family group conferencing cases.
- Children/families not meeting the screening/eligibility criteria could still access these services, but within the existing funding limits for community-based services.

***Longer term implementation strategies (likely beyond 12 months):***

1. Commission the Fairfax-Falls Church Community Services Board to study ways to expand high quality case management for youth with emotional, behavioral and developmental needs who don't qualify for ICC.
2. Establish a work group to study ways to increase the number of child psychiatrists serving special populations and explore opportunities to expand the pool of Medicaid providers serving Fairfax County.
3. Create work group to make recommendations on integration of CSA and other public sources of flexible funds, charitable giving and resources.
4. Expand community home settings to include additional therapeutic foster care services, group homes/supervised apartment and independent living situations as possible.
5. Incorporate linguistic and cultural competence into provision of services through training, recruitment of private providers with the skills needed to address a multi-lingual and multi-cultural population.
6. Create new resources for establishment of vocational and educational services to at risk youth, particularly for those with school achievement and social concerns.

## **Deliverable F: Evidence-Based Practices**

The SOS Services Committee was tasked to:

*Identify and recommend evidence-based and other best practices for implementation in calendar year 2009 in order to prevent or reduce length of stay in residential/group home care, along with suggested implementation strategies.*

### **Process and Background**

The members of the Evidence-based Practice workgroup reviewed numerous models and topics related to advances in mental health treatment and promising practices targeted to the profiles of youth who are at-risk for residential and group home placements in our system of care. The topics and treatments are summarized in Attachment A of this document.

The group met from June through September 2009. The workgroup presented its initial findings to the full SOC Services Committee on September 21, 2009 for review and comments. This report reflects the final discussions of the committee.

The evidence-based treatment (EBT) field is growing and evolving, becoming more sophisticated as more communities initiate moving “science” into “service.” As other systems have found, even when implemented with fidelity, the current array of EBTs cannot always meet the complex needs of all children and families. While there is broad agreement that our system of care needs to focus on increasing the use of evidence-based practices and treatments whenever appropriate, there also needs to be a commitment from all stakeholders to take a systematic, disciplined approach to treatment using proven interventions, promising practices, measurable goals, and analysis of outcomes for youth. The commitment to continuous quality improvement and evaluation is critical to improving our service delivery process – whether those interventions use evidence-based practice or practice-based evidence.

The committee believes that effective treatment occurs when fundamental conditions for change<sup>1</sup> are present. Regardless of technique or model, effective treatment is developmentally focused, gender responsive, family involved, relationship-based, competence centered, culturally and linguistically competent, and trauma-informed. These characteristics describe core competencies needed for all child-serving public and private agency staff. It is the combination of the conditions for change, evidence-based interventions, and evaluation that are necessary to transform service delivery.

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<sup>1</sup> CARE Practice Model, Cornell University, <http://rccp.cornell.edu/caremainpage.html>

## **Recommendations for Evidence-based Approaches**

### Effective Treatment/Conditions for Change

- 1) Infuse principles of Trauma-informed Care<sup>2,3</sup> across stakeholder agencies by:
  - a) Identifying trauma-informed care as a core competency
  - b) Requiring system of care interagency training to include all stakeholders and invite private provider community
  - c) Promoting expanded system-wide capacity for Screening/ Early identification, Assessment, and evidence-based Trauma-specific treatment services
- 2) Promote Cultural and Linguistic Competence across stakeholder agencies by:
  - a) Identifying as a core competency
  - b) Requiring system of care interagency training to include all stakeholders and invite private provider community

### Services and Supports

- 3) Provide critical supports to youth at-risk of residential care and their families
  - a) Increase case management capacity – need appropriate, high quality case management for youth with emotional, behavioral and developmental needs who don't qualify for ICC
  - b) Increase capacity/access to child and adolescent psychiatrists (expertise with developmental disabilities, trauma, and co-occurring MH/SA needed)
  - c) Offer supervised activities and customized programming for special populations of at-risk youth
  - d) Provide transportation so that families may access existing community services and supports
  - e) Offer caregiver supports to meet basic needs through coordinated charitable giving and flexible public funds
  - f) Provide an array of in-community crisis supports – mobile crisis response specifically designed for youth and crisis residential settings for young children are needed
  - g) Provide respite for caregivers with capacity for special populations of youth
  - h) Develop in-community home settings for special populations of youth to include treatment foster care, supervised apartments and possible small group homes within our community

### Promote Evidence-based Treatment

- 4) Explore methods for implementing and increasing the use of evidence-based interventions within public and private providers of services. Possible options include:

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<sup>2</sup> The National Child Traumatic Stress Network, [www.nctsnet.org](http://www.nctsnet.org); Trauma-informed Care <http://mentalhealth.samhsa.gov/nctic/trauma.asp>

<sup>3</sup> Organization model [www.sanctuarynet.com](http://www.sanctuarynet.com)

- a) Establish list of prioritized interventions and distribute across public and private provider community
    - i) Make training widely available to provider partners to promote use of prioritized EBTs (i.e., Learning Collaborative)
    - ii) Explore differential reimbursement for use of prioritized EBTs
    - iii) Explore use of RFP process for specific population of youth with specific EBT model
  - b) Explore common practice elements approach to EBTs – see work of Bruce Chorpita (Hawai'i)<sup>4</sup> and Michael Southam-Gerow (VCU).
  - c) Explore implementation of models like Family Integrated Transitions (FIT) for youth in juvenile justice system<sup>5</sup> or Maryland's Restorative Healing Model<sup>6</sup> that combine a set of EBTs into a package for particular populations of youth
- 5) Support Workforce Development
- a) Develop a process for on-going interagency review and dissemination of EBTs to remain current with the latest developments in treatment services.

Additionally, on September 21, 2009, the committee membership also provided the following comments:

- Opportunities exist for consultation with national experts; examples include Bruce Perry- Cognitive Behavior Therapy, Sandra Bloom - Trauma informed care expert and author of the Sanctuary Model, Dan Siegel- expert on parenting skills development and author of *Parenting to the Brain*.
- Any system-wide training designed and offered should include a component for one-to-one consultation and follow-up/ongoing training and support strategies to imbed new practices into the organizational culture (no “one-time rollouts”).
- Cross-departmental collaboration on curriculum development and strategies for ongoing sustainability of learning within the organization should address multiple strategies/forums for ongoing learning opportunities throughout the organization. Training should also incorporate support to provider partners as well as families. A survey was suggested of all staff to identify existing training/expertise in specific promising or evidence-based practices.
- An evaluation of the financial and resource costs to implement a comprehensive training and transformation effort is recommended. Training prioritization should begin with training on specific populations where services gaps exist, particularly in behavioral health services.

<sup>4</sup> <http://www.ssw.umaryland.edu/commonelements/index.htm>

<sup>5</sup> <http://www.depts.washington.edu/pbhjp/projects/fit.php>

<sup>6</sup> <http://www.woodbourne.org/restorativehealing>

- All parenting skills/family development training developed to address healthy family functioning should incorporate a component of parent practice with their respective child/children. This activity is a fundamental component for reinforcement of learned strategies and is a demonstrated evidence-based approach.

#### Evaluation and Outcomes Assessment

- 6) Centralize data/data collection for evaluation of treatment outcomes
  - a) Develop methods for maximizing the utility of the CSA uniform assessment tool (CANS) for youth outcomes
  - b) Review public and private agency stakeholder's current processes for evaluation and outcomes assessment to determine benefit across the system

#### **Next steps:**

- 1) Establish an on-going EBT workgroup of stakeholders to complete the following short-term tasks and continue working on the longer-term recommendations. Stakeholders include: county department representatives from child serving agencies, public schools, private providers and family representatives.
  - a) Develop survey tool for providers to assess EBTs, promising practices, cultural and language capacity currently offered by providers in the region
    - i) Survey experts within our region (e.g., Kennedy Krieger) as possible sources for enhancing service capacity and for consultation/technical assistance
    - ii) Consider adding information about specific EBTs offered by providers in our CSA provider directory
  - b) Evaluate treatment and service needs of youth in system compared to current array of services and treatments offered by contracted service providers
  - c) Analyze gap between what treatment youth need and what treatment services we have under contract to further refine list of prioritized interventions
  - d) Develop our system's capacity to appropriately screen, assess and treat youth with significant trauma exposure
    - i) Explore using the CANS as our screening tool for trauma;
    - ii) Gather additional information about other screening and assessment tools for trauma;
    - iii) Explore trauma-specific treatment options within our provider community and region
  - e) Provide recommendations for training topics to the interagency training coordination group listed below.
- 2) Establish system of care interagency training committee to coordinate and sponsor regular training for new and experienced workers in core competencies across stakeholder agencies including provider partners
  - i) Establish System of Care distribution list for notification about training and for online registration

- ii) Establish a central location or method for accessing videotapes from county trainings by stakeholders
  - iii) Add information and links regarding EBTs to the CSA Infoweb site and other central information sites
- 3) Establish a stakeholder workgroup to develop and implement a comprehensive Evaluation and Quality Assurance plan with reporting to stakeholders on:
- a) Youth and family clinical outcomes
  - b) Youth and family satisfaction with services
  - c) Fidelity/adherence to EBT models

## **Review of Evidence-Based Treatments and Promising Practices**

The following list of Evidence-based Treatments, Promising Practices, and topic areas were selected based on a review of the literature<sup>7</sup> and the treatment needs identified from the profiles of youth from our community who are commonly served in residential and group home settings. Federal and state entities as well as national organizations have undertaken the task of reviewing research and summarizing the level of scientific support for interventions by population, problem type, clinical diagnosis and field. These sources were utilized extensively by committee members.

### **Scope**

The work of the committee focused on behavioral health treatments as the most effective strategy to achieve the goal of building community capacity as an alternative to residential placement. The committee considered what currently exists and what could be brought forward as recommendations for possible expansion or introduction into the community. The work focused on treatments, and not necessarily settings.

The work of this committee was also aided by several existing studies and resources from a variety of local community efforts to continuously assess and improve practices and approaches. As an example, the state's Children's Services Transformation efforts were reviewed. One notable source is from the Fairfax County Public Schools, which established an evidence-based research forum, whose members currently are advancing various educational and school-based best practice recommendations. The committee's work was intended to supplement, not replicate or duplicate, ongoing daily operational efforts in all agencies and the schools to support program and resource capacity enhancements.

### **Philosophies and approaches**

The committee noted that adoption of evidence-based practices should be consistent with the goal of becoming a family driven system. To assure an appropriate service array is available, particularly for identified gaps and special populations/behavioral issues, protocols are necessary. However, a balance is needed to avoid being overly prescriptive at the expense of flexibility. A range of best practice treatments, models, and options that are accepted and available in the community - based on the individual treatment needs of children/families – are required components of a successful system of care. The individualized approach to service delivery, however, must not preclude development of standards for reporting outcomes, measuring progress/success, and assessment/evaluation of specific service delivery processes and products.

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<sup>7</sup> <http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf> The Findings of the Kauffman Best Practices Project to Help Children Heal from Child Abuse.

<i>Evidence-based Treatments and Program models</i>	<i>Substance Abuse/ Co-occur Mental Health</i>	<i>Building Family Capacity/ Parenting supports</i>	<i>Mental Health</i>	<i>Delinquent/ CHINS</i>
<b>Abuse-focused Cognitive Behavioral Therapy</b>			✓	
<b>Aggression Replacement Training</b>				✓
<b>Brief Strategic Family Therapy</b>	✓	✓		
<b>Child-Parent Psychotherapy for Family Violence</b>		✓		
<b>Dialectical Behavior Therapy (DBT)</b>			✓	
<b>Eye Movement Desensitization and Reprogramming (EMDR)</b>			✓	
<b>Functional Family Therapy (FFT)</b>				✓
<b>Incredible Years</b>		✓	✓	
<b>Multi-dimensional Treatment Foster Care (MDT)</b>				✓
<b>Multi-systemic Family Therapy (MST)</b>				✓
<b>Neuro-sequential Model of Therapeutics (NMT)</b>			✓	
<b>Nurse Family Partnership</b>		✓		
<b>Parent-Child Interaction Therapy (PCIT)</b>		✓		
<b>Positive Parenting</b>		✓		
<b>Strengthening Families</b>	✓	✓		
<b>Trauma-focused Cognitive Behavioral Therapy</b>	✓		✓	

Models and specific research is included in the Appendix A of the report.

## Deliverable G: Systems Barriers

Committee members examined the typical array of services and supports offered in Systems of Care available in other communities. The following systems barriers were identified through discussion, analysis and feedback from staff serving children in residential care or transitioning from care. Additional work to both validate the observations and research alternative responses will be necessary, particularly with full participation of families and youth served through the System of Care.

### System issues

A broad continuum of systems and services are already available in the Fairfax-Falls Church community. However, system barriers exist, including the following:

1. The committee members express their concerns regarding ability to support creation/flexibility of ‘wraparound’ services in community settings.
  - *To address this concern, the committee recommends a strong and sustained organizational training effort, which includes steps for accountability at all steps of service delivery to a family and a child.*
2. Funding constraints may limit ability of the system to be family driven and tailored to individual needs, using best practices.
  - *To address this concern, the committee recommends a strong commitment to responsiveness to families at all levels as part of core curriculum for staff training and accountability measures established to create opportunities in the system to address barriers.*
3. A critical issue for intensive care coordination – being flexible, responsive and immediate in service responses- is impacted by the ability to work effectively in FAPT processes and in access to resources (both money and staffing).
  - *To address this concern, the committee recommends required training for all FAPT team members on the services provided through intensive care coordination and enrollment in training on the concepts and /philosophy of family engagement and that the training be both an ongoing requirement and priority for FAPT team participation.*
  - *Create a standing work team to meet regularly on improvements to intensive care coordination based on experience in FAPTS. Involve the CSB FAPT coordinator, FAPT team members, CSA staff and CSB ICC staff. Review opportunities to streamline referral processes and address provider and parent reports on the process and provide regular updates to the SOC leadership group.*

4. While the county has numerous services and supports, because of its size and unique community features, staff in both public and private provider service delivery agencies face barriers to maintaining knowledge of current resources or to learn of new or changing supports. Improvements to mechanisms for communicating existing resources and available providers are needed.

Suggested areas to strengthen include advertisement and use of the regional 211 system, the county's 222-0880 Coordinated Services Planning services and additional training opportunities to enhance regional work on CSA provider resources information and development efforts.

■ *To address this concern, establish a work group to review existing information and referral data sources, brochures, publications and partners with child serving agencies and private providers on ways to integrate and/or leverage existing supports to provide a more systemic way to communicate resources as they are changed/developed to the community, to providers, parents, educators and child serving staff.*

5. Involving families at all levels of organization is needed for true engagement. Recruitment for participation in planning activities and ongoing participation in services design and evaluation is not consistent.

■ *To address this concern, the committee recommends continued work to promote family participation in planning and evaluation activities. The committee recommends establishment of a family network consistent with state-wide service strategies and that consideration be given to create networks such as the state of Maryland model for family engagement.*

6. Families that are served have multiple and complex needs. The system must assure that issues are addressed through multi-faceted responses. Individual family members will have different characteristics/behaviors that need to be addressed in both treatment and service planning. For example, trauma-informed care approaches will need to include strategies which address both parents and children issues regarding the trauma and how it impacts family as well as individual functioning. Different strategies will be needed for each variable.

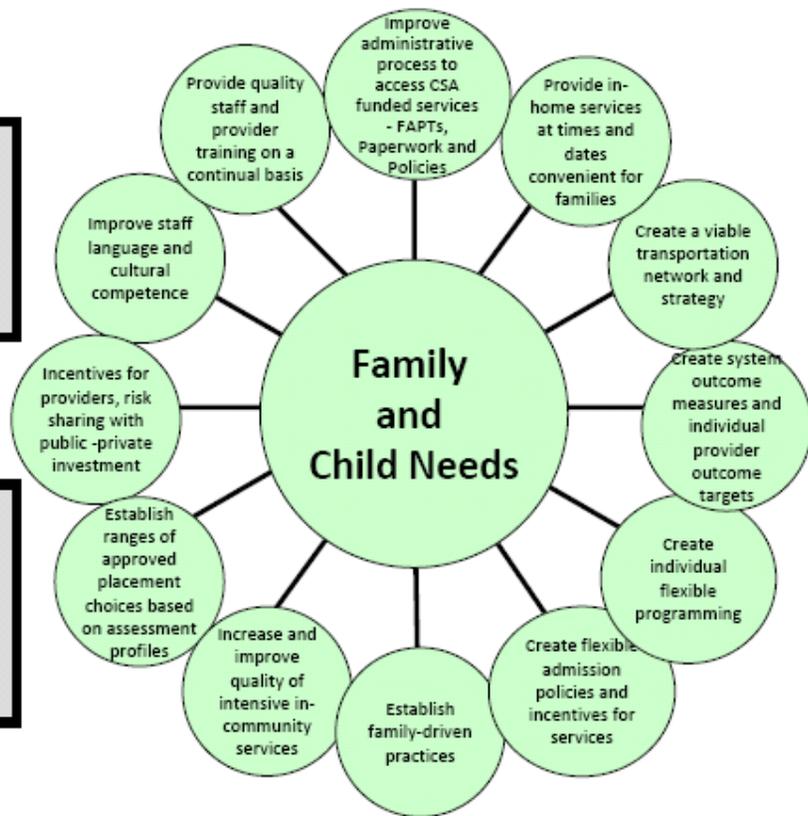
■ *To address this concern, the committee recommends that all service providers, including both public and private providers, participate in a systems of care training that includes the need for service plans to be comprehensive, and that the system focus will be on meeting the needs of families. Additionally, outcomes defined for the system of care should reflect the multiple variations within family/households – and complex situations – of a comprehensive and individualized approach for services.*

7. The integration of physical, neurological, behavioral health care services to assure the overall health and well-being of children in CSA service provision needs additional cross-system supports.
  - **To address this concern, the committee recommends periodic cross-agency (public and private provider) discussions and additional research on the issues related to the provision of primary health care services and current practices in the system, to determine what steps may be needed to assure appropriate and best practice methods are consistently available.**
8. Parent representatives note the importance of prevention as a consideration in the System of Care for At Risk Youth Children. Children eligible for ICC services do not appear overnight, and in many cases exhibit needs for years before residential placement ever becomes a consideration. The SOC effort must place some focus on prevention and include simple support measures that could prevent children from ever reaching the “eligible” group.
  - *To address this concern, the committee recommends:*
    - *Improved access to information and services, such as creation and publicizing a resource website for families*
    - *Improved liaison and linkages between the child serving agencies and various support organizations.*
    - *Accountability to families on processes to access services and evaluation of the services from their perspective – with prompt action taken to improve areas that are deficient*
    - *Additional work on systems barriers with families themselves*

# Responses to System Barriers

- Profiles of at risk children:**
- CHINS
  - Delinquent
  - Co-occurring SA/MH
  - MH/Trauma
  - Neglected/Under-socialized/ "Out of control"
  - Youth with Developmental Disabilities

- Clinical Needs:**
- Trauma history
  - Aggression/ harm to others
    - Sexual behavior
  - Self-injury/ harm to self
    - Runaway with risk behavior
    - Substance abuse
    - Sexual behavior
  - Lack of parenting skills and/or capacity



### Summary of Services Committee Deliverables and Next Steps

Deliverable	Tasks	Status
<b>Review current caseload of residentially placed children</b>	<p>What were the presenting conditions?</p> <p>What were the decision factors? What are referral sources?</p> <p>Identify reasons for coming into CSA service structure – contributing factors:</p> <p>Identify the common elements for the 75% that went into residential care</p> <p>Identify the reasons for those who stayed in care beyond the best practice six to nine month length of stay</p>	 Completed
<b>Develop a screening tool to identify children and youth eligible for referral to the System of Care (SOC)</b>	<p>Identify the common behaviors/conditions that have a significant presence in current CSA referred children and their families</p> <p>Identify risk factors contributing to children requiring restrictive levels of care</p>	 Completed
<b>Develop a protocol using the Child and Adolescent Needs and Strengths assessment instrument (CANS) to assess strengths and needs of children and youth</b>	<p>Develop and implement standard screening, assessment and evaluation tools across all referring programs and providers</p> <p>Develop a protocol for youth and families leaving ICC and transitioning back to agency/program-based case management services</p>	 Completed

### Summary of Services Committee Deliverables and Next Steps

Deliverable	Tasks	Status
<p><b>Develop a framework for Community Services Board (CSB) implementation of an intensive care coordination function</b></p>	<p>Clarify the respective roles of the public and private sectors in screening, assessment and evaluation</p> <p>Identify criteria for qualification for intensive care coordination</p> <p>Distinguish <i>case management</i> from <i>care coordination</i>. Define who is responsible for each, if both are needed</p> <p>Decide how case management is conducted and by whom</p>	<p> Completed</p> <p> Implementation of Intensive Care Coordination model</p>
<p><b>Identify and recommend evidence-based and other best practices for implementation in calendar year 2009 to reduce length of stay in residential/group care</b></p>	<p>Review evidence-based and other best practices for therapy/treatment for common profiles of presenting behaviors for CSA referred children</p>	<p> Completed - for behavioral health treatment</p> <p> - care coordination and other case management models</p>
<p><b>Identify suggested implementation strategies</b></p>	<p>Review and make recommendations</p>	<p> Completed</p> <p>1. Incorporate recommendations of Developmental Disabilities Committee for any unique needs of children with developmental disabilities</p>

### Summary of Services Committee Deliverables and Next Steps

Deliverable	Tasks	Status
<p><b>Implementation strategies for family engagement practices and models</b></p>	<p>Review and make recommendations</p>	<p> Completed - recommendations for participation in family group conferencing and family team meetings</p> <p> Continued work to define strategies to engage families throughout the system, particularly for those not qualifying for formal CSA funded referrals to the FGC/FTM model</p>
<p><b>Strategies for flexible administrative procedures for CSA cost containment exceptions</b></p>	<p>Review and make recommendations</p>	<p> Completed - initial set of recommendations</p> <p> Explore how ICC and other case management strategies can be brought to scale</p> <p>Linkage/changes to existing Child Specific Team (CST) services and approaches</p>

### Summary of Services Committee Deliverables and Next Steps

Deliverable	Tasks	Status
<p><b>Identify Systems barriers that adversely affect services provision for families and youth.</b></p>	<p>Identify the system barriers and challenges that result in out of home placements</p> <p>Develop strategies for outreach, training and education on the systems of care philosophy and principles, screening and assessment tools for staff across departments and in the school system</p>	<p> Completed</p> <p> Recommendation for additional work:</p> <p>Protocols for information sharing - identify existing barriers and resolve legal/public concerns based on national practices and to establish common outcome measures/indicators for each child placement</p> <p><b>Evaluation</b> -Strategies for effective evaluation of quality of care and treatment</p>

## Summary of Services Committee Deliverables and Next Steps

Deliverable	Tasks	Status
<p><b>Identify service gaps in community-based care and recommendations on areas that need to be prioritized</b></p>	<p>Identify what best practices are not available in the community and in private/public residential settings (gap analysis)</p> <p>Recommend service approaches that need to be developed in the community for:</p> <ul style="list-style-type: none"> <li>- children transitioning from residential placements back to the community</li> <li>- children who could be diverted from private residential placements to community settings</li> </ul>	<div style="display: flex; align-items: center;">  <p>Completed – identification of service gaps</p> </div> <ol style="list-style-type: none"> <li>1. Review the existing treatment service capacity.</li> <li>2. Identify resources at the community and school level for these children identified at risk</li> <li>3. Recommend models for purchased treatment services when residential placements are required</li> <li>4. Develop plan for contribution of both formal and informal community support networks into the treatment planning process, including school resource officers, teachers, social workers, faith community members, volunteer mentors, athletic services providers, and other service providers from the public and private sectors</li> <li>5. Process for step down protocol from residential settings to home/community settings (review other models/best practice, including PACT program)</li> <li>6. Incorporate transition planning, process planning, documentation and service delivery)</li> </ol>

## **Appendix A: Evidence-Based Treatments and Models**

The following list of Evidence-based Treatments and topic areas were selected based on a review of the literature<sup>8,9</sup> and the treatment needs identified from the profiles of youth from our community who are commonly served in residential and group home settings in our current system. Federal and state entities as well as national organizations have undertaken the task of reviewing research and summarizing the level of scientific support for interventions by population, problem type, clinical diagnosis and field. These sources were utilized extensively by committee members.

**Please note:** All of the information about evidence-based treatments, promising practices, and treatment models/topics contained in this appendix were drawn from a variety of source materials that are readily available on the Internet. In most cases, the information in this appendix is taken directly from the sources listed within the summaries and authorship is credited to those original sources not workgroup members.

### **Juvenile Justice/ CHINS – Delinquent**

- Multi-systemic Family Therapy (MST)
- Functional Family Therapy (FFT)
- Multi-dimensional Treatment Foster Care (MDT)
- Aggression Replacement Training (ART)

### **Child Welfare /Trauma/MH**

- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Abuse-focused Cognitive Behavioral Therapy (AF-CBT)
- Trauma-informed Care
- Eye Movement Desensitization and Reprogramming (EMDR)
- Neurosequential Model of Therapeutics (NMT)
- Dialectical Behavior Therapy (DBT)

### **Child Welfare/ Parenting**

- Parent-Child Interaction Therapy (PCIT)
- Child-Parent Psychotherapy for Family Violence
- Brief Strategic Family Therapy
- Triple P – Positive Parenting Program
- Strengthening Families
- Incredible Years

### **Topics/Models**

- Interventions for co-occurring substance abuse, trauma, and mental health disorders
- Program for Assertive Community Treatment (PACT)
- Mobile crisis response and stabilization services
- CARE Model: Creating Conditions for Change
- Positive Behavior Intervention and Support (PBIS)

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<sup>8</sup> <http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf> The Findings of the Kauffman Best Practices Project to Help Children Heal from Child Abuse.

<sup>9</sup> <http://www.cachildwelfareclearinghouse.org> California Evidence-based Clearinghouse for Child Welfare

## **MULTISYSTEMIC THERAPY (MST)**

The following paragraphs are from the website listed below:

### **Theoretical Rationale/Conceptual Framework**

Consistent with social-ecological models of behavior and findings from causal modeling studies of delinquency and drug use, MST posits that youth antisocial behavior is multi-determined and linked with characteristics of the individual youth and his or her family, peer group, school, and community contexts. As such, MST interventions aim to attenuate risk factors by building youth and family strengths (protective factors) on a highly individualized and comprehensive basis. The provision of home-based services circumvents barriers to service access that often characterize families of serious juvenile offenders. An emphasis on parental empowerment to modify the natural social network of their children facilitates the maintenance and generalization of treatment gains.

### **Brief Description of Intervention**

MST is a pragmatic and goal-oriented treatment that specifically targets those factors in each youth's social network that are contributing to his or her antisocial behavior. Thus, MST interventions typically aim to improve caregiver discipline practices, enhance family affective relations, decrease youth association with deviant peers, increase youth association with pro-social peers, improve youth school or vocational performance, engage youth in pro-social recreational outlets, and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes. Specific treatment techniques used to facilitate these gains are integrated from those therapies that have the most empirical support, including cognitive behavioral, behavioral, and the pragmatic family therapies.

MST services are delivered in the natural environment (e.g., home, school, community). The treatment plan is designed in collaboration with family members and is, therefore, family-driven rather than therapist-driven. The ultimate goal of MST is to empower families to build an environment, through the mobilization of indigenous child, family, and community resources that promotes health. The typical duration of home-based MST services is approximately 4 months, with multiple therapist-family contacts occurring each week.

Although MST is a family-based treatment model that has similarities with other family therapy approaches, several substantive differences are evident. First, MST places considerable attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Hence, for example, MST priorities include removing offenders from deviant peer groups, enhancing school or vocational performance, and developing an indigenous support network for the family to maintain therapeutic gains. Second, MST programs have an extremely strong commitment to removing barriers to service access (see e.g., the home-based model of service delivery). Third, MST services are more intensive than traditional family therapies (e.g., several hours of treatment per week vs. 50 minutes). Fourth, and most important, MST has well-documented long-term outcomes with adolescents presenting serious antisocial behavior and their families. The strongest and most consistent support for the effectiveness of MST comes from controlled studies that focused on violent and chronic juvenile offenders.

### **Overview of MST Treatment Program**

- Current program description claims to address multiple types of behavioral problems but was originally designed to address treatment for juvenile offenders, as described above; and notably, most research quoted on the website using this modality was done with juvenile court and substance abuse populations; website suggests the model is modified for specific target groups.
- Treatment program listed on federal juvenile justice (<http://ojjdp.ncjrs.org/>) website as EBP
- Program requires supervisors and providers to have been trained by MST Services (5 day training); from the website description of how to start a MST program, it appears that the program requires adherence to their methods from the very beginning of the program, from their initial evaluation of the population to be served, to weekly consultation with MST Services staff; this approach utilizes a manualized approach with modules for different problems; it emphasizes strict fidelity to the treatment model through the use of both paper and in-person methods of measuring adherence for strict quality assurance.
- Model is very intensive, home based with providers providing all therapy in the home (including substance abuse treatment) and requires providers to be available 24/7; suggests the primary therapists should have master's degrees and clinical supervisors have Ph.D.s., although it permits "very experienced" bachelors and masters levels to provide same services.
- Claims to be cost effective in the long run.
- See Addendum 1 for comments by 2 people involved with MST programs or training.

**Website:** See <http://www.mstservices.com> for in-depth description of program

**Reviewer:** Kolleen Martin, Ph.D., Fairfax-Falls Church CSB, MH

## FUNCTIONAL FAMILY THERAPY (FFT)

**Types of Maltreatment:** not specified

**Target Population:**

- Youth ages 11-18 demonstrating delinquent and/or antisocial behaviors and their families

**Functional Family Therapy (FFT)** is a structured model of weekly family therapy, which can be provided in an office or home setting. It is often completed in 12 sessions, but no more than 30. Hallmarks of the intervention include clear theoretical demarcations between the beginning, middle and ending phases of treatment, with corresponding foci for assessment and attention to protective and risk factors in the family. This assists the therapist to maintain treatment focus in the midst of potential chaos and disorganization in the family. It focuses on the functions of behaviors in both the individual and family context, related relational patterns, motivation and behavior change.

**Training:** FFT requires at least one year of training with a tuition cost of approximately \$30,000. Two additional years of training are available at approximately \$17,000 additional. To be a certified FFT provider, however, three years is required, including year-long internships, on site visits and phone consultations by FFT consultants. FFT providers are generally agencies/ groups of providers.

**More information:** [www.fftinc.com](http://www.fftinc.com); <http://www.fft-sverige.se/pdf/workshop-alex-1.pdf>

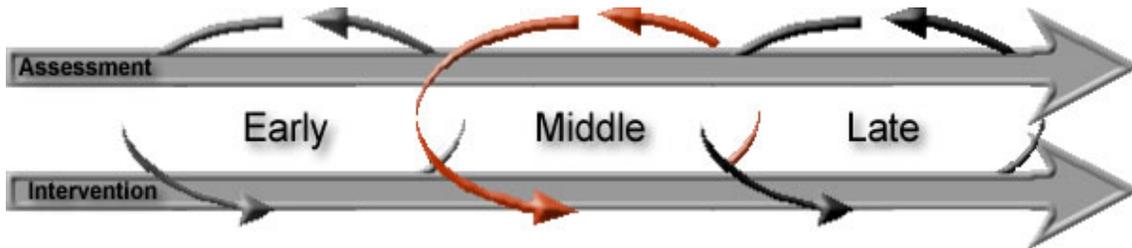
**Reviewer:** Kolleen Martin, PhD; Fairfax-Falls Church CSB, MH

## FUNCTIONAL FAMILY THERAPY (FFT)

FFT provides the information below as a description of the treatment program:

### **Clinical Model**

The FFT clinical model is appealing because of its clear identification of specific phases which organize intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.



	Engagement/Motivation	Behavior Change	Generalization
<b>Phase Goal</b>	Develop alliances. Reduce negativity & resistance. Improve communication. Minimize hopelessness. Reduce dropout potential. Develop family focus. Increase motivation for change.	Develop & implement individualized change plans. Change presenting delinquency behavior. Build relational skills (e.g., communication & parenting).	Maintain/generalize change. Prevent relapses. Provide community resources necessary to support change.
<b>Risk &amp; Protective Factors Addressed</b>	Negativity & blaming (risk). Hopelessness (risk). Lack of motivation (risk). Credibility (protective). Alliance (protective). Treatment availability (protective).	Poor parenting skills (risk). Negativity & blaming (risk). Poor communication (risk). Positive parenting skills (protective). Supportive communication (protective). Interpersonal needs (depends on context). Parental pathology (depends on context). Developmental level (depends on context).	Poor relationships with school community (risk). Low level of social support (risk). Positive relationships with school community (protective).
<b>Assessment Focus</b>	Behavior (e.g., presenting problem, risk)	Quality of relational skills	Identification of community resources

	& protective factors). Relational problems sequence (e.g., needs/functions). Context (risk & protective factors).	(communication, parenting). Compliance with behavior change plan. Relational problem sequence.	needed. Maintenance of change.
<b>Therapist Skills</b>	Interpersonal skills (validation, positive interpretation, retribution, reframing, & sequencing). High availability to provide services.	Structure (session focusing). Change plan implementation. Modeling, focusing, directing, training.	Family case manager. Resource help. Relapse prevention interventions.

**Overview of the FFT treatment program:**

- Website is very limited in terms of detailed explanations of program in comparison to MST website
- Appears to be designed, as was original MST, for juveniles involved with criminal justice system; appears to be used about as frequently as MST
- Focuses on family functioning and relationships

**Reviewer:** Kolleen Martin, Ph.D., Fairfax-Falls Church CSB, MH

## COMPARISON OF MST AND FFT

Model programs for delinquent youth share key characteristics:

1. Family-focused
2. Home- and community-based
3. Responsibility for engagement is on the provider
4. Constant focus on treatment fidelity and accountability
5. Defined length of treatment

### **Functional Family Therapy** ([www.fftinc.com](http://www.fftinc.com))

- Targets high-risk youth ages 11-18 and their families
- Focuses on family relations and communication; builds on youth and family strengths as motivation for change
- Cost: \$3,000-\$3,500 per youth
- Length of treatment: average 12 sessions
- Reductions in recidivism: 25-55% across studies v. control group
- Currently in over 30 states and four countries

### **Multisystemic Therapy** ([www.mstservices.com](http://www.mstservices.com)):

- Targets chronic and violent delinquents ages 12-18
- Focuses on the entire ecology of the youth including family, school, peer and community relations
- Cost: \$6,000-\$9,500 per youth
- Length of treatment: average 4 months (60 hours)
- Reductions in recidivism: 30-70% v. control groups
- Currently in over 35 states and eight countries

### **Reference:**

[http://www.evidencebasedassociates.com/resources/presentations/Diffusing\\_Model\\_EBPs\\_\(OMH\\_LA\)\\_07\\_1206.pdf](http://www.evidencebasedassociates.com/resources/presentations/Diffusing_Model_EBPs_(OMH_LA)_07_1206.pdf)

**Reviewer:** Kolleen Martin, Ph.D., Fairfax-Falls Church CSB, MH

## Multi-dimensional Treatment Foster Care

**Type of Maltreatment:** not specified

**Target Population:**

- Youth, from preschool through adolescence, which are exhibiting antisocial, disruptive, and harmful behavior which place them at risk of out of home placement in hospital, juvenile detention or other residential placement

**Multidimensional Treatment Foster Care (MTFC)** is an evidence-based practice involving the treatment of youth in the homes of foster families trained in MTFC (clear structure, expectations, consequences) away from an antisocial/delinquent peer group, supported by 24 hour/7 day per week crisis intervention supplied by the therapeutic foster care agency staff. The model is customized for three age groups, the original being for adolescents (MTFC-A, ages 12-17), and adapted for preschoolers (MTFC-P, ages 3-5) and for middle childhood (MTFC-C, ages 6-11). In any version, hallmarks of the intervention include it being the only intervention for the youth and their family, providing intensive family therapy and skill training for the birth or adoptive parents/after placement resource, and high levels of supervision of the youth in the foster home, at school, and in the community. The model uses a team approach including a supervisor, family therapist, child therapists, foster parent recruiter/trainer, Skills trainer, daily caller to the foster families and a consulting psychiatrist. Contact is made with foster parent typically 7 times per week, the child attends both individual and skills training weekly, and the biological family has at least a weekly skill building session.

**Training and costs:**

Multidimensional Treatment Foster care is a “brand name” and as such cannot be used unless a treatment foster care program is certified by TFC Consultants, Inc, an agency dedicated to the implementation of model-adherent MTFC programs. They provide training, consultation and technical assistance to develop and maintain MTFC programs. TFC Consultants certifies programs with a rigorous certification assessment, and first year implementation protocol. A program may be certified in this “brand name” without formal training from TFC Consultants, however. Training costs from TFC Consultants runs \$400 per person for a 4 day training in Oregon. This is geared toward an agency’s clinical staff. The costs for a first year implementation range from \$45,500 - \$49,750, with a \$2,500 certification cost and \$2,720 annually for online support and training.

**Local provider:**

The President of TFC Consultants indicated via email that Central Virginia Community Services in Lynchburg is a certified provider of the model.

**More information:** Official website: [www.mtfc.com](http://www.mtfc.com)

**Reviewer:** Jean Bartley, LCSW, Fairfax-Falls Church CSB

## **Aggression Replacement Training (ART)**

**Type of Maltreatment:** Exposure to violence, physical and emotional abuse.

**Target Population:**

- Originally focused on the adolescent population in the juvenile justice system; 12 to 17 year olds who were incarcerated.
- Now used in school based settings and adapted for preschool curriculum, mental health settings, and for adults.
- Some limited use with autism spectrum, particularly Asperger's.

**ART: Aggression Replacement Training:**

ART was designed by Arnold P. Goldstein and Barry Glick in the 1980's. It is a synthesis of a number of other theories for working with youth. It is an evidenced based practice utilized both across the US and internationally (ICART). USDOE calls it a promising practice. The Promising Practices Network has not yet thoroughly reviewed it but preliminary review suggests it may be effective and is highly regarded by other credible organizations (DOE, Drug Free Schools Programs). It was also rated effective by the Office of Juvenile Justice and Delinquency Prevention.

ART is a cognitive behavioral intervention to help children and adolescents improve social skill competence and moral reasoning, better manage anger and reduce aggressive behavior. The program consists of 10 weeks (30 sessions) of intervention. There are 3 components: social skills training, anger control training, and training in moral reasoning. Clients attend a one hour session in each of these components each week for 10 weeks. Social skills training teach youth what to do in threatening or stressful situations and are the behavioral component. Anger Control Training is the affective component focusing on losing anti social skills and replacing them with pro social skills. And the cognitive component of ART is Moral Reasoning training. This provides opportunities to take other perspectives than their own and learning to view the world more fairly.

**Training:**

The only approved training is provided by G and G Consultants, LLC. They offer 3 levels of training: basic facilitator level, advanced level and the Master's level. It is a 5 day 36 to 40 hour institute. Including program/clinical supervision as the program is implemented. See <http://g-gconsultants.org> They also offer licenses to jurisdictions, systems, and agencies (public and private) to operate training centers.

**Reviewer:** Sandy Porteous, MA, Manager, Phillips Family Partners

## **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**

**Type of Maltreatment:** exposure to domestic violence and sexual abuse

**Target population:**

- Children who are experiencing significant PTSD symptoms, whether or not they meet the full diagnostic criteria.
- Children with depression, anxiety, and/or shame related to their traumatic exposure.
- Children experiencing Childhood Traumatic Grief can also benefit from this treatment

**Treatment:**

1. Short-term, 12-18 sessions
2. Conjoint, child and parents
3. Out patient setting

**Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** was developed by Judith Cohen, MD and Anthony Mannarino, PhD at the Allegheny General Hospital Center for Traumatic Stress in Children and Adolescents in Pittsburgh, Pa. This psychotherapeutic intervention targets symptoms of Post Traumatic Stress Disorder (PTSD) but also deals with associated concerns commonly seen in children who have experienced trauma including self esteem, trust, mood, self-injurious behavior and substance abuse. In TF-CBT children develop skills in stress management, cognitive processing, communication, problem solving, safety and feelings identification. Children learn to talk about their trauma in a supportive environment thus learning to manage their trauma-related symptoms. The parents participate in a parallel process where they learn to support their child, learn effective parenting skills and explore their thoughts and feeling about the trauma.

**Website/ more information:**

Trauma-Focused Cognitive Behavioral Therapy SAMHSA Model Programs

<http://modelprograms.samsha.gov/pdfs.model/tfcbt.pdf>

The California Evidence-Based Clearinghouse for Child Welfare, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) report: [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org) [Click here for a detailed report](#) which includes Essential Components, Relevant Published, Peer-Reviewed Research, Education and Training Resources, etc.

**Training:**

Training is offered by Dr. Judith Cohen @ Center for Traumatic Stress in Children & Adolescents Allegheny General Hospital. After completing the free 10 credit online course @ [www.musc.edu/tfcbt](http://www.musc.edu/tfcbt) Dr. Cohen provides a 2 day on –site training @ \$3,000 per day plus expenses. Follow-up consultation calls (2 per month) for up to 12 therapists is \$200 per call. Stakeholder training is 2-3 hours for \$1500. Advanced training for those with 6-12 months experience is \$3,000 per day

**Reviewer:** Maureen Altman, LCSW, CSA, Utilization Review Specialist

## **Abuse- Focused Cognitive Behavioral Therapy**

**Type of maltreatment:** physical and emotional abuse

**Target population:** school age children and their physically abusive or coercive caretakers

**Treatment:** short term, 3-6 months; 1-2 contacts per week, minimum 60 minutes; Out patient, in home or residential setting

**Abuse Focused-Cognitive Behavioral Therapy**-developed and tested by David J. Kolko, PhD at the Western Psychiatric Institute and Clinic of the University Of Pittsburgh School Of Medicine in Pittsburgh, Pa.

Often parents in families where physical abuse has occurred maintain negative perceptions of their children, exhibit anger or hostility, foster coercive family relationships and use harsh or punitive discipline. Children may subsequently exhibit aggression, behavioral problems, trauma-related emotional symptoms, poor social and relationship skills and cognitive impairment. AF-CBT is intended to improve family relationships, reduce family conflict, and promote appropriate pro-social behavior while discouraging coercive, aggressive or violent behavior. AF-CBT starts with an assessment to identify presenting problems and parental and family issues that might be contributing to the abuse as well as to identify the child's and family's strength that could influence change. In AF-CBT children and parents, or caretakers, participate in separate sessions but use parallel materials to the extent possible. They also have joint sessions at various times throughout treatment. Treatment is tailored to the specific strengths and challenges of the family with the goals of reducing parental anger and use of force, promoting alternatives to physical discipline, minimizing risks for additional abusive incidents, enhancing the child's coping skills and adjustment, encouraging prosocial problem-solving and improving communication within the family. Treatment programs for children and parents incorporate the use of specific skills, role-playing exercises, performance feedback, and home practice exercises. Parent-child or family therapy focuses on completing a family assessment and indentifying family treatment goals, discussing a no-violence agreement, clarifying attributions of responsibility for abuse, developing safety plans, communication skills, training in non aggressive problem solving, home practice and community and social systems, as needed.

**Training:** For 15-20 people, training cost - \$15-20,000 for 5-6, 8 hour days of training and consultation calls provided by Dr. Kolko's staff. See [www.pitt.edu/~kolko](http://www.pitt.edu/~kolko)

**Website/ More information:** [www.childwelfare.gov/pubs/cognitive/cognitiveva.cfs](http://www.childwelfare.gov/pubs/cognitive/cognitiveva.cfs) The Child Welfare Information Gateway; The California Evidence-Based Clearinghouse for Child Welfare Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) summary report. [www.cachildwelfareclearinghouse.org](http://www.cachildwelfareclearinghouse.org)

**Reviewer:** Maureen Altman, LCSW, CSA Utilization Review Specialist

## Trauma-Informed Treatment

The literature suggests that many, if not most, of the children who receive services for mental health problems have a history of trauma. The Adverse Childhood Effects (ACE) study<sup>10</sup>, by Kaiser Permanente and the Centers for Disease Control and Prevention looked at over 17,000 participant's exposure to childhood trauma. They reported that trauma is more prevalent than previously believed and that the impact of untreated trauma is cumulative and can lead to social, emotional, behavioral and cognitive difficulties.

A trauma- informed treatment model acknowledges trauma experiences and supports trauma- specific treatment services to support healing. A clear understanding of the extent of the trauma is essential to providing effective treatment. The needs of traumatized children can best be addressed by providing evidence-based treatment models that were developed for those with current and/or past trauma. Trauma-specific treatment services are thought to address directly the impact of trauma on an individual's life and facilitate recovery. Trauma-informed treatment is based on evidence-based and best practice models that have been shown to facilitate recovery from trauma in the context of a trauma-informed service system that acknowledges and understands the cumulative effects of trauma and the benefit of client empowerment.

Components of a trauma informed treatment program include:

- Providers understand the dynamics of trauma and violence
- Staff is trained about trauma, violence and how to provide appropriate treatment
- Providers understand that the use of seclusion, restraint and forcing certain medication can be re-traumatizing.
- Clients need to be assessed for trauma and violence before entering the program
- Environment is physically and practically designed to avoid re-traumatization.
- Environment is safe and nurturing
- Environment is empowering
- Environment is culturally competent

The Sanctuary Model<sup>11</sup> represents an organizational approach for creating a trauma-informed environment for treatment.

### **Websites/ More information:**

[A Closer Look: Trauma Informed Treatment in Behavioral Health Settings](#)<sup>12</sup> - Ohio Legal Rights Service January 2007; National Trauma Consortium [www.nationaltraumaconsortium.org](http://www.nationaltraumaconsortium.org) ; Trauma - the "Common Denominator" prepared with assistance from CMHS National Center for Trauma-Informed Care [www.witnessjustice.org](http://www.witnessjustice.org)

**Reviewer:** Maureen Altman, LCSW, CSA Utilization Review Specialist

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<sup>10</sup> The Adverse Childhood Experiences (ACE) Study: Bridging the Gap between childhood trauma negative consequences later in life. [www.cestudy.org](http://www.cestudy.org)

<sup>11</sup> Sanctuary model for organization change, Sandra Bloom, [www.sanctuaryweb.com](http://www.sanctuaryweb.com)

<sup>12</sup> [www.olrs.ohio.gov/asp/trauma.asp](http://www.olrs.ohio.gov/asp/trauma.asp)

## **Eye Movement Desensitization Reprocessing**

**Types of Maltreatment:** Exposure to traumatic life experiences

**Target Population:**

- Children who are experiencing symptoms of Post-Traumatic Stress Disorder, such as flashbacks, intrusive thoughts, whether or not they meet full diagnostic criteria

**Eye Movement Desensitization Reprocessing (EMDR)** is a standardized intervention with a clearly defined protocol typically used as part of ongoing individual therapy focusing on resolving symptoms of trauma. It is a multi-modal treatment that accesses and targets emotional, cognitive, somatic, and narrative elements of disturbing events and the memory networks that contain them. There is literature indicating it has been used in group settings with school children targeting a specific traumatic event. It has been widely studied in adults in both randomized and nonrandomized clinical trials, less so in youth. More recently, elements of the “original” “standard” protocol have been taken and applied in different treatment contexts to good effect, especially regarding establishing safety and self soothing for clients, thereby allowing further processing of traumatic material. Therefore, EMDR can be used in its “original” format, or elements of the protocol can be used as the clinical presentation suggests. While some literature indicates rapid results with single- or limited-event trauma histories with the use of standard protocol, the method is generally viewed as part of a longer term therapeutic intervention, particularly with complex (multiple events, multi-sphere) post-traumatic stress.

**Training:**

There are varying levels of training for practitioners, and a certification is available. Certification is not a requirement for utilization of the intervention. Clinicians with the first level of intervention may be competent for certain basic EMDR interventions. Basic training costs roughly \$1530 through EMDRIA, the National EMDR organization. EMDR-HAP (Humanitarian Assistance Program) offers the same training for free, with the caveat that staff trained by EMDR-HAP will offer some services pro bono.

**Website/more information:**

Official website: [www.EMDR.com](http://www.EMDR.com), which offers information on training and is a good general resource. There is also [www.emdria.org](http://www.emdria.org) which is the website of the international organization, which sponsors certification.

**Reviewer:** Jean Bartley, LCSW, Fairfax-Falls Church CSB, MH

## **Neurosequential Model of Therapeutics (NMT)**

**Types of maltreatment:** neglect, physical or emotional abuse

**Target population:** at-risk, maltreated and traumatized children

**Neurosequential Model of Therapeutics (NMT)**, developed by Dr Bruce Perry and colleagues at the Child Trauma Academy in Houston Texas, attempts to explain how the brain develops in a sequential and hierarchical fashion and is adversely affected by maltreatment and trauma. In order to effectively treat children who have experienced trauma this model proposes that one needs to determine where the insult occurred then focus reparative activities starting at that area of the brain. NMT identifies the child's strengths and vulnerabilities in order to develop therapeutic activities that will match the child's current needs in various domains of functioning, i.e., social, emotional, cognitive and physical. NMT uses patterned, repetitive and developmentally-appropriate activities while stressing the importance of the nurturing relationship. NMT involves caregivers and other adults who are involved with the child in order to incorporate therapeutic activities into various environments and relationships. Key components of NMT are assessment, staffing/training and therapeutic, educational and enrichment activities.

Dr Rick Gaskill and his associates at the Sumner Mental Health Center in Wellington, KS, in conjunction with Dr Perry and the Child Trauma Academy, have developed an NMT-informed preschool program. Dr Sharon Barfield from the University of Kansas's research supported the efficacy of this program.

[http://www.childtrauma.org/aboutCTA/bio\\_gaskill.asp](http://www.childtrauma.org/aboutCTA/bio_gaskill.asp)

Information provided by Child Trauma Academy website [www.childtrauma.org](http://www.childtrauma.org) Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics by Bruce Perry, MD, PhD

**Training:** Case-based live meeting training series teleconference

Organizations, with up to 25 participants per "connection", may enroll for a flat fee of \$1825 per 10 session series (15 hours of clinical consultation and training)

Individual professionals not enrolling as part of an organization's subscription may enroll for a flat fee of \$650 per 10 session series (15 hours of clinical consultation and training).

**Websites/ for more information:** Child Trauma Academy website @ [www.childtrauma.org](http://www.childtrauma.org);

**Reviewer:** Maureen Altman, LCSW, CSA Utilization Review Specialist

# NEUROSEQUENTIAL MODEL OF THERAPEUTICS (NMT)

By: Lon Woodbury

*(This insight was written based on Lon's notes after attending a two-day training seminar conducted by Dr. Bruce Perry, MD, PhD, on March 5-6, 2008, at Sandhill Child Development Center, Linda Zimmerman - Founder, Los Lunas, NM, 505-866-9271, [lzimmerman@sandhillcenter.org](mailto:lzimmerman@sandhillcenter.org), [www.sandhillcenter.org](http://www.sandhillcenter.org).)*

Dr. Bruce Perry is an entertaining lecturer who can present complex concepts in a way that can be easily understood. About 70 professionals attended, and Dr. Perry rapidly gained the attention of everybody present and maintained their interest throughout the whole seminar.

His purpose at the seminar was to explain the model he has been developing for several years of understanding and treating children with problems. He calls his approach Neurosequential Model of Therapeutics (NMT), which simply is stating that the brain is the source of all that we do and think. The brain develops in a precise sequence and most problems occur because of some developmental delays in brain development.



Dr. Perry started with the observation that the brain is responsible for everything we do, and the brain for the most part reflects our experience through life. When a child or an adult has problems, the cause is usually some kind of developmental delay in some area of the brain. The trick is to identify what part of the brain has not developed appropriately and focus interventions to impact that area.

NMT is a departure from the assumptions and techniques of mainstream psychological assessment and therapy. The heart of this therapy is the Diagnostic and Statistical Manual of Mental Disorders (DSM) developed by the American Psychiatric Association. Dr. Perry describes the DSM as an early attempt to categorize complex behavior by checklists of symptoms. He points out that this makes diagnosis a very tentative matter since categorization is based on results (or symptoms) instead of causes, which means diagnoses and drug interventions are more a trial and error process relating to observations of

symptoms rather than based on isolating and treating the root cause of the problematic behavior which is the brain.

NMT postulates that the brain is constantly changing and develops in the growing child in sequence, roughly from the lower part, the brain stem, to the upper part such as the cortex. The brain develops through the life experience of the child, through a sequence where vulnerability differs with age, that is, different areas of the brain are developing at different times. For proper development the brain must be exposed to the proper stimulation at the time the brain is ready to develop that area. How well each area develops depends on the life experience of the child at that time.

For example, Dr. Perry explained that cortical function of the brain is highly developed through the child learning to speak and read. In addition to those basic useful skills, this also teaches the all-important ability of self-control. He pointed out experience has shown that one of the best anti-recidivism techniques in prison is teaching the inmates to read or to improve their reading and speaking skills.

As an example of how important it is to teach these brain developing skills when the brain is ready to develop in that area, he reported studies of people who grew up without any verbal stimulation as children, and as adults they were unable to learn to speak except in a very limited way. The window of opportunity for the brain ever learning that particular skill had closed permanently.

Dr. Perry also asserts that the best biological intervention for problematical behaviors and brain organization or re-organization is human interaction. He attributes this to the way humans evolved. He points out that humans are not designed for the world in which we now live. Humans evolved in small groups called tribes, competing with other small groups. In this culture, especially, the key to survival was building and maintaining strong relationships. Consequently, relational health is vital to proper brain development throughout life and vital to a successful life. One of the most destructive aspects to proper development is a poverty of relationships. Dr. Perry used this poverty of consistent relationships as a major reason our foster system of child care has such problems.

Dr. Perry explains that poverty of relationships creates stress, which creates a hunger for the reward that should have come from positive relationships. As a result, substitutes are selected for that craving such as drinking, drugs or other unhealthy behaviors. Treatment is based on developing an environment for the child of healthy relationships, where the child has enough moderate stress to feel safe enough to explore without being overwhelmed with unpredictable events creating harmful stress. A safe environment with moderate novelty for the brain to learn and develop will allow the brain to heal and reorganize from the unhealthy development from earlier life experiences.

As NMT has evolved, Dr. Perry has developed assessment tools that are designed to determine what areas of the brain have been developmentally delayed, and interventions have been developed to heal those specific areas. Healthy relationships, of course, form a major part of treatment, but a wide and creative variety of other interventions can be used.

For example, since the brain is a rhythmic organ, music and movement are often exactly what the brain needs in order to heal and overcome problematical behaviors.

The key thing in NMT is a change in focus. Instead of looking at symptoms and a checklist as a guide, the clinician looks beyond symptoms, to the brain as the root cause of the problematic behaviors. Treatment is then focused on healing the brain, which will take care of the problematical behaviors.

**About the Presenter:**

*Dr. Bruce Perry is Senior Fellow at the Child Trauma Academy in Houston Texas [www.childtrauma.org](http://www.childtrauma.org). He is one of the leading authorities in the country on brain trauma and child development. This seminar was a staff training session for the staff of Sandhill Center and other invited professionals.)*

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(Author provided permission for article to be included in Appendix.)

Article above can be located @ [www.strugglingteens.com](http://www.strugglingteens.com)

## **Dialectical Behavior Therapy**

**Type of Maltreatment:** constitutionally sensitive youth who may be in chronically invalidating familial environments

**Target Population:**

- Adolescents who present with symptoms of Borderline Personality Disorder, regardless of meeting the complete diagnostic criteria, and who exhibit self harmful (i.e. cutting, burning, overdosing) and/or risky (unsafe sexual practices, significant runaway) behaviors, often in combination.
- Chronically para-suicidal females who have history of multiple hospitalizations related to suicidal ideation, actions, and self harmful behaviors.

**Dialectical Behavioral Therapy (DBT)** is a blend of standard cognitive behavioral therapy with Eastern philosophy and meditation practices, with an emphasis on the relationship between the client and therapist. It is a twofold approach including individual therapy centering on establishing and maintaining the client's safety, as well as psycho-educational groups focusing on building skills to promote healthier coping. It has been empirically shown to be an effective treatment for improvement of self harmful behaviors and the distress resulting from symptoms of Borderline Personality Disorder in adults as well as youth. DBT originated as a structured outpatient program for adults but has been adapted for use in inpatient and outpatient settings with adolescents. Literature exists to show that this intervention has also been helpful in the treatment of substance abuse and eating disorders in adolescents. Additionally, it has been adapted for use in inpatient settings, as well as for use with families.

### **Training**

There are specific training programs by the founder, Marcia Linehan, Her organization offers a 4-day intensive training for approximately \$2500; online courses are available at a rate of \$400 for a 3 month period. Other training is widely available by clinicians who are doing DBT in their practice. Many skills and protocols of the model, and adaptations of them, are possible without the intensive training. It appears there is no "required" training in order for a clinician to say they do DBT work.

**Website/more information:**

[www.behavioraltech.org](http://www.behavioraltech.org) is the official site linking visitors to trainings conducted by Dr. Linehan and her colleagues, as well as online trainings on topics related to DBT work.

Additional websites which have general information would include:

- [www.behavioraltech.org/downloads/dbtFaq\\_cons.pdf](http://www.behavioraltech.org/downloads/dbtFaq_cons.pdf)
- [www.mentalhelp.net/poc/view\\_doc.php?type+doc&id](http://www.mentalhelp.net/poc/view_doc.php?type+doc&id)

**Reviewer:** Jean Bartley, LCSW; Fairfax-Falls Church, CSB

## **Parent-Child Interaction Therapy (PCIT)**

### **Target Population:**

- Young children (2 – 8) with disruptive behavior disorders (e.g., oppositional defiant disorder) and their caregiver
- Physically-abusive caregivers with children (ages 4 – 12), irrespective of children’s behavior problems

**Parent-Child Interaction Therapy (PCIT)** was developed by Sheila Eyberg, Ph.D., currently of the Child Study Laboratory, Department of Clinical and Health Psychology, University of Florida, Gainesville, FL. Goals of this intervention include: improved parenting skills, decreased child behavior problems, and improvement in the quality of the parent-child relationship. The model is a social learning therapy composed of two phases, child directed interaction (CDI) and parent directed interaction (PDI) focused on breaking the cycles of defiant child behavior and abusive parental interactions. An initial standardized assessment tool guides and informs the treatment as it progresses through the two stages. The CDI phase focuses on increasing positive interaction between parent and child by teaching the parent to attend to the child. There are homework assignments geared toward the goal of ignoring the child’s negative behaviors and increasing positive encounters. The PDI phase is geared toward assisting the parent in managing oppositional behavior, and giving directives. Parents are coached and tasks are broken down into smaller tasks. Both phases of the intervention are best conducted in an outpatient clinic setting using a one way mirror, and a “bug-in-the-ear” device.

PCIT is a manualized approach which requires specific training in use of the tool and the CDI and PDI protocols. Treatment typically takes 14-20 weeks, and can be conducted in an outpatient or in home setting. It is cited in *The Findings of the Kaufmann Best Practices Project to Help Children Heal from Child Abuse.*

### **Training:**

Training is conducted at the University of Florida in Gainesville. The 5 day initial training costs \$3,000.

### **Website/more information:**

[www.pcit.org](http://www.pcit.org)

**Reviewers:** Janet Bessmer, Ph.D., CSA Utilization Review Manager and Mary Phelps, Child Abuse and Neglect Prevention Programs Manager, DFS

## **Child Parent Psychotherapy for Family Violence**

**Type of Maltreatment:** Exposure to domestic violence, physical abuse, and physical neglect

**Target Population:**

- Children under the age of seven, who have experienced a traumatic event and their non-offending caregivers

**Child Parent Psychotherapy for Family Violence (CPP-FV)** is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. Child-parent interactions are the focus of six intervention modalities aimed at: restoring a sense of mastery, security, and growth, promoting congruence between bodily sensations, feelings, and thinking on the part of both child and parent and in their relationship with one another. The six intervention modalities include: play, physical contact and language; developmental guidance; modeling protective behavior; interpretation, emotional support and empathic communication; and crisis intervention, case management and assistance with problems of daily living. The model can be implemented either in the home (birth, foster or adoptive) or in an outpatient clinic setting, and is comprised of weekly one hour sessions over approximately 12 months.

This model is not appropriate if a batterer continues to be in the home.

**Training:**

Historically, training has been conducted at the University of California-San Francisco and requires a full training year including intensive supervision and weekly case conferences. Masters level clinicians are eligible for the training. The National Child Traumatic Stress Network has created a three phase, 3-5 day didactic training program with follow up consultation, also held at the UCSF campus.

**More information/website:**

**<http://www.cachildwelfareclearinghouse.org/program/10/detailed>**

**Reviewer:** Janet Bessmer, Ph.D., CSA Utilization Review

## **Brief Strategic Family Therapy**

**Types of Maltreatment:** Problem family interactions including substance abuse, conduct disorders and association with antisocial peers.

**Target Population:**

- Children and adolescents 6 to 17 years old displaying or at risk of developing behavior problems, including substance abuse.
- The program was developed with Hispanic/Latino families and adapted and tested with African American families. Both male and female children and adolescents.

**Brief Strategic Family Therapy:** is a short term, problem focused intervention with an emphasis on modifying maladaptive patterns of interactions. Typical sessions last from 60 to 90 minutes with 12 to 15 sessions over 3 months. It is based on a family systems approach assuming that the family system influences all members of the family. BSFT targets the family interaction patterns that are directly related to the youth's behavior problems and establishes a plan to help the family develop more effective patterns of interaction.

There are 3 primary components: joining (understanding resistance and engaging the family in therapy), Diagnosis (identifying the interaction patterns that encourage problematic youth behavior), and Restructuring (developing a specific plan to help change maladaptive family interaction patterns by working in the present, reframing, and working with boundaries and alliances).

BSFT was developed at the Spanish Family Guidance Center in the Center for Family Studies at the University of Miami. It is a SAMHSA Model Program and recognized by the Center for Substance Abuse Prevention. It can be implemented in a variety of settings such as community social services agencies, mental health clinics, and family clinics. The family and counselor can meet in the office or the family home. There are 4 steps that are important to the process: organize a counselor-family work team; diagnose family strengths and problem relations; develop a change strategy capitalizing on strengths and correct problematic family relations to increase family competence; implement change strategies and reinforce family behaviors that sustain new level of family competence.

**Training:** A standard training package includes: a 3 day intensive workshop, monthly telephone consultations for 12 months consisting of review of video or audio tape and feedback to therapists and supervisors. A follow up 2 day skill development workshop is also available. Cost of the package is \$18,000 plus travel expenses and long distance expenses for monthly consultations. The ideal counselor has a master's degree in social work or MFT; however, individuals with a bachelor's degree and experience working with families may qualify. One full time counselor can provide BSFT to 15 to 20 families for in office sessions and 10 to 12 families for home sessions. BSFT is a flexible model that stresses availability to the family schedule but is not a simple to follow recipe. It requires considerable skill and training as an advanced clinical model.

**Reviewer:** Sandy Porteous, Manager, Phillips Family Partners

## **Positive Parenting Program (Triple P)**

**Type of Maltreatment:** not specified

### **Target Population:**

- Youth developing with normal or mild levels of behavioral difficulty (Level 2)
- Youth experiencing more significant levels of behavioral disturbance (Level 3)
- Parents of youth experiencing high levels of behavioral disturbance (Level 4)
- Youth from birth to age 16

### **Treatment strategy:**

- Variable: Level 2 consists of 1-2 brief (~20 minute) conversations targeted to specific behavioral issues, i.e. toilet training; Level 3 is more intensive, increasing to up to 4 flexible consultations of a similar duration
- Level 4 is designed to teach positive parenting skills and their applications to a range of target behaviors, settings and children, and is delivered in 10 individual or 8 group sessions totaling about 10 hours. Level 4 Standard Triple P, delivered in individual sessions, could perhaps be considered as a possibility for a home-based curriculum. Level 5 and other variations such as Pathways – could be added as the needs of the family requires.)

**Positive Parenting Program (Triple P)** is a standardized curriculum developed to increase positive parenting practices, and reduce ineffective ones as well as reducing disruptive behaviors of children. It is an intervention that has multiple levels of intervention. Level 1 is community communication strategy for advertising the program, while levels 2 and 3 are targeted for brief interventions with parents on specific behavioral issues. Level 4 focuses on more personalized interventions with parents, either individually or in groups, to intervene with more significant behavioral disruptions. Additionally, there is a Level 4 Group Teen Triple P program which is different from other Triple P programs due to its unique 8-week construction: 4 weeks of once/week group classes, followed by 3 weeks of once/week phone consultation, followed by a final group meeting. Other unique aspects include the strongly behavioral focus of the curriculum (charting behaviors and monitoring progress toward specific goals), specific/clear advice on how to respond to discrete problem behaviors, the level of participation required for attendees (through class activities and required homework), and verbatim transcripts for facilitators re: how to facilitate the class (what to say/ask, how to say it, how to respond, etc.) Enhanced Triple P adds a brief (8 weeks) structured family therapy component which is used when there are additional family stressors in addition to the presence of youth behavioral problems. All Triple P parenting resource materials for the birth to age 12 programming are available in English and Spanish. Materials have also been translated into Chinese, Farsi, German and Japanese. The program originated in Australia, so training videos involve Australian accents and idioms which may be unfamiliar.

### **Training:**

The estimated cost for a service provider to prepare for Triple P implementation ranges from \$900 to \$1,500, depending on the level and variant of Triple P to be used. This cost

figure includes professional Triple P training and the practitioner resources needed to conduct the intervention.

Training on Triple P, available from Triple P America, includes two parts delivered on site. Part 1 is a 2-, 3-, or 5-day training. Part 2 is a 1-day training conducted 8-10 weeks after Part 1, and provides an opportunity for intensive practice with feedback. Training costs for each Triple P course includes the course fee (a flat fee that covers up to 20 participants and the trainer traveling to the organization's site), and the cost for Triple P practitioner materials prorated for the number of participants in the course.

**More information/website:**

Web site: [www.triplep-america.com](http://www.triplep-america.com) Information about implementation: Operations Manager, Triple P America, 4840 Forest Drive, #308, Columbia, SC 29206 Phone: (803) 787-9944; Fax: (803) 787-9941; E-mail: [triplepa@bellsouth.net](mailto:triplepa@bellsouth.net)

**Reviewer:** Mary C. Phelps, Manager, Child Abuse and Neglect Prevention Programs, DFS

## **Strengthening Families Program**

**Type of maltreatment:** not specified

**Treatment:** 14 week group sessions involving parents and teens

**Strengthening Families Program 12-16** is different from other programs currently being offered due to its duration (14 sessions), endorsements as an effective evidence-based program, inclusion of both parents and teens, clarity of curriculum presentation, focused relationship-building between parents and teens, and behavioral specificity of targeted teen behaviors. A combination of 5 model and treatment programs, SFP uses behavioral parent training, family skills training and children's social skills training. The program was developed for high risk children of alcohol and drug abusing parents, but has been widely used successfully with non-substance abusing parents/caretakers and high-risk ethnic, immigrant families. Strengthening Families Program has a strong research base. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) considered this program to be a Family Therapy program type. It was given an Exemplary I rating, the highest possible rating. The strengtheningfamilies.org website (a collaboration grant from OJJDP and SAMHSA/CSAP) evaluated many family focused parenting programs. It considered SFP to be a Family Skills Training program, and gave it a rating of Exemplary I, the highest rating.

### **Training:**

Two days of training are needed for preparation for delivery of the program and it requires two trainers. To have the trainers come for the 2-day training will cost approximately \$3250 for 35 trainees; the cost is less for fewer trainees. Recommended cost to attend a training done elsewhere is \$200 - \$300 for two days of training. For a class of 10 families, 2 leaders for Parent Training group, 2 leaders for Adolescent Skills Training, and those 4 leaders would be available for the Family Program Session (parents and adolescents together). Does not require expertise beyond basic social work skills.

Volunteers, non-agency staff or program graduates can potentially be program leaders. The program and all materials are on CD. Cost of CD is \$350. All testing and homework materials are also included on the CD. Indirect costs would include copying of materials for manuals for facilitators, parents and teens, flip charts, some art materials.

### **More information/website:**

Website: [www.strengtheningfamiliesprogram.org/index.html](http://www.strengtheningfamiliesprogram.org/index.html) Phone: 801-581-8498;

Karol L Kumpfer, Ph.D; Program Director; phone: 801-581-7718; e-mail:

[kkumpfer@xmission.com](mailto:kkumpfer@xmission.com)

Henry Whiteside, Director of Training; phone: 801-583-4601; e-mail:

[lutragroup@att.net](mailto:lutragroup@att.net)

**Reviewer:** Mary C. Phelps, Manager, Child Abuse and Neglect Prevention Programs, DFS

## **Incredible Years**

**Type of maltreatment:** not specified

**Target population:** youth ages 2-12 exhibiting no violence or significant behavioral problems

**Treatment:**

- 12-14 2-hour weekly sessions for children 2-7;
- 4 add-on parent training components and 2 separate child training components: one in classroom for ages 4-8, (delivered in classroom) OR the second child program delivered to small groups of children with conduct problems, delivered by therapists or counselors

**Incredible Years** is a set of comprehensive curricula targeting children, their parents and teachers – specifically targeting parents of high-risk children or children displaying behavior and mental health problems. As a family support/parent education/risk prevention strategy, the focus is on improving skills in parents of identified youth to foster safe and healthy children. Incredible Years is an evidenced-based practice, and has received OJJDP's highest possible rating – Exemplary I – involving replication of outcomes by independent investigations. NREPP also rated the program in a range from 3.6-3.7 on a scale of 0-4.0 for all 6 outcomes measured. The Center for Substance Abuse Prevention has also noted Incredible Years as a Model Program (highest level) with an Exemplary I (highest level meaning replicated by independent investigation) rating.

**Training:**

Implementation costs: \$376/parent x group of 12 parents = \$5712;

**More information/website:**

<http://www.incredibleyears.com/>

**Reviewer:** Mary C. Phelps, Manager, Child Abuse and Neglect Prevention Programs, DFS

## **Children in Residential Experiences: Creating Conditions for Change**

CARE is a multi-level program model that involves (a) providing residential child care personnel with the capacity to implement a set of core practice principles that are solidly grounded in current social science literature and best practices standards, (b) facilitating organizational changes to support and sustain the implementation of those core principles at all levels of the organization.

The CARE practice model is founded on six research and standards-informed principles designed to guide residential child care staff's practice and interactions with children in order to create the conditions for change in children's lives. The research-informed principles support care and treatment that is developmentally focused, family involved, relationship based, competency centered, trauma informed and ecologically oriented. These best practices principles are grounded in theory, in evidence-based practices, in practice wisdom, and in child care standards. The principles were established after literature reviews, surveys of experienced child care workers and supervisors, and standards reviews. In order for these principles to be integrated into practice, an agency's leadership must 1) support an organizational climate and culture that expects these principles to be integrated into practice, 2) develop professional learning and accountability systems to ensure their use on-the-job, and 3) support participatory and collaborative management practices that address active use of data and data analysis to promote organizational learning that sustains and manages the CARE practice model and its long-term utilization.

For more information, contact Martha Holden at [mjh19@cornell.edu](mailto:mjh19@cornell.edu).

The CARE model of practice incorporates well-established findings from the social sciences literature, specifically, from the fields of developmental psychology, residential care and treatment, social work, youth development, clinical psychology, and organizational development. It is a deliverable package of research-based practice principles that apply universally to all children in out of home care. The optimal residential group care experience for children should reflect the following six CARE practice principles.

**Developmentally focused.** All children have the same basic requirements for growth and development. Activities offered to children need to be appropriate to each child's developmental level and designed to provide them with successful experiences on tasks that they perceive as challenging, whether in the realm of intellectual, motor, emotional, or social functioning. Research and theory has shown that activities that are developmentally appropriate help to build children's self-efficacy and improve their overall self-concept.

**Family involved.** Children need opportunities for constructive contact with family. Contact with family and community is one of the few indicators of successful treatment that has empirical validation. Parents and children, in partnership with residential care, can facilitate a transition to the home and the community. This partnership contributes to increased social and emotional adjustment by improving children's feeling of connection to family and community, their self-concept, and resiliency.

**Relationship based.** Children need to establish healthy attachments and trusting, personally meaningful relationships with the adults who care for them. These attachments are essential for increased social and emotional competence. Healthy child-adult relationships help children develop social competencies that can be applied to other relationships. A child's ability to form relationships and positive attachments is an essential personal strength and a manifestation of resiliency associated with healthy development and life success.

**Trauma informed.** A large percentage of children in residential care have a history of violence, abuse, and neglect resulting in debilitating effects on their growth and development. Adults need to respond sensitively and refrain from responding coercively when children exhibit challenging behavior rooted in trauma and pain. These trauma sensitive responses help children regulate their emotions and help maintain positive adult-child relationships.

**Competence centered.** Competence is the combination of skills, knowledge, and attitudes that each child needs to effectively negotiate developmental tasks and the challenges of everyday life. Residential programs must help children become competent in managing their environment as well as motivating them to cope with challenges and master new skills. Learning problem-solving and critical thinking skills and developing flexibility and insight are all essential competencies that help children achieve personal goals and increase their motivation for new learning. All interactions and activities in residential care should be purposeful and goal oriented with the aim of building these competencies and life skills.

**Ecologically oriented.** Children are engaged in dynamic transactions with their environment as they grow and develop. To optimize growth and development, children must live within a milieu that is engaging and supportive. Residential care staff must understand that the relationships with the children in their care are part of a larger ecology. Their face-to-face interactions with children, the activities they promote, and the physical environment in which they work all have an impact on the developmental trajectories of children. Competent staff using skill sets informed by the CARE principles can only be effective when they are used in ecology of residential care that will allow their expression.

**Reviewer:** Steven Sheard, MA, Director of Youth Residential Programs, Fairfax-Falls Church CSB

## **Co-occurring Substance Abuse: Understanding the Links between Adolescent Trauma and Substance Abuse**

### Treating Youth with Substance Abuse and Traumatic Stress

There is a dearth of research evaluating integrated treatment approaches for youth with substance abuse and traumatic stress problems, and thus no recognized effective model. However, a review of the adolescent substance abuse treatment literature suggests that traumatized youth do not do well in treatment focusing only on substance use. Adolescents who have experienced trauma and adversity often turn to alcohol and drug use in order to cope with painful emotions. Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of these types of problems. When these problems are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies. Although the research on integrated treatment approaches for this population is limited, there are guidelines that providers can follow to better serve this population. Given the multiple and complex needs of youth with co-occurring traumatic stress and substance abuse problems, several investigators have proposed the following recommendations:

- Include assessments of substance abuse problems and traumatic stress as part of routine screening and assessment procedures
- Provide youth and families with more intense treatment options to address the magnitude of difficulties often experienced by this population

Additionally, it appears that flexibility of the therapeutic intervention (content and structure) is preferred, in order to manage the complex needs these youths and their families present. Management of both PTSD/trauma and substance use symptoms and triggers, as well as psycho-education about both substance abuse and trauma to youth and their families are suggested as means to treat these dual needs. Additionally, stress management and emotional regulation skills have been suggested as valuable to assist in both areas. Understanding the impact of culture and context is also an important factor in effectively establishing rapport and credibility with the youth/family. Various assessment tools exist to assess both youth substance abuse, strengths, needs and exposure to trauma, and can be useful in determining the extent of the youth's needs, and subsequent interventions.

#### **More information/website:**

[http://www.nctsnet.org/nctsn\\_assets/pdfs/satoolkit\\_4.pdf](http://www.nctsnet.org/nctsn_assets/pdfs/satoolkit_4.pdf)

[http://www.nctsnet.org/nctsn\\_assets/pdfs/satoolkit\\_providerguide.pdf](http://www.nctsnet.org/nctsn_assets/pdfs/satoolkit_providerguide.pdf)

**Reviewer:** Michael Moxley, MS, CACAD, Site Director Falls Church, CSB, Alcohol & Drug Services

## **Program of Assertive Community Treatment (PACT)**

### **Type of Maltreatment:**

Not specified

### **Target Population:**

- Adults with chronic mental illness such as Schizophrenia, Bipolar Disorder with psychotic features, etc.
- Adults who experience significant and persistent disruption and dysfunction in their life as the result of their mental illness; typically adults with a history of significant and repeated psychiatric hospitalizations who have not responded to repeated less intensive interventions

**Assertive Community Treatment Programs (ACT)** are based on the philosophy of creating a “hospital without walls” in the community to treat adults with major mental illness. They developed concurrently with the deinstitutionalization movement, to assist communities in managing the many chronically mentally ill adults discharging from long term psychiatric facilities. ACT programs are community based programs employing psychiatrists, nurses, clinicians, vocational specialists, and substance abuse counselors. It provides treatment and case management in the community 24 hours per day, and is meant to be a comprehensive treatment approach. The model requires rigid adherence to specific staffing patterns, numbers of clients to be served at any time (no more than 100), percentage of therapeutic contacts in the community (versus in the office), and therapeutic protocols etc. There have been a few “adaptations” of the program to serve fewer clients, which have been more cost effective for some smaller communities. It has been shown to be effective in restoring SMI adults to increased functioning in the community and reduced numbers of hospitalizations and incarcerations. It has been widely researched and is viewed by SMHSA as an evidence-based practice.

### **Training**

As a treatment approach, PACTs require no specific training, but rather a team approach within the model’s specifications. At a typical 10:1 ratio of staff to clients, it is more labor intensive than many programs, but demonstrates significant improvements in outcomes, and certainly contains community treatment costs, with significant savings in monies spent for inpatient hospitalization and incarceration.

**Reviewer:** Jean Bartley, LCSW, Fairfax-Falls Church CSB

## Mobile Crisis and Crisis Stabilization

These organizations have “community-based” crisis intervention services in place as part of a larger array of services.

<http://www.mys.mb.ca/programs-vecss.php>

<http://www.mhmr.ky.gov/mhsas/Crisis%20Stab%20Prgms.asp>

Policy Guidance-Development of Community Based Crisis Stabilization Services (from North Carolina

<http://www.dhhs.state.nc.us/MHDDSAS/announce/commbulletins/commbulletin035-2.pdf>

**Reviewer:** Steven Sheard, MA, Director of Youth Residential Services, Fairfax-Falls Church CSB

## **School-based Mental Health Interventions: Positive Behavioral Interventions and Supports**

**Target population:** preschool through grade 12

**Setting/duration:** applied across multiple levels in a school- school-wide, classroom, targeted-group, and individual, intensive

**Positive Behavior Support (PBS)** is a framework developed to improve behavioral and academic outcomes that aligns behavioral support to students' level of need. A three tiered approach to behavior support is implemented systematically across the school. Home and community linkages also are encouraged. Outcomes are selected and data are collected to guide decision-making at each tier. PBS evolved from the integration of principles from applied behavior analysis, inclusion, and person-centered values. Key concepts from each have been applied within the framework to meet the needs of all students including those with the most behavioral challenges. Specific practices are aligned with each tier. At Tier 1 prevention strategies (e.g., identification and teaching of expectations, acknowledgement, and procedures for dealing with rule violations) are promoted. Tiers 2 practices focus on interventions to support small groups of students with similar needs (e.g., social skills group, group mentoring with self-management). For those students exhibiting the greatest needs, an individual, intensive intervention is designed at Tier 3. Based upon the findings of a Functional Behavior Assessment completed by that student's "support team" a Behavior Intervention Plan is created and implemented. In addition, person-centered planning and community mental health services can be combined with school services at tier 3 to offer a more individualized, comprehensive plan. A main premise of PBS is to change the problem context to change the student's behavior while simultaneously teaching the appropriate alternative skill needed to be successful at school or in the community.

**More information/website:**

[www.pbis.org](http://www.pbis.org)

**Reviewers:** Howard Johnson, Ed.D, Coordinator, Contract Services, FCPS and Janet Bessmer, Ph.D., CSA Utilization Review

## Positive Behavioral Interventions and Supports (PBIS)

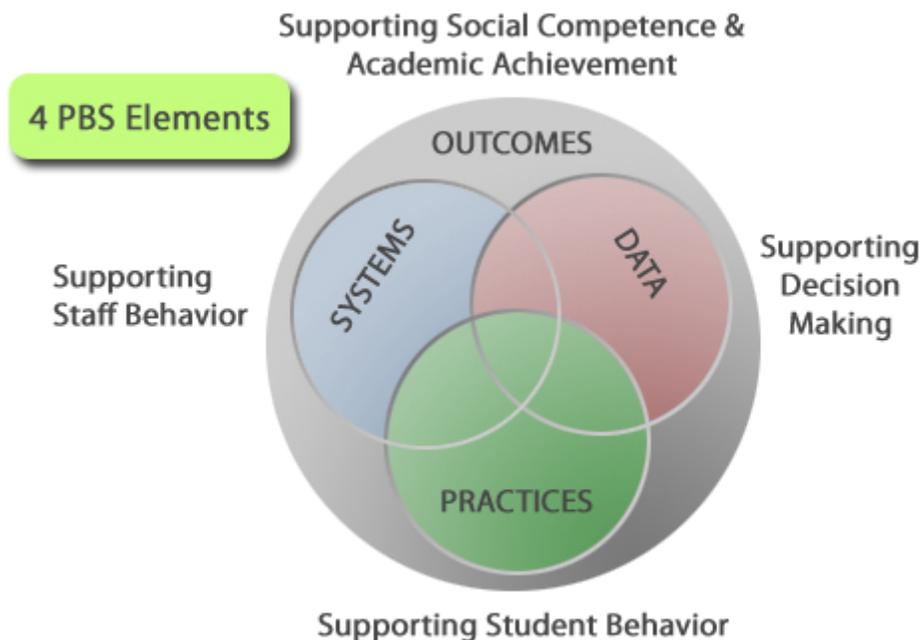
The following information is directly from the website [www.pbis.org](http://www.pbis.org).

### 1. What is School-Wide Positive Behavioral Interventions & Supports?

Improving student academic and behavior outcomes is about ensuring all students have access to the most effective and accurately implemented instructional and behavioral practices and interventions possible. SWPBS provides an operational framework for achieving these outcomes. More importantly, SWPBS is NOT a curriculum, intervention, or practice, but IS a 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.

### 2. "What Does School-Wide PBIS Emphasize?"

In general, SWPBS emphasizes four integrated elements: (a) data for decision making, (b) measurable outcomes supported and evaluated by data, (c) practices with evidence that these outcomes are achievable, and (d) systems that efficiently and effectively support implementation of these practices.



These four elements are guided by six important principles:

- Develop a continuum of scientifically based behavior and academic interventions and supports
- Use data to make decisions and solve problems
- Arrange the environment to prevent the development and occurrence of problem behavior
- Teach and encourage pro-social skills and behaviors
- Implement evidence-based behavioral practices with fidelity and accountability
- Screen universally and monitor student performance & progress continuously

### 3. What Outcomes are Associated with Implementation of PBIS?

Schools that establish systems with the capacity to implement SWPBS with integrity and durability have teaching and learning environments that are

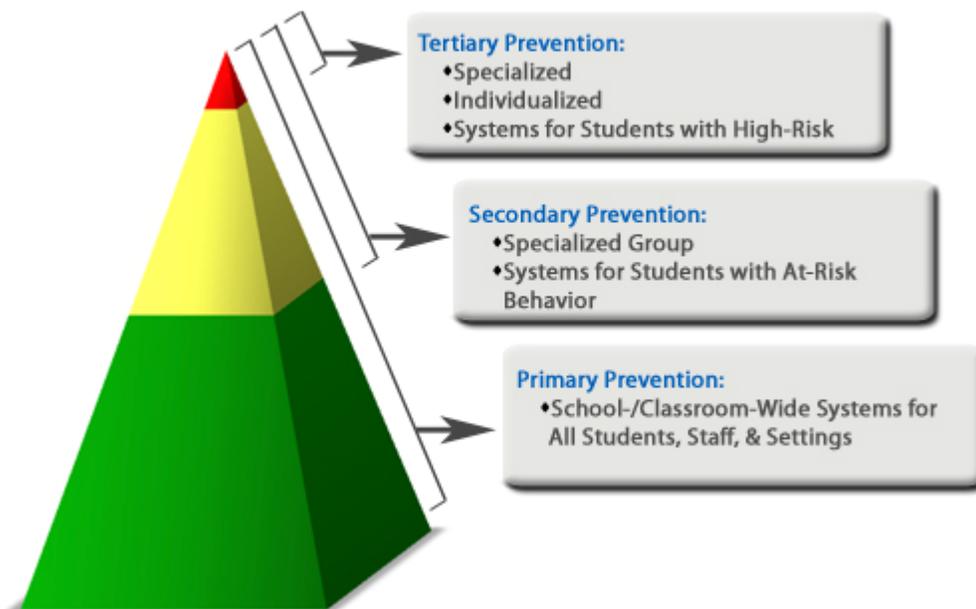
- Less reactive, aversive, dangerous, and exclusionary, and
- More engaging, responsive, preventive, and productive
- Address classroom management and disciplinary issues (e.g., attendance, tardies, antisocial behavior),
- Improve supports for students whose behaviors require more specialized assistance (e.g., emotional and behavioral disorders, mental health), and
- Most importantly, maximize academic engagement and achievement for all students.



#### 4. What is a Continuum of SWPBS?

SWPBS schools organize their evidence-based behavioral practices and systems into an integrated collection or continuum in which students experience supports based on their behavioral responsiveness to intervention. A three-tiered prevention logic requires that all students receive supports at the universal or primary tier. If the behavior of some students is not responsive, more intensive behavioral supports are provided, in the form of a group contingency (selected or secondary tier) or a highly individualized plan (intensive or tertiary tier).

#### Continuum of School-Wide Instructional & Positive Behavior Support



## **Appendix B: Resources**

The following resources were used as part of the Committee's analysis and research. Web references are available as noted and selected website links and/or documents stored on the Fairfax County FFXSystemsofCare collaborative network page (Yahoo). Additional hard copy materials are available in the CSA office.

### **General/Organizations/Technical Assistance Resources**

1. Alliance for Children and Families - <http://www.alliance1.org>
2. American Institutes for Research – Children's Mental Health Resources ([www.air.org](http://www.air.org))
3. California Clearinghouse for Evidence Based Practice in Child Welfare
4. Campbell Collaborative National Child Welfare Resource Center for Organizational Improvement
5. Children's Bureau U.S. Department of Health and Human Services
6. Office for Victims of Crime, U.S. Department of Justice
7. Child Welfare League of America – [www.cwla.org](http://www.cwla.org)
8. Cochrane Collaborative – [www.ich.ucl.ac.uk](http://www.ich.ucl.ac.uk)
9. National Association of Public Child Welfare Administrators
10. National Child Traumatic Stress Network [www.nctsnet.org](http://www.nctsnet.org)
11. National Clearinghouse on Child Abuse and Neglect - child welfare information clearinghouse [www.childwelfare.gov](http://www.childwelfare.gov)
12. National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development
13. Research and Training Center on Family Support and Children's Mental Health at Portland State University, Portland Oregon. [www rtc.pdx.edu](http://www rtc.pdx.edu)
14. Strengthening America's Families
15. Substance Abuse, Mental Health and Services Administration, U.S. Dept. HHS -SOC Model Programs:
  - Hillsborough County, Florida
  - Broward County, Florida
  - North Carolina – [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas) and [www.ncdhhs.gov/mhddsas/childandfamily](http://www.ncdhhs.gov/mhddsas/childandfamily)

- Chicago, Illinois –SOC Chicago [www.systemofcarechicago.org](http://www.systemofcarechicago.org)
16. Family and Community Together (FACT) Orange County, California – [www.childrenshomeandaid.org](http://www.childrenshomeandaid.org)
  17. Southwest Community Partnership, Detroit Michigan
  18. Mid-Columbia Child and Family Partnership SOC Oregon-CMHS National Evaluation Aggregate Data Profile Report, December 2005
  19. Glossary of terms on children's mental health from HHS, <http://mentalhealth.samhsa.gov/publications/allpubs/CA-0005/default.asp>
  20. Maryland Coalition of Families for Children's Mental Health Md state coalition site for families on infor/referral and research <http://www.mdcoalition.org>
  21. National Federation of Families for Children's Mental Health <http://http://www.ffcmh.org/>
  22. National Resource Center for Family Centered Practice and Permanency Planning, Hunter College School of Social Work in New York - HHS contractor, [www.hunter.cuny.edu/socwork/nrcfcpp/index.html](http://www.hunter.cuny.edu/socwork/nrcfcpp/index.html)
  23. Office for Victims of Crime, <http://www.ojp.usdoj.gov/ovc>
  24. State of Virginia Comprehensive Services Act website, official Virginia website for CSA, <http://www.csa.state.va.us>
  25. New Jersey System of care study, Dr Lyons report completed in 2004, <http://www.state.nj.us/humanservices/Press-2005/41905JLSystem%20sizing%20Reportfinal2.doc>
  26. Technical Assistance Partnership for Child and Family MH Home page for the technical assistance partnership <http://www.tapartnership.org/default.php>
  27. Technical Assistance Partnership for Child and Family MH resource page on evidence based treatment [www.tapartnership.org/advisors/mental\\_health/faq/Sept04.asp](http://www.tapartnership.org/advisors/mental_health/faq/Sept04.asp)
  28. Health Care Reform Tracking Project (HC RTP)
  29. State provided services: Arizona, Delaware, Hawaii, New Jersey, North Carolina, Pennsylvania, and Texas
  30. Managed care programs/services:
    - Michigan, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties

- Indiana -DAWN Project in Marion County
- Massachusetts- Mental Health Services Program for Youth
- Wisconsin - Wraparound Milwaukee in Milwaukee County – wraparound fidelity index, 2004  
[www.depts.washington.edu/wraeva/wrapder.html](http://www.depts.washington.edu/wraeva/wrapder.html)

### **Eligibility/Screening tools/criteria/approaches**

1. Child and Adolescent Needs and Strengths (CANS), Virginia Comprehensive tool 5+, 2009
2. “Eligibility Screening”, Anthem
3. “Magellan Medical Necessity Criteria”, 2009, Magellan Behavioral Health, Inc.
4. *Healthy Families* screening and referral instrument
5. YASI – Youth Assessment and Screening Instrument, Orbis Partners, 2009 [www.orbispartners.com](http://www.orbispartners.com)
6. “DJJ risk assessment model” – Risk and Protective Factors project (Catalano and Hawkins), 2009
7. “Virginia Enhanced Maintenance Assessment Tool” (VEMAT) 2009, Virginia Department of Juvenile Justice
8. State provided services: Arizona, Delaware, Hawaii, New Jersey, North Carolina, Pennsylvania, and Texas

### **Managed care programs/services**

1. Michigan, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
2. Indiana -DAWN Project in Marion County – ChoicesTeam  
[www.ChoicesTeam.org](http://www.ChoicesTeam.org)
3. Massachusetts- Mental Health Services Program for Youth
4. Wisconsin - Wraparound Milwaukee in Milwaukee County CANS
5. Milwaukee Wraparound enrollment – reference Phases and Activities for the Wraparound Process, Walker, Bruns et al., October 2004, National Wraparound Initiative

6. North Carolina Family Assessment Scale, <http://www.nfpa.org/reunification/assessment-tool.html>
7. United Methodist Family Services, Service description for school based Medicaid services, [www.umfs.org/documents/flyerparents.pdf](http://www.umfs.org/documents/flyerparents.pdf)

### **Training and Organizational Development resources**

1. University North Carolina – Greensboro, CenterPoint Local Management Entity SOC Planning – November 2006 Training plan process
2. “Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists”, American Psychological Association, 2003
3. “Measures/Indicators of Cultural Competence”, Georgetown University Child Development Center, National Center for Cultural Competence, Checklist of Values and Attitudes, 2000
4. “Staying the Course with Wraparound Practice: Tips for Managers and Implementers”, Focal Point, The Research and Training Center (no date).

### **Family Engagement models**

1. Parent to Parent Network of New York, connecting families and youth website for NY state, <http://www.parenttoparentnys.org/index.htm>
2. Strengthening America's Families, Effective Family Programs for prevention of juvenile delinquency, <http://www.strengtheningfamilies.org>

### **Additional State and Federal studies and presentations**

1. HD 34 Study of Parental Relinquishment of Custody, Commonwealth of Virginia
2. Medicaid Support for Community-Based Health Services, SAMHSA. Project Director, Mary B. Tierney, MD; partners Bazelon Center for Mental Health Law and National Mental Health Association.

3. Child Welfare: Early Experiences Implementing a Managed Care approach, U.S. General Accounting Office, October 1998.
4. Foster Care: State Practices for Assessing Health Needs, Facilitating Services Delivery and Monitoring Children’s Care, U.S. General Accounting Office, February 2009.
5. “Children’s system of care: a guide for mental health planning and advisory councils”, US Department of Health and Human Services, SAMHSA, 2001.
6. VA Dept Beh Svcs report on SOC reforms, presentation by Dr. Reinhard,  
<http://www.dmhmrsas.virginia.gov/documents/reports/CFS-IntegratedPolicyPlan311E2008Report>

### **Local studies**

1. An Analysis of the Needs and Strengths of Children and Youth Living in Fairfax County, Virginia Served in Residential Treatment. John S Lyons, Ph.D., and Alison Schneider, Northwestern University August 2008.
2. Foster Care Case Study Overview, Fairfax County Department of Family Services, spring 2009.
3. Guide to Court Services, more information about court services  
<http://infoweb.fairfaxcounty.gov/hs/jdrc/Documents/Misc/Guide%20to%20Court%20Services%20-%202007.pdf>

### **Evidence-based Practices**

1. Evidence for Intensive Home and Community-Based Interventions, Barbara J. Burns, 2008.
2. California Evidence-Based Clearinghouse for Child Welfare, descriptions of programs for targeted populations,  
<http://www.cachildwelfareclearinghouse.org>
3. Center for Effective Collaborative Practices  
 promising practices website  
<http://cecp.air.org/promisingpractices/>

4. Center for Study and Prevention of Violence Blue Print project  
Clearinghouse and technical assistance for services and treatments for juvenile offenders
5. Child Physical and Sexual Abuse Guidelines for Treatment  
Treatment approaches  
[http://academicdepartments.musc.edu/nvcv/resources\\_prof/OVC\\_guidelines04-26-04.pdf](http://academicdepartments.musc.edu/nvcv/resources_prof/OVC_guidelines04-26-04.pdf)
6. Child Trends EBP catalog  
Child Trends is a nonprofit, nonpartisan research group  
[http://www.childtrends.org/catdisp\\_page.cfm?LID=CD56B3D7-2F05-4F8E-BCC99B05A4CAEA04](http://www.childtrends.org/catdisp_page.cfm?LID=CD56B3D7-2F05-4F8E-BCC99B05A4CAEA04)
7. Coalition for Evidence -Based Policy  
This site summarizes a select group of randomized controlled trials  
<http://www.evidencebasedprograms.org/static/>
8. Cooccurring Center for Excellence  
<http://coce.samhsa.gov>
9. [http://coce.samhsa.gov/cod\\_resources/PDF/OverarchingPrinciples\(OP3\).pdf](http://coce.samhsa.gov/cod_resources/PDF/OverarchingPrinciples(OP3).pdf)
10. Findings of Kauffman Best Practices Project  
Closing the Quality Chasm in Child Abuse Treatment; Identifying and Dissemination Best Practices.  
<http://www.chadwickcenter.org/kauffman.htm>
11. Multnomah County Oregon Child Safety Task Force report 2007  
[http://www.co.multnomah.or.us/docs/Child%20Safety\\_01-13-08.pdf](http://www.co.multnomah.or.us/docs/Child%20Safety_01-13-08.pdf)
12. National Alliance for Mental Illness family resource best practices for youth, Family reference source for Evidence Based Practices  
<http://www.nami.org/Content/ContentGroups/CAAC/ChoosingRightTreatment.pdf>

13. National Network on Youth Transition - for Behavioral Health  
University of South Florida site for children with ED/LD aging out of foster care services, <http://ntacyt.fmhi.usf.edu/default.cfm>
14. National Registry for Evidence Based Programs and Practices  
SAMSA site, <http://nrepp.samhsa.gov/>
15. Promising Practices for Behavioral health services to children  
Accountability in Managed Care systems  
[http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising\\_approaches/issues/issue\\_04/HCRT-PAS4-QA.pdf](http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/issues/issue_04/HCRT-PAS4-QA.pdf)
16. Promising Practices Network on Children, Families and communities  
web resource on research for EBP for Youth and families  
[http://www.promisingpractices.net/Texas state clearinghouse of best practices for behavioral health](http://www.promisingpractices.net/Texas%20state%20clearinghouse%20of%20best%20practices%20for%20behavioral%20health)  
<http://www.dshs.state.tx.us/mhsa/clearinghouse/bestpractices.shtm>