Texas Resilience and Recovery

Utilization Management Guidelines: Child and Adolescent Services

Updated 2016

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Children's Public Mental Health System in Texas

"Hope, Resilience, and Recovery for Everyone" is the vision statement of the Texas Department of State Health Services (DSHS) Mental Health and Substance Abuse Division. This vision is aligned with the national movement to incorporate resilience and recovery-oriented services, supports, practices, and beliefs into publicly-funded mental health service delivery models. The service delivery system in Texas for community-based mental health services is Texas Resilience and Recovery (TRR). The TRR model acknowledges that youth experiencing adverse mental health symptoms and serious emotional disturbance (SED) are on a continuum of mental health and have natural supports and strengths which should be built upon to foster resilience and recovery. TRR was designed using the System of Care philosophy, which is child-centered and family-focused, and takes into account the youth's and family's strengths and supports, as well as their needs and challenges.

The modern framework of the TRR system utilizes an intensity-based approach to service delivery. This model requires the use of an internationally recognized assessment instrument, the Child and Adolescent Needs and Strengths (CANS) assessment. The CANS assessment is a comprehensive multi-purpose tool developed for children's mental health services to support decision making, including selection of the level of care, recovery and service planning, quality improvement initiatives, and monitoring of service outcomes. The Texas CANS Comprehensive serves as the psychosocial assessment, as well as a trauma screening and suicide screening tool, for all youth entering community mental health services in Texas. In addition, the Texas CANS comprehensive is used to determine eligibility for community mental health services and to determine the appropriate level of care recommended under TRR services. An array of evidence-based practices (EBPs) and promising practices can be individualized in each level of care to meet the youth's needs and build upon the unique strengths of each youth. Services and supports provided via the TRR model are expected to result in improved behavioral and emotional functioning.

The goals of the Utilization Management (UM) Guidelines are to increase understanding of TRR, guide the selection of levels of care and services, and serve as a reference tool for service providers. **The UM Guidelines: Child and Adolescent Services manual should be distributed in its entirety to all clinical staff who serve youth and families.** Providing the entire manual as a readily available resource will allow clinical staff to better understand the TRR continuum of care, the services that are available for youth with more intense needs, and which lower level services will be available as youth improve in treatment.

The TRR UM Guidelines do not replace or supersede existing legal requirements, legal statutes, state rules (e.g., Texas Administrative Code [TAC], Health and Safety Code, etc.), or Performance Contract requirements for providers contracted with DSHS.

TAC §412.304(b) states:

> Providers must comply with the department's *Utilization Management Guidelines,* which are incorporated by reference, if contractually obligated to provide any mental health community services, including mental health rehabilitative, mental health case management, supported housing, supported employment, or Assertive Community Treatment (ACT). The department is responsible for monitoring compliance by providers that contract with the department and the [Local Mental Health Authority] LMHA and [Managed Care Organization] MCO are responsible for requiring and monitoring compliance of providers in their networks.

RECOVERY & RESILIENCE

The Substance Abuse and Mental Health Services Administration (SAMSHA) defines recovery as:
"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (SAMHSA, 2012).

To support recovery of individuals, SAMHSA identifies four dimensions, which are applicable to children's development across the lifespan: health, home, purpose, and community (SAMHSA, 2012). Each of these four dimensions is addressed in the TRR LOCs.

Historically, CMH service delivery models have focused on building resilience in youth. SAMHSA defines resilience as:

"Resilience refers to an individual's ability to cope with adversity and adapt to challenges or changes. Resilience develops over time and gives an individual the capacity not only to cope with life's challenges but also to be prepared for the next stressful situation. Optimism and the ability to remain hopeful are essential to resilience and the process of recovery" (SAMHSA, 2013).

SUMMARY OF CHILD AND ADOLESCENT TRR SERVICE PROVISION

TRR VALUES

The values that serve as the foundation for the TRR model are:

Child-Centered, Family-Focused: Child-centered means that youth should be engaged as equal partners in care and should have their voices heard throughout their involvement in the TRR system. The family-focused value honors the caregivers' role as primary decision-makers in the care of the youth. The youth's and family's goals for recovery are incorporated as the centerpiece that guides the recovery plan. Involving caregivers and youth helps to ensure that culturally competent services are delivered.

Engagement: Engagement emphasizes a respect for the youth's and caregiver's capabilities and their roles as part of the solution to the identified challenges. Barriers to access and participation in the appropriate level of care and recovery services are continuously addressed. Attention is placed on finding solutions to barriers to ensure that the youth and family are working together toward recovery.

Evidence-Based Practices: According to SAMHSA's Co-Occurring Center for Excellence (COCE, 2007), an EBP "is a practice which, based on research findings and expert or consensus opinion about available evidence, is expected to produce a specific clinical outcome." EBPs are programs or practices that effectively integrate the best research evidence with clinical expertise, cultural competence, and the values of the individuals receiving the services. EBPs must be appropriate to the target population(s) and service settings in order to achieve desired outcomes.

Fidelity: Fidelity is the "extent to which a treatment approach as actually implemented corresponds to the treatment strategy" as it was designed to be implemented (COCE, 2007). Appropriate implementation of an EBP with high fidelity will result in the outcomes intended by the intervention. Fidelity requirements outline the manner in which specific principles, practices, and procedures are implemented. Fidelity adherence is an element of continuous quality improvement.

LEVELS OF CARE CONTINUUM

The TRR model is comprised of a continuum of levels of care that reflect youths' and families' needs, strengths, and services. The System of Care framework recommends that the determination of levels of care, recovery supports, and mental health treatment resources be allocated based on a continuum of intensity of services guided by youths' needs (Stroul and Blau, 2008). The intensity of needs in the TRR model is determined by the Uniform Assessment, which includes the CANS assessment. CANS assessment scores are used to determine youths' LOCs, as well as to identify needs and strengths to be addressed in the recovery plan. When CANS assessment scores are higher, the level of care will increase due to the youth's higher needs. As the youth improves, decreased needs and increased strengths will be reflected on the CANS assessment and the level of care may decrease. The provider should utilize CANS assessment scores and clinical judgment to support deviation to other levels of care.

It is important to use language that is easy for youth and families to understand, within their context of culture, level of education, and development. It is recommended that providers use Motivational Interviewing techniques when engaging a resistant individual (youth or caregiver) that is having difficulty understanding why a given LOC is the best match for the youth/family in services. It is recommended that providers collaborate with their local Certified Family Partners to help engage families in services. Providers should use the Family Guide (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/) as a resource for families starting in services.

Table 1, Texas Resilience and Recovery Levels of Care Continuum, describes the levels of care.

LOC Youth Empowerment Services (YES) Waiver is the most intensive level of care. LOC-4 (Intensive Family Services) is the next highest LOC. Both LOC-4 and LOC-YES utilize the national model of Wraparound planning process to deliver intensive case management services and care coordination. Youth in these LOCs have multi-system involvement and are at risk of out-of-home placement.

In LOC-3 (Complex Services), youth have needs identified in both the Child Emotional/Behavioral Needs and Life Domain Functioning domains on the CANS assessment. In LOC-3, youth receive routine case management, counseling, and skills training services.

In LOC-2 (Targeted Services), youth demonstrate a low to moderate level of needs, and an intensity of services and resources focusing on one primary need. In this LOC, youth receive as a core service either counseling or skills training, in addition to case management.

In LOC-1 (Medication Management), youth demonstrate a low level of needs and are stable. Youth in this LOC will rarely be new clients, but will likely be individuals who have successfully completed a course of treatment (e.g., counseling, skills training) and now need medication maintenance services. Medication management is the core service in LOC-1.

Special Levels of Care

In LOC-0 (Crisis), youth do not currently have an open case in the TRR model and are experiencing an acute psychiatric crisis. For youth who have an open case and are in LOC 1, 2, 3, 4, YES, Residential Treatment Center (RTC), or Youth Child (YC), the crisis service array is available in the authorized level of care.

In LOC-YC, children ages 3-5 receive services addressing their needs and strengths from a developmental perspective.

In LOC-RTC, youth ages 5-17 receive services in private RTCs through the DSHS/Department of Family and Protective Services (DFPS) RTC Project. Youth may only be authorized into LOC-RTC when the

DSHS RTC Coordinator provides notification that RTC admission to a DSHS-funded private RTC bed has occurred and requests deviation to LOC-RTC.

Psychiatric Hospitals and Residential Treatment Center Services

Although TRR is comprised of community mental health services, youth who meet medical necessity criteria for psychiatric hospitalization may access the state psychiatric hospital system or private psychiatric hospitalization depending on available funding sources. Likewise, youth ages 13-17 who meet medical necessity criteria for residential treatment may be referred to the Waco Center for Youth (WCY). WCY is the only state-funded RTC, but youth may also be referred to private RTCs.

Community Resource Coordination Groups (CRCGs)

Community Resource Coordination Groups (CRCGs) originated when the Texas Legislature passed Senate Bill 298 into law in 1987. The bill directed state agencies who serve youth to improve coordination of services by requiring interagency coordination and developing a community-based approach. CRCGs are local interagency groups comprised of public and private agencies who come together to develop service plans for youth and families who have multi-agency needs and require interagency coordination. CRCGs provide a way for individuals, families, and service providers to prepare an action plan together to address the complex needs of youth and families. (http://www.hhsc.state.tx.us/crcg/crcg.htm)

Recovery Plans

A recovery plan, formerly referred to as a treatment plan, is a person-centered service plan that is completed with the youth, caregiver/LAR (legally authorized representative), and provider. The recovery plan should be individualized, developmentally appropriate, and child-centered and family-focused. It must address the needs and strengths identified in the uniform assessment.

- For youth in LOC-YES and LOC-4, the wraparound plan and the recovery plan can be one document that includes all of the required sections.
- TAC §416.56 details various components that should be included in the recovery plan. These components include transition planning to the community, supplementing the youth's natural resources, and developing the plan in conjunction with the youth and his/her caregiver(s).
- In LOC-RTC, a recovery plan is not required as the RTC coordinates recovery planning.
- Reviewed every 90 days in all LOCs except:
  - LOC-1
- Who can complete recovery plans?
  - QMHP
  - LPHA
  - MD

Consent to Treatment

Youth who are 16 years old or older may consent to mental health treatment without a caregiver's consent/approval (Family Code Sec. 32.003). Specifically, youth who are 16 years old or older may consent to counseling for suicide prevention; chemical addiction or dependency; and sexual, physical, or emotional abuse (Family Code Sec 32.004).

Definitions

- Adolescent: An individual who is at least 13 years of age, but younger than 18 years of age (TAC §412.303).
- Child: An individual who is at least 3 years of age, but younger than 13 years of age (TAC §412.303).
- Youth: An individual who is at least 3 years of age, but younger than 18 years of age.

Table 1. Texas Resilience and Recovery Levels of Care

LOC	LOC-0 Crisis Services	LOC-1 Medication Management	LOC-2 Targeted Services	LOC-3 Complex Services	LOC-4 Intensive Family Services	LOC-YES Youth Empowerment Services	LOC-RTC Residential Treatment Center	LOC-YC Young Child Services	LOC-5 Transition Services	LOC-8 Waitlist	LOC-9 Ineligible
CANS Scores	**CANS Completion Not Required**	Severity & Complexity of Symptoms →				**Medicaid Waiver**	**RTC Criteria**	**Full Range of Scores**	**Temporary Services**	**Full Range of Scores**	**Not Eligible for Services**
		← Increased Natural Supports & Strengths									
LOC Indicator	**Crisis**	**Low Emotional, Behavioral, Life Domain Needs**	**Emotional Needs *OR* Behavioral Needs**	**Emotional, Behavioral, *and/or* Life Domain Needs**	**Multi-System Involvement**	**Ages 3-18 Meets YES Wavier Eligibility**	**Ages 5-17 Meets RTC Eligibility AND Admitted to RTC**	**Ages 3-5 with Behavioral *and/or* Emotional Needs**	**Ages 3-17 Temporary Services for Transitioning Individuals**	**Wait List**	**Ineligible**
Profile of Youth	Youth currently in crisis situation without current LOC authorization Expected to be a brief intervention to resolve crisis and prevent additional crisis events Following stabilization of the crisis, youth will be reassessed & assigned new LOC	Stable youth whose only identified treatment need is for medication management, with an occasional need for routine case management	Youth with behavioral OR emotional needs, but NOT BOTH	Youth with complex behavioral AND emotional needs May have multiple life domain functioning and/or caregiver needs	Youth with severe risk behaviors, threatened community tenure, risk of juvenile justice involvement, expulsion from school, displacement from home, and/or serious injury to self/others or death, along with significant caregiver needs, and behavioral and/or emotional needs	Youth enrolled in YES Services Includes all Medicaid services which the youth is entitled	Youth referred to DSHS by Child Protective Services due to risk of parental relinquish-ment of custody Referred youth have severe risk behaviors, potential involvement of multiple child-serving systems, and significant caregiver needs	Child between 3 & 5 years of age or is develop-mentally within this age range and has emotional and/or behavioral needs	Assists youth & caregivers in maintaining stability, preventing additional crises, and engaging youth into appropriate LOCs or accessing appropriate community services Highly individualized and length of stay is based on individual need	Youth that has received a full Uniform Assessment, but is currently waiting for services Individuals with Medicaid may not be placed in LOC-8	Youth whose assessment scores or other service eligibility criteria do not qualify the youth to receive services other than Crisis Services (LOC-0) should a psychiatric crisis occur
Core Services	Crisis Intervention Services	Medication Management	Routine Case Management Counseling Skills Training	Routine Case Management Counseling Skills Training	Intensive Case Management (Wraparound) Family Partner Counseling Skills Training	In addition to TRR services, youth has access to additional Medicaid services within YES Waiver	Family Case Management Family Partner	Routine Case Management Counseling Skills Training			

TRR LEVELS OF CARE

Level of Care 0: Crisis Services

Purpose for Level of Care

The services in this LOC are brief interventions provided in the community that ameliorate the crisis situation. Services are intended to resolve the crisis, avoid more intensive and restrictive intervention, and prevent additional crisis events. *Any service offered must meet medical necessity criteria.*

Note: These services do not require prior authorization. However, Utilization Management (UM) staff must authorize the crisis service within two business days of presentation. If further crisis follow-up and relapse prevention services are needed beyond the authorization period, the youth may be authorized for LOC-5.

NOTE: Detailed information about suicide safety planning, the Safety Planning Intervention, and a safety plan template to assist youth in crisis are located in Appendix A: Crisis Services and Planning.

Special considerations for youth presenting in a true or perceived crisis at the time of CANS administration:

If a youth enrolled in another LOC experiences a psychiatric crisis, or reports a personal or subject crisis event, crisis services should be delivered within that current LOC assignment.

LOC-0 may only be assigned to a youth who is ***not currently assigned to an LOC***. Following stabilization of the crisis, the youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

When a youth not currently assigned to an LOC does not meet the clinical crisis threshold and the youth or family reports that the youth is experiencing a personal or subjective crisis event, the youth can be immediately authorized to LOC-0 in order to receive crisis services. The providers do not have to complete the CANS assessment in its entirety, but have to complete the two CANS domains listed below before they can deviate the LOC Recommended (LOC-R) to LOC-0. This will allow staff to provide crisis services, screen the youth, and determine needs and possible referral resources.

- For the CANS 6-17, the provider has to complete two CANS assessment domains (Child Risk Behaviors and Child Behavioral/Emotional Needs) before deviating to LOC-0. This will help providers to determine needs and make clinical recommendations.
- For the CANS 3-5, the provider has to complete the following two CANS assessment domains (Child Risk Behaviors and Child Risk Factors) before deviating to LOC-0.

Level of Care Assignment Criteria

A youth may be assigned LOC-0 for the following reasons:

- The youth is not currently assigned to an LOC **AND**
  - The Uniform Assessment indicates an LOC-R of 0; or
  - The Uniform Assessment indicates an LOC-R of 1, 2, 3, 4, Young Child (YC), or 9, and it is clinically determined that the youth is in an acute or perceived acute crisis; or
  - The Uniform Assessment is incomplete, but clinical judgment indicates the need for immediate crisis intervention.

Note: A mental health diagnosis is not required.

Criteria for Level of Care Review

Authorization for this LOC will expire in seven days, unless reauthorized. Additional authorizations may be given if medically necessary.

If the youth cannot be treated safely or effectively within this LOC and his/her acuity level increases, hospitalization may be indicated.

Discharge Criteria

The youth may be discharged from this LOC for any of the following reasons:

- The crisis has been resolved and the youth has been transitioned to LOC 1, 2, 3, 4, 5, YES, YC, RTC, or EO.
- The crisis has been resolved and the youth has been placed on a waiting list for the indicated LOC (NOTE: Individuals who are Medicaid Eligible may not be placed on a waiting list or be underserved due to resource limitations).
- The youth and/or caregiver are referred and linked to community resources outside the DSHS system.
- The youth and/or caregiver have found services in the community to meet their needs.
- The youth and/or caregiver terminate services.

Expected Outcomes

The following outcomes can be expected as a result of delivering crisis services:

- Reduced risk of placement in a more restrictive environment, such as a psychiatric hospital, residential treatment center, or juvenile detention center; and/or
- Youth and/or caregiver report improved symptom management, behaviors, and/or functioning; and/or
- The youth and/or caregiver is engaged in appropriate follow-up treatment and linked with natural and community support systems.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team, and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Role-modeling the concepts of hope and resilience through articulation of the Certified Family Partner's successes regarding his/her child's mental health;
- Assistance in understanding and advocating for the youth's mental health needs during the crisis episode; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 0 Table Overview

Authorization Period: 7 Days	
Average Monthly Utilization Standard For This Level of Care: N/A In LOC-0, overall expected hours of utilization are undeterminable. For youth authorized in LOC-0, it is expected that the services in the crisis service array will be utilized as medically necessary and available to treat and stabilize the psychiatric crisis.	
Core Services: Identified by the uniform assessment and must be offered to the youth.	**Individual Services in LOC – 0** **Estimated Utilization Per 7 Days**
	High Need Therapeutic
Crisis Intervention Services	**3.75 hours** (15 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**1 Event** (1 unit)
Pharmacological Management	**10 Events** (10 units)
Safety Monitoring	**2 hours** (8 units)
Crisis Transportation (Event)	**1 Event** (1 unit)
Crisis Transportation (Dollar)	**As necessary** ($1 units)
Crisis Flexible Benefits (Event)	**As necessary** (Event)
Crisis Flexible Benefits (Dollar)	**As necessary** ($1 units)
Respite Services: Community-Based	**6 hours** (24 units)
Respite Services: Program-Based (not in home)	**3 bed days** (3 units)
Extended Observation	**1 unit** (1 bed day)
Children's Crisis Residential	**4 units** (4 bed days)
Family Partner Supports	**6 hours** (24 units)
Engagement Activity	**6 hours** (24 units)
Inpatient Hospital Services	**As necessary** (1 bed day units)
Inpatient Services (Psychiatric)	**As necessary** (1 bed day units)
Emergency Room Services (Psychiatric)	**As necessary** (Events)
Crisis Follow-up & Relapse Prevention	**8 hours** (32 units)

Level of Care 1: Medication Management

Purpose for Level of Care

The services in this LOC are intended to meet the needs of youth whose only identified treatment need is medication management. Youth served in this LOC may have an occasional need for routine case management services, but do not have ongoing treatment needs outside of medication-related services. While services delivered in this LOC are primarily office-based, services may also be provided at school, in the community, or via telemedicine.

The purpose of this LOC is to maintain stability and utilize the youth's and/or caregiver's natural supports and identified strengths to help them transition to community-based providers and resources, if available.

Special Considerations During Crisis

If the youth's symptoms or behaviors increase to a crisis level, crisis services should be delivered within this current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned LOC-1 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 1; or
- The Uniform Assessment indicates an LOC-R of 2, 3, YC, or 9, and the youth meets deviation reason criteria and is overridden into LOC-1.

Criteria for Level of Care Review

The following indicators require a review of the LOC authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the Level of Care Authorized (LOC-A); or
- The clinician determines the youth meets criteria for admission into a more intensive LOC; or
- The youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Discharge Criteria

The youth may be discharged from this LOC for any of the following reasons:

- The youth has been linked to medication services provided in the community.
- The youth does not meet criteria for admission into a more intensive LOC and medication services are not indicated, have been effectively discontinued, or have been declined.
- The youth and/or caregiver terminates services or moves outside of service area.
- The youth and/or caregiver is not receptive to treatment after all required engagement efforts have been exhausted.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver is linked with—and utilizing—natural and community support systems.
- The youth and/or caregiver reports stabilization of symptoms or maintenance of stability.
- The youth and/or caregiver is engaged in appropriate follow-up treatment and linked with natural and community support systems.

Special Considerations for Certain Adjunct Services

Family Partner Supports:
As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the youth's mental health needs, including provision of expertise in navigating child-serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills;
- Facilitation of family support groups;
- Connection to community resources and informal supports in preparation for the youth's transition out of the mental health system;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 1 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 0.5 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 0.5 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan.	**Individual Services in LOC – 1** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Pharmacological Management	**1 Event** (1 unit)	**2 Events** (2 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Medication Training and Support either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Routine Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Parent Support Group	**1 hour** (1unit)	**4 hours** (4 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

Level of Care 2: Targeted Services

Purpose for Level of Care

The purpose of this LOC is to improve mood symptoms or address behavioral treatment needs while building strengths in the youth and caregiver.

The services in this LOC are intended to meet the needs of the youth with identified emotional ***or*** behavioral treatment needs. The youth must **not have** identified needs in both areas. In general, the youth will have low life domain functioning needs.

The targeted service in this LOC is either counseling ***or*** individual skills training and targets a specific, identified treatment need. The only exception occurs when counseling is the primary intervention for the youth, but individual skills training is also provided as a component of parent skills training. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available.

Note: If the youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement activities must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within this current LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned to LOC-2 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 2; or
- The Uniform Assessment indicates an LOC-R of 1, 3, 4, YC, or 9, and the youth meets deviation reason criteria and is overridden into LOC 2.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the LOC-A; or
- The clinician determines the youth meets criteria for admission into a more intensive LOC; or
- The clinician determines the youth and caregiver have obtained maximum clinical benefit from services and recommends transition to LOC-1 or services in the community; or
- The youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Step-Down/Discharge Criteria

The youth may be stepped down from this LOC or discharged from services for any of the following reasons:

- The Uniform Assessment indicates an LOC-R of 1 *and* the youth has completed the indicated course of treatment.
- The youth and/or caregiver report improved mood or behavioral symptoms, have no additional identified goals, and clinical judgment supports transition to LOC-1 or transition to the community.
- The youth and/or caregiver have found services in the community to meet their needs.
- The youth and/or caregiver choose not to participate in services at the indicated intensity, all required engagement efforts have been exhausted, and clinical judgment of risk supports the transition to a lower level of care.
- The youth and/or caregiver terminate services or move outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver reports improved mood symptom management or behaviors.
- The youth and/or caregiver is transitioned to a lower level of care.
- The youth and/or caregiver is linked with—and utilizing—natural and community support systems.
- The youth and/or caregiver reports increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

Family Partner Supports:

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the youth's mental health needs, and provision of expertise in navigating child-serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents through the use of a DSHS-approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the youth's transition to a less intensive LOC and resilience and recovery;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 2 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 3 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan. NOTE: In this LOC, the youth should receive counseling *or* skills training as a core service.	**Individual Services in LOC – 2** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**2 hours** (8 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**0.5 hours** (2 units)	**2 hours** (8 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**3.75 hours** (15 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care 3: Complex Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the youth with identified behavioral *and* emotional treatment needs. The youth may also exhibit a moderate degree of risk behaviors and/or life domain functioning impairments that require multiple service interventions. This may indicate a need for interventions aimed at preventing juvenile justice involvement, expulsion from school, displacement from home, or further exacerbation of symptoms and/or behaviors.

The purpose of this LOC is to reduce or stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the youth and caregiver. Services should be provided in the most convenient location for the youth and caregiver, including the office setting, school, home, or other community location. Services may also be provided via telehealth/telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the youth and caregiver.

Note: If the youth and/or caregiver choose not to participate in core services offered at this level of care, engagement activities must be provided and efforts must be documented in the clinical record.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be completed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned LOC-3 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 3; or
- The Uniform Assessment indicates an LOC-R of 1, 2, 4, Young Child (YC), or 9, and the youth meets deviation reason criteria and is overridden into LOC 3.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the LOC-A; or
- The clinician determines the youth meets criteria for admission into LOC-4; or
- The clinician determines that it is contraindicated to offer counseling and skills training services concurrently and recommends deviation to LOC-2; or
- The clinician determines the youth and caregiver has obtained maximum clinical benefit from services and recommends transition to a less intensive LOC or services in the community; or
- The youth experiences a psychiatric crisis and must be reassessed to determine if a more intensive LOC is indicated.

Step Down

The TRR model supports moving youth into less intensive levels of care based on improvement in treatment as informed by clinical impressions, family reports, and the reassessment.

Discharge Criteria

The youth may be discharged from services for any of the following reasons:

- The youth and/or caregiver have found services in the community to meet their needs.
- The youth has completed treatment and is no longer in need of services.
- The youth and/or caregiver terminate services or move outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver report improved emotional and/or behavioral functioning.
- The youth and/or caregiver report improvement within the domains of risk behavior or life domain functioning.
- The youth is transitioned to a lower level of care.
- The youth and/or caregiver are linked with and utilizing natural and community support systems.
- The youth and/or caregiver report increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/).
- Assistance in understanding and advocating for the youth's mental health needs, and provision of expertise in navigating child-serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the youth's transition to a less intensive LOC and resilience and recovery;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care 3 Table Overview

Authorization Period: 90 Days

Average Monthly Utilization Standard For This Level of Care: 5 hours
Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 5 hours/month. Ideally, the average hours will be achieved through delivery of core services and supplemented by adjunct services when clinically appropriate.

Core Services: Identified by the uniform assessment and addressed in the recovery plan. NOTE: In this LOC youth should receive counseling *and* skills training as core services.	**Individual Services in LOC-3 Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**6 hours** (24 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**0.75 hours** (3 units)	**2 hours** (8 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Respite Services: Community Based	**N/A**	**6 hours** (24 units)
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

*When prescribed or indicated by a physician these services must be offered.

Level of Care 4: Intensive Family Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of youth with identified behavioral and/or emotional treatment needs, who are involved with multiple child-serving systems, or who are at risk for removal from their home or community. The identified behavioral or emotional treatment needs may have resulted in—or are likely to result in—juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, or serious injury to self, others, or animals.

The purpose of this LOC is to reduce symptoms and risk behaviors, improve overall functioning, and build strengths and resiliency in the youth and his/her caregiver through a team approach. Services should be provided in the most convenient location for the youth and his/her caregiver, including at home, school, or other community location. Services may also be provided via telehealth/telemedicine if available. Providers will need to consider flexible office hours to support the intensive needs of the youth and his/her caregiver.

Caregiver resilience is fostered using the Wraparound planning process to identify and build upon existing natural supports and strengths, as well as through referrals and support in accessing other needed community-based services and resources. DSHS has identified the National Wraparound Initiative (NWI: http://nwi.pdx.edu/) model for the provision of Wraparound planning in the delivery of Intensive Case Management services.

The Wraparound team is meant to reduce the risk of out-of-home placement for the youth, therefore, due to the high level of symptom severity of the youth, the Wraparound team – specifically a member of the treatment team – shall be accessible to the youth and his or her caregiver 24 hours a day, 7 days a week. Wraparound child and family team meetings shall take place at least monthly to achieve Wraparound fidelity and comply with ICM provisions in TAC §412.407. When a crisis has been identified by any member of the Wraparound team, a Wraparound team meeting shall occur within 72 hours or at the earliest time available to the youth and family team members following the crisis. All Wraparound team meetings must include the youth and his/her caregiver.

Note: If the youth and/or caregiver choose not to participate in core services offered at this level of care, appropriate engagement activities must be provided. Provision of engagement efforts including a detailed account of the steps taken to engage the youth and/or caregiver must be documented in the clinical record.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered within this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth for LOC assignment.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned to LOC-4 for the following reasons:

- The Uniform Assessment indicates an LOC-R of 4; or
- The Uniform Assessment indicates an LOC-R of 1, 2, 3, Young Child (YC), or 9, and the youth meets deviation criteria to be overridden into LOC-4.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the youth that is different from the LOC-A; or
- The clinician determines the youth's needs can be met in a lower level of care (clinician must provide detailed documentation including clinical justification for deviation); or
- The clinician determines the youth and caregiver have obtained maximum clinical benefit from services and recommends transition to a lower level of care.

Step-Down

The TRR model supports moving youth into less intensive levels of care based on improvement in treatment as informed by clinical impressions, family reports, and the reassessment.

Discharge Criteria

The youth may be discharged from services for any of the following reasons:

- The youth and/or caregiver have found services in the community to meet their needs.
- The youth has completed treatment and is no longer in need of services.
- The youth and/or caregiver terminate services or move outside of service area.

Expected Outcomes

Any or all of the following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver reports improved emotional and/or behavioral functioning.
- The youth and/or caregiver are linked with and are utilizing natural and community support systems.
- The youth and/or caregiver are able to be transitioned to a lower level of care.
- The youth and/or caregiver report increased individual and caregiver strengths.
- The youth and/or caregiver report improved stability in areas of life domain functioning, including reduced risk of out of home placement or juvenile justice involvement.

Special Considerations for Family Partner Supports

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following services to the primary caregiver:

- Engagement of families as equal members of the youth's Wraparound team and assistance making informed choices regarding the youth's plan for recovery;
- Assurance that family voice and choice are articulated by the family and heard by professional staff;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (https://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the youth's mental health needs, and provision of expertise in navigating child-serving systems as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS-approved protocol;
- Connection to community resources and informal supports that support the youth's transition to a less intensive LOC;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Special Considerations for Certain Adjunct Services

Routine Case Management:
Routine Case Management may only be provided in this LOC when Intensive Case Management is not available. If Intensive Case Management cannot be provided due to resource limitations, the youth may be authorized into LOC-4 and Routine Case Management may be provided until such time that Intensive Case Management is available.

Intensive Case Management is a core service in this LOC. Once the youth and their family are participating in the Wraparound planning process, per the DSHS-approved model for Intensive Case Management, Intensive Case Management shall be provided and Routine Case Management discontinued.

If despite appropriate engagement efforts, the youth and their family continue to refuse participation in the Wraparound planning process, deviation to a less intensive LOC may be indicated. See Appendix F: Reasons for Deviation for guidance.

Note: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver should continue to be appropriately engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. Detailed documentation of all attempts at engagement must be included in the clinical record.

Level of Care 4 Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 7.5 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 7.5 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan. NOTE: In this LOC the individual should receive counseling *and/or* skills training as core services.	**Individual Services in LOC – 4 Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Intensive Case Management (Wraparound)	**4 hours** (16 units)	**8 hours** (32 units)
Family Partner Supports	**2 hours** (8 units)	**6.25 hours** (25 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Engagement Activity	**1.5 hours** (6 units)	**2.5 hours** (10 units)
Pharmacological Management*	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support* either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training includes any/both of the following:		
Family Training (Individual)	**3 hours** (24 units)	**6 hours** (12 units)
Family Training (Group)	**3 hours** (24 units)	**6 hours** (12 units)
Parent Support Group	**1 hour** (1 units)	**4 hours** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Flexible Community Supports	**N/A**	**1.25 hours** (15 units)
Routine Case Management: Routine and Intensive Case Management Services *are not* to be authorized or provided concurrently	**2 hours** (8 units)	**6 hours** (24 units)
Respite Services: Community Based	**6 hours** (24 units)	
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)

Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***

*When prescribed or indicated by a physician these services must be offered.

Level of Care YES: YES Waiver

Purpose for Level of Care

All youth (age 3 to 18) enrolled in YES must be authorized to LOC-YES. LOC-YES includes all Medicaid services available in TRR. In addition to TRR, the youth receives Medicaid services unique to the YES Waiver which are provided outside of TRR. These YES Waiver services may include: community living supports, specialized therapies, respite, adaptive aids, transition assistance, employment services, family support, and minor home modifications.

The services in this LOC are intended to provide a complete continuum of flexible community-based services and supports for youth with SED, and their families, who otherwise would need institutional care (e.g., psychiatric inpatient care) or whose parents would turn to state custody for care. Services are intended to improve the clinical and functional outcomes of youth, reduce and stabilize symptoms and/or risk behaviors, improve overall functioning, and build strengths and resiliency in the youth and caregiver through a team approach.

Intensive Case Management (ICM) is utilized to develop a Wraparound/ICM plan through and delivered using the Wraparound process - a family-centered planning process. The plan developed using the Wraparound process serves as the recovery plan, ICM plan and is used to coordinate and authorize services in LOC-YES. Each youth must have one recovery plan that is completed in the context of the Wraparound planning process. YES Waiver leverages ICM using the Wraparound process to coordinate YES services and develop a YES Waiver Individual Plan of Care (IPC) to authorize YES services. The Wraparound plan is used by both TRR and YES and therefore should include all of the TRR and YES Waiver services provided to the youth.

Caregiver resilience is fostered through building upon natural supports and strengths that are identified by the caregiver, and linkage to community resources through the Wraparound planning process. DSHS has identified the National Wraparound Implementation Center (NWIC) model of Wraparound for the delivery of ICM services. Wraparound Child and Family Team (CFT) meetings shall take place at least monthly to achieve Wraparound fidelity and comply with ICM provisions in TAC §412.407.

Due to the high level of symptom severity of the youth, the CFT – specifically a member of the treatment team – should be accessible to the youth and his/her caregiver 24 hours/day, 7 days/week. When a crisis as identified by a member of the CFT occurs, a Wraparound team meeting should occur within 72 hours. The availability of the Wraparound team is meant to reduce the risk of out-of-home placement for the youth.

Services provided in this LOC are provided in accordance with applicable DSHS policies and procedures, YES Waiver policies and procedures (http://www.dshs.state.tx.us/mhsa/yes/), and Centers for Medicare and Medicaid Services (CMS) 1915(c) waiver federal regulations.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services must be delivered within this LOC.

LOC-0 may only be used for a youth who is not currently assigned to LOC-YES or another LOC.

Level of Care Assignment Criteria

A youth may be authorized to LOC-YES for the following reasons:

- The youth meets all eligibility requirements for enrollment in YES Waiver;
- The Clinical Eligibility Determination (CED) has been authorized by DSHS; and
- The youth is enrolled in YES Waiver in accordance with YES Waiver policies and procedures.

Note: See Appendix F: Reasons for Deviation for clinical guidance on deviation reasons when deviating a youth to LOC-YES.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The CED indicates the youth is not eligible for YES Waiver; or
- The youth meets YES Waiver discharge criteria in accordance with YES Waiver policies and procedures.

Step-Down

Clinical eligibility for YES Waiver is 365 days. Children enrolled in YES Waiver must be authorized in LOC-YES.

Discharge Criteria

The youth must be stepped down from this LOC if discharged from YES Waiver services in accordance with YES Waiver policies and procedures (http://www.dshs.state.tx.us/mhsa/yes/).

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver reports improved emotional and/or behavioral functioning.
- The youth and/or caregiver are linked with and are utilizing natural and community support systems.
- The youth is able to be discharged from YES Waiver and/or transitioned to less intensive services.
- The youth and/or caregiver report increased individual and caregiver strengths.
- Improved stability in areas of life domain functioning, including reduced risk of out of home placement, hospitalization, or multi-system involvement.

Special Considerations for Routine and Intensive Case Management

The provision of ICM is required by the YES Waiver approved by CMS. This includes participants who are 18 years of age.

If ICM cannot be provided due to resource limitations, the youth may be authorized in LOC-YES and Routine Case Management may be provided until such time that ICM is available. In accordance with federal requirements for person-centered planning for YES Waiver services, Wraparound shall be utilized in this LOC regardless of the provision of Intensive Case Management or Routine Case Management.

Special Age Group Considerations: Assessments

Youth age 3-18 may be enrolled in YES Waiver and must therefore be able to access LOC-YES. Eligibility for YES Waiver is determined using the CANS 6-17. Therefore specific processes must be completed to authorize children ages 3-5 and youth aged 18+.

Ages 3-5: The CANS 3-5 cannot be used to determine YES Waiver clinical eligibility. The LMHA must perform and directly enter a CANS 6-17 in the DSHS YES Waiver LMHA Location in Clinical Management for Behavioral Health Services (CMBHS).

Age 18: The ANSA cannot be used to determine YES Waiver clinical eligibility. The LMHA will directly enter the CANS 6-17 data in the DSHS YES Waiver LMHA Location in CMBHS.

Level of Care YES Table Overview

Authorization Period: 90 Days

Average Monthly Utilization Standard For This Level of Care: N/A

Across the population served in this LOC, some individuals may require more/less intense provision of services, utilize services at a higher/lower rate, and/or may access different services through YES Waiver or other community resources.

Entitled Services: Youth enrolled in YES Waiver are enrolled in Medicaid and entitled to all Medicaid behavioral health services as well as services specific to the YES Waiver service array. Information on YES Waiver service array, provided by YES Comprehensive Provider Agencies may be found at http://www.dshs.state.tx.us/mhsa/yes/.	**Individual Services in LOC – YES** **Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Intensive Case Management (Wraparound)	**4 hours** (16 units)	**8 hours** (32 units)
Routine Case Management*	**4 hours*** (16 units)	**8 hours*** (32 units)
Counseling includes any/all of the following:		
Counseling (Individual)	**2 hours**	**4 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Pharmacological Management	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**4.5 hours** (18 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***	

* To be used only if ICM is not available and to be discontinued upon availability of ICM. In accordance with the Waiver approved by CMS, person-centered planning must be utilized in the development of the IPC. Therefore, if Routine Case Management is utilized, Wraparound process planning will be utilized to coordinate LOC-YES services and Waiver services, and the anticipated utilization of Routine Case Management is equivalent to the anticipated utilization of ICM.

Level of Care RTC: Residential Treatment Center Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of youth who are admitted to private residential treatment centers (RTCs) through the DSHS/DFPS RTC Project. LOC-RTC is not intended for youth admitted to the Waco Center for Youth or to private RTCs outside of the RTC Project.

Youth in this LOC have identified behavioral and/or emotional treatment needs that meet medical necessity criteria for residential treatment. Additionally, prior to RTC placement parents/guardians of youth in this LOC are in danger of parental relinquishment of custody to DFPS due solely to a lack of mental health resources. The youth's behaviors and/or mood symptoms may have resulted in, or could potentially result in, psychiatric hospitalization, juvenile justice involvement, expulsion from school, serious injury to self or others, or death, as well as displacement from home to DFPS custody. Receiving needed RTC services prevents more restrictive psychiatric hospital care, in addition to preventing parental relinquishment of custody.

In order to authorize youth into LOC-RTC, providers should complete the CANS assessment after being notified by the DSHS RTC Coordinator that the youth has been admitted to an RTC. The CANS assessment may be completed by phone with the youth, the caregiver, and the youth's RTC therapist if the RTC is located at a distance from the provider. LOC-RTC is available by deviation only, with a deviation reason of clinical need.

The purpose of LOC-RTC is to build strengths and resiliency in the parents/guardians, to participate in treatment planning with the RTC, and to prepare the family for successful reunification with the youth upon discharge from the RTC. In LOC-RTC, routine case management includes weekly communication with the RTC about the youth's progress in treatment. Case management is completed mostly through telephone conference calls, but the LMHA/North Texas Behavioral Health Authority (NTBHA) case manager may also choose to attend treatment team meetings in person at the RTC and/or to meet in person with the parents/guardians. The compiled information from these meetings is intended to assist with recovery planning for the youth at the RTC, as well as with planning outpatient services that will be provided to the youth and family upon RTC discharge. Best practice models for youth in RTCs include coordination between the RTC and the agency that will provide community mental health services; this coordination leads to improved success for youth post-RTC discharge (Blau, Caldwell & Lieberman, 2014).

Intensive Case Management (ICM) is available as an adjunct service in LOC-RTC. ICM utilizes the Wraparound planning process to coordinate services in LOC-RTC and provide supports to the youth and family in preparation for reunification. The plan developed using the Wraparound process serves as the recovery plan. It is recommended that youth who are discharged from RTCs enter LOC-YES or LOC-4. Both of these LOCs will allow the Wraparound planning process to continue and to assist the youth and family during the transition period.

Caregiver resilience is fostered through building upon natural supports and strengths that are identified by the caregiver, and linking to community resources through the Wraparound planning process. DSHS has identified the National Wraparound Implementation Center (NWIC) model of Wraparound for the delivery of ICM services. Wraparound Child and Family Team (CFT) meetings shall take place at least monthly to achieve Wraparound fidelity and comply with ICM provisions in TAC §412.407.

Family partner supports are also a core service in LOC-RTC in order to teach parenting skills to parents/guardians and to provide support during the RTC placement.

Services should be provided in the most convenient location for the youth and parents/guardians, including the office setting, school, home, or other community location. Services may also be provided via telemedicine, if available. Providers may need to consider flexible office hours to support the complex needs of the youth and parents/guardians.

Note: If parents/guardians choose not to participate in core services offered at this level of care, engagement activities must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

The youth's crisis level symptoms or behaviors will be addressed by the RTC during placement. If a youth who has been discharged from an RTC and who has not yet been authorized to an outpatient level of care experiences crisis symptoms, crisis services should be delivered in this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth for LOC assignment.

LOC-0 may only be used for a youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A youth may be assigned to LOC-RTC for the following reason:

- Notification has been received from the DSHS RTC Coordinator that the youth meets RTC criteria **and** has been admitted to a DSHS-funded private RTC bed.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The caregiver indicates that he/she would like to discharge the youth from RTC services. The DSHS RTC Coordinator should be notified immediately.
- The caregiver indicates that he/she no longer desires to participate in treatment with the LMHA/NTBHA and/or RTC. The DSHS RTC Coordinator should be notified immediately.

Step-Down

- Within seven days of discharge from the RTC and readmission into outpatient services, the youth should be reassessed using the UA, including the CANS.
- LOC-YES or LOC-4 is the recommended LOC for youth reunifying with their families. If the LOC-R is anything other than LOC-4, the youth should be deviated to LOC-YES or LOC-4 to maintain treatment gains achieved at the RTC. If after 90 days the next Uniform Assessment indicates an LOC-R lower than LOC-4, the youth may continue treatment in the lower level of care if this is clinically appropriate.

Discharge Criteria

The youth may be discharged from services for any of the following reasons:

- The youth is discharged from the RTC and the youth and/or caregiver have found services in the community to meet their needs.
- The youth is discharged from the RTC and the youth and/or caregiver refuse outpatient services.
- The youth and/or caregiver move outside the service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and caregiver will be reunited and will utilize the skills learned as a result of RTC services and family therapy.
- The youth and caregiver will be connected with natural and community support systems, and will be motivated to utilize outpatient services.
- The youth and/or caregiver will report increased individual and caregiver strengths.
- The youth and/or caregiver will report improved stability in areas of life domain functioning, child risk behaviors, and child emotional/behavioral functioning, including reduced risk of out of home placement or juvenile justice involvement.

Special Considerations for Family Partner Supports

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the youth's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Assurance that family voice and choice are articulated by the family and heard by professional staff;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the youth's mental health needs, and provision of expertise in navigating child-serving systems as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS-approved protocol;
- Connection to community resources and informal supports that support the youth's transition to a less intensive LOC and resilience and recovery;
- Identification of the family's natural supports and strengths and guidance, and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Level of Care RTC Table Overview

Authorization Period: 365 Days		
Average Monthly Utilization Standard For This Level of Care: 2.0 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 2.0 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and admission to an RTC.	**Individual Services in LOC – RTC Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Therapeutic**
Routine Case Management (by phone or in person) A recovery plan is not required for youth and families receiving routine case management in LOC-RTC as recovery planning is coordinated by the RTC.	**1 hour** (4 units)	**3 hours** (12 units)
Family Partner Supports	**0.5 hours** (2 units)	**2 hours** (8 units)
Adjunct Services: Identified by the uniform assessment and/or by the case manager, family partner, or RTC during treatment.	**Standard Therapeutic**	**High Need Therapeutic**
Intensive Case Management (Wraparound) A recovery plan is required here to coordinate services identified by the Wraparound planning process.	**4 hours** (16 units)	**8 hours** (32 units)
Engagement Activity	**0.5 hours** (2 units)	**1 hour** (4 units)
Skills Training & Development (delivered to the caregiver or LAR)	**1 hour** (4 units)	**2 hours** (8 units)
Family Training includes any/both of the following:		
Family Training (Individual)	**1 hour** (4 units)	**2 hours** (8 units)
Family Training (Group)	**1 hour** (4 units)	**2 hours** (8 units)
Parent Support Group	**0.5 hours** (2 units)	**2 hours** (8 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis.	***Utilization guidelines for the Crisis Service Array are located on page 44.***	

Level of Care YC: Young Child Services

Purpose for Level of Care

The services in this LOC are intended to meet the needs of the young child (ages 3-5) with identified behavioral *and/or* emotional treatment needs. The young child may also exhibit a moderate degree of life domain functioning impairments that require multiple service interventions.

All services are available in this level of care and the recovery plan should be developed based on the individual needs of the child. The provider may recommend any core service that will help address the developmental, behavioral, and emotional needs of the child. In this level of care, the participation of the caregiver in all services is strongly recommended and most services will require the participation of both the child and caregiver in treatment.

The purpose of this LOC is to reduce or stabilize symptoms, improve overall functioning, and build strengths and resiliency in the child and caregiver. The focus of services is placed on the dyad relationship as this relationship is the primary context for young children. These primary relationship(s) set the stage for future social-emotional behavior and future relationship behavior. Services should be provided in the most convenient location for the child and caregiver, including the office setting or home. Services may also be provided via telemedicine/health, if available. Providers may need to consider flexible office/service hours to support the needs of the child and caregiver.

Note: If the youth and/or caregiver chooses not to participate in core services offered at this level of care, engagement activities must be provided. Provision of engagement efforts must be documented in the clinical record.

Special Considerations During Crisis

If the child's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered in this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the child and caregiver to determine if more intensive services are indicated.

LOC-0 may only be used for a child or youth who is not currently assigned to an LOC.

Level of Care Assignment Criteria

A child may be assigned LOC-YC for the following reasons:

- The Uniform Assessment indicates an LOC-R of YC; or
- The Uniform Assessment indicates an LOC-R of 1, 2, 3, 4, or 9, and the child meets deviation reason criteria and is overridden into LOC-YC.

The TX CANS 3-5 is specifically developed for children this age and is administered for assessment and treatment planning purposes. When the TX CANS 3-5 indicates that a young child might meet criteria for the LOC YES Waiver, the TX CANS 6-17 must then be administered to determine if the young child meets criteria for LOC-YES Waiver.

Criteria for Level of Care Review

The following indicators require a review of the level of care authorized:

- The Uniform Assessment indicates an LOC-R for the child that is different from the LOC-A; or
- The child has been served in LOC-YC and after reaching age 6 has an LOC-R of 1, 2, 3, 4, and the clinician recommends that the child should continue to be served in LOC-YC; or
- The child is newly admitted to services and has an LOC-R 1, 2, 3, 4, and the clinician feels it is developmentally appropriate for the child to be served in LOC-YC; or

- The clinician determines the child and caregiver has obtained maximum clinical benefit from services and recommends transition to services in the community or LOC-1 (if medication services only are indicated).

Age out

The child has a birthday and turns 6 years old and has completed the indicated course of treatment. This child will transition into LOC-A of 1, 2, 3, 4 or YES Waiver. (Note: if the child is age 6 and the course of treatment **has not** been completed, the child should remain in LOC-YC for continuity of care until treatment goals have been reached or the child turns 7 years old.)

Discharge Criteria

The child may be discharged from services for any of the following reasons:

- The caregiver locates services within the community to meet their needs.
- The youth has completed treatment and is no longer in need of services.
- The youth and/or caregiver terminates services or moves outside of service area.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The child and/or caregiver report improved emotional and/or behavioral functioning.
- The child and/or caregiver are linked with and are utilizing natural and community supports.
- The child and/or caregiver report increased individual and caregiver strengths.

Special Considerations for Certain Adjunct Services

As formal members of the treatment team, Certified Family Partners should be utilized in this LOC to provide the following to the primary caregiver:

- Engagement of families as equal members of the child's treatment team and assistance making informed choices regarding the youth's plan for recovery;
- Mentorship in the mental health system by preparing families for what to expect, including the use of the "Family Guide to Children's Mental Health Services" (http://www.dshs.state.tx.us/mhsa/mh-child-adolescent-services/);
- Assistance in understanding and advocating for the child's mental health needs, and provision of expertise in navigating child serving systems and medication training and support as appropriate;
- Role-modeling options of parenting skills, advocacy skills, and self-care skills, including provision of individual skills training to parents and/or caregivers through the use of a DSHS approved protocol;
- Facilitation of family support groups;
- Connection to community resources and informal supports that support the child's resilience;
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships; and
- Celebrating the youth's resilience and recovery.

For more information about Family Partner Supports, refer to Appendix D: Family Partner Supports.

Intensive Case Management:
The provision of Wraparound planning process (Intensive Case Management) in this LOC is determined by the clinical needs of the child. One or more of the following scores on the TX CANS 3-5 represents an intense clinical need and may indicate that the child needs the Wraparound planning process:

- Child Risks Factors:
  - Abuse/Neglect score of 3
- Life Domain Functioning:
  - Living Situation score of 3

    - Daycare score of 3
    - Relationship Permanence score of 3
- Caregiver Strengths/Needs:
    - Involvement score of 3

This is not an exhaustive list of indicators and/or scores that may indicate a need for Wraparound planning process. Some CANS 3-5 indicators, such as Residential Stability, may also indicate a need for Wraparound planning process. Services provided must be related to the clinical need of the child and clinicians must use clinical judgment in making this service determination. Justification for services provided must be documented in the clinical record.

Once the child and family are participating in the Wraparound planning process, Intensive Case Management shall be provided. Intensive Case Management and Routine Case Management may not be provided concurrently. Wraparound child and family team meetings shall take place at least monthly to achieve Wraparound fidelity and comply with ICM provisions in TAC §412.407.

Level of Care YC Table Overview

Authorization Period: 90 Days		
Average Monthly Utilization Standard For This Level of Care: 3.5 hours Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than 3.5 hours/month. Ideally, the average hours will be achieved through delivery of Core Services and supplemented by Adjunct Services when clinically appropriate.		
Core Services: Identified by the uniform assessment and addressed in the recovery plan.	**Individual Services in LOC-YC Estimated Utilization Per Month**	
	Standard Therapeutic	**High Need Utilization**
Psychiatric Diagnostic Interview Examination	**N/A**	**1 Event** (1 unit)
Routine Case Management	**1 hour** (4 units)	**2 hours** (8 units)
Counseling includes any/all of the following:		
Counseling (Child-Parent/Dyad)	**3 hours**	**5 hours**
Counseling (Group)	**2 hours**	**4 hours**
Counseling (Family)	**2 hours**	**4 hours**
Skills Training & Development includes any/all of the following:		
Skills Training & Development (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Skills Training & Development (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Standard Therapeutic**	**High Need Utilization**
Engagement Activity	**0.75 hours** (3 units)	**2 hours** (8 units)
Intensive Case Management (Intensive Case Management can be authorized if clinically necessary; however Routine and Intensive Case Management Services *are not* to be authorized or provided concurrently.)	**3.75 hours** (15 units)	**6.25 hours** (25 units)
Pharmacological Management (when prescribed/ indicated by a physician these services must be offered.)	**1 Event** (1 unit)	**4 Events** (4 units)
Medication Training and Support either/both of the following:		
Medication Training and Support (Individual)	**0.5 hours** (2 units)	**3 hour** (12 units)
Medication Training and Support (Group)	**0.5 hours** (2 units)	**3 hour** (12 units)
Family Partner Supports	**1 hour** (4 units)	**2 hours** (8 units)
Skills Training & Development (delivered to the caregiver or LAR)	**3 hours** (12 units)	**6 hours** (24 units)
Family Skills Training includes either/both of the following:		
Family Training (Individual)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group	**1 hour** (1 unit)	**4 hour** (4 units)
Family Case Management	**0.5 hours** (2 units)	**1 hour** (4 units)
Flexible Funds	**N/A**	**$1,500 cap/year** ($1 increments)
Flexible Community Supports	**N/A**	**1.25 hours** (15 units)
Respite Services: Community Based	**6 hours** (24 units)	
Respite Services: Program Based	**N/A**	**3 Bed days** (3 units)
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***	

Level of Care 5: Transitional Services

Purpose for Level of Care

The services in this LOC are intended to assist youth and their caregivers in maintaining stability, preventing additional crisis events, engaging youth and their caregivers into the appropriate level of care, and/or assisting in accessing appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary based on individual need.

Special Considerations During Crisis

If the youth's symptoms or behaviors exacerbate to a crisis level, crisis services should be delivered in this LOC. *Any service offered must meet medical necessity criteria.* Following stabilization of the crisis, the uniform assessment should be competed with the youth to determine if a more intensive LOC is indicated.

LOC-0 may only be used for a youth who is not currently assigned to an LOC and does not have an active CANS LOC-R.

Level of Care Assignment Criteria

A youth may be assigned LOC-5 for the following reasons:

- The youth has been discharged from LOC-0 or released from the hospital and is not eligible for ongoing services and is in need of more than crisis services to stabilize; or
- The youth has been discharged from LOC-0 or released from the hospital and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the youth/caregiver and the youth is in need of transitional services; or
- The youth is identified as part of a high need population (e.g., homelessness, substance abuse issues, primary healthcare needs, or juvenile justice involvement) and is not eligible for ongoing services, but is in need of more than crisis services to stabilize; or
- The youth is identified as part of a high need population (e.g., homelessness, substance abuse issues, primary healthcare needs, or juvenile justice involvement) and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the youth/caregiver and the youth is in need of transitional services; or
- The youth has been discharged from LOC-0, released from the hospital, or identified as part of a high need population and has selected a community-based provider, but is in need of transitional services.

The following items may also indicate that LOC-5 is the most appropriate level of care:

- The youth has intensive service needs and is underserved or on the wait list for all services (LOC-8). LOC-5 may be authorized for up to 90 days to stabilize or avoid further crisis events until the appropriate level of care can be provided.
- The youth has a Medicaid entitlement and may be authorized LOC-5 to ensure access to medically necessary services.

Criteria for Level of Care Review

Authorization for this LOC will expire in 90 days. If eligibility criteria are met, continued services may be provided in LOC 0, 1, 2, 3, 4, or YC.

Transition/Discharge Criteria

The youth may be transitioned to a different LOC or discharged from services for the following reasons:

- The crisis is stabilized and no additional services are indicated; or

- The crisis is stabilized and the youth has been transitioned to the appropriate level of care for ongoing services; or
- The crisis is stabilized and the youth has been in LOC-5 for 90 days and is placed on a waiting list for ongoing services; or
- The youth and caregiver have been referred and linked to community based services and supports.

Expected Outcomes

The following outcomes can be expected as a result of delivering services at this level of care:

- The youth and/or caregiver report improved mood symptom management or behaviors, and/or improved life domain functioning; or
- The youth and/or caregiver are engaged in the appropriate level of care; or
- The youth and/or caregiver are linked with and are utilizing natural and community support systems; or
- The youth and/or caregiver are better able to use natural and community support systems.

Level of Care 5 Table Overview

Authorization Period: 90 Days	
Average Monthly Utilization Standard For This Level of Care: N/A Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate. This LOC is designed to flexibly meet the needs of the individual prior to admission into ongoing services; services should reflect the youth's needs.	
Adjunct Services: Identified by the uniform assessment and addressed in the recovery plan.	**Individual Services in LOC-5** **Unit**
Routine Case Management	15 minutes
Psychiatric Diagnostic Interview Examination	Event
Pharmacological Management	Event
Medication Training and Support (Individual)	15 minutes
Medication Training and Support (Group)	15 minutes
Counseling: includes any/all of the following:	
Counseling (Individual or Child-Parent/Dyad)	Event
Counseling (Group)	Event
Counseling (Family)	Event
Skills Training & Development includes any/all of the following:	
Skills Training & Development (Individual)	15 minutes
Skills Training & Development (Group)	15 minutes
Skills Training & Development (delivered to the caregiver or LAR)	15 minutes
Family Partner Supports	15 minutes
Family Training	
Family Training (Individual)	15 minutes
Family Training (Group)	15 minutes
Parent Support Group	15 minutes
Engagement Activity	15 minutes
Flexible Funds (dollars)	$1 increments
Flexible Community Supports (time)	15 minutes
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis	***Utilization guidelines for the Crisis Service Array are located on page 44.***
Transition Age Youth: Additional adjunct services for transition age youth may be provided in this LOC.	***Utilization guidelines for the transition age youth population are located on page 62.***

APPENDICES

Appendix A: Crisis Services and Planning

Crisis Services Utilization

This appendix describes crisis services for youth currently in an LOC who are experiencing a crisis. Per the Texas Administrative Code, for youth and/or families who report experiencing a crisis, whether or not the clinician agrees, the situation should be treated as an acute crisis for the individual, and crisis services should be immediately provided.

As indicated in the description of each LOC, crisis services should be delivered within the assigned LOC whenever indicated (Note: youth currently enrolled in services must not to be deviated to LOC-0 in order to receive crisis services). Additionally, each crisis service delivered must meet medical necessity criteria.

Regardless of how the need for crisis services is identified, when a crisis *is* identified it is essential to join with the youth and his/her caregiver in the development of a safety plan. The 2012 National Strategy for Suicide Prevention recommends that a safety plan developed with a youth should include elements such as warning signs/triggers, coping strategies, natural supports, and safekeeping measures. The following pages provide a list of the crisis services available within the service array as well as a sample safety plan that clinicians may use to help develop safety plans with youth and their caregivers. For more information on suicide prevention, safety planning, and crisis follow-up best practices, please see the Action Alliance for Suicide Prevention website: http://actionallianceforsuicideprevention.org/

Texas Zero Suicide toolkit for providers is located at HTTPS://Sites.utexas.edu/zest/. The national zero suicide in behavioral health care model that has been adopted as the Texas suicide safe care practice is outlined in detail in the toolkit referenced above. In our public mental health system we have adopted the use of the Columbia Suicide Severity Rating Scale (www.cssrs.columbia.edu/) as the recommended best practice screening tool. There is a free online training with a printable certificate available on this website, which also offers free, downloadable screeners and risk assessments.

There are a variety of factors that can impact the quality of a suicide screener and a risk assessment, including stigma, societal or cultural attitudes, and clinical discomfort. Individuals may be unwilling to disclose information on ideation, intent, plans, or behaviors because they do not want an attempt thwarted or are wary of the potential response. Research on risk assessments conducted over a national crisis hotline has identified some of the core characteristics of helpful interactions as reported by the person at risk (Mishara, Chagnon, Daigle, et. al., 2007b). Approaches that were tied to positive outcomes included the demonstration of empathy and respect, as well as the use of a supportive approach and collaborative problem-solving. The assessor should approach the interaction as a collaboration, focused on working together to determine what to do next. Providers need to be aware of any direct or indirect communication to the individual that they are uncomfortable with a discussion of suicide, prefer negative responses to questions, or are shocked by the information they hear.

Another best practice to consider is the conduct of the professional administering the screening tool. A best practice approach, such as the CASE approach, is recommended. It is preferable to facilitate a collaborative conversation between the youth and the staff person, which uses motivational interviewing techniques to elicit a truer response from the youth within the context of a caring conversation, instead of a rote checklist-driven screening approach.

The CASE Approach, developed by Shawn Shea, provides a strategy for enhancing the quality of the information gathered from an individual during a suicide risk assessment. Dr. Shea posits that: *Real Suicide Intent = Stated Intent + Reflected Intent + Withheld Intent*
Dr. Shea points out that the stronger the individual's actual intent, the more likely he/she is to withhold his/her true intent. The individual's reflected intent may be the most important component for determining real suicide intent. Reflected intent is "the quality and quantity of the patient's suicidal thoughts, desires,

plans, and extent of action taken to complete the plans." (Shea, 2009). Shea states that it is the amount of time spent thinking, planning, preparing and practicing for an attempt that may be the strongest indicator of imminent risk of a suicide attempt.

The CASE Approach is a best practice interviewing strategy designed to maximize the likelihood that the assessor is gathering valid information about the stated and reflected intent and to minimize withheld intent. The CASE Approach draws on research to identify strategies to raise the issue of suicidality in a way that minimizes shame and stigma, as well as ways of formulating questions to maximize validity. Training on the CASE Approach can be obtained through the Training Institute for Suicide Assessment and Clinical Interviewing. Shea, S. C., Green, R., Barney, C., et al. (2007) provide a resource training providers in the CASE Approach.

After a risk assessment is conducted and a positive score indicated elevated risk for suicide, a best practice based risk assessment should be administered. As far as the frequency of screening, the C-SSRS should be used as a screening tool during crisis assessments, clinical assessments, and assessments in which the CANS or ANSA Suicide Risk scale is elevated. In addition, the C-SSRS should be utilized as a brief measure of risk at every consumer contact for those individuals found to be at moderate or high suicide risk (up to once daily). There is no activity more critical than identifying increases in suicide risk for individuals at risk of suicide.

All youth within the public mental health system who are identified as potentially at risk during a suicide screening will receive an evidence-informed suicide risk assessment. This suicide risk assessment should include all of the core components of an effective risk assessment.

A comprehensive risk assessment should include the following information gathered from the individual and his/her natural supports (adapted from SAMHSA's SAFE-T and the Joint Commission's B-SAFE):

- Suicide Inquiry - Current and previous suicidal thoughts, plans, behavior, and intent
- Warning signs – Characteristics that are temporally related to the acute onset of suicidal behaviors (hours to a few days)
- Risk factors – Characteristics that statistically put an individual at increased risk
- Protective factors – Characteristics that statistically indicate lower risk
- Determine risk level – Develop appropriate treatment plan to address risk in least restrictive environment
- Documentation - Document risk level, rationale, treatment plan, and follow-up.

DSHS is recommending the use of the **Columbia Suicide Severity Rating Scale** (C-SSRS) to insure a comprehensive, evidence-based assessment of current and previous suicidal thoughts, behaviors, intent, and plan.

Documentation

Determining Risk Level

Determining and documenting risk level is a critical component of the risk assessment. No study has identified one specific risk factor or set of risk factors that specifically predicts suicide or suicidal behavior; therefore, the determination of risk level will depend on careful consideration of the information gathered in the assessment and the clinical judgment of the assessor. The determination of the best setting of care and course of treatment should consider not only the level of risk, but also the benefits and potential risks to the individual. While a more restrictive care setting may be necessary to safeguard against potential self-harm, there may also be negative effects from this course of treatment that must be weighed in the decision, such as disruption of employment, disruption of therapeutic alliance, and increased family conflict. When possible, the provider should collaborate with the individual in understanding and weighing different treatment options.

Considerations for Each Risk Level

Urgent/ High	Suicidal thoughts with intent to act in past 30 days (C-SSRS Item 4) Ideation with plan and intent in past 30 days (C-SSRS Item 5) Any suicide behavior in past 90 days (C-SSRS Item 6)	One or more risk factors likely to be present; extra concern for psychiatric diagnoses with severe symptoms, including psychosis; recent discharge from psychiatric inpatient unit; lack of family and/or social support; lack of engagement in care; intent with lethal means.
Emergent/ Moderate	Suicidal thoughts with method in past 30 days (but no plan or intent; C-SSRS Item 3) Suicidal thoughts with intent to act (but no plan) at worst ever (C-SSRS Item 4) Suicidal thoughts with specific plan and intent at worst ever (C-SSRS Item 5) Any suicide behavior at worst ever (C-SSRS Item 6)	Absence or presence of risk and protective factors may play stronger role in overall risk.
Low or Chronic Risk	Wish to be dead in past 30 days (C-SSRS Item 1) General thoughts of killing self without thoughts of methods (C-SSRS Item 2)	Modifiable risk factors, strong protective factors; available social support.

Information on the potential interventions and monitoring to be considered at each level of risk can be found in the *Pathways to Care* and *Safety Planning* chapters of the Suicide Safe Care and Zero Suicide Texas Toolkit for providers at https://sites.utexas.edu/zest/.

All youth with moderate or high risk for suicide will work collaboratively with a trained provider to develop an effective, individualized safety plan.

Crisis Service Array for youth currently enrolled in services

Authorization Period: N/A	
The crisis services below are available for all youth who are experiencing a crisis and are enrolled in a level of care. Please see the LOC-0 section of this document to identify the crisis services available to individuals who have not been assigned to a level of care.	
Crisis Service Array	**Individual Crisis Services**
	Unit/Event
Crisis Intervention Services	**3.75 Hours** (15 units)
Psychiatric Diagnostic Interview Examination	**1 Event** (1 unit)
Pharmacological Management	**10 Events** (10 units)
Safety Monitoring	**2 hours** (8 units)
Crisis Transportation (Event)	**1 Event** (1 unit)
Crisis Transportation (Dollar)	**As necessary** ($1 units)
Crisis Flexible Benefits (Event)	**As necessary** (Event)
Crisis Flexible Benefits (Dollar)	**As necessary** ($1 units)
Respite Services: Community-Based	**6 hours** (24 units)
Respite Services: Program-Based (not in home)	**3 bed days** (3 units)
Extended Observation	**1 unit** (1 bed day)
Children's Crisis Residential	**4 units** (4 bed days)
Family Partner Supports	**6 hours** (24 units)
Engagement Activity	**6 hours** (24 units)
Inpatient Hospital Services	**As necessary** (1 bed day units)
Inpatient Services (Psychiatric)	**As necessary** (1 bed day units)
Emergency Room Services (Psychiatric)	**As necessary** (Events)
Crisis Follow-up & Relapse Prevention	**8 hours** (32 units)

Description of the Safety Planning Intervention

The Safety Plan Intervention (SPI; Stanley & Brown, 2011) is a brief 20 to 45 minute intervention that provides an individual with a set of steps that can be used progressively to attempt to reduce risk and maintain safety when suicidal thoughts emerge. SPI should follow a comprehensive risk assessment after strong rapport has been developed. Safety plans should be developed within a collaborative process among a provider (including peer providers), the individual at risk, and his or her close family or friends. Safety planning can be a stand-alone intervention, utilized during crisis contacts (e.g., in emergency departments, mobile crisis contacts) or as a part of an on-going treatment relationship.
The Safety Planning Intervention includes the following **core components**, each of which is documented in the individual's plan:

- Recognizing warning signs of an imminent suicidal crisis, i.e., changes in mood, thoughts or behaviors.
- Utilizing internal coping skills that can help reduce distress;
- Using people in the individual's support network as a means of distraction from suicidal thoughts;
- Reaching out to family or friends to help manage the crisis;
- Contacting mental health professionals or emergency contacts (i.e., hotlines); and
- Reducing access to potential lethal means.

Training and Resources for the Safety Planning Intervention

All individuals who will conduct safety planning with individuals at risk should be trained and competent in the intervention. Several resources are available to support staff training. An introductory training on SPI, lasting about 30 minutes, can be found on the Zero Suicide website. The training includes the rationale for the model, the core components, and a video example of Dr. Stanley intervening with a mock individual.

Additional training in safety planning is recommended and information on training resources is available at http://www.suicidesafetyplan.com/Training.html. DSHS has also supported the development of in-state trainers in SPI. A list of regional trainers is available from Jenna Heise at Jenna.Heise@dshs.state.tx.us. The workshop training is four hours in length and consists of both didactic learning and role playing of safety planning steps to provide additional opportunities for practice and feedback. Follow-up coaching is recommended to assist providers learning the model to receive feedback on skills development and to have an opportunity to bring questions and challenges to the trainer or their colleagues.

The following safety planning intervention resources provide further information:

1. A general description can be found at Stanley, B. & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19,* 256-264. (http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog___Beh_Practice.pdf)
2. A Safety Planning manual can be accessed through the Safety Planning website at http://www.suicidesafetyplan.com/Page_8.html.
3. Dr. Stanley also developed a smartphone app for safety planning titled, "Safety Net" on the online app store.

A template to support documentation of safety planning is included on the next page or can be accessed from http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf.

SAFETY PLAN

Step 1: Warning signs: (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____

2. _____

3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity)**:**

1. _____

2. _____

3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____

2. Name_____ Phone_____

3. Place_____

4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____

2. Name_____ Phone_____

3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____

Clinician Pager or Emergency Contact #_____

2. Clinician Name_____ Phone_____

Clinician Pager or Emergency Contact #_____

3. ***Suicide Prevention Lifeline: 1-800-273-TALK (8255)***

4. Local Emergency Service _____

Emergency Services Address_____

Emergency Services Phone _____

Making the environment safe:

1. _____

2. _____

The one thing that is most important to me and worth living for is:

_____

_____

A critical component of safety planning is counseling individuals at risk and their loved ones to limit access to lethal means. Research has shown that reducing access to lethal means can be an effective prevention strategy because many suicide attempts are impulsive acts undertake as a reaction to a short-term crisis. The best practice Counseling on Access to Lethal Means (CALM) was developed by Elaine Frank and Mark Ciocca. In CALM, the provider learns how to ask individuals and their families about their access to lethal means and to develop a plan to reduce access, particularly around firearms and medication.

A free, web-based training is available from the Suicide Prevention Resource Center at http://training.sprc.org/enrol/index.php?id=3. The training requires approximately two hours to complete and includes didactic information and video-based examples of counseling interventions. All staff responsible for safety planning should complete this online training or a live training from a certified training provider. The developers offer master trainer certification if agencies prefer to provide face-to-face training. Texas offers a version of this training for mobile crisis and first responders titled, “CALM for First Responders.”

Appendix B: Training Requirements

The training requirements for each approved protocol vary per treatment practice; the training requirements for each protocol are outlined below:

a. **Cognitive Behavior Therapy (CBT):** There are no training requirements for CBT; however, proof of competency is required. For specific competency requirements, reference the CBT competency requirements outlined in the performance contract notebook. http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml

b. **Trauma-Focused CBT (TF-CBT):** Clinicians must complete the ten hour online TF-CBT webinar and the online Childhood Traumatic Grief webinar from the Medical University of South Carolina. Both are found on their website, http://ctg.musc.edu/. Clinicians must also complete the two-day face-to-face TF-CBT training from an approved national trainer. Additional clinical supervision requirements are listed in the performance contract notebook. (http://tfcbt.musc.edu/)

c. **Parent-Child Psychotherapy (Dyadic Therapy):** Clinicians must meet the national training requirements for Parent-Child Interaction Therapy (PCIT) as outlined on the PCIT website: http://www.pcit.org/training-guidelines/pcit_training_guidelines_2009/ and must be trained by an approved national trainer (http://www.pcit.org/certified-trainers/); *or* clinicians may document Parent-Child Psychotherapy certification from a DSHS approved university-based institute or program. See the performance contract notebook for trainings approved prior to the implementation of the above requirements. (http://www.pcit.org/)

d. **Seeking Safety:** Must complete one-day training by a national, approved trainer, or must complete the four video training series. The completion of the four video training series must be documented by the staff member's clinical supervisor. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=376)

e. **Nurturing Parenting** – Must complete the three-day basic Nurturing Parenting trainer by an approved organizational trainer or by a national, approved trainer of Nurturing Parenting.

    - Organizational Trainer Requirements: Must complete the basic three days of training to become a Nurturing Parenting facilitator and have provided two cycles of the DSHS approved Nurturing Parenting protocols (the Tertiary Treatments of Nurturing Parenting) for a period of eight to twelve months. Following the practical experience, the individual must complete an approved Nurturing Parenting Training of Trainers (TOT) and be deemed competent by the TOT trainer. The individual must have documentation that he/she has met all these requirements. Note: The "organizational" trainer is not an approved national trainer and only has permission to train within the DSHS contracted organization that employs him/her. DSHS contracted providers may share organizational trainers. (http://www.nurturingparenting.com/)

f. **Aggression replacement techniques and socials skills (Skill streaming):** Must complete a DSHS approved training in either Aggression Replacement Training®, *or* Social Skills Training and Aggression Replacement Techniques (START), *or* must complete the Teaching Pro-Social Behavior DVD training *and* complete one fidelity review. (http://aggressionreplacementtraining.com/)

g. **Preparing Adolescents for Young Adulthood (PAYA):** At this time, there are no specific training requirements for this protocol. (http://www.itsmymove.org/training_resources_lifeskills.php)

h. **Barkley's Defiant Child and Barkley's Defiant Teen:** At this time, there are no specific training requirements for this protocol. (http://www.russellbarkley.org/)

i. **Wraparound Planning Process:** Wraparound care planning process is required for Level of Care (LOC) 4 and YES and the provision of Intensive Case Management (ICM). (http://nwi.pdx.edu/wraparound-basics/)

Facilitators must meet the following training requirements through a DSHS approved entity:

1. Be a QMHP-CS, CSSP, or LPHA; and
2. Have completed, or be in the process of completing, each of the core trainings listed below in the order in which they are listed. These trainings must be provided by a person/entity that has been certified as a training entity by the National Wraparound Implementation (NWIC) standards:
    i. Introduction to Wraparound
    ii. Engagement in the Wraparound Process
    iii. Intermediate Wraparound: Improving Wraparound Practice
3. At least once per month, Wraparound Facilitators must receive ongoing Wraparound supervision from a Wraparound Supervisor who has completed the following training which must be provided by a person/entity that has been certified as a training entity by NWIC:
    i. Advancing Wraparound Practice—Supervision and Managing to Quality

The following sections provide guidance in selecting the most appropriate counseling or skills training protocol(s) for the youth based on the needs identified on the CANS.

Appendix C: Selecting an Intervention

The following interventions are evidence-based or promising practices available in TRR levels of care. Training and/or competency is required for providers to deliver these services. Training and competency requirements are included in Info Item A. Established competency in CBT covers the provision of most CBT protocols. However specific competency must be demonstrated for TF-CBT and PCIT. It is the responsibility of the LMHA to procure and fund the training necessary for each provider to achieve competency. Many of these trainings are provided through the Centralized Training Infrastructure (www.centralizedtraining.com).

Counseling

Counseling can take place in an individual, family, and/or group setting. A therapist will use a therapeutic process through conversations, therapeutic activities, or games to address personal, family, and situational issues. Counseling can improve individual and family relationships or circumstances. It can also address parent-child relationships, depression and/or anxiety, or traumatic events.

Cognitive Behavioral Therapy (CBT): CBT is an empirically supported treatment which helps youth to overcome difficulties by changing thinking, behavior, and emotional responses. Although there is not a specific protocol identified to provide Cognitive Behavioral Therapy, this general treatment modality can be used to treat diverse disorders or specific behavior problems in youth such as: Obsessive Compulsive Disorder, Specific Phobias, Bipolar Disorder, Substance Abuse, and anger issues in youth diagnosed with Oppositional Defiant Disorder or Conduct Disorder. (http://www.nimh.nih.gov/health/topics/psychotherapies/index.shtml). CBT may not be indicated for youth with a diagnosis of intellectual developmental disorder, traumatic brain injury or a medical condition that significantly impacts their cognitive functioning.

The following manualized CBT treatments are approved to treat youth:

1. *Coping Cat* – for youth ages 7-13 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=91)

2. *The Cat Project* – for youth ages 14-17 to treat anxiety related disorders such as: Generalized Anxiety, Anxiety Disorder NOS, Panic Disorder, Social Phobia (Social Anxiety Disorder), etc. (http://www.promisingpractices.net/program.asp?programid=153).

3. *Taking Action* – for youth ages 9–13 to treat depressive mood disorders, such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc. (https://www.msu.edu/course/cep/888/Depression/taking.htm).

4. *Adolescent Coping with Depression Course (CWD-A)* – for youth ages 13-17 to treat depressive mood disorders such as: Major Depression, Depressive Disorder NOS, Mood Disorder NOS, etc. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=11).

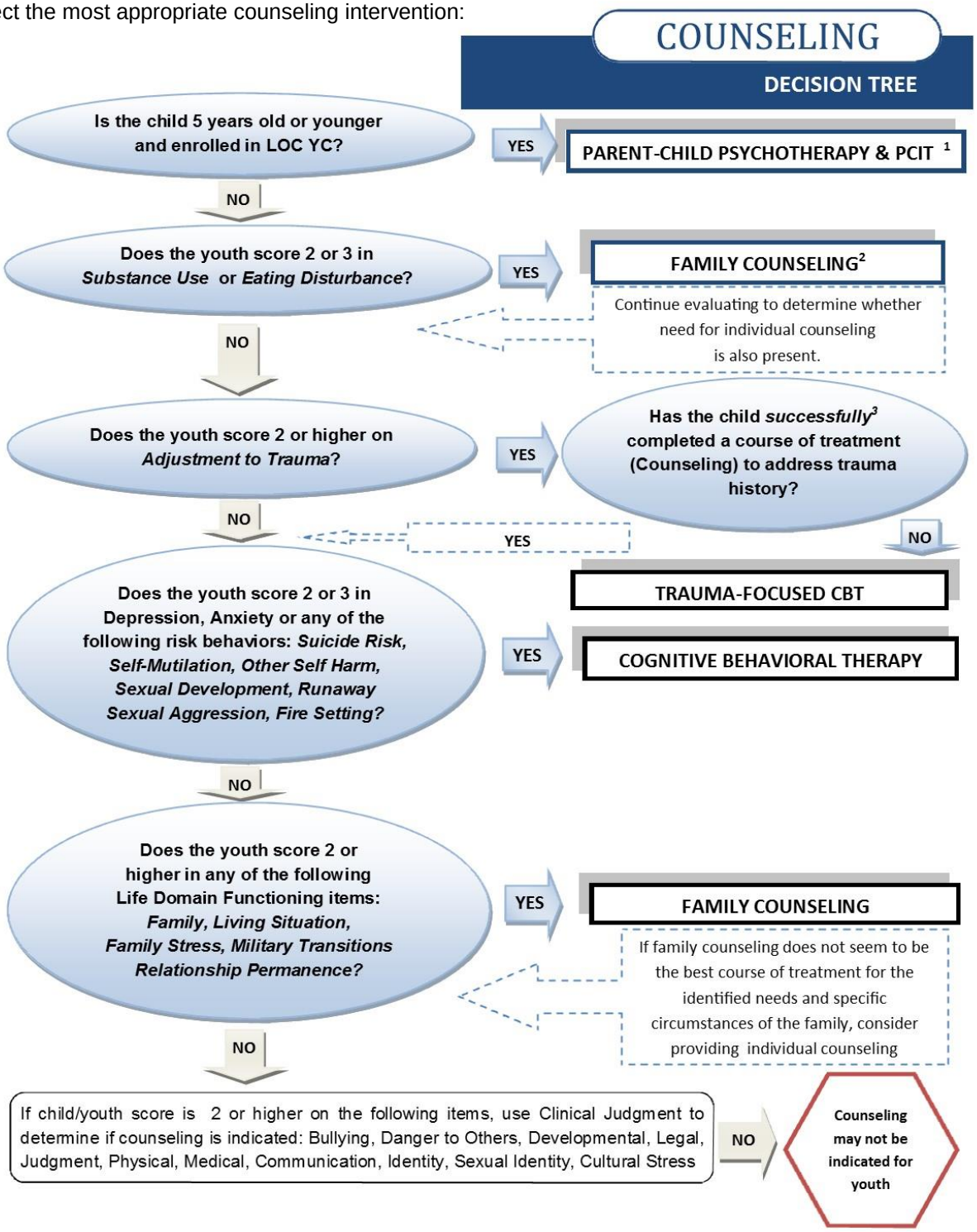
Trauma-Focused CBT (TF-CBT): TF-CBT is a recognized evidence-based treatment that can be used with youth ages 3-18. This treatment is a components-based model of psychotherapy that addresses the unique needs of youth with PTSD symptoms, depression, behavior problems, or any other difficulties related to exposure to traumatic life events, including childhood traumatic grief. The average length of treatment ranges between 12 to 16 sessions; however, if compounding complex trauma is present, the length of treatment could be significantly longer. This counseling modality requires both individual sessions for the youth and caregivers/parents, as well as joint sessions. (http://tfcbt.musc.edu/)

Parent-Child Psychotherapy and Parent Child Interaction Therapy (PCIT): The focus of this research-based therapeutic intervention is to support and strengthen the relationship between the child and caregiver as a vehicle for restoring the child's sense of safety, attachment, appropriate affect, and to improve the child's cognitive, behavioral, and social functioning. This treatment modality is to be used with children ages 3-6 years old. If the specific evidence-based intervention Parent Child Interaction Therapy (PCIT) is provided, it can be used with children ages 3-7 years old. Providers must use DSHS approved models of Parent-Child Psychotherapy as outlined in the contract. (http://www.pcit.org/)

Family Therapy (Family Counseling): Family therapy or family counseling is a type of psychological counseling in which family members are treated together to solve relational conflicts or address specific psycho-social needs of the youth within the context of the family. Certain modalities of family therapy have been found effective (or designated as evidenced-based practices) for youth with conduct disorder, substance abuse issues and/or eating disorders. Providers should use the modality that will be most effective for the specific youth and family. Family therapy is allowed for ages 3 to 17 based on the youth's needs. Couple's counseling is not an approved family therapy modality by DSHS. (https://store.samhsa.gov/shin/content/SMA13-4784/SMA13-4784.pdf)

Appendix C, Cont.: *Selecting an Intervention*
Counseling

This flow chart is intended to guide clinicians in utilizing needs identified on the CANS assessment to select the most appropriate counseling intervention:



1. Parent-Child Psychotherapy and Parent Child Interaction Therapy (PCIT) may also be provided to children six years old authorized into LOC-YC if the children have developmental needs that indicate this course of treatment. Clinical judgment should be used.
2. Although research shows that family counseling is indicated for substance abuse or eating disorders, individual counseling may also be beneficial.
3. "Successfully" indicates that the youth and/or LAR agree that the youth's functioning is not affected by trauma since completion of treatment.

Appendix C, Cont.: *Selecting an Intervention*
Skills Training and Development

Skills Training

Skills training is used to address negative behaviors that are symptoms of emotional disturbance. A skills trainer works with youth to build skills that improve their ability to cope with their unique symptoms. These skills will help youth function independently in school, at home, and in the community. Skills training is also available for parents. This goes beyond basic parenting techniques and is specifically designed to help parent address their youth's mental health needs.

Aggression Replacement Techniques: Aggression replacement techniques are intended to help youth ages 7-17 improve social skills and moral reasoning, better manage anger, and reduce aggressive behaviors. This skills training protocol is divided into the following two groups, which can be provided individually or in a group format:

1. *Aggression replacement techniques* – These techniques can be used to treat youth with anger issues, oppositional defiant behavior, conduct disorder, and delinquent behavior. The techniques, created by Dr. Arnold Goldstein, consist of three components: social skills (skill streaming), anger control, and moral reasoning.

   The components of the aggression replacement techniques were originally developed to be provided in sets of three components in one week, creating a weekly set of skills. However, the protocol has been adapted for outpatient community mental health settings and it is expected that this skills training intervention will be provided at least once per week. The three components of the aggression replacement techniques must be provided in a sequenced order and each session must address at least one component. It should be noted, however, that a maximum of two components can be provided in one session following the established sequence. The sequence of the components must follow this order: social skills, anger control, and moral reasoning. The order of the components is repeated in the following manner as the youth progresses in treatment: social skills #1, anger control #1, moral reasoning #1, social skills #2, anger control #2, moral reasoning #2, social skills #3, and so on. Thus, one session may cover both social skills #1 *and* anger control #1 components, if clinically appropriate.

   For youth in elementary school the social and anger control skills to be used are from the book *Skillstreaming: The Elementary School*. For youth that need aggression replacement techniques all treatment components are inside the aggression replacement techniques manual.

2. *Social skills training* – This component will be provided using the series of manuals called *Skillstreaming.* Skillstreaming is a pro-social skills training treatment created by Dr. Arnold Goldstein. It employs a systematic four-part training approach that includes modeling, role-playing, performance feedback, and generalization to teach essential pro-social skills to youth. Skillstreaming is integrated in the components of aggression replacement techniques, but it can be used as a single skills training protocol for youth in need of social skills training. Skillstreaming has a series of grouped and sequenced skills training curriculum. The groupings are used as skills training modules based on the needs of the youth and the age group (e.g., "Group III: Skills for dealing with feelings" is targeted toward youth with difficulties expressing and coping with their feelings).

The following books should be used as manuals for delivering the aggression replacement techniques and social skills training:

a. Aggression Replacement Training® Manual (https://www.researchpress.com/books/409/aggression-replacement-training)
b. Skillstreaming: The Elementary School Child (https://www.researchpress.com/books/727/skillstreaming-elementary-school-child)

c. Skillstreaming: In Early Childhood (https://www.researchpress.com/books/716/skillstreaming-early-childhood)
d. Skillstreaming: The Adolescent* (https://www.researchpress.com/books/719/skillstreaming-adolescent)

*Note: The A.R.T. ® manual contains "Skillstreaming: The Adolescent" in the section "Social Skills/Skillstreaming".

Nurturing Parenting: This evidence-based skills training is a Tertiary Prevention-Treatment for caregivers of youth receiving mental health services. It treats abusive or neglecting parent-child dysfunctional interactions and develops caregiver's pro-social skills that will help the functioning of the youth and caregiver. Nurturing Parenting can be provided individually or in a group format. There is a sequence to be followed according to each protocol. Nurturing Parenting combines meeting with the youth and caregiver separately and then jointly depending on the age group. The typical length of treatment is 16 sessions. The following are the DSHS approved Nurturing Parenting skills training protocols:

a. Parents and Their Infants, Toddlers & Preschoolers – 16 sessions (Available in English and Spanish)
b. Parents & Their School- Age Children 5-11 years
c. Spanish Speaking Parents and Their Children 4-12 Years (Crianza Con Cariño)
d. Parents & Adolescents (Available in English and Spanish)
e. It's All About Being a Teen (http://nurturingparenting.com/ecommerce/category/1:3/)

Barkley's Defiant Child: This is a research-based skills training protocol for children ages 3–12 with disruptive behavior disorders. DSHS allows the use of Barkley's Defiant Child only for children with a single diagnosis of Attention Deficit/Hyperactivity Disorder or Disruptive Behavior Disorder, Unspecified. If anger issues are present, aggression replacement techniques should be provided instead of Defiant Child. (http://www.russellbarkley.org/)

Barkley's Defiant Teen: This is a research based skills training protocol for youth ages 13-17 with disruptive behavior disorders. DSHS allows the use of Barkley's Defiant Teen only for youth with a single diagnosis of Attention Deficit/Hyperactivity Disorder or Disruptive Behavior Disorder, Unspecified. If anger issues are present, aggression replacement techniques should be provided instead of Defiant Child. (http://www.russellbarkley.org/)

Seeking Safety: This is a present-focused therapy (skills training) to help individuals attain safety from trauma/PTSD and substance abuse. The treatment was designed for flexible use and can be conducted in both a group and individual format. Seeking Safety can be used with youth (ages 13 and older) that have *both* substance abuse issues *and* a history of trauma. However, note that a diagnosis of PTSD is *not* required in order for an individual to receive the Seeking Safety intervention. The first three sessions of this protocol must be provided in sequence; after the 3rd session, all subsequent sessions are provided based on the identified needs of the youth. Providers may follow the suggested sequence but, as previously stated, should base treatment on the youth's identified needs. A minimum of 10 sessions have been found to be most effective in achieving desired outcomes. (http://legacy.nreppadmin.net/ViewIntervention.aspx?id=376)

Preparing Adolescents for Young Adulthood (PAYA): This skills training curriculum is to be used with youth ages 14-17 facing issues related to transitioning from adolescence to adulthood. PAYA consists of five modules; each module addresses a group of transitioning-youth skills. PAYA is a promising practice created by the Casey Life Skills Foundation and was envisioned to be self-directed by youth to support and facilitate the development of self-determination. It can be delivered by a Qualified Mental Health Professional (QMHP) with the direction of the youth. It is recommended that the QMHP use the "Gateway to the World: A toolkit and curriculum" to understand the principles that guide the use of the PAYA modules. Each module contains an assessment to identify which transitioning skills the youth needs. Based on the identified needs, sections of the PAYA modules that address those needs are selected to

provide skills training. It is not required that the entire module is used with a single youth nor is it required that all modules be provided to a single youth. The use of PAYA as a skills training protocol is flexible and does not require a specific sequence of sessions.

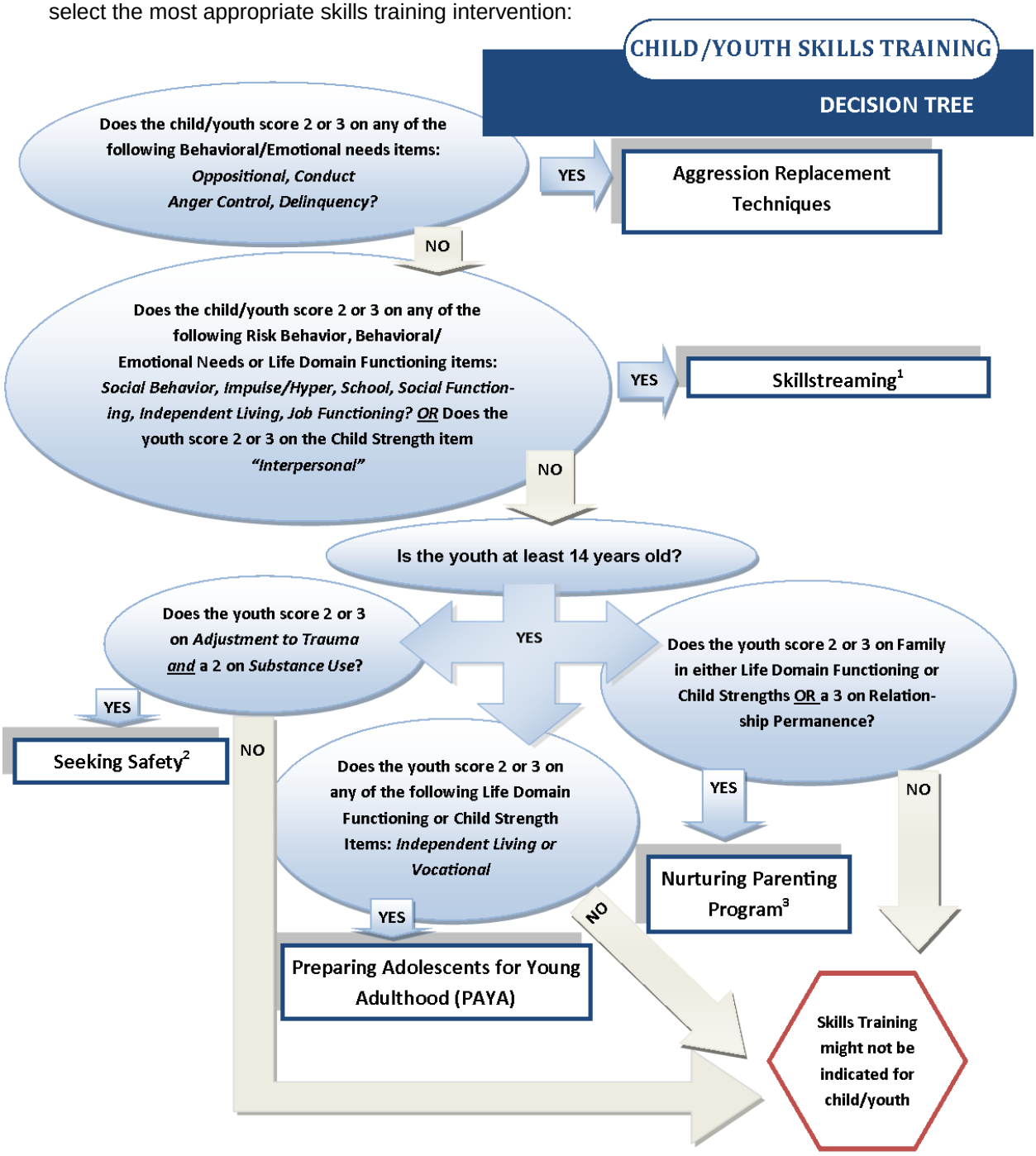
The six PAYA modules are listed below:

i. Module 1: Money, Home and Food Management
ii. Module 2: Personal Care, Health, Social Skills and Safety
iii. Module 3: Education, Jobs Seeking Skills and Job Maintenance Skills
iv. Module 4: Housing, Transportation, Community Resources, Understanding the law and Recreation
v. Module 5: Young Parents Guide
vi. Module 6: Household Management Activities

For more clinical guidance on services provided to transition-age youth, please reference Appendix E: Transition-Age Youth.
(http://www.itsmymove.org/training_resources_lifeskills.php)

Appendix C, Cont.: *Selecting an Intervention Skills Training*

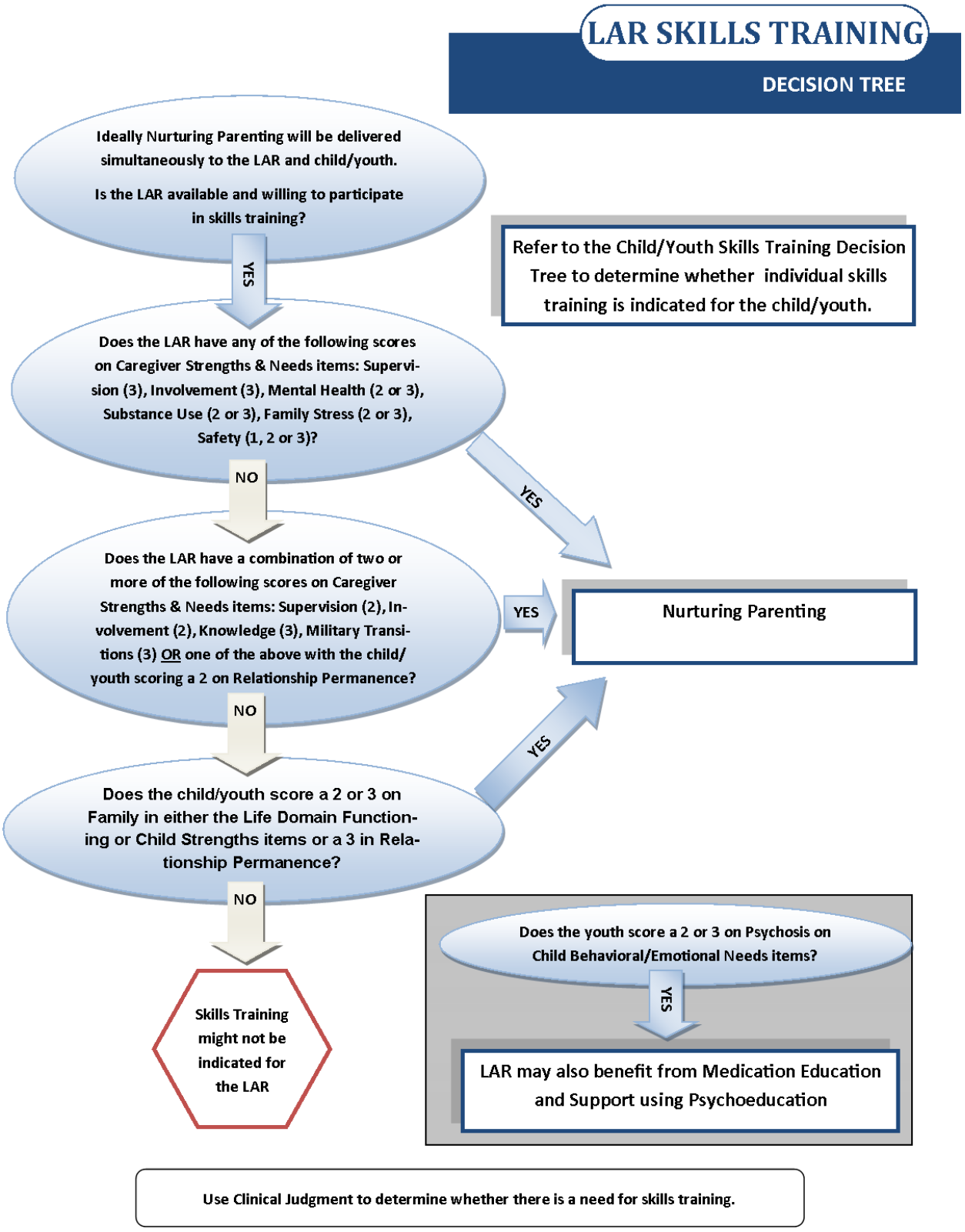
This flow chart is intended to guide clinicians in utilizing needs identified on the CANS assessment to select the most appropriate skills training intervention:



Use Clinical Judgment to determine if there is need for skills training, and if so, which protocol(s) to deliver. If more than one protocol is appropriate, use Clinical Judgment to determine if they should be delivered simultaneously or one at a time.

Note:
1. Delivered independently of the other Aggression Replacement Techniques components
2. Youth must **NOT** be receiving TF-CBT in order to receive Seeking Safety.
3. Nurturing Program may be delivered individually to youth if LAR not available, appropriate, or willing to participate. Refer to LAR skills training decision tree.

Appendix C, Cont.: *Selecting an Intervention*
Skills Training Delivered to the Caregiver(s)/LAR



Appendix D: Family Partner Supports

Certified Family Partners

Certified Family Partners are members of the recovery team. They provide support and advocate for families to assist in engagement, empowerment, self-advocacy, and wellness as they actively participate in the recovery of their child. Family Partners assist families in making informed decisions that drive families toward wellness and recovery. As a supportive partner, the Family Partner has a strong connection to the community and is knowledgeable about resources, services and supports for families. Certified Family Partners provide supports to the LAR and/or primary caregivers of the youth and do not provide services directly to the youth. Access to quality family partner supports can be instrumental in engaging families as active participants in the youth's care. The Family Partner's lived experience is critical to earning respect and establishing trust as they mentor and coach families to find and develop their voice and learn how to use it effectively in their child's treatment, wellness and recovery. The Family Partner assists families in making informed decisions on a routine basis, in crisis and during the wraparound process. The Family Partner provides general consultation to staff. A Certified Family Partner can be a mediator, facilitator, and a bridge between families and agencies; and ensure each family is heard and their individual needs are being addressed and met. Through their work with primary caregivers, parents, and/or LARs, Certified Family Partners directly impact the youth's resilience and recovery.

Special Considerations for Family Partner Supports

As formal members of the treatment team, Certified Family Partners should be utilized in every LOC to engage caregivers as equal members of a youth's treatment team and to provide the following to parents/primary caregivers and/or LAR of youth:

- Advocacy that encourages the positive choices of the caregiver, promotes self-advocacy for caregivers and their youth, and supports the positive vision that the caregiver has for their youth's mental health and recovery;
- Mentoring through the transfer of knowledge, insight, experience and encouragement including the Certified Family Partners' articulation of their own successful experience of navigating a child-serving system;
- Role-modeling the concepts of hope and positive parenting, advocacy and self-care skills that will ultimately benefit the resilience and recovery of the youth (this may include the provision of Family Skills Training using the DSHS approved protocol for primary caregivers);
- Experienced guidance in navigating the child-serving systems, including mental health, special education, juvenile justice, child protective services, etc.;
- Connection to community resources and informal supports;
- Identification of the family's natural supports and strengths and guidance; and practical guidance in nurturing those relationships;
- Stewardship of family voice and choice as a member of all recovery teams including the Wraparound team; and
- Support through the facilitation of parent support groups.

Minimum Qualifications

Certified Family Partners are the parent or LAR of a youth with a serious emotional disturbance and have at least one year of experience navigating a child-serving system. Individuals shall meet minimum qualifications to fill the role of Family Partner. Via Hope, the training and credentialing entity recognized by DSHS, has stated the following minimum requirements to be a Certified Family Partner. All Family Partners must meet these requirements and become certified within one year of hire.

- Must be a parent or legally authorized representative (LAR) with a minimum of one year of lived experience being responsible for making the final decisions for a youth (person 17 years or under) who has been diagnosed with a mental, emotional or behavioral disorder.

- Must be at least 18 years or older and must have a high school diploma or GED.
- Have successfully navigated a child-serving system for at least one year (i.e., mental health, juvenile justice, social security or special education) and be able to articulate their lived experience as it relates to advocacy for their youth and success in navigating these systems.
- Have lived experience that speaks to accomplishments concerning their youth's mental health including their youth being in a stable place in their recovery and/or resiliency.
- Can meet requirements for a Medicaid background check.

Appendix E: Level of Care – Early Onset (LOC-EO)

Note: This LOC will be listed as LOC-CEO if the individual is under the age of 18. The LOC is listed as LOC-AEO if the individual is over the age of 18. They are known collectively as LOC-EO. LOC-EO is only allowed to those centers participating as a pilot site for the Coordinated Specialty Care for First Episode of Psychosis program. If your center is not participating in this pilot, please continue to serve clients in their recommended LOC.

Purpose for Level of Care

The purpose of LOC-EO is to provide a specialized treatment approach for those experiencing their first episode of psychosis. Individuals in this level of care will have a diagnosis that includes psychotic features and will vary in terms of need and severity. The Early Onset LOC's goal is to identify and help individuals before their symptoms and/or diagnosis are the primary feature of his/her life. Due to the early intervention model, many individuals may be entering behavioral health services for the first time and require a comprehensive array of services be available.

The team-based approach is a vital aspect of the assistance an individual will receive when they participate in this LOC. Teams are trained in the Coordinated Specialty Care model and provide an individual with all of the clinical and support services so that care is provided efficiently and with a focus on recovery.

Level of Care Assignment/Deviation Criteria

The admission criteria to be met are:

- The individual must be between the ages of 15 and 30.
- The individual must a diagnosis that contains psychosis that was first given within the last two years.
- Individual must live in the service area of a pilot site.

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. DSHS endeavors to facilitate processes that acknowledge this role. As such, the following recommendations highlight how peers and/or family partners might be best utilized within this level of service:

- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual's interests, health clubs, etc.
- Provide medication training and support as appropriate.
- Provide education about the Early Onset Program.
- Provide Engagement interventions to individuals to foster full participation in treatment.
- Certified Peer Specialists and/or Certified Family Partners may serve as a member of the treatment team offering feedback to other providers regarding his or her observations of an individual's stage of recovery and/or efforts made towards fulfilling the individual's recovery goals.

Note: All the tasks identified in this section are services/assistance that can be provided by any treatment-providing staff with the exception of peer-specific functions, such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this LOC:

- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual will develop additional skills needed to continue working toward, maintaining or achieving recovery.
- The individual will obtain skills to prepare for gainful employment and/or educational obtainment.

Discharge Criteria

ANY of these indicators would support discharge or transition from this LOC:

- The individual moves outside of the geographic service area of the CSC team. To the extent possible, the CSC team must facilitate referral of the individual to a provider of services sufficiently capable of satisfactorily addressing the individual's needs.
- Individual is determined to not have a qualifying diagnosis. Due to diagnostic uncertainty when first entering this LOC, it is possible an individual may be assigned this LOC initially before a true diagnosis is given. Should the individual be given a diagnosis that is not on the allowable list, the individual must be transitions to the next most appropriate LOC.
- The individual has been enrolled in LOC EO for a total of 36 months.
- The individual is determined to not meet the age requirement.

LOC-CEO Table Overview

Authorization Period: 180 Days **Recovery Plan: 180 Days**		
Average Monthly Utilization Standard for this Level of Care Is Based on Determined Need Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate and indicated in the recovery plan.		
Core Services: Identified by the uniform assessment and indicated in the recovery plan.	**Level of Care CEO** **Estimated Utilization Per Month** **(These Are Guidelines Only)**	
	Standard Therapeutic **5.87 hours per month**	**High Need Therapeutic** **20.35 hours per month**
Psychiatric Diagnostic Interview Examination (coded 90791, 90792)	**1 event/year**	**1 event/year**
Pharmacological Management (coded 99201-99205, 99211-99215, 99241-99245, M0064)	**0.25 hours** (1 unit)	**0.5 hour** (2 units)
Administration of an Injection (coded 96372)	**As needed**	
Skills Training and Development (Individual) (coded H2014)	**3 hours** (12 units)	**4.5 hours** (18 units)
Skills Training and Development (Group) (coded H2014)	**3 hours** (12 units)	**4.25 hours** (17 units)
Supported Employment and Education (coded H2023HA)		
Supported Housing (coded H0046HAU2)		
Medication Training & Support Services (Individual) (coded H0034)	**1 hour** (4 units)	**1.5 hours** (6 units)
Medication Training & Support Services (Group) (coded H0034)	**0.75 hour** (3 units)	**5 hours** (21 units)
Individual Psychotherapy (coded 90832, 90833, 90834, 90836, 90837, 90838)	**3 hours** (3 events)	**4 hours** (16 events)
Family Counseling (coded 90847)	**3 hours** (3 events)	**4 hours** (16 events)
Multiple Family Psychotherapy (coded 90849)	**3 hours** 3 events Not reimbursed by Medicaid	**4 hours** 16 events
Group Counseling (other than multiple family) (coded 90853)	**3 hours** (3 events)	**4 hours** (16 events)
Family Partner Services (coded H0038)	**3.5 Hours** (14 units)	**7 hours** (29 units)
Case Management (Individual) coded T1017 (Individual) T1017 Routine T1017 Intensive Individual (Wraparound)	**1hr** (4 units)	**6 hours** (24 units) **8 hours** (32 units)
Case Management (Family) (coded T1016)	**0.5 hour** (2 units)	**1 hour** (4 units)
Family Training (Individual) (coded H2019)	**3 hours** (12 units)	**6 hours** (24 units)
Family Training (Group) (coded H2019)	**3 hours** (12 units)	**6 hours** (24 units)
Parent Support Group (coded H0025HAHQ)	**1 hour** (1 unit)	**4 hours** (4 units)
Engagement Activity (coded H0025HATS)	**6 hours** (24 units)	

Adjunct Services: Identified by the uniform assessment and indicated in the recovery plan.	**Standard Therapeutic**	**High Need Therapeutic**
Flexible Funds (coded H2016)	**Unit type: $1**	**Unit type: $1**
Flexible Community Supports (coded H2016)	**Unit type: 15 min=1 unit**	**Unit type: 15 min=1 unit**
Crisis Services Array: Authorized as medically necessary and available during psychiatric crisis	Utilization of crisis services within this Level of Care is similar to LOC-0 as described in the UM guidelines. Also includes crisis versions of above italicized services	
Crisis Intervention Services (coded H2011)	**Unit type: 15 min=1 unit**	
Safety Monitoring (coded H0046)	**2 hours** (8 units)	
Crisis Transportation (Event) (coded A0160)	**As necessary** Unit type: event	
Crisis Transportation (Dollar) (coded A0160)	**As necessary** Unit type: $1	
Respite Services: Community-Based (coded T1005)	**6 hours** (24 units	
Respite Services: Program-Based (not in home) (coded H0045)	**3 bed days** (3 units)	
Extended Observation (coded 99218HA-99220HA)	**1 unit** (1 bed day)	
Children's Crisis Residential (coded H0018)	**4 units** (4 bed days)	
Inpatient Hospital Service (coded 90816-90819, 90821-90824, 90826-90829, 99221-99223, 99231-99236, 99238, 99239, 99251-99255)	**As necessary** Unit type: bed day	
Inpatient Services (Psychiatric) As necessary (coded T2048HA)	**As necessary** Unit type: bed day	
Emergency Room Services (Psychiatric) As necessary (coded 99281-99285)	**As necessary** Unit type: event	
Crisis Follow-up & Relapse Prevention (coded H0036)	**8 hours** (32 units)	
Crisis Stabilization Unit (coded H0017)	**As necessary** Unit type: bed day	

LOC-AEO Table Overview

Authorization Period: 180 Days **Recovery Plan: 180 Days**		
Average Monthly Utilization Standard for this Level of Care Is Based on Determined Need Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate and indicated in the recovery plan.		
Core Services: Identified by the uniform assessment and indicated in the recovery plan.	**Level of Care AEO** **Estimated Utilization Per Month** **(These Are Guidelines Only)**	
	Standard Therapeutic **5.87 hours per month**	**High Need Therapeutic** **20.35 hours per month**
Psychiatric Diagnostic Interview Examination (coded 90791, 90792)	**1 Event/year** coded 90791, 90792	**1 Event/year**
Routine Case Management (coded T1017-Individual, T1017 Routine)	**1hr** (4 units)	**6 hours** (24 units)
Psychosocial Rehab (Individual) (coded H2017)	**3.5 Hours** (14 units)	**7 hours** (29 units)
Psychosocial Rehab (Group) (coded H2017HQ)	**2.25 Hours** (9 units)	**8.6 hours** (35 units)
Peer Support (H0038)	Non-billable	Non-billable
Pharmacological Management (coded 99201-99205, 99211-99215, 99241-99245, M0064)	**0.25 hours** (1 unit)	**0.5 hour** (2 units)
Administration of an injection (coded 96372)	**1 unit**	**1 unit**
Medication Training & Support Services (Individual) (coded H0034)	**1 hour** (4 units)	**1.5 hours** (6 units)
Medication Training & Support Services (Group) (coded H0034HQ)	**0.75 hour** (3 units)	**5 hours** (21 units)
Family Counseling (coded 90847)	**3 hours** (3 events)	**4 hours** (16 events)
Individual Psychotherapy (coded 90832, 90833, 90834, 90836, 90837, 90838)	**3 hours** (3 events)	**4 hours** (16 events)
Group Counseling (other than multiple family) (coded 90853)	**3 hours** (3 Events)	**4 hours** (16 events)
Supported Housing	**3 hours** (12 units)	**4.25 hours** (17 units)
Supported Employment	**3 hours** (12 units)	**4.5 hours** (18 units)
Engagement Activity		
Flexible Funds (coded H2016)	Unit type: $1	Unit type: $1
Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.	**Standard Therapeutic**	**High Need Therapeutic**
Flexible Community Supports (coded H2016)	**Unit type: 15 min=1 unit**	**Unit type: 15 min=1 unit**
Crisis Service Array: Authorized as medically necessary and available during psychiatric crisis.	**Utilization of crisis services within this LOC is the same as LOC-0.** Please refer to LOC-0 for utilization guidelines.	

Uniform Assessment Instructions for LOC-EO

SECTION	FREQUENCY
Adult Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths (CANS) Assessment	▪ Upon admission ▪ Every 180 days ▪ Upon any other change in condition ▪ Upon discharge ▪ Following any crisis event ▪ Following any hospitalization
Diagnosis-Specific Rating Scales:	▪ Upon admission ▪ Every 180 days (unless no pharmacological appointment required within 180 days) ▪ Upon discharge ▪ These scales are not required for individuals who are not part of the target population.
Community Data	▪ Every time ANSA or CANS is completed
Authorizations	▪ LOC EO – 180 Days

Appendix F: Transition-Age Youth

Between the ages of 16-25, the age range commonly referred to as "transition age," individuals undergo tremendous change in all domains of life including physical, cognitive, relationships, educational, vocational, and housing. It is important to start conversations about transitions with youth and their caregivers early while promoting environments where youth may obtain skills necessary for success in adulthood.

Youth with serious emotional disturbance (SED) or a mental health diagnosis are at increased risk for school dropout, arrest, unemployment, and challenges associated with independent living. However, with future planning and preparation, these outcomes may be avoided. Acknowledging and addressing the needs of transition-age youth is critical for those served in the Children's Mental Health System.

Considerations for Working with Transition-Age Youth

In the TRR system, youth are served in CMH services until age 18. Therefore, it is important to prepare youth to transition to AMH services. If youth are involved with the YES waiver, they will continue to be served until the month before their 19th birthday.

Youth should be engaged in an individualized and developmentally appropriate process that assesses strengths and needs in the area of transition to adulthood. Transition goals should be determined and a plan to reach these goals created. Using a person-centered approach, youth are partners in this process and leaders in their own care.

TRR providers should consider the following guidelines in their work with transition-age youth. Services and supports should:

- Be accessible, coordinated, strengths-based, non-stigmatizing, and developmentally appropriate.
- Involve and engage youth through person-centered planning.
- Focus on youths' futures utilizing developmentally appropriate engagement activities.
- Build on strengths to enable youth to identify and achieve their goals across multiple transition domains such as:
  - School and Future Educational Opportunities
  - Job Functioning and Future Career Opportunities
  - Living Situation and Independent Living
  - Social Functioning
  - Recreation and Community Involvement
  - Overall Functioning and Well-Being
- Encourage personal and social responsibility with youth.
- Provide specific leadership opportunities within the organization (e.g., serving on an advisory board or assisting with special projects).
- Identify a support network by involving youths' parents, family members, significant others, friends, and other formal and informal supports.
- Assist youth in developing necessary skills to achieve self-sufficiency and confidence.

Strengths and Needs Assessment for Transition Age Youth

Providers should utilize the CANS assessment to identify strengths, resources, needs, and other formal and/or informal supports of the youth to develop a Transition Plan. The Transition Plan should be developed in collaboration with the youth, family members, and other supports, and use a strengths-based approach. Other assessments could be used to supplement the CANS assessment to discover youth and family strengths and needs. Please refer to the list of resources at the end of this appendix. Assessments in the area of transition to adulthood also allow for:

- Identification of the strengths and resources of the youth and his/her family, including resiliency skills.

- Demonstration of interest in the youth and the perspectives of people who are important to him/her.
- Promote positive interactions and activities for the youth and individuals important to him/her.

Creating a Plan for the Transition to Adulthood

Individualized transition plans should include:

- Needs and strengths/resources identified in the transition assessment.
- Measureable and achievable goals, objectives, and tasks.
- Appropriate timelines to achieve goals and complete objectives, which include reviewing accomplishments and celebrating successes.
- Identification of formal and informal supports that may assist the youth in achieving his/her transition goals.

Transitioning to Adult Mental Health (AMH) Services or a Community Mental Health (MH) Provider

Mental health conditions that begin in childhood or adolescence often continue into adulthood and can develop into severe mental illness (SMI). Once the youth turns eighteen, difficulties in accessing appropriate supports and services in the community often plague youth, their families, and providers. Eligibility criteria, funding mechanisms, and different philosophies across systems may create challenges obtaining appropriate services for youth upon their eighteenth birthday. Therefore, supporting the transition from CMH to AMH or a community MH provider is vital.

Ongoing conversations about the transition process should begin between the ages of 14 and 16 years. The transition process can be a successful and positive experience if youth are offered the appropriate services while they are still enrolled in the children's MH system. Six months to a year before transitioning to AMH services, youth may benefit from accessing transitional services and interacting with any new AMH team members they may be working with in the near future. These services/activities may include:

- Use of the Adult Needs and Strengths Assessment (ANSA) at the youth's last UA before transfer to AMH.
- Introduction to the future AMH case manager who will provide an overview of AMH services that should include a comprehensive review of the role, rights, and responsibilities of transition age youth as recipients of AMH services.
- Follow-up meeting with CMH case manager and AMH case manager to answer any questions and build rapport
- Tour of the AMH facility (if the facility is a separate or new environment for youth)
- Provision of Supportive Housing, as appropriate in both the CMH and AMH system.
- Provision of Supportive Employment, as appropriate in both the CMH and AMH system.
- Explanation of Medicaid and Social Security benefits and the application process, when applicable. Emphasis on possible outcomes of the process, such as applying multiple times before being approved, should be included.

Providers must also follow the Texas Administrative Code (TAC) §412.324: Additional Standards of Care Specific to Mental Health Community Services for Children and Adolescents. Providers should develop a transition plan for each youth who will need adult mental health community services. This transition plan must be developed collaboratively with the youth, LAR, and future providers while allowing enough time to avoid disruption in mental health services. The transition plan may incorporate the guidelines for planning as stated above as well as the TAC. Transition plans must include:

- Summary of the mental health community services and treatment youth has received;
- Current status (e.g., diagnosis, medications, uniform assessment guideline calculation, and unmet needs);

- Information from the youth and the LAR regarding the youth's strengths, preferences for mental health community services, and responsiveness to past interventions;
- Description of the mental health community services the youth will receive as an adult;
- List of resources for other recovery supports (e.g., volunteer opportunities, family or peer organizations, 12-step programs, churches, colleges, or community education);
- Documentation that the youth's services continued throughout the transition without disruptions; and
- Documentation of follow-up from providers to ensure successful transition to adult services.

Considerations for Youth Peer Support

Youth peer support during adolescence is especially powerful because of the impact of peers on social development. Peer support within the mental health system can help reduce stigma and help the youth feel understood and supported during this time of change and transition. Peer support can happen through an adult-led, peer support group or a youth guided group (e.g., Youth Motivating Others through Voices of Experience (Youth M.O.V.E.). Youth M.O.V.E works to raise awareness regarding youth who have experiences in public systems such as the public mental health and juvenile justice. Chapters exist around the country and can be formed in areas that do not currently have a youth peer support network. Although challenges exist when creating peer support, it is possible and beneficial.

Additional Tools for Use with Transition Age Youth

- Skills Training: PAYA increases understanding of the fundamentals of independent living and enhances abilities to make successful and smooth transitions to self-sufficient young adulthood: http://www.itsmymove.org/training_resources_lifeskills.php.
- The Transition to Independence Process (TIP) model is an evidence-supported practice that demonstrates improvements in outcomes for youth. Resources, including transition planning forms, can be found at their website: http://www.tipstars.org/OverviewofTIPModel.aspx.
- NAMI has learned a tremendous amount through interacting with young adults and has designed a website to better meet the needs of this group: http://strengthofus.org/.
- Transition of Youth and Young Adults with Emotional or Behavioral Difficulties: An Evidence Supported Handbook by Hewitt B. Clark and Deanne K. Unruh http://www.tipstars.org/TransitionHandbook.aspx.
- Pathways Research and Training Center with Portland State University consistently publishes online trainings and articles on supporting Transition Age Youth: http://www.pathwaysrtc.pdx.edu/.
- Transitions Research and Training Center with the University of Massachusetts is a complimentary entity to Pathways. It also offers online trainings and articles on supporting transition age youth: http://www.umassmed.edu/transitionsrtc.
- The Department of Assistive and Rehabilitative Services (DARS) offers the following services and programs to transitioning age youth: (http://www.dars.state.tx.us/drs/).
    - The Independent Living (IL) Services And Centers
    - Transition Planning
    - The Vocational Rehabilitation (VR) program, a state-federal partnership since 1929, helps people with disabilities prepare for, find and keep jobs. Work related services are individualized and may include counseling, training, medical treatment, assistive devices, job placement assistance, and other services.

Appendix G: Reasons for Deviation

Every effort should be made to authorize a youth into the LOC that will best meet his/her needs and support his/her resilience and recovery. The term "every effort" refers to the need for the clinician to thoroughly and completely explain to the family why the services in the recommended LOC are appropriate to help the youth and caregivers achieve agreed upon treatment goals. It also refers to the need to explain why the services in the recommended LOC may not be adequate to reach the desired outcomes. The LOC-R is based upon the uniform assessment (UA) including the CANS assessment. The CANS is a reliable, dynamic, and comprehensive tool that allows for a significant level of confidence that the LOC-R reflects the clinical need and is based on the current presentation of the youth. However, because an assessment tool does not have the sensitivity to identify underlying treatment needs, it is imperative that clinicians use clinical judgment when determining the LOC-A.

A recommended LOC is deviated to a higher or lower service intensity when it is determined that the LOC-R will not meet the youth's recovery goals. When authorizing an LOC that is different from the LOC-R, UM staff will make a determination based on the clinician's recommended deviation (LOC-D), the information provided in the uniform assessment, and availability of resources. This section describes the allowed reasons for deviating from LOC-R.

Using the Provider Requested Deviation– LOC-D

The purpose of the LOC-D is to allow the clinician the option to request a deviation from the LOC-R as calculated by the CANS/Uniform Assessment. The parameters for the use of the LOC-D are as follows:

- The LOC-D shall be completed by the clinician, but is only necessary if the LOC-D is different from the LOC-R.
- The clinician justifies the LOC-D and the UM staff shall take this into consideration when determining the LOC-A.
- The clinician may not site resource limitations for the LOC-D.

Definitions of Reasons for Deviation

The LOC-A may deviate from the LOC-R due to the following reasons:

- *Clinical Need:* To be used when the Licensed Practitioner of the Healing Arts (LPHA) identifies the clinical need/medical necessity for a more or less intensive level of care than the level of care recommended.
    - Deviation for Clinical Need must be documented in the clinical record and medical necessity signed by an LPHA, verifying medical necessity.

- *Resource Limitations:* To be used when the UM staff member identifies that there are not enough resources to offer services at the recommended level of care. Resources are defined as personnel, a slot within a specific level of care, or monetary resources necessary to provide services within the level of care.

NOTE: A youth who has Medicaid may not be deviated to the waitlist or to an LOC where a clinically indicated core service is not available.

- *Continuity of Care:* To be used when there is an identified need to deviate the youth to a level of care that is different from the level of care recommended in order to maintain continuity of care. Justification for the deviation must be documented in the clinical record. The following are examples of appropriate utilization of this deviation reason:
    - The youth is incarcerated or placed in juvenile detention center, but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or

- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave youth open to services; or

- *Consumer Refused:* To be used when the individual is provided with information necessary to make an informed decision and refuses the recommended level of care. The information discussed with the individual must be documented in the clinical record.
  - All efforts at engagement must be documented in the clinical record

- *Other:* To be used when none of the reasons listed above accurately describe the reason for deviation.
  - Justification for the deviation must be documented in the "Notes" field of the uniform assessment and retained in the clinical record.

Considerations for Core Services Within an LOC-A

Core Services in the LOC-R are determined to be essential to resilience and recovery. For this reason, all core services in the LOC-A must be offered to the youth and should be delivered. If a youth is not receiving a core service, justification must be documented in the clinical record.

LOC-0: Crisis Services

A youth may only be deviated to LOC-0 if he/she is not currently assigned to an LOC. Following stabilization of the crisis, the youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

If the youth does not have an active UA (i.e., is new to services) *and* the following criteria are met, it may indicate a need for deviation to LOC-0:

- The clinician determines the youth is in crisis (this includes a perceived subjective crisis on the part of the individual); *and*
- The LOC-R is not LOC-0

NOTE: The UA does not need to be completed before treating a crisis. Address the crisis first. If a youth who is currently enrolled in an LOC other than LOC-0 experiences a psychiatric crisis, crisis services should be delivered within the current LOC assignment.

LOC-R YC (LOC-YC: Young Child Services)

To be authorized into LOC-YC, the 3-5 CANS must be completed.
All developmentally appropriate services for children ages 3-5 are available in LOC-YC.

Reasons for Deviation to a Less Intensive LOC-A

NOTE: Because the services available in LOC-YC are imperative to resilience and recovery for this population, it is *not* advised that children be deviated to an LOC where counseling and skills training are not available. Providers must make every reasonable effort to authorize children with an LOC-R YC into this LOC.

Clinical Need
The following are clinical reasons that may indicate a deviation from LOC-R YC to LOC-1 and must be documented in the clinical record and medical necessity signed by an LPHA;

- A core service is required in LOC-YC, but the child is receiving that service from another mental health provider in the community and the child otherwise only has a clinical need for medication management.
- Due to developmental needs associated with a Pervasive Developmental Disorder (PDD) and/or Intellectual Disability (ID), the child is not able to benefit from a core service required in LOC-YC at this time; or

NOTE: Because the services available in this LOC will likely be developmentally appropriate, regardless of the child's diagnosis of PDD and/or IDD, this reason must be justified by the clinician based on clinical presentation and not solely based on the child's diagnosis. This reason for deviation should *not* be commonly used.

Continuity of Care
The following are reasons that may justify deviation to LOC-1 for continuity of care and must be documented in the clinical record.

- The child is hospitalized and provider communicates with the child and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The child is living out of the service area for a planned and defined period of time (i.e., summer vacation) and provider plans to leave the child open to services.

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R YC and must be documented in the clinical record:

- The caregiver/LAR refuses counseling, skills training *and* Wraparound (if clinically indicated), but does not refuse services available in LOC-1. If after attempts at engagement in the LOC-R YC, caregiver/LAR continues to refuse counseling, skills training *and* Wraparound (if clinically indicated), deviation to LOC-A 1 may occur.
- If the child is *new* to services and has an LOC-R YC and caregiver/LAR refuse all services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child should be deviated to LOC-A 6 (Refused All Services); or
- If the child is *currently enrolled* in services and upon reassessment has an LOC-R YC and the child and/or caregiver/LAR refuse all services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child should be discharged from services.

NOTE: Core Services in the LOC-YC are determined to be essential to resilience and recovery. The caregiver/LAR should continue to be engaged and participate in all clinically indicated core services, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

A child may only be deviated to LOC-A 1 or LOC-A 8 (Waitlist) with a reason of resource limitations if *all* core services cannot be provided because of those resource limitations and the child does not have Medicaid.

When deviating to LOC-A 1 for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the child was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the child and/or caregiver/LAR attended the initial appointment).

NOTE: If *all* core services within LOC-YC cannot be provided due to resource limitations, the child may remain in the LOC and also be placed on a waitlist for the core service until the service becomes available.

LOC-R 1 (LOC-1: Medication Management)

Reasons for Deviation to a Less Intensive LOC-A (Waitlist or Refused All Services)

Consumer Refused

The following are reasons that may indicate a deviation from the LOC-R 1 and must be documented in the clinical record:

- If the youth is *new* to services and has an LOC-R 1 and the youth and/or caregiver/LAR refuse medication services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the youth does not have a clinical need for services available in a more intensive LOC, he/she should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment has an LOC-R 1 and the youth and/or caregiver/LAR refuse medication services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the youth does not have a clinical need for services available in a more intensive LOC, discharge from services should be considered.

NOTE: All attempts at engagement must be documented in the clinical record.

Resource Limitations

Deviation to LOC-A 8 may not occur if the child has Medicaid. A youth may only be deviated to LOC-A 8 with a reason of resource limitations if medication management cannot be provided because of those resource limitations and the youth does not have Medicaid.

When deviating to LOC-A 8 for resource limitations, the clinician must provide a referral for the medication management and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

Reasons for Deviation to a More Intensive LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from the LOC-R and must be documented in the clinical record and medical necessity signed by an LPHA:

- Upon initial assessment, the youth has an LOC-R 1 and based on clinical judgment of underlying treatment needs, the clinician determines core services available in a more intensive LOC are indicated (e.g., identified need for transition age youth skills training). This treatment need should be reflected on the UA; or
- Upon reassessment, the youth has an LOC-R 1 but has not completed a course of treatment being delivered in a more intensive LOC. The clinician may deviate to ensure completion of recommended course of treatment; or
- The youth has an LOC-R 1 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the youth should be authorized to a more intensive LOC.
- The youth has an LOC-R 1 where a core service that the caregiver has identified as a treatment need is not available. If after reviewing the UA with the caregiver, the clinician determines that the service is clinically indicated, the youth may be deviated to a more intensive LOC. The clinician must ensure that the UA reflects this treatment need.

LOC-R 2 (LOC-2: Targeted Services)

Reasons for Deviation to a Less Intensive LOC-A

The following are clinical reasons that may indicate a deviation from LOC-R 2 to LOC-A 1

Clinical Need
The following reasons justify clinical need for deviation and must be documented in the clinical record and medical necessity signed by an LPHA:

- A core service is required in this LOC, but is contra-indicated for this youth based on the clinician's assessment of underlying treatment needs; or
- A core service is required in this LOC, but the service is not appropriate for the youth at this time due to cognitive deficits; or
- A core service is required in this LOC, but the youth is receiving that service from another mental health provider in the community; or
- A core service is required in this LOC; but the youth has already completed this course of treatment, the treatment was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR); or
- A core service is required in this LOC; but the youth has completed this course of treatment, the treatment was provided to fidelity, *and* negative clinical outcome were observed and attributed to the treatment. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR)

NOTE: The clinician may consider authorizing a different course of treatment (skills training or counseling) that can meet the clinical needs of the youth without deviating to different LOC.

Continuity of Care
The following are reasons that justify deviation to LOC-1 for continuity of care and must be documented in the clinical record:

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (i.e. summer vacation) and provider plans to leave the youth open to services.

Consumer Refused
The following are reasons that may indicate a deviation from the LOC-R 2 and must be documented in the clinical record:

- The youth and/or caregiver refuse a core service (counseling or skills training), but do not refuse services available in LOC-1. If after attempts at engagement in the LOC-R, the youth and/or caregiver/LAR continue to refuse the core service in the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the youth is *new* to services and the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services, the child should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the child should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged and participate in all clinically indicated core

services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations
If a youth has Medicaid he/she may not be deviated from LOC-R 2 to LOC-A 1 for resource limitations, because the core services of Counseling and Skills Training are not available in LOC-1. A youth without Medicaid may only be deviated to LOC-A 1 with a reason of resource limitations if counseling and skills training cannot be provided because of those resource limitations.

When deviating to LOC-A 1 for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

NOTE: If a core service cannot be provided due to resource limitations, the youth may remain in LOC-2 and be placed on a waitlist for the core service until the service becomes available.

Reasons for Deviation to a More Intensive LOC-A

The following are clinical reasons that may indicate a deviation from LOC-R 2 to LOC-A 3 or 4:

Clinical Need
The following reasons justify clinical need for deviation and must be documented in the clinical record and medical necessity signed by an LPHA:

- Youth has an LOC-R 2 where counseling and skills training are not available concurrently and the clinician determines that both services are indicated based on the assessment of underlying treatment needs (Note: This may include an identified need for transition age youth skills training while the individual is receiving counseling services); or
- Upon reassessment, the youth has an LOC-R 2 but has not completed a course of treatment that should continue to be provided concurrently; or
- The youth has an LOC-R 2, but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the youth should be authorized to a more intensive LOC;
- The youth has an LOC-R 2 where a core service that the caregiver/LAR has identified as a treatment need is not able to be provided concurrently. If after reviewing the UA with the caregiver/LAR, the clinician determines that delivery of both services is clinically indicated, the youth may be deviated to a more intensive LOC. The clinician must ensure that the UA reflects this treatment need; or
- The youth has a clinical need for Wraparound process planning (e.g., youth has several severe needs in areas of life domain functioning that place him/her at risk for displacement from his/her community).

Reason for Deviation to LOC-A Young Child

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need
A child's developmental needs may indicate deviation to the LOC-YC in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older, he/she may not be deviated into LOC-YC.

LOC-R 3 (LOC-3: Complex Services)

Reasons for Deviation to a Less Intensive LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 3 and must be documented in the clinical record and medical necessity signed by an LPHA:

- The clinician determines that counseling and skills training services should not be provided to the youth concurrently. The youth may be deviated down from LOC-R 3 to LOC-A 2; or
- A core service is required in LOC-3, but is contra-indicated for this youth based on the clinician's assessment of underlying treatment needs. The remaining recommended services must be available in the LOC-A; or
- A core service is required in this LOC, but the service is not appropriate for the youth at this time due to cognitive deficits. The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3, but the youth has already completed this course of treatment, the treatment was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR). The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3 but the youth has completed this course of treatment, the treatment was provided to fidelity, *and* negative clinical outcome were observed and attributed to the treatment. (This indicates a review of the treatment plan with participation of the youth and caregiver/LAR.) The remaining recommended services must be available in the LOC-A; or
- A core service is required in LOC-3, but the youth is receiving that service from another mental health provider in the community. The remaining recommended services must be available in the LOC-A

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record:

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave the youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from the LOC-R 3 and must be documented in the clinical record:

- The youth and/or caregiver/LAR refuse a core service (counseling and/or skills training). If after attempts at engagement in the LOC-R, the youth and/or caregiver/LAR continue to refuse the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the youth is *new* to services and the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the caregiver/LAR and engagement should be provided. the LAR continues to refuse *all* services, the youth should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment the youth and/or caregiver/LAR refuse *all* services, the UA should be been reviewed with the caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the youth should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

If a youth has Medicaid, he/she may not be deviated from LOC-R 3 to LOC-A 1 for resource limitations, because the core services of Counseling and Skills Training are not available in LOC-1. A youth without Medicaid may only be deviated to LOC-A 1 with a reason of resource limitations if counseling and skills training cannot be provided because of those resource limitations.

When deviating to a less intensive LOC-A for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

NOTE: If a core service cannot be provided due to resource limitations, the youth may remain in LOC-3 and be placed on a waitlist for the core service until the service becomes available.

Reasons for Deviation to a More Intensive LOC-A (4: Intensive Family Services)

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 3 and must be documented in the clinical record and medical necessity signed by an LPHA:

- Youth has a clinical need for Wraparound process planning. Clinical need may be indicated by the following (Note: This is not an exhaustive list):
  - The youth has several severe needs in areas of life domain functioning that place him/her at risk for displacement from his/her community; or
  - The youth is currently participating in the Wraparound process and for completion of the Wraparound process, should remain in LOC-4; or
  - The youth has an LOC-R 3 but in order to ensure that clinical improvements from services in a higher LOC –including hospitalization or residential placement– are maintained, the youth should be authorized to LOC-4 where he/she can receive Wraparound.

Reason for Deviation to LOC-A Young Child

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need

A child's developmental needs may indicate deviation to the young child level of care (LOC-YC) in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older, he/she may not be deviated into LOC-YC.

LOC-R 4 (LOC-4: Intensive Family Services)

Reasons for Deviation to a Less Intensive LOC-A

Clinical Need

The following are clinical reasons that may indicate a deviation from LOC-R 4 and must be documented in the clinical record and medical necessity signed by an LPHA:

- The youth has an LOC-R 4, but the clinician determines that Wraparound process planning is not clinically indicated; or
- The youth is receiving Wraparound process planning from another child-serving agency in the community and the Wraparound facilitator is under the supervision of the other child-serving agency. (Note: Clinicians should be prepared to participate as a Wraparound team member if requested by the family); or
- Wraparound process planning is required in LOC-4, but the youth and caregiver has completed the Wraparound process, it was provided to fidelity, *and* no positive clinical outcomes were observed. (This indicates a review of the treatment plan and Wraparound process plan with participation of the youth and caregiver);or
- Wraparound process planning is required in LOC-4, but the youth has completed the Wraparound process, it was provided to fidelity, *and* negative clinical outcomes were observed and attributed to participation in the Wraparound process. (This indicates a review of the treatment plan and Wraparound process plan with participation of the youth and caregiver).

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record.

- The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
- The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
- The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave the youth open to services.

Consumer Refused

The following are reasons that may indicate a deviation from LOC-R 4 and must be documented in the clinical record:

- The youth and/or caregiver/LAR refuse Wraparound process planning. If after attempts at engagement in the LOC-R, the youth and/or caregiver/LAR continue to refuse the LOC-R, deviation from the LOC-R may occur. The remaining clinically indicated core services must be available in the LOC-A; or
- If the youth is *new* to services and the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the youth and caregiver/LAR and engagement should be provided. If the caregiver/LAR continues to refuse *all* services, the youth should be deviated to LOC-A 6 (Refused All Services); or
- If the youth is *currently enrolled* in services and upon reassessment the youth and/or caregiver/LAR refuse *all* services, the UA should be reviewed with the youth and caregiver/LAR and engagement should be provided. If the LAR continues to refuse *all* services the youth should be discharged from services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

If a youth has Medicaid, he/she may *not* be deviated from LOC-R 4 for resource limitations, because the core service of Wraparound process planning is not available in a less intensive LOC. A youth without Medicaid should be deviated to the next most appropriate LOC where resources are available. All efforts should be made to provide an LOC higher than LOC-A 1 when a youth has an LOC-R 4.

When deviating to a less intensive LOC-A for resource limitations, the clinician must provide a referral for the core service that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

NOTE: If a core service (i.e. counseling, skills training, or Wraparound) cannot be provided due to resource limitations, the youth may remain in LOC-4 and be placed on a waitlist for the core service until the service becomes available.

Reason for Deviation to LOC-A Young Child

Note: To be authorized into LOC-YC the 3-5 CANS must be completed.

Clinical Need

A child's developmental needs may indicate deviation to the LOC-YC in order to ensure the child receives developmentally appropriate services. This deviation must be documented in the clinical record and medical necessity signed by an LPHA.

NOTE: If a child is age 7 years or older, he/she may not be deviated into LOC-YC.

LOC-5: Transition Services

A youth may only be authorized to LOC-5 following authorization into LOC-0, a crisis episode, discharge from psychiatric hospitalization stabilization or residential treatment setting. After the end of the authorization period for LOC-5, the youth should be reassessed to determine further eligibility and the most appropriate LOC for continuation of services.

If a youth who is currently enrolled in an LOC other than LOC-0 experiences a psychiatric crisis, crisis services may be delivered within the current LOC assignment.

Clinical Need

The following are clinical reasons that may indicate a deviation to LOC-A 5 and must be documented in the clinical record and medical necessity signed by an LPHA:

- If the youth has an LOC-R 9 but the clinician determines that short term services are clinically indicated; or
- If the youth has an LOC-R 1, 2, 3, 4, or YC, but he/she and/or their LAR has selected another provider in the community but needs short term transitional services LOC-5.

Continuity of Care

The following are reasons that may justify deviation to a less intensive LOC for continuity of care and must be documented in the clinical record.

- If the youth has an LOC-R 9 but has been discharged from a psychiatric hospital or residential treatment setting and requires transitional support.

Consumer Refused

The following are reasons that may indicate a deviation to LOC-A 5 and must be documented in the clinical record:

- If the youth has an LOC 1, 2, 3, 4, or YC, and he/she and/or LAR refuses the LOC-R but agrees to begin short term services in LOC 5.
- If the youth is enrolled in LOC 1, 2, 3, 4, or YC, but he/she or their LAR has refused to continue enrollment in the LOC-R but agrees to continue short term services in LOC-5. LOC-5 may be authorized for purposes of engagement in continuing services.

NOTE: Core Services in the LOC-R are determined to be essential to resilience and recovery. The youth and/or caregiver/LAR should continue to be engaged to participate in all clinically indicated core services at the LOC-R, regardless of the LOC-A. All attempts at engagement must be documented in the clinical record.

Resource Limitations

The following are reasons that may indicate a deviation to LOC-5 for resource limitations and must be documented in the clinical record:

- If the youth has an LOC-R 1, 2, 3, 4, or YC, but there is not capacity in the LOC-R; or
- If the youth is being discharged from ongoing services due to resource limitations and short term services are indicated to assist with the transition.

NOTE: If a youth has Medicaid, he/she may *not* be deviated to LOC-5 from LOC-R 4 for resource limitations as Wraparound process planning is not available in LOC-5.

When deviating to a less intensive LOC-A 5 for resource limitations, the clinician must provide a referral for core services that are indicated in the LOC-R that cannot be provided and document the following information in the clinical record:

- Name and contact information of the person or agency to which the youth was referred (Note: it is recommended that clinicians assist in scheduling the appointment, whenever possible).
- The date the referral was made.
- The disposition (i.e., whether the youth attended the initial appointment).

Deviation to LOC-YES: Youth Empowerment Services

Every youth enrolled in YES Waiver must be authorized into LOC-YES regardless of his/her LOC-R. The Uniform Assessment will not result in an LOC-R YES and youth must be deviated to LOC-A YES.

A youth may only be authorized to LOC-YES if his/her Clinical Eligibility Determination is authorized by DSHS for enrollment into the YES Waiver.

NOTE: Until the Service Request /Authorization Form (SRF) includes LOC-YES, LMHAs should indicate LOC-4 as the LOC-R and provider requested LOC for youth enrolled in YES Waiver on the Service Request /Authorization Form (SRF). Managed Care Organizations (MCOs) have been instructed to approve LOC-4 for youth enrolled in YES Waiver.

All complaints/inquiries regarding this guidance should be routed to the Health Plan Management (HPM) Complaints box for tracking and trending.

Clinical Need

The following are clinical reasons that may indicate a deviation to LOC-A YES:

- If the youth has an LOC-R of any LOC and is to be or continues to be enrolled in YES Waiver.

Continuity of Care

The following are reasons that may justify deviation to LOC-YES for continuity of care:

- If the youth has an LOC-R of any LOC and is to be or continues to be enrolled in YES Waiver.

LOC-R 9: Ineligible

A youth may only be deviated from LOC-R 9 if he/she has not received an LOC-R 9 for more than two consecutive authorizations.

Reasons for Deviation to an LOC-A where services may be provided

Clinical Need

The following are clinical reasons that may indicate a deviation from the LOC-R 9 and must be documented in the clinical record and medical necessity signed by an LPHA;

- Upon initial assessment, the youth has an LOC-R 9 and based on clinical judgment of underlying mental health needs, the clinician determines core mental health services available in full LOC are indicated. This treatment need should be reflected on the UA; or
- Upon reassessment, the youth has an LOC-R 9 but has not completed a course of treatment being delivered in an LOC where services have been provided. The clinician may deviate to ensure completion of recommended course of treatment; or
- The youth has an LOC-R 9 but in order to ensure that clinical improvements are maintained, should be authorized to an LOC where services may be provided.

Continuity of Care

The following are reasons that may justify deviation to an LOC where services may be provided for continuity of care and must be documented in the clinical record.

- If upon initial assessment the youth has an LOC-R 9 but has been recently discharged from a psychiatric hospital or residential treatment setting and requires transitional support in LOC-5.
- If upon reassessment, the youth has an LOC-R 9 and continues to have a clinical need for mental health services but has any of the following circumstances
    - The youth is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility; or
    - The youth is hospitalized and provider communicates with the youth and/or caregiver/LAR and hospital staff regarding care and transition to the community; or
    - The youth is living out of the service area for a planned and defined period of time (e.g., summer vacation) and provider plans to leave youth open to services.

Deviation Reasons and Deviation Grid Table

	Allowable Deviations to LOC-A and Reasons for Deviation (provided the parameters outlined above have been met)				
LOC-R	Clinical Need	Continuity of Care	Consumer Refused	Resource Limitations	Other
0	Not allowable	Not allowable	Not allowable	Not allowable	Not allowable
1	0, 2, 3, 4, YES or YC (must complete 3-5 CANS)	Youth should be engaged in LOC-A 1, or YES	5 or 6	5 or 8 (unless Medicaid eligible, then reason not allowable)	Requires justification in notes section of UA.
2	0, 1 (requires justification in notes section of UA), 3, 4, YES, or YC (must complete 3-5 CANS) or 5	1 (requires justification), YES or 5	1, 5, or 6	1, 5, or 8 (unless Medicaid eligible, then only 5 if after crisis)	Requires justification in notes section of UA.
3	0, 1 & 2 (requires justification in notes section of UA), 4, YES or YC (must complete 3-5 CANS) or 5	1 (requires justification), YES, or 5	1, 2, 5 or 6	1, 2, 5, or 8 (unless Medicaid eligible, then only 2 or 5 if after crisis)	Requires justification in notes section of UA.
4	0, 2 & 3 (requires justification in notes section of UA), YES or YC(must complete 3-5 CANS), or 5	1 (requires justification)YES, or 5	1, 2, 3, 5, or 6	1, 2, 3, 5, or 8 (unless Medicaid eligible, then reason is not allowable)	Requires justification in notes section of UA.
YC	1 (requires justification in notes section of UA) YES (must complete 6-17 CANS) or 5	1 (requires justification) or YES	1 or 6	1 or 5 (unless Medicaid eligible then only 5 if after crisis)	Requires justification in notes section of UA.
9	0, 1, 2, 3, 4, YC, or 5 (deviation not allowable for more than two consecutive authorizations)	0, 1, 2, 3, 4, YC, or 5 (deviation not allowable for more than two consecutive authorizations)	Not applicable	Not applicable	Not applicable

Appendix H: Provider Qualifications: Standard Requirements for Services

In accordance with TAC §412.316, a*ll staff must demonstrate required competencies before providing services to youth, and periodically throughout the staff's tenure of employment or association with the LMHA, MMCO, or provider.*

The following chart details the minimum qualifications required to deliver each service:

Service	Minimum Qualification
Counseling	LPHA or LPHA Intern
Crisis Follow-up and Relapse Prevention	QMHP-CS
Crisis Intervention Services	QMHP-CS
Family Case Management	Certified Family Partner or Family Partner pursuing certification QMHP-CS CSSP
Family Partner Supports	Certified Family Partner or Family Partner pursuing certification
Family Training	Certified Family Partner or Family Partner pursuing certification QMHP-CS CSSP
Intensive Case Management	QMHP-CS CSSP
Medication Training and Support	QMHP-CS CSSP Certified Family Partner
Parent Support Group	Certified Family Partner or Family Partner pursuing certification QMHP-CS
Pharmacological Management	MD RN PA Pharmacy D APN LVN
Psychiatric Diagnostic Interview Examination	MD
Psychological Diagnostic Interview Examination	LPHA
Recovery Plan	QMHP-CS LPHA PA
Routine Case Management	QMHP-CS CSSP
Safety Monitoring	QMHP-CS Trained and Competent Paraprofessional
Skills Training and Development	QMHP-CS CSSP Certified Family Partner

In accordance with TAC §412.303, MH Community Services Standards:

The minimum qualifications are defined as:

- **CSSP or Community Services Specialist** ~ A staff member who, as of August 31, 2004 received:
  - a high school diploma; or
  - a high school equivalency certificate issued in accordance with the law of the issuing state;
  - had three continuous years of documented full-time experience in the provision of mental health rehabilitative services or case management services; and
  - demonstrated competency in the provision and documentation of mental health rehabilitative or case management services in accordance with Chapter 419, Subchapter L of this title (relating to Mental Health Rehabilitative Services) and Chapter 412, Subchapter I of this title (relating to Mental Health Case Management Services).

- **Family Partner** ~ An experienced, trained primary caregiver (i.e., parent or LAR of an individual with adverse mental health symptoms or serious emotional disturbance) who provides peer mentoring, education, and support to the caregivers of a youth who is receiving mental health community services. In addition to the TAC definition, Family Partner qualifications include:
  - Must be a parent or legally authorized representative (LAR) with a minimum of one year of lived experience being responsible for making the final decisions for a youth (person 17 years or under) who has been diagnosed with a mental, emotional or behavioral disorder.
  - Must be at least 18 years or older and must have a high school diploma or GED.
  - Has at least one year of lived experience raising a youth with an emotional or mental health issues as a parent or LAR;
  - Has at least one year of experience navigating a child-serving system (e.g., mental health, juvenile justice, social security, or special education) as a parent or LAR; and
  - Has successfully completed the certified family partner (CFP) training and passed the certification examination recognized by the department within one year of date of hire.

- **LPHA** or licensed practitioner of the healing arts ~ A staff member who is a:
  - **Physician** ~ licensed as a physician by the Texas Medical Board in accordance with Texas Occupations Code, Chapter 155; or authorized to perform medical acts under an institutional permit at a Texas postgraduate training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or the Texas Medical Board;
  - **Licensed Professional Counselor (LPC)** ~ a licensed professional counselor by the Texas State Board of Examiners of Professional Counselors in accordance with Texas Occupations Code, Chapter 503;
  - **Licensed Clinical Social Worker (LCSW)** ~ a licensed as a clinical social worker by the Texas State Board of Social Worker Examiners in accordance with the Texas Occupations Code, Chapter 505;
  - **Licensed Psychologist** ~ licensed as a psychologist by the Texas State Board of Examiners of Psychologists in accordance with Texas Occupations Code, Chapter 501;
  - **Advanced Practice Nurse (APN)** ~ a registered nurse approved by the Texas Board of Nursing as a clinical nurse specialist in psychiatric/mental health or nurse practitioner in psychiatric/mental health, in accordance with Texas Occupations Code, Chapter 301; or
  - **Licensed marriage and family therapist (LMFT)** ~ a licensed marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists in accordance with Texas Occupations Code, Chapter 502.

- **LVN or Licensed Vocational Nurse** ~ A staff member who is licensed as a licensed vocational nurse by the Texas Board of Nursing in accordance with Texas Occupations Code, Chapter 301.

- **Pharmacy D** ~ "Class D pharmacy license" or "clinic pharmacy license" means a license described by Section 560.051, authorizes a pharmacy to dispense a limited type of drug or device under a prescription drug order.

- **Physician Assistant ~** A staff member who is licensed as a physician assistant by the Texas State Board of Physician Assistant Examiners in accordance with Texas Occupations Code, Chapter 204.

- **QMHP-CS or qualified mental health professional-community services** ~ A staff member who is credentialed as a QMHP-CS who has demonstrated and documented competency in the work to be performed and:
    - has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major (as determined by the LMHA or MCO in accordance with §412.316(d) of this title [relating to Competency and Credentialing]) in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
    - is a **Registered nurse (RN)** ~ licensed as a registered nurse by the Texas Board of Nursing in accordance with Texas Occupations Code, Chapter 301; or
    - completes an alternative credentialing process identified by the department.

Appendix I: Definitions

Adjunct Services: Clinically indicated services that are customized and may be delivered to support the recovery of the individual. Adjunct Services are identified by the Uniform Assessment and must be addressed in the treatment plan.

Children's Crisis Residential: Twenty-four hour, usually short-term residential services provided to an individual demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting. This service may use crisis beds in a residential treatment center or crisis respite beds.

Cognitive Behavioral Therapy (CBT): CBT is the selected counseling modality for individuals ages 7 to 17, and Parent Child Psychotherapy is the selected counseling modality for ages 3 to 7. TF-CBT and Family Therapy are allowed for ages 3 to17 when clinically indicated. [Note: Appendix C of these UM Guidelines provides a description of counseling modalities and guidance on treatment modality selection.]

Core Services: The services in a level of care that are essential and are expected to be delivered to all persons to support recovery. Core Services are identified by the Uniform Assessment and must be addressed in the treatment plan.

Counseling: Individual, family, and group therapy focused on the reduction or elimination of a youth's symptoms of emotional disturbance and increasing the youth's ability to perform activities of daily living. The following counseling modalities are allowed in LOCs 2, 3, and 4: Cognitive Behavior Therapy (CBT), Trauma-Focused Cognitive Behavior Therapy (TF-CBT), and Family Therapy. TF-CBT is the approved counseling treatment model for children/youth with trauma disorders or children/youth whose functioning or behavior is affected by their history of traumatic events. For LOC-YC, Parent -Child Psychotherapy (Dyad Therapy), Parent Child Interaction Therapy (PCIT), and Play Therapy are the allowed counseling modalities. All counseling services shall be provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of his or her own license or by an individual with a master's degree in a human services field pursuing licensure under the direct supervision of an LPHA, if not billed to Medicaid.

Certified Family Partner (CFP): A person who has real life experience parenting a child with mental, emotional or behavioral health disorders and can articulate the understanding of their real life experience with another parent or family member. This LAR may be a birth parent, adoptive parent, foster parent or family member standing in for an absent parent. He/she also must be able to complete the DSHS approved certification process within one year of date of hire.

Crisis Flexible Benefits: Non-clinical supports that reduce the crisis situation, reduce symptomatology, and enhance the ability of the youth to remain in the home. Examples in children's mental health services include home safety modifications, child care to allow the family to participate in treatment activities, and transportation assistance.

Crisis Follow-up & Relapse Prevention: A service provided to or on behalf of individuals who are not in imminent danger of harm to self or others, but require additional assistance to avoid recurrence of the crisis event. The service is provided to attain stability and prevent future crisis events.

Crisis Intervention Services: Interventions in response to a crisis in order to reduce severe mental health symptoms or emotional disturbance, and to prevent admission of a youth to a more restrictive environment.

Crisis Transportation: Transporting individuals receiving crisis services or Crisis Follow-up and Relapse Prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel, or, when appropriate, by ambulance or qualified staff.

Emergency Room Services (Psychiatric): Emergency department visit for the evaluation and management of a youth, which requires three key components: An expanded problem-focused history, an expanded problem-focused examination, and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the youth's and/or family's needs.

Engagement Activities: Short-term planned activities with the youth and caregiver to develop treatment alliance and rapport. Activities include, but are not limited to: enhancing the youth and/or caregiver's motivation to participate in services, explaining recommended services, and providing education regarding value of services. Adherence to the recommended LOC and its importance in recovery are also explained. This service should not be provided in a group, and should be provided in accordance with confidentiality requirements.

Extended Observation: Up to 48-hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically-supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher level of care when needed.

Family Case Management: Activities to assist the client's family members in accessing and coordinating necessary care and services appropriate to the family members' needs.

Family Partner Supports: Peer mentoring and support provided by Certified Family Partners (or Family Partner pursuing certification) to the primary caregivers of a youth who is receiving mental health community services. This may include introducing the family to the treatment process, modeling self-advocacy skills, providing information, making referrals, providing non-clinical skills training, and assisting in the identification of natural/non-traditional and community supports.

Family Partner: Parent or LAR of a youth with adverse mental health symptoms or serious emotional disturbance and has at least one year of experience navigating a child-serving system (e.g., mental health, juvenile justice, social security, special education) as the LAR to that youth. Family Partners document the provision of all family partner supports, including both face-to-face and non-face-to-face activities.

Family Training: Provided to the youth's primary caregivers to assist the caregivers in coping and managing the youth's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training. Concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.

Flexible Community Supports: Non-clinical supports that assist the youth with community integration, reducing symptomatology, and maintaining quality of life. Flexible community supports include, but are not limited to: transportation services, educational training (e.g., computer skills, budgeting, etc.), temporary child care, job development and placement activities, and independent living support.

Flexible Funds: Funds utilized for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration. Community supports that may be purchased through flexible funds (FF) include, but are not limited to: tutors, family aides, specialized camps, therapeutic child-oriented activities, temporary child care, temporary kinship care, initial job development and placement activities, initial independent living support, transportation services, short-term counseling for family members who do not meet the child or adult priority population definitions.

Inpatient Hospital Services: Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provide intensive interventions designed to

relieve acute psychiatric symptomatology and restore the youth's ability to function in a less restrictive setting.

Intensive Case Management: Activities to assist a youth and his/her caregiver to obtain access to necessary care and services appropriate to the youth's needs. The Wraparound planning process is utilized to deliver intensive case management.

Level of Care (LOC): The Texas Resilience and Recovery service delivery model is comprised of a continuum of levels of care that reflect youths' and families' needs and strengths. Levels of care are based on an intensity of services model.

Medication Training and Support: Education and guidance about medications and their possible side effects provided to youth and caregiver(s) (TAC §416.8). Education materials are available at http://www.dshs.state.tx.us/mhsa/patient-family-ed/.

Parent Support Group: Routinely scheduled support and informational meetings for the youth's primary caregiver(s).

Pharmacological Management: A service provided by a physician or other prescribing professional who focuses on the use of medication and the in-depth management of psychopharmacological agents to treat adverse mental health symptoms.

Psychiatric Diagnostic Interview Examination: A face-to-face interview with the youth and family to evaluate the youth's psychiatric diagnosis and treatment needs provided by a licensed professional practicing within the scope of his/her license.

Respite Services: Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at a temporary residential placement outside the client's usual living situation. Community-based respite services are provided by respite staff at the client's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.

Residential Treatment Center (RTC): An RTC is a non-hospital facility where mental health services are delivered in a safe therapeutic environment with 24-hour supervision to youth with a serious emotional disturbance. Services include individual, group, and family therapy; recreation therapy; psychiatric consultations; and medication management. Staff providing 24-hour supervision assist youth to de-escalate from stressful situations and learn healthy social skills. Some RTCs also provide adjunct therapies, such as music, dance/movement, and art therapy. RTCs contracted with DSHS are licensed as General Residential Operations (GROs) by the Department of Family and Protective Services (DFPS).

Routine Case Management: Primarily site-based services that assist a youth or caregiver in gaining and coordinating access to necessary care and services appropriate to the youth's needs.

Safety Monitoring: Ongoing observation of a youth to ensure the youth's safety. An appropriate staff person shall be continuously present in the youth's immediate vicinity, provide ongoing monitoring of the youth's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.

Skills Training and Development: Training provided to a youth and the primary caregiver that addresses the serious emotional disturbance and symptom-related problems that interfere with the youth's functioning, provides opportunities for the youth to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the youth's community integration and increases his or her community tenure. This service includes treatment planning to facilitate resiliency.

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