Behavioral Health Services Guide

A Resource for Juvenile Probation Officers and Other Youth Service Professionals

Developed by

The Behavioral Health Subcommittee
of
The PA Council of Chief Juvenile Probation Officers

January 2025

PCCJPO Behavioral Health Services Guide

Table of Contents

1. Introduction

The Behavioral Health (BH) Subcommittee of the PA Council of Chief Juvenile Probation Officers (PCCJPO) is pleased to offer this online *Behavioral Health Services Resource Guide* for juvenile probation officers and other youth service professionals. While the Subcommittee attempted to identify behavioral health information it thought would be useful, the Guide is far from a comprehensive source of behavioral health information. It is designed to provide basic information and then offer links to the websites of official and recognized agencies and organizations related to behavioral health that provide more comprehensive and detailed information. As behavioral health continues to benefit from ongoing research and development of evidence-based practices, as does juvenile justice, users of this guide are encouraged to frequently visit these websites for the most updated information. These websites include:

National Institute of Mental Health
Office of Substance Abuse and Mental Health Services Administration
Pennsylvania Office of Mental Health and Substance Abuse Services
National Alliance on Mental Illness
Mental Health Association in Pennsylvania
National Youth Screening and Assessment Project
National Center for Mental Health and Juvenile Justice
Pennsylvania State University EPISCenter
Other Behavioral Health and Juvenile Justice-related agencies and organizations

It is essential for juvenile probation officers to engage with their respective county Mental Health/Developmental Services (MH/DS) offices as processes, practices and resources can vary from county-to-county. Again, this Guide is designed to provide basic information. County MH/DS offices can provide more detailed information and explanations on requirements and processes to access behavioral health services for youth involved with the juvenile justice system.

Finally, but very importantly, the PCCJPO BH Subcommittee is comprised of representatives from the behavioral health and juvenile justice systems and recognizes that cross-system collaboration and cooperation is crucial to effectively access and deliver the services and interventions that may be required for youth and their families through both the behavioral health and juvenile justice systems. Professionals of all youth serving systems are encouraged to identify and participate in local structures that promote and permit cross-systems collaboration and planning. Planning structures/processes for behavioral health and related systems include Child and Adolescent Social Service Program (CASSP), Systems of Care and High-Fidelity Wraparound.. Links to their websites are provided. Wherever possible, juvenile probation and other juvenile justice professionals are encouraged to participate in these structures and processes for individual cases, but also to promote better cross system understanding and collaborative development.

Special Acknowledgement

The PA Council of Chief Juvenile Probation Officers' Behavioral Health Subcommittee would like to acknowledge the contributions of Henry "Hank" Thielemann, past-Chair, whose vision for the need for a Behavioral Health Services Guide to better address the behavioral health needs of youth who come in contact with Pennsylvania's juvenile justice system initiated the development of this resource.

PA Council of Chief Juvenile Probation Officers Behavioral Health Subcommittee	
Name	**Agency/Organization**
Jay D. Leamy, Ph.D. - Chair	Chester County Juvenile Probation
Michelle Auer	Southwood Psychiatric Hospital
Tim Borgia	Harborcreek Youth Services
Crystal Doyle	PA Department of Human Services
Mary Gaspari	Chester County Juvenile Probation
Jeff Geibel	PA Department of Drug and Alcohol Programs
Aliyah Good	Westmoreland County Juvenile Probation
Kathy Hooven	Autism Services, Education, Resources & Training Collaborative
Megan Johnston	Cumberland-Perry CASSP Coordinator
William Keim	Juvenile Court Judges' Commission
Jackie Kreshock	PA Council of Children, Youth, & Families Services
Lucy Kitner	PA Association of County Administrators of Mental Health and Developmental Services
Nicole Miller	Lehigh County Juvenile Probation
Jim Sharp	Rehabilitation & Community Providers Association
Clark Sheehe	Blair County Juvenile Probation
Scott Talley	PA Office of Mental Health & Substance Abuse Services Bureau of Children's Behavioral Health
Alan Tezak	PA Council of Chief Juvenile Probation Officers
Jennifer Ungarino	Montogomery County Juvenile Probation
Jeanine Wartell	Montogomery County Juvenile Probation
Mike Wieland	Blair County Juvenile Probation
Kara Winchester	Chester County Juvenile Probation
Angela Tornatore Work	Juvenile Court Judges' Commission
	12/31/24

2. Mission Statements

2.1.1 The Mission of Pennsylvania's Juvenile Justice System

The philosophy of Balanced and Restorative Justice (BARJ) serves as the foundation for the Juvenile Justice System in Pennsylvania, which directly supports the purpose/mission of the juvenile justice system as stated in Pennsylvania's Juvenile Act:

> "…to provide for children committing delinquent acts programs of supervision, care and rehabilitation which provide balanced attention to the protection of the community, the imposition of accountability for offenses committed and the development of competencies to enable children to become responsible and productive members of the community."

Balanced and Restorative Justice is rooted in the following principles:

Community Protection – the citizens of Pennsylvania have a right to safe and secure communities.

Accountability – In Pennsylvania, when a crime is committed by a juvenile, an obligation to the victim and the community is incurred.

Competency Development – Juveniles who come within the jurisdiction Pennsylvania's juvenile justice system should leave the system more capable of being responsible and productive members of their communities.

Individualization – Each case referred to Pennsylvania's juvenile justice system presents unique circumstances and the response by the system must therefore be individualized and based upon an assessment of all relevant information and factors.

Please see Pennsylvania's Juvenile Act

2.1.2. Pennsylvania's Juvenile Justice System Enhancement Strategy

As a national leader in juvenile justice, Pennsylvania has an ongoing commitment to improving its balanced and restorative justice outcomes through innovation and vision, strong partnerships at both the state and local levels, and cooperation with both public and private sector service providers.

Most recently, between 2005 and 2010, the John D. and Catherine T. MacArthur Foundation selected Pennsylvania as the first state in the country to participate in its Models for Change initiative. Virtually all components of Pennsylvania's juvenile justice system were engaged, in some way, in system reform. Pennsylvania's Models for Change reform efforts focused on three targeted areas of improvement: coordinating the mental health and juvenile justice systems, improving aftercare services and supports for youth and their families, and addressing disproportionate minority contact within the juvenile justice system. Models for Change accelerated the pace of Pennsylvania's previous efforts at reform at both the state and local levels, and supported various evidence-based practices, such as the introduction of screening and assessment instruments. A number of juvenile probation departments began working toward implementing a valid and reliable risk/needs instrument, developing a case plan model to address the identified risks and needs, and providing targeted evidence-based interventions.

In June 2010, with the five-year commitment of the MacArthur Foundation drawing to a close, the Executive Committee of the Pennsylvania Council of Chief Juvenile Probation Officers and Juvenile Court Judges' Commission (JCJC) staff agreed, at their annual strategic planning meeting, that the "Juvenile Justice System Enhancement Strategy" (JJSES) was needed, both to consolidate the gains of the previous five years "under one roof ", and to develop strategies to sustain and enhance those efforts. Pennsylvania's JJSES rests on two interlinked foundations: the best empirical research available in the field of juvenile justice and a set of core beliefs about how to put this research into practice.

These beliefs assert that:

- Children should be diverted from formal court processing whenever appropriate
- Meeting the needs of victims is an important goal of the juvenile justice system
- We need to develop and maintain strong partnerships with service providers
- We can, and should, do a better job of involving families in all that we do

To these ends, a JJSES coordinator was appointed, a leadership team was created, and The Carey Group, Inc. was retained to begin developing an implementation strategy. One year later, the Center for Juvenile Justice Reform at Georgetown University selected Berks County and the Commonwealth of Pennsylvania as one of four sites in the nation to participate in its Juvenile

Justice System Improvement Project (JJSIP). The JJSIP assists states in improving outcomes for juvenile offenders by better translating knowledge on "what works" into everyday policy and practice—an approach very consistent with Pennsylvania's JJSES. Pennsylvania intends to incorporate "lessons learned" from Berks County's participation in the JJSIP into the statewide Juvenile Justice System Enhancement Strategy.

JJSES Statement of Purpose

We dedicate ourselves to working in partnership to enhance the capacity of Pennsylvania's juvenile justice system to achieve its balanced and restorative justice mission by:

- Employing evidence-based practices, with fidelity, at every stage of the juvenile justice process;
- Collecting and analyzing the data necessary to measure the results of these efforts; and, with this knowledge,
- Striving to continuously improve the quality of our decisions, services and programs.

Pennsylvania's Council of Chief Juvenile Probation Officers

2.1.3. Pennsylvania Office of Mental Health and Substance Abuse Services

Bureau of Children's Behavioral Health Services Mission and Vision:

The mission of the Bureau of Children's Behavioral Health Services is to promote the emotional well-being of children and ensure that children with emotional and behavioral challenges disorders live, learn, work and thrive in their communities. The bureau supports the objective of the Office of Mental Health and Substance Abuse Services that is specifically related to the behavioral health needs of children and adolescents: to transform the children's behavioral health system to a system that is family driven and youth guided.

Supporting priorities:

- Establish child and family teams and implementation of high-fidelity wraparound through the work of the Youth and Family Training Institute
  - Create home and community-based alternatives to residential treatment
- Partner with the Department of Education to support the development of effective school-based supports and interventions, including the Student Assistance Program and Positive Behavioral Interventions and Supports
- Develop a process for identifying and implementing evidence-based practices, promising practices and culturally relevant practices
  - Develop strategies to address the needs of transition age youth
- Create behavioral health competency to honor the strengths and address the unique individualized needs of infants and toddlers as well as children and adolescents:
    - In the child welfare system
    - In, or at risk of entering, the juvenile justice system
    - In the drug and alcohol system
    - With Fetal Alcohol Spectrum Disorder
    - Who are deaf or hard-of-hearing
    - With traumatic brain injury
    - With Autism Spectrum Disorder or other Pervasive Developmental Disorder
    - With physical disabilities
    - At risk for suicide

OMHSAS Info | Department of Human Services | Commonwealth of Pennsylvania

Pennsylvania's Mental Health Procedures Act.

3. Planning Processes/Structures

3.1.7.1. System of Care

A System of Care is a philosophical change in the way government works, emphasizing the equal inclusion of youth and families in decision-making processes as trusted partners. This philosophy is driven by the State Leadership and Management Team (SLMT) and each County Leadership Team (CLT), who are responsible and accountable for outcomes that fulfill the hopes and dreams of youth and families.

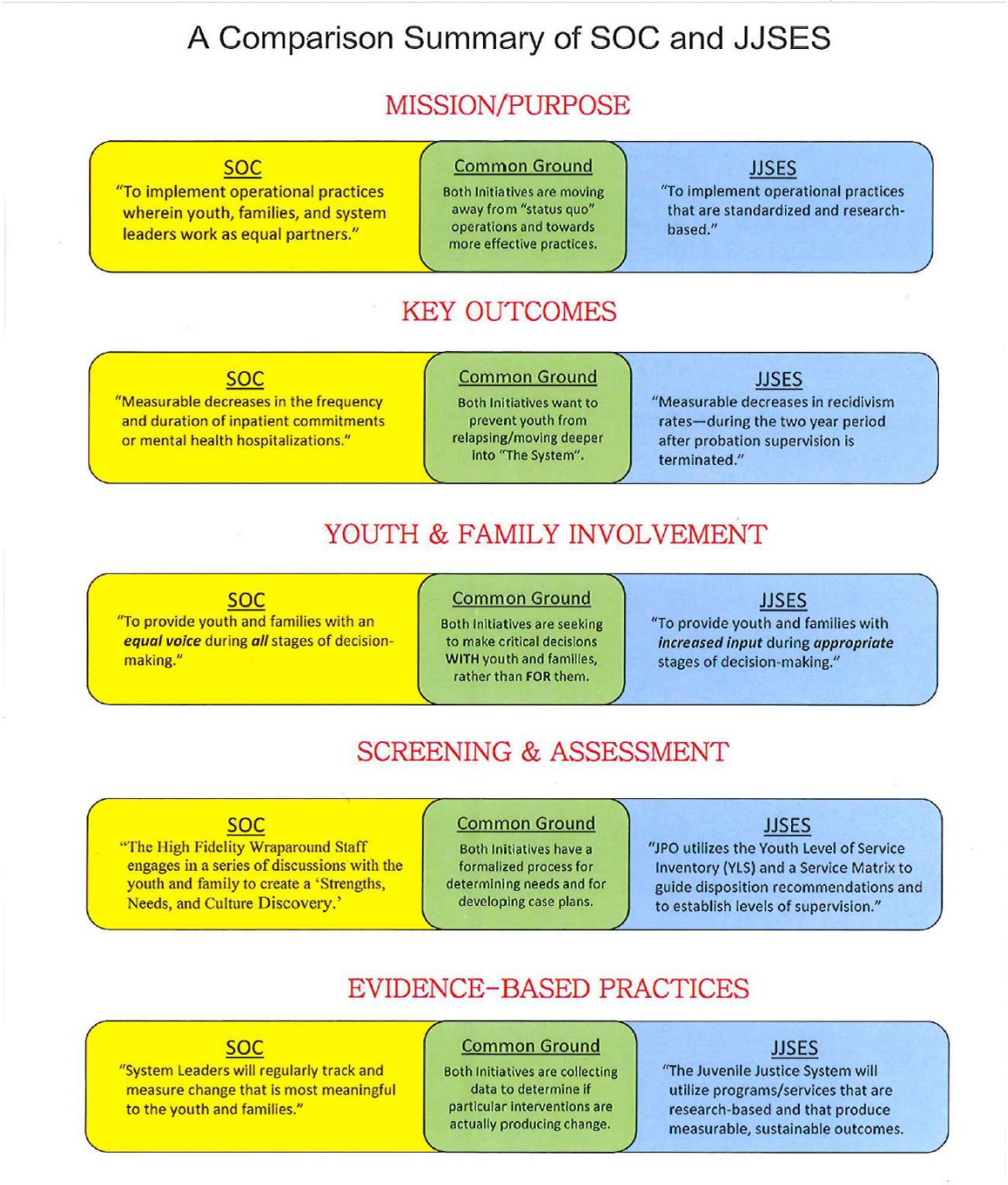
A driving force in this philosophy is the utilization of a youth and family services and supports planning process, where youth and family supports are embedded in teams to ensure youth and family voices are expressed and natural supports are identified and engaged. The system of care philosophy and practices are unique based on the function, structure, and culture of each state and county.

The PA System of Care is founded on the following core values:

1. Youth-driven
2. Family-driven
3. Home- and Community-based
4. Strength-based & Individualized Practices & Processes
5. Trauma-informed
6. Culturally and Linguistically Competent
7. Connected to Natural Helping Networks
8. Data-driven, Quality and Outcomes-Oriented
9. County Leadership Team and Governance Boards
10. Multi-System Integration
11. Youth and Family Services and Supports Planning Process

Additional Information can be found at: ABOUT US | PA Care Partnership

Below is a comparison of the PA System of Care and the PA Juvenile Justice System Enhancement Strategy which identifies the features that the two initiatives have in common.



3.1.7.2 High Fidelity Wraparound

High Fidelity Wraparound (HFW) is a youth-guided and family-driven planning process that follows a series of steps to help youth and their families realize their hopes and dreams. It is a process that allows more youth to grow up in their homes and communities. It is a planning process that brings people together (natural supports and providers) from various parts of the youth and family's life. The HFW workforce (HFW Facilitator, and if desired, a HFW Family Support Partner and HFW Youth Support Partner), helps the youth and family achieve the goals that they have identified and prioritized, with assistance from their natural supports and system providers. This is the HFW team. Regardless of the differences in the various implementer counties, High Fidelity Wraparound is driven by the same HFW Principles, and follows the same HFW Phases and basic HFW activities. High Fidelity Wraparound services are not available in every county in the Commonwealth.

Family-driven means families have a decision-making role in the care of their own children as well as in the policies and procedures governing care for all children in the community, state, and nation. This includes choosing supports, services; providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth.

Youth-guided means that youth are engaged in the idea that change is possible in his or her life. Youth feel safe, cared for, valued, useful and spiritually grounded. Youth are empowered in their planning process from the beginning and have a voice in what will work for them.

3.1.7.3. Family Involvement in Pennsylvania's Juvenile Justice System

Whenever possible, families are a critical aspect in the care, supervision and treatment of their children involved with the juvenile justice system. The importance of the role of families is clearly embedded in the foundational principles of Pennsylvania's juvenile justice system. Families' goals for their children are consistent with mission set forth in Pennsylvania's Juvenile Act which requires balance attention to community safety, accountability to victims, and development of competency of youth. Families want their children to live in **safe communities**, to be appropriately **accountable** for their conduct, and to grow and develop into **competent** individuals.

The monograph *Family Involvement in Pennsylvania's Juvenile Justice System* was developed by the Mental Health Association in Pennsylvania and the Pennsylvania Council of Chief Juvenile Probation Officers-Balanced and Restorative Justice Implementation Committee's Family Involvement Workgroup offers the following recommendations for officials at a local level to more effectively involve families in the juvenile justice process:

- Family members are treated with respect and dignity by juvenile justice system professionals.

- Families are considered important to ensuring successful outcomes for youth.
- Family members are actively sought out and their views, insights and experiences are valued and utilized.
- Information is regularly provided to families from the time of initial contact – arrest, detention, intake, hearings, disposition and placement, and is provided in a variety of means which respect the families' culture, experience, and needs.
- Family members have a single point of contact within the local juvenile justice system that they can rely on to provide open, honest and up-to-date information regarding their child.
- Information is made available to family members – such as brochures, resources, or other materials – that describes the mission, goals and expectations of the juvenile justice system.
- Families are referred to self-help resources including local and state level family peer advocacy projects.
- Professional training courses or other resources available to professional staff include information on family systems, communications skills, and family involvement
- Families are included in planning activities associated with the care and treatment of their child, and the plans address the needs of the family to support their child, as identified by the family.
- Family members are routinely included in all decisions regarding their child, all planning meetings, and ongoing monitoring. Their input is valued and reflected in the plan, and they come to the table with sufficient knowledge and skills to support their effective involvement.
- When a youth is in out-of-home placement, regular communication, visitation and transportation is provided or arranged for family members.
- Aftercare planning for a youth in placement includes a 'family plan' that is developed in partnership with the family.
- Family centered resources and programs, such as Functional Family Therapy, Multi-Systemic Therapy, or Family Group Decision Making are currently available, or plans are underway to make them available in a jurisdiction.[1]

Please see Family Involvement in Pennsylvania's Juvenile Justice System for more information.

3.1.7.4. Student Assistance Program (SAP)

The Pa Student Assistance Program (SAP) is a team process used to mobilize school resources to remove barriers to learning or success. SAP is designed to identify academic, social, attendance, substance use, mental health, and other concerns which pose a barrier to student success. The

[1] *Family Involvement in Pennsylvania's Juvenile Justice System*, Prepared for Models for Change-Pennsylvania, Mental Health Association in Pennsylvania, Pennsylvania Council of Chief Juvenile Probation Officers-Balanced and Restorative Justice Implementation Committee's Family Involvement Workgroup, John D. and Catherine T. MacArthur Foundation, 2009, p. 16.

primary goal of the SAP is to help students overcome these barriers so that they may achieve, advance, and remain in school. The core of the SAP program is to incorporate a team of professionally trained individuals that include school staff and liaisons from community drug and alcohol, mental health, or behavioral health agencies. SAP team members are trained to review incoming referrals, gather data, and make recommendations to support students. These recommendations may include supports and services offered within the school and/or the community. Community liaisons conduct a screening or an assessment to support the students needs for services within the community. The engagement of students and families throughout the SAP process is essential. The SAP team also supports the guardian in accessing any recommended services and supports. SAP teams are predominantly in the secondary schools (middle to high school) however some counties may have an elementary SAP team (known as ESAP). For further information contact the students school counselor to determine if a team exists within the school. For further information: Pennsylvania Network for Student Assistance

3.1.7.5. Accessing Mental Health Services

Mental Health (MH) services are voluntary services for children and adolescents can be accessed through private (primary) insurance. However, there are some services that will require Medical Assistance (MA) which is a federally funded insurance. Children and adolescents can be eligible for MA or Children's Health Insurance Program (CHIP). Children insurance options: Commercial (private) Insurance, Medicaid (MA) Medicaid | Department of Human Services | Commonwealth of Pennsylvania, CHIP for children under the age of 18 CHIP | Department of Human Services | Commonwealth of Pennsylvania, or PA Health Insurance Premium Payment Program (HIPP). HIPP is a cost containment program that assigns the applicant Medial Assistance (MA) who have access to medical insurance through their employment. This insurance is not enrolled with the managed care organization (MCO) but is fee for service. If you have a juvenile open with HIPP, contact your CASSP Coordinator to seek our guidance in accessing mental health services

3.1.7.6. Consent for Treatment in Pennsylvania

Act 65 of 2020 allows children ages 14 and up to consent for their own mental health treatment, which cannot be overridden by their parent/legal guardian's refusal. However, this updated law also reaffirms the fact that parents/legal guardians can consent to mental health treatment for their children, of any age, with or without the child's consent.
For further information see: Consent for Mental Health Treatment for Minors.

4. Role of the Juvenile Probation Officer

4.1.1 Role of the Juvenile Probation Officer

To understand the multi-faceted and sometimes complex role of the juvenile probation officer is important to understand their responsibilities as defined under the ***Pennsylvania Juvenile Act: 42 Pa. C.S. subsection 6301 et seq.*** Two specific section that outline their responsibilities under the law are: ***subsection 6301 Short title and purposes.*** and ***subsection 6304 Powers and Duties of Probation Officers.***

6301. Short title and purposes of chapter.

(a) Short title.--*This chapter shall be known and may be cited as the "Juvenile Act."*

(b) Purposes.--*This chapter shall be interpreted and construed as to effectuate the following purposes:*

(1) To preserve the unity of the family whenever possible or to provide another alternative permanent family when the unity of the family cannot be maintained.

(1.1) To provide for the care, protection, safety and wholesome mental and physical development of children coming within the provisions of this chapter.

(2) Consistent with the protection of the public interest, to provide for children committing delinquent acts programs of supervision, care and rehabilitation which provide balanced attention to the protection of the community, the imposition of accountability for offenses committed and the development of competencies to enable children to become responsible and productive members of the community.

(3) To achieve the foregoing purposes in a family environment whenever possible, separating the child from parents only when necessary for his welfare, safety or health or in the interests of public safety, by doing all of the following:

(i) employing evidence-based practices whenever possible and, in the case of a delinquent child, by using the least restrictive intervention that is consistent with the protection of the community, the imposition of accountability for offenses committed and the rehabilitation, supervision and treatment needs of the child; and

(ii) imposing confinement only if necessary and for the minimum amount of time that is consistent with the purposes under paragraphs (1), (1.1) and (2).

(4) To provide means through which the provisions of this chapter are executed and enforced and in which the parties are assured a fair hearing and their constitutional and other legal rights recognized and enforced.

By definition, juvenile probation officers are officers of the Juvenile Court and as such required to implement Orders issued by the Juvenile Court Judge consistent with the purpose as defined above. This requires the juvenile probation officer to consider and balance (1) the protection of the community, (2) the restoration of victims, and (3) development of competencies of the youth to enable them to become responsible and productive members of the community). The Juvenile

Court operates within the context of these principles of Balanced and Restorative Justice, while attempting to maintain the unity of the family, providing for the wholesome mental and physical development of the child, employing evidence-based practices, where ever possible, in the least restrictive environment, and protecting constitutional and legal rights.

The powers and duties of probation officers can be found under the Pennsylvania Juvenile Act: 42 Pa. C.S. subsection 6304 et seq.:

6304. Powers and duties of probation officers.

(a) General rule.--*For the purpose of carrying out the objectives and purposes of this chapter, and subject to the limitations of this chapter or imposed by the court, a probation officer shall:*

(1) Make investigations, reports, and recommendations to the court.

(2) Receive and examine complaints and charges of delinquency or dependency of a child for the purpose of considering the commencement of proceedings under this chapter.

(3) Supervise and assist a child placed on probation or in his protective supervision or care by order of the court or other authority of law.

(4) Make appropriate referrals to other private or public agencies of the community if their assistance appears to be needed or desirable.

(5) Take into custody and detain a child who is under his supervision or care as a delinquent or dependent child if the probation officer has reasonable cause to believe that the health or safety of the child is in imminent danger, or that he may abscond or be removed from the jurisdiction of the court, or when ordered by the court pursuant to this chapter or that he violated the conditions of his probation.

(6) Perform all other functions designated by this chapter or by order of the court pursuant thereto.

For youth that are referred to the Juvenile Court and may have behavioral health issues, the juvenile probation officer's role, consistent with balancing the needs of the community, victim, and youth may include, but not limited to, as follows:

- Conducting or referring for screening, assessment, and/or evaluation the youth's risk to re-offend, behavioral health needs, or other intervention or treatment needs

- Developing a case plan to recommend to the Juvenile Court to address the youth's risks and needs.

- Implementing and monitoring of the requirements of case plan and any conditions ordered by the Juvenile Court Judge.

- Coordinating and communicating with the other child–serving systems (including behavioral health), providers, and the youth's family to ensure that services are provided and the requirements of the case plan and condition of probation are fulfilled.

- Monitoring of behavioral health services and interventions for youth with behavioral health needs referred to Juvenile Court but have diverted from formal Juvenile Court processing.

- Participating in development of the behavioral health treatment plan, with the behavioral health case manager and service providers.

- Participating in the development of the discharge plan for youth in residential treatment facilities.

- Reviewing and approving home passes for youth under Juvenile Court jurisdiction in residential treatment facilities.

- Monitoring services and supervising the youth upon their release from residential treatment facilities.

A valuable resource in understanding the role of juvenile probation officers and their responsibilities to assess and balance a youth's risk to offend and mental health needs is a document published by the Technical Assistance Partnership for Child and Family Mental Health entitled, "Screening & Assessment in Juvenile Justice Systems: Identifying Mental Health Needs and Risk of Reoffending", and authored by Dr. Gina Vincent of the National Youth Screening & Assessment Project.

5. Role of the Behavioral Health Case Manager

5.1.1 Role of the Behavioral Health Case Manager

The role of the behavioral health case manager is also multi-faceted and can be complex. Not all youth may have a behavioral health case manager. Case management services are available to any consumer currently registered in the County Mental Health System. to determine if eligible please contact the youth's County Mental Health/Intellectual Disabilities (MH/ID) Offices. Contact information can be found at: County Mental Health/Intellectual Disabilities (MH/ID) Offices | Department of Human Services | Commonwealth of Pennsylvania.

The primary responsibilities of the behavioral health case manager are to:

- Supports assessment of a youth's behavioral health needs to determine appropriate services to address the needs.
- Supports the development of a detailed plan, which includes the services of mental health counselors, substance abuse programs, life skills counseling, psychiatric services, etc.
- Identify resources for a youth and his/her family to improve their functioning within the community in multiple aspects of their lives, including housing, employment, etc.
- Assists the youth and family to access physical and behavioral health care needs.
- Coordinates with other agencies and professionals, including juvenile probation to ensure that youths' needs are met.

Both the behavioral health case manager and juvenile probation officer have similar roles and responsibilities; and therefore, communication and coordination are essential. While they may have slightly a different focus the objective is the similar – to have the youth with mental health who may have Juvenile Court involvement to function in the community as a productive, law-abiding individual.

Additional information regarding the role of the behavioral health care manager can be found in a document published by the Technical Assistance Partnership for Child and Family Mental Health entitled, *"A Primer for Mental Health Practitioners Working with Youth Involved in the Juvenile Justice System"* and authored by Robert Kinscherff, Esq. of the National Center for Juvenile Justice and Mental Health at the Massachusetts School of Professional Psychology.

6. Role of the CASSP Coordinator

6.1.1 CASSP Coordinators

When CASSP began in Pennsylvania more than 20 years ago, funding was provided for each county to hire a CASSP coordinator to help develop an infrastructure for an effective children's mental health system at the county level. Over time, the roles of CASSP and children's mental health coordinators have evolved, and many of them serve a variety of functions in their counties. In general, however, the individuals in the above list understand how the children's behavioral health system works in their counties and can serve as a resource to family members, providers, and others who need assistance.

A CASSP coordinator is assigned to all 67 counties (Childrens-Behavioral-Specialists_4-3-2024.pdf) and is responsible with the facilitation of the development and coordination of quality services for children and their families within their perspective county. The CASSP coordinator takes a multidisciplinary perspective by pulling together social service departments, providers, other involved individuals, families and the child to problem solve and coordinate a best practice comprehensive plan. The CASSP coordinator takes the lead within the Child/Adolescent Mental Health system by providing advocacy, referral and information to families, schools, professional, agencies, and the community to support the connection of the most appropriate services and supports for the child and family

CASSP (Child and Adolescent Service System Program) is based on a well-defined set of principles for mental health services for children and adolescents with or at risk of developing severe emotional disorders and their families. These principles are embedded within all the children/adolescent mental health system under Medical Assistance (MA) in six core statements.

Child-centered: Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

Family-focused: The family is the primary support system for the child and it is important to help empower the family to advocate for themselves. The family participates as a full partner in all stages of the decision-making and treatment planning process including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents, other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

Community-based: Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider

agencies, but also social, religious, cultural organizations and other natural community support networks.

Multi-system: Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

Culturally competent: Culture determines our worldview and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

Least restrictive/least intrusive: Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family. See Child and Adolescent Service System Program (CASSP)

7. Managed Care Organization (MCO)

7.1.1 Health Choices Behavioral Health Program

The HealthChoices Behavioral Health Program, makes mental health and drug and alcohol services available to individuals served through Medicaid. The three goals of the program are to: 1) assure greater access to behavioral health services; 2) improve of the quality services provided; and manage costs. HealthChoices Behavioral Health Program is available in all 67 counties in the Commonwealth of Pennsylvania and ensures access to recovery-oriented services and supports for individuals served by the program.

HealthChoices Behavioral Health Program was built in partnership with county government, which is legally responsible for providing and managing mental health services under the MH Act of 1966. County government is given the "right of first opportunity" to bid on the HC-BH program to manage risk-based contracts. HC-BH unifies service development and financial resources at the local level closest to the people served. Medicaid eligible individuals enrolled in the program are automatically enrolled in the BH program in the county of their residence. A risk-based contract allows flexibility to make decisions that meet the unique needs of the county and, if savings are created, the county must reinvest the money in approved programs and supports that meet the needs of people served. The HC-BH model has lived up to its mission and fostered counties' success in controlling the growth of Medicaid spending while increasing access and improving quality.

While each MCO may function differently, they all have assigned clinical care managers when an individual is authorized for in home to out of home treatment. It can be beneficial for a juvenile probation officer to reach out to a clinical care manager when they are interested in obtaining treatment history, seeking out provider information, seeking guidance and support treatment options and coverage, etc. A clinical care manager can attend treatment team meetings to provide additional resources and supports.

The following link provides information on Behavioral HealthChoices: Behavioral HealthChoices | Department of Human Services | Commonwealth of Pennsylvania

8. Accessing Behavioral Health Services

8.1.1. Identification of Funding

Behavioral health services are often paid for by Medical Assistance. *If private insurance is available for the youth, it is normally required that payment for services be first sought through private insurance.*

In some cases, when services need to begin quickly and Medical Assistance is not immediately accessible, the county may pay for the services to begin using money in the Human Services Block Grant, Office of Children, Youth and Families (OCYF) Special Grants, or other county funds. Private insurance, Third Party Liability (TPL), requires private insurance to pay for services when it's a covered service.

8.1.2 Medical Assistance

- **Behavioral Health Managed Care Organizations**

  In Pennsylvania, each county has a contract with behavioral health managed care organizations (BH-MCOs) to manage Medical Assistance.

- **Medical Assistance Eligibility**

  In order for a youth's treatment to be paid for by Medical Assistance, he/she must first be deemed M.A.-eligible by the County Assistance Office. In Pennsylvania a

youth may be eligible for M.A. based on financial need and/or a physical or behavioral health disorder that impairs the youth's functioning.

In many cases, a youth coming to the attention of the juvenile justice system will already have Medical Assistance. If a youth does not yet have Medical Assistance, an application packet will need to be submitted to and reviewed by the County Assistance Office. If you have a youth that does not have Medical Assistance on your caseload, you can also reach out to your mental health department (CASSP Coordinator) and inquire about the various ways for a family to apply. Some counties have access to an enrollment specialist, families can download the compass application as an app, or they can go directly to the local county assistance office.

- **Interagency Service Planning Team**

  Depending on the type of service, an Interagency Service Planning Team (ISPT) meeting may be required before services can be authorized by the BH-MCO for M.A. payment. Ideally, an ISPT meeting is held before services begin, since the primary goal of the ISPT is to engage the various systems involved with the youth in collaborative and coordinated service planning.

  The ISPT should include, at minimum:

  - the youth and his/her caregivers
  - a representative of the county Mental Health system
  - representatives of the child welfare and juvenile probation system, if involved with the youth
  - a school representative
  - a representative from the BH-MCO
  - any other agencies or services involved with the youth
  - if possible, the psychologist or physician evaluating the youth

  The ISPT designates a primary case manager, develops a Plan of Care Summary, and develops an interagency service plan that includes treatment goals, services and interventions to be used, and a discharge plan

- **Authorization of Services**

  The BH-MCO must review each case and determine whether to authorize the requested services. If so, M.A. will pay for the treatment. Depending on the type of service, this determination is made before services begin, while services are in

progress, or after-the-fact. Sometimes the youth's need for services will be reviewed periodically to determine whether to continue the authorization.

The decision to authorize a service depends largely on medical necessity, which is determined through an evaluation by a psychologist or psychiatrist, as well as the recommendation of an Interagency Service Planning Team.

8.1.3 Complaint and Grievance Procedures

In the event, that there is denial for a service or dissatisfaction with a service provided through one of the Behavioral Health Managed Care Organizations (BH-MCOs) a complaint or grievance maybe filed. Each of the BH-MCOs provide information on their website of the process to be followed. Please see the following link: Behavioral Health MCOs | Department of Human Services | Commonwealth of Pennsylvania

8.1.4 County Funding

Counties vary in terms of what behavioral health services they fund, which youth are eligible, and how to access the funding. Information regarding services and funding can be obtained through the county Mental Health and Developmental Services (MH/DS) offices.

For additional information on what funding may be available for services and the process of accessing services, please contact the local county Mental Health and Developmental Services (MH/DS) office.

9. Basic Behavioral Health Terms and Definitions

9.1.1. Behavioral Health Screening

Behavioral Health screening instruments are designed to be a relatively brief process to obtain information and to "triage" the need for 1) further evaluation or 2) an immediate intervention.[2] A screening does not provide a psychiatric diagnosis and should not be used to develop a long-term plan or disposition.

[2] Grisso, T. (2005). Why we need mental health screening and assessment in juvenile justice programs. In T. Grisso, G. Vincent, D. Seagraves (eds.), Mental health screening and assessment in juvenile justice (pp.3-21). New York: Guilford Press.

Grisso and Underwood (2004) described behavioral health screening of youth involved with the juvenile justice system in the following manner:

> *"Screening typically is intended not to provide an accurate psychiatric diagnosis, but rather to distinguish a set of exceptionally troubled youth for whom some special and relatively immediate response is necessary. Examples of responses to "red flags" in juvenile justice screening might include closer monitoring by staff, assignment of a staff member to briefly inquire further about the youth's current feelings, placement on suicide watch, scheduling for a diagnostic interview and consultation with a mental health professional, or, in some cases, immediate transfer to an inpatient psychiatric facility. Identifying the need for further evaluation, however, is a more frequent purpose of screening".*[3]

In selecting an appropriate behavioral health screening instrument for use in juvenile justice settings, the following factors should be considered:

- ✓ Is the instrument scientifically valid and reliable (evidence-based)?
- ✓ Does the instrument correlate reasonably well to more sophisticated assessment/evaluation/diagnostic tools?
- ✓ Does the instrument have an ability to prioritize the need for more extensive and expensive assessment or intervention?
- ✓ Is the instrument relatively brief and easy to administer?
- ✓ Does the instrument require clinical staff to manage, administer or interpret?
- ✓ Does the instrument require minimal staff training?
- ✓ Is the instrument relatively inexpensive to use on an ongoing basis?
- ✓ Is the instrument designed in way to enable data/information to be collected to inform policy and resource decisions?
- ✓ Is the instrument accepted "across" systems and enable a common language to be established between the juvenile justice, child welfare, and mental health systems/

Some examples of behavioral health screening instruments that are used in probation intake or detention include:

- *Massachusetts Youth Screening Instrument: Second Version* (MAYSI~2: Grisso & Barum, 2006): a 52-question self-report screening instrument that measures symptoms on seven scales pertaining to emotional, behavioral, or psychological disturbance, including suicide ideation. This tool has been examined in more than 50 research studies, and it is possibly the only tool with national norms.

[3] Grisso, T. & Underwood, L.A. (2004) *Screening and Assessing Mental Health and Substance Use Disorders Among Youth and in the Juvenile Justice System: A Resource Guide for Practitioners.* US Department of Justice, Office of Justice Programs, office of Juvenile Justice and Delinquency Prevention, pg. 2.

- *Suicide Ideation Questionnaire* (SIQ; Reynolds 1988): a 25-item self-report screening instrument used to assess suicidal ideation in adolescents. It can be administered individually or in a group setting.

- *Global Appraisal of Individual Needs-Short Screener* (GAINS-SS; Dennis, Scott, Funk, & Foss, 2005): a 20-item behavioral health screening tool designed to identify adolescents in need of more detailed assessment for substance use or mental disorder. Many studies have been conducted to demonstrate that this tool accurately identifies drug and alcohol problems.

- *Voice-Diagnostic Interview Schedule for Children* (Voice-Disc; Wasserman, McReynolds, Fisher, & Lucas, 2005): a self-report computerized tool based on the DSM-IV that produces computer assisted diagnoses. This instrument can take up to 1 hour to complete, yet it is often classified as a screen because a follow-up assessment is recommended to confirm any diagnosis.[4]

9.1.2. Behavioral Health Assessment

A behavioral health assessment normally involves a more in-depth, comprehensive process and may require specially trained or credentialed staff. Again, Grisso and Underwood (2004) distinguished behavioral health assessment accordingly.

> *"In contrast, assessment is a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening, including the type and extent of mental health and substance abuse disorders, other issues associated with the disorders, and recommendations for treatment intervention.*
> *Assessments typically are more expensive than screening because they require more individualized data collection, often including psychological testing, clinical interviewing, and obtaining past records from other agencies for review by the assessor. Thus, assessment typically requires the expertise of a mental health professional. These facts mean that assessments should be used only for a subset of youth who, through screening or other means, are identified as most likely to be in need of such evaluation".* [5]

There are multiple options for instruments that may be used as part of a more comprehensive assessment. These instruments may require administration by clinically trained or credentialed

[4] Vincent, G. (2012). Juvenile Justice Resource Series. *Screening and Assessment in the Juvenile Justice Systems: Identifying Mental Health Needs and Risk of Offending.* Technical Assistance Partnership for Child and Family Mental Health, Substance Abuse and Mental Health Services Administration: U.S. Department of Health and Human Services. pgs. 4-5.
[5] Grisso, T. & Underwood, L.A. (2004) *Screening and Assessing Mental Health and Substance Use Disorders Among Youth and in the Juvenile Justice System: A Resource Guide for Practitioners.* US Department of Justice, Office of Justice Programs, office of Juvenile Justice and Delinquency Prevention. pgs. 2-3

staff and may be included as part of a psychological and/or psychiatric evaluation. The following are used in youth systems and have varying degrees of research to support their use: Below are examples of assessments that can be used and may vary based on the child, youth or young adult and/or the provider or mental health professional.

Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000): a functional assessment that rates youth on the basis of the adequacy and deficits in functioning within life domains such as home and school and with regard to potential problems areas such as substance use or self-harmful behavior. It was developed to assist in identifying those individuals with "serious emotional disturbances" for the purposes of determining service eligibility. A screening version of this assessment – the *Juvenile Inventory for Functioning* – has been created and is currently undergoing validation.

Child and Adolescent Needs and Strengths-Comprehensive (CANS-C); Lyons, Griffin, Fazio, & Lyons, 1999): the CANS has several versions. Although the content of this tool included information about a youth's mental health problems and risk, it does not measure its characteristics, but rather provided a mechanism to support consistent communication about a youth's service needs and level of functioning. It is considered a needs assessment tool that documents functioning in several domains, including substance abuse, mental health, other risk behaviors, and caregiver needs. It has some reliability evidence.

Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2001) – formerly known as the *Child Behavior Checklist*: a widely studied and used 118-item self-report form focusing on eight behavioral and problem dimensions that can be grouped into two broader types of pathology: "externalizing" (outward expression) and "internalizing" inward feelings and thoughts). It is completed by the youth, parents, or teachers.

Behavioral Assessment System for Children (BASC-2; Reynolds & Kamphaus, 2004): a self-report tool that has different versions for the adolescent, parent/guardians, and teacher. The BASC-2 has different age-appropriate versions ranging from childhood to young adulthood. It provides norm-based information about problem areas including aggression, anxiety, attention problems, conduct problems, and depression.

Practical Adolescent Dual Diagnosis Interview (PADDI: Estroff & Hoffman, 2011): a guided interview procedure that identifies suggested diagnoses related to substance abuse and mental disorders. It can be useful in mental health clinics, private practices, courts and juvenile justice facilities.[6]

[6] Vincent, G. (2012). Juvenile Justice Resource Series. *Screening and Assessment in the Juvenile Justice Systems: Identifying Mental Health Needs and Risk of Offending.* Technical Assistance Partnership for Child and Family Mental Health, Substance Abuse and Mental Health Services Administration: U.S. Department of Health and Human Services. pgs. 5-6.

Risk to Re-Offend Assessment

Behavioral health screening and assessments instruments should not be confused with juvenile justice risk assessment or risk to re-offend assessment instruments. Juvenile justice risk assessment instruments are designed to provide an indication of the level of criminogenic risk and need presented by a juvenile. Behavioral health screening and assessment instruments are not designed to predict the risk to re-offend, nor are risk to re-offend assessments able to provide mental health diagnoses. Both behavioral health assessments and risk to re-offend assessments but can be complimentary and helpful if used as part of an integrated screening and assessment protocol by juvenile probation.[7] In addition to providing information as to whether any emotional or mental health disorders exist, behavioral health screening and assessment processes can provide insight into issues that might impede the youth's responsiveness or responsivity to an intervention. *Responsivity* is a key concept, along with the principles of *Risk* and *Need*, of juvenile justice evidence-based practice. In order to reduce recidivism, a primary goal of the juvenile justice system, the *Risk-Need-Responsivity (R-N-R)* principles define *who* (Risk) should be targeted, *what* (Need) should be targeted, and *how* (Responsivity) it should be targeted. [8]

Responsivity describes the ability and motivation of a juvenile to learn and subsequently change behavior. If a youth is experiencing an emotional or mental disorder, the ability to learn and change behavior may be significantly hindered. Therefore, it would be necessary to identify and begin to treat the underlying behavioral health issues to improve the ability of the youth to respond to interventions designed to address criminogenic risks and needs.

The Youth Level of Service/Case Management Inventory (YLS/CMI) is the risk assessment instrument adopted for use by Juvenile Probation departments within Commonwealth of Pennsylvania. A brief summary description of the YLS/CMI is below.

Youth Level of Service/Case Management Inventory (YLS/CMI: Hoge & Andrews, 2006): a well-validated, comprehensive, standardized inventory for assessing risk among youth ages 12-17 involved with the juvenile court. It includes measures of static and dynamic risks that can assist with post-adjudication case planning. Created specifically for administration by probation officers, it is probably the most widely used tool by probation offices in the United States.

9.1.3. Psychological Evaluation

Psychological evaluations are written, visual, or verbal tests and assessments administered to measure the cognitive and emotional functioning of children and adults. Psychological evaluations are used to assess a variety of mental abilities and attributes, including achievement and ability, personality, and neurological functioning.

[7] Ibid, pgs. 6-7.
[8] Pennsylvania's Juvenile Justice System Enhancement Strategy: Achieving Our Balanced and Restorative Justice Mission Through Evidence-based Practice (April 2012). pg. 8.

In the juvenile justice system, psychological evaluations can be used to assist in the development and implementation of an appropriate juvenile court disposition and case plan, including treatment or interventions. Psychological evaluations are only one aspect of what may be considered in the development and implementation of a juvenile court disposition and case plan. The level of risk to re-offend and the youth's responsibility to his/her victim(s) are primary considerations in the process.

All psychological or neuropsychological evaluations should be administered, scored and interpreted by a trained professional. Professional guidelines require that whomever administers the evaluation advises the youth and parents/guardians of the intended use of the results and with whom the results will be disclosed. An informed consent may need to be signed to share the results of the evaluation with other professionals.

Psychological Evaluations can be utilized to determine if the youth meets medical necessity for in home mental health treatment. However It is impetrative to ensure that the evaluator is paneled (accepts) the youths insurance plan.

Tests and Assessments

Tests and assessments are two separate but related components of a psychological evaluation. Psychologists use both types of tools to help them arrive at a diagnosis and a treatment plan.

Testing involves the use of formal tests such as questionnaires or checklists. These are often described as "norm-referenced" tests. That simply means the tests have been standardized so that test-takers are evaluated in a similar way, no matter where they live or who administers the test. A norm-referenced test of a child's reading abilities, for example, may rank that child's ability compared to other children of similar age or grade level. Norm-referenced tests have been developed and evaluated by researchers and proven to be effective for measuring a particular trait or disorder.

A psychological assessment can include numerous components such as norm-referenced psychological tests, informal tests and surveys, interview information, school or medical records, medical evaluation and observational data. A psychologist determines what information to use based on the specific questions being asked.

For example, assessments can be used to determine if a youth has a learning disorder, is competent to stand trial or has a traumatic brain injury.

One common assessment technique, for instance, is a clinical interview. When a psychologist speaks to a youth about his/her concerns and history, they're able to observe how the youth

thinks, reasons and interacts with others. Assessments may also include interviewing other people who are close to the client, such as family members or care givers.

Together, testing and assessment allows a psychologist to see the full picture of a youth's strengths and limitations.

For more information on psychological evaluations see the American Psychological Association website.

9.1.4. Psychiatric Evaluation

Evaluation by a child and adolescent psychiatrist is appropriate for any child or adolescent with emotional and/or behavioral problems. Most children and adolescents with serious emotional and behavioral problems need a comprehensive psychiatric evaluation.

Comprehensive psychiatric evaluations usually require a few hours over one or more office visits for the child and parents. With the parents' permission or youth age 14 years or older, other significant people (such as the family physician, school personnel, or other relatives) may be contacted for additional information. This Includes input from the youth, parent/guardian, and any members of the youth's team that have pertinent information to be able to help the psychiatrist be aware of the youth across settings

The comprehensive evaluation frequently includes the following:

- Description of present problems and symptoms
- Information about health, illness and treatment (both physical and psychiatric), including current medications
- Parent and family health and psychiatric histories
- Information about the child's development
- Information about school and friends
- Information about family relationships
- Interview of the child or adolescent
- Interview of parents/guardians
- If needed, laboratory studies such as blood tests, x-rays, or special assessments (for example, psychological, educational, speech and language evaluation)

The child and adolescent psychiatrist then develops a formulation. The formulation describes the child's problems and explains them in terms that the parents and child can understand. The formulation combines biological, psychological, and social parts of the problem with developmental needs, history, and strengths of the child, adolescent, and family.

Time is made available to answer the parents' and child's questions. Parents often come to such evaluations with many concerns, including:

- Is my child normal? Am I normal? Am I to blame?
- Am I silly to worry?
- Can you help us? Can you help my child?
- What is wrong? What is the diagnosis?
- Does my child need additional assessment and/or testing (medical, psychological etc.)?
- What are your recommendations? How can the family help?
- Does my child need treatment? Do I need treatment?
- What will treatment cost, and how long will it take?

Parents are often worried about how they will be viewed during the evaluation. Child and adolescent psychiatrists are there to support families and to be a partner, not to judge or blame. They listen to concerns and help the child or adolescent and his/her family define the goals of the evaluation. Parents should always ask for explanations of words or terms they do not understand.

When a treatable problem is identified, recommendations are provided, and a specific treatment plan is developed. Child and adolescent psychiatrists are specifically trained and skilled in conducting comprehensive psychiatric evaluations with children, adolescents, and families.

For more information on psychiatric evaluations for children and adolescents see the American Academy of Child and Adolescent Psychiatry website.

Written order/Prescription

A written order or prescription can be prescribed for in home treatment such as Intensive Behavioral Health Services (IBHS) which include: IBHS (Formally known as BHRS), Multi systematic Treatment (MST), Functional Family Therapy (FFT), Family Based Mental Health (FBMH). These services can be prescribed by a physician, licensed psychologist, certified registered nurse practitioner, physician assistant, licensed social worker, licensed professional counselor, or licensed family therapist that is paneled with Medical Assistance (MA). The written order/script recommendation must be based on a face-to-face interaction with the child and be written within 12 months of the start of services. The written order must include a behavioral health disorder diagnosis listed in the most recent edition of the DSM or ICD, and include the following: A. Clinical information to support the medical necessity of the service ordered; B. Maximum number of hours of each service per month; C. Settings where services may be provided.

For more information on IBHS: CHAPTER 5240. INTENSIVE BEHAVIORAL HEALTH SERVICES

9.1.5. Life Domain Format for Psychiatric/Psychological Evaluations

Although the disciplines of psychiatry and psychology differ in training and expertise in some ways, in Pennsylvania both psychiatrists and psychologists can evaluate children, youth and young adults and make recommendations of behavioral health services based on the medical necessity of the youth. These services can range from community -based services to more intensive services to include in-patient or residential services. Since the Life Domain Format helps the evaluator obtain comprehensive information about the child that includes but goes beyond presenting behaviors and symptoms of concern, it can be used (note the 2007 revision of the Life Domain Format).

A useful evaluation cannot be part of an assembly-line process, and instead must be the considered summation of an evaluator's intense contact with a unique child and family at a critical moment in time. A useful evaluation should build on child and family strengths ,experiences, cultures and include thoughtful, individualized recommendations.

The Life Domain Format is provided in the "Guidelines for Child and Adolescent Mental Health Services" published by the Pennsylvania Department of Human Services , Office of Mental Health and Substance Abuse Services, Bureau of Children's Behavioral Health Services.

The *goals* of *the Life Domain Format for Psychiatric/Psychological Evaluations: Initial and Continued Care* are:

a) To help implement a strengths-based interview and written report that identify competencies and resources as well as needs, so that each child and adolescent can be understood biologically, psychologically, and socially (e.g., understood within various life domains), resulting in a comprehensive understanding of the child and family.
b) To identify crisis situations, and ascertain when a child requires a highly restrictive level of care such as inpatient psychiatric hospitalization or RTF.
c) To obtain core information, so that the interagency team is free to promote an envisioning of positive, future outcomes and to develop a creative treatment plan, rather than engage in a recitation of past failures.
d) To assist in recommending individualized services and natural supports consistent with CASSP Principles, which support the child's remaining in the natural family or elsewhere in the community, when possible, or the child's successful return to the community.
e) To support the inclusion of parents/caregivers and other treatment team members in a portion of the evaluation process.
f) To encourage participation by the psychiatrist or psychologist as an active member of the interagency and treatment teams, helping to achieve consensus regarding needs and services, and monitoring progress.
g) To create a comprehensive document that serves as a baseline for future evaluations, and as a source of reference for a subsequent review of the child's progress over time.

The recommended *format* guides the systematic collection of core information about a child or adolescent with a serious emotional disorder and assists the evaluator in prescribing medically necessary behavioral health services and in making relevant recommendations.

The Life Domain Format makes use of seven primary categories or sections:

I. *Identifying Information*
II. *Reason for Referral*
III. *Relevant Information*
IV. *Interview*
V. *Discussion*
VI. *Diagnosis*
VII. *Recommendations*

Please see: Life Domain Format for Psychiatric/Psychological Best Practice Evaluations: Initial and Continued Care - Providers - PerformCare

9.1.6. Outpatient Treatment

Outpatient services are provided based on the need of the youth suffering minimal to moderate distress. Services are delivered in a structured setting such as an office and/or may be school-based. Activities include: individual, group and family therapy, medication management, and psychiatric evaluations. There are different types of outpatient options- such as specialized (trauma focused, Parent-Child Interaction Therapy, etc.)

9.1.6.1. Individual Therapy

Individual therapy is a form of therapy in which the youth is treated one-on-one with a therapist. The most popular form of therapy, individual therapy may encompass many different treatment styles including psychoanalysis and cognitive behavioral therapy.

9.1.6.2. Group Therapy

Group therapy is a type of psychotherapy that involves one or more therapists working with several people at the same time. Group therapy is sometimes used alone, but it is also commonly integrated into a comprehensive treatment plan that also includes individual therapy and medication.

9.1.6.3. Family Therapy

Family therapy is a type of psychotherapy designed to identify family patterns that contribute to a behavior disorder or mental illness and help family members break those habits. Family therapy

involves discussion and problem-solving sessions with the family. Some of these sessions may be as a group, in couples, or one on one. In family therapy, the web of interpersonal relationships is examined and, ideally, communication is strengthened within the family.

9.1.6.4. Specialized Therapies

The following specialized therapies are considered evidence-based. Evidence-based programs and interventions use evidence from scientifically-based research studies to design, deliver, and evaluate the services and interventions they provide. These programs and interventions have been studied using utilizing rigorous research principles to determine their effectiveness. Other evidence-based programs may be available by checking with the local County Office of Mental Health/Developmental Services.

Specialized Therapies include a wide variety of treatments are provided by specially trained or credentialed therapists. Examples of specialized therapies include Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy (DBT).

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is considered a cognitive behavioral treatment for children who have Post-Traumatic Stress Disorder (PTSD). It was initially developed to address symptoms related to childhood sexual abuse, although it has since been adapted to treat other traumatic experiences of childhood as well. It targets maladaptive and unhealthy thoughts and behaviors that a victim of sexual abuse might experience; for example, TF-CBT may help children modify inaccurate beliefs that lead to unhealthy behaviors, such as beliefs that they are to blame for the abuse. It also identifies unhealthy patterns of behaviors (for example, acting out or isolating) or fear responses to certain stimuli and attempts to modify these by identifying healthier ways of responding to certain stimuli, or in particular situations. For further information see: Trauma-Focused Cognitive Behavior Therapy | Psychology Today

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach for individuals with both mental health diagnoses and co-occurring diagnoses. The two key characteristics are a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual. For further information see: Dialectical Behavior Therapy | Psychology Today

Contingency Management (CM) is a scientifically-based treatment approach grounded in the principles of behavior management and cognitive-behavioral therapy that provides incentives for abstaining from drug abuse. Techniques involved in this treatment include positive reinforcement for drug abstinence and negative consequences for returning to drug use, with the emphasis on positive reinforcement and the celebration of success. This celebration of success helps the family and youth remain motivated to change and provide a positive and welcoming treatment environment. This approach is very similar to Graduated Responses that are used by juvenile probation. For further information see:

9.1.7. Community-Based Services

Community-Based Services is term used to describe behavioral health services such as Intensive Behavioral Health Services (IBHS), but also includes services such as Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), or other services. The distinction is that the service in provided in the home or community

9.1.7.1 Family-Based Mental Health Services

A team delivered service rendered in the home and community that is designed to integrate mental health treatment, family support services and casework so that families may continue to care for their children and adolescents with a serious mental illness or emotional disturbance at home. The service reduces the need for psychiatric hospitalization and out-of-home placement by providing a service, which enables families to maintain their role as the primary care giver for their children and adolescents. Services are available 24 hours a day, 7 days a week. Families have a least one face-to-face contact per week for up to 32 weeks. This treatment is accessed through a prescription of an evaluation or written order. The child/adolescent must have medical assistance to access this service.

9.1.7.2. Intensive Behavioral Health Services (IBHS)

Intensive Behavioral Health Service (IBHS) are behavioral health services prescribed for children/youth with serious emotional/behavioral disorders, whose needs cannot be effectively addressed by more traditional, office-based mental health treatment. These services may be provided when the problems or difficulties of the child/youth with managing emotions/behaviors occur in the home, school or community. The services are intended to build on the child's/youth's strengths and teach skills relevant to the youth's behavioral health needs and goals.

Services may be delivered by the following mental health professionals, including a Behavior Consultant, a Mobile Therapist, and Behavioral Health Technician (BHT) :

A Behavior Consultant (BC) designs and directs the implementation of a behavior modification intervention plan. The BC identifies the behavioral goals and intervention techniques to be used by the child/youth, family, and other individuals identified in the behavior plan who work with the child/youth such as school staff or community resources such as daycare or Boys and Girls club. The BC works with the family and other treatment team members, but does not typically provide direct services to the child/youth. BC may be the only BHR service or, when medically necessary, may consult to an MT and/or BHT. A BC must be a mental health clinician. The BH-MCO may have additional qualifications such as a certain number of years' experience.

Mobile Therapy (MT) provides intensive therapeutic services such as assessment of strengths and therapeutic needs to a child/youth and family in settings other than the provider agency or office. Settings can include the child's/youth's home, school, church, or a community center. Depending on the needs of the child/youth, MT services may be the only BHR service or, when medically necessary, may work in conjunction with a BSC and/or a BHT. A mobile therapist must be a licensed mental health professional or an individual with a Master's degree in a mental health field. The BH-MCO may have additional qualifications such as a certain number of years' experience.

The Behavioral Health Technician provides one-to-one interventions based on a behavior/treatment plan typically created by an MT or BSC to a child/youth in a home, school or community setting based on a behavior/treatment plan typically created by a MT or BSC. BHT is not a stand-alone serviced.

Applied Behavior Analysis (ABA)— treatment is offered under IBHS services by providing BCBA (Board Certified Behavioral Analyst), BA (Behavior Analytic), RBT (Registered Behavior Technician). ABA treatment designs the implementation of environmental modifications, using behavioral stimuli and consequences, to increase positive social improvement with behavior or to prevent loss of attained skill. This treatment modality measures and tracks data analysis in relation of the client's environment and behavior

- Peer Support Specialist -Peer Support Specialist is a prescription-based service which serves adolescents, 14 and older. The service provides specialized therapeutic interactions conducted by self-identified current (or former) consumers of behavioral health services who have achieved significant recovery. Peer Specialists are trained and certified to offer support and assistance in helping others in their recovery and community integration process. This program is fund under MA

9.1.7.3. Multisystemic Therapy (MST)

Multisystemic Therapy (MST), along with Functional Family Therapy (FFT) are two of the more widely known Evidence-Based Programs and are classified as "Blue Print Programs"[9]. MST and

[9] See: http://blueprintsprograms.com/

FFT are funded under Pennsylvania's Medical Assistance Program. MST may not be available in all counties.

Multisystemic Therapy (MST) is an evidence-based program developed to treat delinquent youth by intervening in the various systems in which the youth is embedded (i.e., family, school, peer, community) to change factors that contribute to or maintain problem behaviors. MST is a practical and goal-oriented treatment that draws from social-ecological and family systems theories of behavior.

In MST, a single therapist delivers services to 4 – 6 families. For the purposes of supervision, consultation, training, and monitoring, clinical staff are organized into teams of 2 – 4 therapists led by an MST Supervisor. The therapist meets with the youth or family at least weekly throughout most of the treatment and often multiple times per week, depending on need. Services occur in the family's home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their clients, and therapists and/or their supervisors are on-call for families 24/7. On average, a youth receives MST for 3 to 5 months, and typically no longer than 6 months.[10]

Please Penn State EPISCenter for additional information on Multisystemic Therapy

9.1.7.4. Functional Family Therapy (FFT)

Evidence-Based Programs use evidence from scientifically-based research studies to design, deliver, and evaluate the services and interventions they provide. Evidence-Based Programs have been studied using rigorous research principles to determine their effectiveness. Functional Family Therapy (FFT), along with Multisystemic Therapy (MST), are two of the more widely known Evidence-Based Programs and are classified as "Blueprint Programs"[11]. MST and FFT are funded under Pennsylvania's Medical Assistance Program. FFT may not be available in all counties. Other Evidence-Based Programs may be available by checking with the local County Office of Mental Health/Developmental Services.

Functional Family Therapy (FFT) is a short-term, behaviorally oriented family therapy program that targets youth ages 10-18 with severe behavior problems and chronic delinquency, as well as youth at risk for delinquency. Trained FFT therapists address a youth's referral behavior by providing intensive family therapy to change patterns of family interaction that are contributing to the problem behavior and by helping family members develop specific skills (e.g., communication, problem solving, conflict resolution and effective parenting skills). After change has been achieved within the family, the FFT therapist helps the family generalize changes to other situations and settings, such as peers, school, and community, and identifies supports that can help to maintain the progress made. Treatment is structured around five phases of

[10] Excerpted from Penn State EPISCenter website at: https://www.episcenter.psu.edu/ebp/mst

[11] See: http://blueprintsprograms.com/

treatment, each with specific assessment and intervention components that are tailored to the unique characteristics of each family. Sessions occur at least once per week and more often if needed, typically for 3-4 months, and can be delivered in both community-based and office-based settings. Research shows that FFT reduces the likelihood of out-of-home placement, reduces youth substance use and criminal recidivism, and improves family functioning and youth behavior. FFT is an evidence-based treatment program and is recognized as a Blueprints for Healthy Youth Development Model Program.[12] Please see Penn State EPISCenter for more information on Functional Family Therapy.

9.1.8. Intensive Case Management, Resource Coordination & Blended Case Management, and Administrative Case Management

County mental health departments offer various options regarding mental health case management services such as Intensive Case Management (ICM), Resource Coordination (RC), Administrative Case Management (ACM, and Blended Case Management. All of these positions offer support with referrals and linkage for the clients needs. These case management services support children to adults with a diagnosed mental health disability. The targeted adult population must have a documented serious and persistent mental illness and children with a serious mental illness or emotional disorder. All case management positions are designed to insure access to community agencies, services and people to provide support, and assistance required for a stable, safe and healthy community life. ICM is targeted to individuals with serious mental illness with a need for intensive assistance and has an on-call component Resource Coordination is targeted for persons who have mental illness with a need for assistance. Blended Case Management blends aspects of Intensive Case Management and Resource Coordination dependent upon the needs of the individual. Administrative case management (ACM) is available either by phone or in person but primarily provides support via the phone. ACM offers general system information and referral support, develops service plans, identify resources, make referrals, coordinate services, and provide follow-up to assure the individual is able to access the needed mental health services.

9.1.9. Mental Health Crisis Services

Immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress. Services are provided to adults or children and adolescents and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The services provide rapid response to crisis situations, which threaten the well-being of the individual or others. Mental Health Crisis Intervention (MHCI) services include the intervention, assessment, counseling, screening and disposition services which are considered appropriate to the provision of Mental Health Crisis Intervention.

[12] Excerpted from Penn State EPISCenter website

Responsibility for the provision of these services either directly, or through contract, is assigned to the county MH/IDD Administrator.

Crisis service is available 24 hours a day, 7 days a week, providing face-to-face contact for an individual in crisis or for individuals seeking assistance for a person that is experiencing a crisis. Location of these services may look different from county to county but is typically embedded within the emergency room (ER). Services include assessment and evaluation, information and referral, crisis counseling, crisis resolution, resource coordination, emergency psychiatric, medical consultation, and may have a mobile component. Family involvement is necessary throughout the crisis process. There is no insurance required for this support. Telephone crisis service is available 24 hours a day, 7 days a week, to individuals in crisis or callers asking for assistance with mental health struggles.

Please see the following link: Get Suicide or Mental Health Crisis Help (988) | Commonwealth of Pennsylvania

.

9.1.10. Partial Hospitalization

Partial Hospitalization is a nonresidential treatment modality for children and adolescents which includes psychiatric, psychological, recreational, social and vocational elements under medical supervision. It is designed for patients with moderate to severe mental or emotional disorders. Partial hospitalization patients require less than 24-hour care, but more intensive and comprehensive services than are offered in outpatient treatment programs. Partial hospitalization is provided on a planned and regularly scheduled basis for a minimum of 3 hours, but less than 24 hours in any 1 day. This service is used to prevent inpatient psychiatric care, as a transition from inpatient, or as a more intensive treatment program than are afforded by outpatient settings. The primary benefit is to stabilize mental health behaviors. This program is funded by commercial insurance, MA, and/or CHIP. Please note that transportation may not be offered by the provider, and the treatment team is encouraged to check on transportation needs.

9.1.11. Community Residential Rehabilitation (CRR)

CRR host homes are less restrictive than Residential Treatment Facilities (RTFs). CRRs are treatment homes with trained and supported caregiver that provide treatment whose psychiatric and/or behavioral health needs are such that they cannot be safely treated within their own home but can benefit from treatment within the community. This treatment can also be accessed as a step down from a resident treatment facility (RTF). The goal of this treatment option is to stabilize the child/adolescent symptoms enough to return to the legal guardian.

Host homes are single family residences. The program relies upon community schools for educational services. This program offers at least one hour a week of therapy (this varies among

providers). This service requires an evaluation by a psychologist or psychiatrist. The child/adolescent must have medical assistance as an insurance to access this treatment.

3.1.12. Residential Treatment Facility (RTF)

Residential Treatment Facility (RTF) A residential facility that provides services to treat the behavioral health needs of children, youth or young adults under the direction of a psychiatrist. Provides inpatient mental health services

One of the primary goals of the RTF is to prepare the individual for return to the home and/or community. Discharge planning, involving the family and including the identification of, and access to, community supports is an integral part of the process.

3.1.13. Inpatient Psychiatric Care

Inpatient psychiatric care provides 24-hour inpatient hospital care in a community psychiatric inpatient facility or a unit within a larger medical facility. Care is short-term and stabilizes the youth's acute mental health crisis. The facility will provide diagnostic and evaluative information upon discharge and recommend follow-up treatment and supports.

4. Common Behavioral Health Diagnoses in Children & Adolescents

Mental illness is common in the juvenile justice population. A study published in the Journal of the American Medical Association by Northwestern Juvenile Project found that that 2/3 of boys and 3/4 of girls in juvenile detention met the criteria for a psychiatric diagnosis.

The most common diagnoses in children and adolescents experiencing behavioral health disorders are ADHD, mood disorders such as depression, Conduct Disorder, and Anxiety Disorders (e.g., panic disorder, generalized anxiety, Post-Traumatic Stress Disorder). Autism Spectrum Disorders have also appeared in juvenile justice populations in increasing numbers.

4.1.1 Attention Deficit/Hyperactivity Disorder (ADHD)

ADHD affects approximately 5-8% of youth. The main features of ADHD include symptoms of hyperactivity/impulsiveness and/or inattention. To be diagnosed with ADHD, symptoms must occur in multiple settings, clearly interfere with the youth's functioning, and occur with greater frequency and severity than is age-appropriate. Some symptoms of ADHD include:

- Difficulty finishing tasks or activities that require concentration
- Don't seem to listen when spoken to
- Excessively active—running or climbing at inappropriate times, excessive fidgeting and squirming, trouble staying seated
- Very easily distracted and forgetful, often loses things
- Talk incessantly, often interrupting or blurting out responses before questions are finished
- Difficulty waiting their turn in games or groups

As a result of their symptoms, youth with ADHD often experience academic difficulties and poor peer relationships. They may exhibit disruptive behaviors that get them into trouble at home, school, or in the community, perhaps resulting in a diagnosis of Oppositional Defiant Disorder or Conduct Disorder. Around 1 in 4 youth with ADHD also have a specific learning disability, and many will experience depression, anxiety, or problems with substance use.

For treatment of ADHD, best practice suggests a *multi-modal approach* that involves parent training, school consultation, and child-focused interventions, and uses a behavioral approach. Individual counseling and office-based therapy has not been shown effective.

- **Parent Training:** Parents are taught effective skills for managing the youth, either in individual or group sessions. A specific curriculum may be used.
- **School Consultation:** Specific interventions may be suggested to the teacher to improve the youth's classroom behavior and performance. A daily "report card" may be sent back

and forth between home and school to monitor behavior and enable frequent rewards and consequences. In some cases, special educational programs help a child keep up academically.

- **Child-focused Intervention:** These interventions are generally offered in a group format, where the youth can learn and practice skills.

Many youth also benefit from medication, which should be closely monitored and managed by a family physician or a child/adolescent psychiatrist. Between 70-80% of youth with ADHD respond to medication. It is important to note that in many cases medication helps to reduce, but does not eliminate, the youth's ADHD symptoms.

A landmark study by the National Institute for Mental Health showed that youth receiving a combination of medication management and behavioral treatment showed the best outcomes with respect to their ADHD symptoms, oppositional behavior, and adjustment.

4.1.2 Depression

Depression is a mood disorder characterized by persistent feelings of sadness or irritability and/or a loss of interest in many or all activities. Other common symptoms of depression include changes in sleep patterns, eating, and energy levels; difficulty concentrating; thoughts of suicide; and feelings of guilt or worthlessness. Depression can range from mild to very severe. While more common in adolescent girls, many boys experience depression as well. It is important to note that depressed youth may not appear sad to others, but instead present as irritable, angry, or emotional.

Youth experiencing depression may also exhibit:

- A sudden drop in school performance
- Withdrawal from friends, family, and activities
- Feelings of helplessness or hopelessness
- Expressions of fear or anxiety
- Acting out behaviors such as aggression, refusal to cooperate, antisocial behavior
- Use of alcohol or other drugs
- Physical complaints (e.g., headaches, stomachaches, aching arms or legs, or stomach) with no apparent medical cause

Cognitive-behavioral therapy (CBT) can be recommended as treatment for depression. It may be offered individually or in a group. Common elements of CBT include helping the youth recognize positive and negative feelings; identify triggers for different feelings; increase involvement in pleasurable activities that can help improve mood; and teaching the youth to challenge maladaptive or negative thinking patterns. Developing skills for coping, relationships, and

communication may also be needed. Where appropriate, work may be done with the parents to ensure the home environment is a positive one and strengthen the parent-child relationship.

Some children also respond to antidepressant medications, but use of these medications must be closely monitored. Psychiatric medication should not be the only form of treatment but should be part of a comprehensive program.

4.1.3. Conduct Disorder

Approximately 1 to 5% of youth meet the criteria for a diagnosis of Conduct Disorder. The percent of youth in the juvenile justice system with Conduct Disorder is significantly higher, because these youth often come in contact with the legal system as a result of their behavior.

Children with conduct disorder exhibit behavior that shows a persistent disregard for the norms and rules of society. However, young people with conduct disorder often have underlying problems that have been missed or ignored, such as attention deficit disorder, depression, or even underlying medical conditions. Children who have demonstrated at least three of the following behaviors over six months should be evaluated for possible conduct disorder:

- Stealing
- Constantly lying
- Deliberately setting fires
- Often starting fights
- Skipping school
- Breaking into homes, offices, or cars
- Deliberately destroying others' property
- Displaying physical cruelty to animals or humans
- Forcing others into sexual activity
- Using weapons in fights

Historically, Conduct Disorder proved difficult to treat. However, in recent years treatment options showing strong evidence for effectiveness have emerged. Multisystemic Therapy (MST) and Functional Family Therapy (FFT) are two models for the treatment of Conduct Disorder. Other effective treatments include Aggression Replacement Training (ART), parenting training models, Brief Strategic Family Therapy, and cognitive-behavioral therapy.

For youngsters who have another diagnosis in addition to Conduct Disorder, such as depression or ADHD, treatment of the associated disorder through therapy or medication is also important and can help to alleviate antisocial behaviors.

4.1.4 Post-Traumatic Stress Disorder (PTSD)

Post-Traumatic Stress Disorder (PTSD) is a Trauma and Stressor Related Disorder that may develop after a person has experienced a life-threatening or dangerous event. When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to

defend against the danger or to avoid it. This “fight-or-flight” response is a healthy reaction meant to protect a person from harm. But in PTSD, this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they’re no longer in danger.

PTSD develops in all ages and in response to a wide array of traumas. This includes war veterans and survivors of physical and sexual assault, abuse, accidents, disasters, and many other serious events. Not everyone with PTSD has witnessed or experienced extreme danger first-hand. PTSD can also be diagnosed in individuals who have had someone close to them experience a trauma, which may include the near-death or death of a loved one through an accident or violent event.

Symptoms of PTSD can be grouped into four categories:

1. **Re-experiencing symptoms:**

    - Flashbacks or intrusive memories of the trauma. The person may feel like they are reliving the trauma over and over and may experience physical symptoms of fear or panic such as a racing heart or sweating, as well as extreme distress.
    - Bad dreams or traumatic nightmares.

    Re-experiencing symptoms may cause problems in a person’s everyday routine. They can start from the person’s own thoughts and feelings. Smells, sounds, words, objects, or situations that are reminders of the event can also trigger re-experiencing symptoms. Sometimes these triggers seem very benign to others and are difficult to identify, even for the individual with PTSD.

2. **Avoidance symptoms:** The person makes an effort to avoid thoughts, feelings, or reminders associated with the trauma. This may include staying away from places, events, or objects that are reminders of the experience. The individual may change his or her personal routine to avoid trauma-triggers. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car.

3. **Negative changes in thinking or mood:** This category includes a number of possible symptoms, such as:

    - Trouble remembering important aspects of the dangerous event.
    - Negative, sometimes extreme, changes in how the person sees him/herself and the world; often distrust of others or a view of the world as a dangerous place.
    - Feeling emotionally numb or unable to experience positive emotions
    - Persistent negative feelings, such as fear, guilt, anger, shame, or horror
    - Losing interest in activities that were enjoyable in the past
    - Feeling alienated or detached from others.

4. **Alterations in arousal or reactivity:**

- Being hypervigilant or easily startled; feeling tense or “on edge”
- Irritability, aggressive or angry outbursts, reckless behavior
- Difficulty sleeping
- Difficulty concentrating

Rather than being triggers by reminders of the trauma, symptoms of hyperarousal may be more constant and persistent throughout the person’s day-to-day. They may negatively impact relationships and the youth’s ability to do what is expected of him/her at home or school.

Effective treatment for PTSD typically involves therapy with a clinician trained and experienced in the treatment of trauma. Research supports the use of cognitive-behavioral approaches, such as Trauma-Focused CBT (TF-CBT), Stress Inoculation Therapy, and Cognitive Processing Therapy. Eye Movement Desensitization and Reprocessing (EMDR) has started to have some more positive studies. The Sanctuary Model is also highly recommended when dealing with survivors of trauma in the juvenile justice system.

How can trauma impact families?

Trauma can have profound effects on families as they work to recover and adapt to their environment. These experiences can create a range of emotions that one may experience from emotional distress, physical health concerns, mental health distress, etc. It should be noted that family members within the same household may responded differently from the same traumatic event.

How can traumatic experiences impact family relationships?

Families that experience traumatic events may experience disruption within the family dynamics. Increase parent-child conflict, emotional distance, and compassion fatigue are some symptoms which parents may experience. When parents emotionally detach or are struggling with their own reactions, they may struggle being attentive their children’s reactions and responses to the traumatic experiences.

How can human service stakeholder agencies provide support to families through a trauma informed lens?

Building a relationship with the family by showing empathy, demonstrating active listening skills, and ensuring safety when discussing traumatic events can help strengthen the family’s ability to discuss difficult experiences. Instead of asking families what is wrong with you but what happened to you is one approach in learning how to best provide supports for the family. It may be necessary for the probation office to determine if the caregivers are in need of treatment support. For additional resources please see on Trauma Informed Systems in Juvenile Justice

4.1.5. Autism Spectrum Disorders

Autism Spectrum Disorder (ASD) is a complex developmental disorder that can result in issues with processing thoughts, feelings, language, and may interfere with the ability to relate to others. ASD is a neurological disorder, which means it affects the functioning of the brain. How ASD affects a person and the severity of symptoms are different in each person. In the vast majority of cases, ASD is a lifelong disorder.

Autism is usually first diagnosed in early childhood. ASD is three to four times more common in males than females.

ASD differs from person to person in severity and expression of symptoms. There is a great range of abilities and characteristics of individuals with ASD—no two individuals appear or behave the same way. Symptoms can range from mild to severe and may change over time. Characteristics of ASD include:

- **Communication issues** – difficulty using or understanding language. Some individuals with ASD focus their attention and conversation on a few focused topic areas, some frequently repeat phrases, and some have very limited speech or are non-verbal.
- **Difficulty relating to people, things and events** – trouble making and keeping friends and interacting with people, difficulty reading facial expressions, or may not make eye contact.
- **Repetitive body movements or behaviors** – engage in stereotyped, repetitive behaviors like hand flapping or repeating sounds or phrases.

Many individuals with ASD prefer routines and sameness and have difficulty adjusting to unfamiliar surroundings or changes in routine. People with ASD may have normal or above average cognitive skills and/or IQ, while others may have challenges with cognitive processing. Individuals with ASD often present with other co-occurring psychiatric and medical conditions – such as sleep problems and seizures.

It is not clear exactly what causes ASD. Several factors probably contribute to ASD, including genes an individual is born with or perhaps something in the environment. The risk of ASD is greater if there is a family member with ASD. Research has shown that it is not caused by bad parenting, and it is not caused by vaccines.

ASD is diagnosed through a thorough assessment by a trained clinician who is knowledgeable in and experienced in ASD, and will often include observation of the individual, interviews with parents and caregivers, and the use of standardized assessment tools. There is no medical test for ASD.

While there is no cure for ASD and individuals don't "outgrow" it, studies have shown that symptoms and functioning can improve with early, intensive treatment. Because ASD is a developmental disorder, it is often associated with medical conditions and/or delays in other areas (motor skills, language, etc.), and looks different from person-to-person, treatment varies and may include a range of services to best meet the needs of the individual and family.

Depending on the exact nature and severity of symptoms, treatment may include:

- Applied Behavior Analysis (ABA) is perhaps the most widely accepted intervention for ASD. ABA, which is delivered by a trained professional, is a behavioral approach to treatment and can take a number of different forms.
- Training and support for parents
- Speech therapy, occupational therapy, and/or physical therapy
- Social skills training
- Special education services
- Medication to manage symptoms (e.g., aggressive or self-injurious behavior, inattention, anxiety)

Additional information on the resources available for individuals with ASD and their families can be found at the Autism Services, Education, Resources, & Training Collaborative (ASERT) website. The ASERT Collaborative also has a Resource Center call line which can be accessed by any Pennsylvanian with autism, family member, service provider or community member, including JPOs.

www.paautism.org

More comprehensive information on behavioral health diagnoses and treatment can be found at the website of the National Institute of Mental Health (NIMH). NIMH is part of the National Institutes of Health, a component of the U.S. Department of Health and Human Services.

Autism Spectrum Disorder - National Institute of Mental Health (NIMH) (nih.gov)

Additional information can be found at the American Psychological Association website for Effective Child Therapy

5. Commonly Prescribed Psychotropic Medications

5.1.1 Medications for Depression

Depression is commonly treated with antidepressant medications. Antidepressants work to balance some of the natural chemicals in our brains. These chemicals are called neurotransmitters, and they affect our mood and emotional responses. Antidepressants work on neurotransmitters such as serotonin, norepinephrine, and dopamine. The most popular types of antidepressants are called selective serotonin reuptake inhibitors (SSRIs). These include:

- Fluoxetine (Prozac)
- Citalopram (Celexa)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)

Other types of antidepressants are serotonin and norepinephrine reuptake inhibitors (SNRIs). SNRIs are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta). Another antidepressant that is commonly used is bupropion (Wellbutrin). Bupropion, which works on the neurotransmitter dopamine, is unique in that it does not fit into any specific drug type.

SSRIs and SNRIs are popular because they do not cause as many side effects as older classes of antidepressants. Older antidepressant medications include tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs). For some people, tricyclics, tetracyclics, or MAOIs may be the best medications.

5.1.2 Medications for Attention Deficit/Hyperactivity Disorder

Attention deficit/hyperactivity disorder (ADHD) occurs in both children and adults. ADHD is commonly treated with stimulants, such as:

- Methylphenidate (Ritalin, Metadate, Concerta, Daytrana)
- Amphetamine (Adderall)
- Dextroamphetamine (Dexedrine, Dextrostat)

In 2002, the FDA approved the nonstimulant medication atomoxetine (Strattera) for use as a treatment for ADHD. In February 2007, the FDA approved the use of the stimulant lisdexamfetamine dimesylate (Vyvanse) for the treatment of ADHD in children ages 6 to 12 years.

5.1.3 Medications for Anxiety Disorders, including Post-Traumatic Stress Disorder

Antidepressants were developed to treat depression, but they also help people with anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa) are commonly prescribed for panic disorder, Obsessive Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), and social phobia. The serotonin and norepinephrine reuptake inhibitors (SNRI) venlafaxine (Effexor) is commonly used to treat Generalized Anxiety Disorder (GAD). The antidepressant bupropion (Wellbutrin) is also sometimes used. When treating anxiety disorders, antidepressants generally are started at low doses and increased over time.

Some tricyclic antidepressants work well for anxiety. For example, imipramine (Tofranil) is prescribed for panic disorder and GAD. Clomipramine (Anafranil) is used to treat OCD. Tricyclics are also started at low doses and increased over time.

Monoamine oxidase inhibitors (MAOIs) are also used for anxiety disorders. Doctors sometimes prescribe phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan). People who take MAOIs must avoid certain food and medicines that can interact with their medicine and cause dangerous increases in blood pressure.

The anti-anxiety medications called benzodiazepines can start working more quickly than antidepressants. The ones used to treat anxiety disorders include:

- Clonazepam (Klonopin), which is used for social phobia and GAD
- Lorazepam (Ativan), which is used for panic disorder
- Alprazolam (Xanax), which is used for panic disorder and GAD

Buspirone (Buspar) is an anti-anxiety medication used to treat GAD. Unlike benzodiazepines, however, it takes at least two weeks for buspirone to begin working. Clonazepam, listed above, is an anticonvulsant medication.

5.1.4 Medications for Autism Spectrum Disorder

Currently, the only medications approved by the FDA to treat the symptoms associated with Autism Spectrum Disorder (ASD) are the antipsychotics risperidone (Risperdal) and aripripazole (Abilify). These medications can help reduce irritability, aggression, self-harming acts, or tantrums—in children ages 5 to 16 who have ASD. There is no approved medication that can treat all symptoms of ASD.

Some medications that may be prescribed off-label for individual with ASD include the following:

- **Antipsychotic medications** are more commonly used to treat serious mental illnesses such as schizophrenia. These medicines may help reduce aggression and other serious behavioral problems in children, including children with ASD. They may also help reduce repetitive behaviors and hyperactivity.

- **Anti-depressant medications**, such as fluoxetine (Prozac) or sertraline (Zoloft), are usually prescribed to treat depression and anxiety but are sometimes prescribed to reduce repetitive behaviors in children with ASD. Some antidepressants may also help control aggression and anxiety in children with ASD. However, researchers still are not sure if these medications are useful for treating repetitive behaviors; a recent study suggested that the antidepressant citalopram (Celexa) was no more effective than a placebo (sugar pill) at reducing repetitive behaviors in children with ASD.

- **Stimulant medications**, such as methylphenidate (Ritalin), are commonly used to treat people with attention deficit hyperactivity disorder (ADHD). Methylphenidate has been shown to effectively treat hyperactivity in some children with ASD as well. But not as many children with ASD respond to methylphenidate treatment, and those who do have shown more side effects than children with ADHD without ASD.

More comprehensive information on medications and treatment of ASD and other behavioral health disorders can be found at the website of the National Institute of Mental Health (NIMH). NIMH is part of the National Institutes of Health, a component of the U.S. Department of Health and Human Services.

6. Common Side Effects of Psychotropic Medications

6.1.1. Common Side Effects of Medications taken for Depression

Antidepressants may cause mild side effects that usually do not last long. **Any unusual reactions or side effects should be reported to a doctor immediately**.

The most common side effects associated with SSRIs and SNRIs include:

- Headache, which usually goes away within a few days.
- Nausea (feeling sick to your stomach), which usually goes away within a few days.
- Sleeplessness or drowsiness, which may happen during the first few weeks but then goes away. Sometimes the medication dose needs to be reduced or the time of day it is taken needs to be adjusted to help lessen these side effects.
- Agitation (feeling jittery).
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex.

Tricyclic antidepressants can cause side effects, including:

- Dry mouth.
- Constipation.
- Bladder problems. It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected.
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex.
- Blurred vision, which usually goes away quickly.
- Drowsiness. Usually, antidepressants that make you drowsy are taken at bedtime

People taking monoamine oxidase inhibitors (MAOIs) need to be careful about the foods they eat and the medicines they take. Foods and medicines that contain high levels of a chemical called tyramine are dangerous for people taking MAOIs. Tyramine is found in some cheeses, wines, and pickles. The chemical is also in some medications, including decongestants and over-the-counter cold medicine.

Mixing MAOIs and tyramine can cause a sharp increase in blood pressure, which can lead to stroke. People taking MAOIs should ask their doctors for a complete list of foods, medicines, and other substances to avoid. An MAOI skin patch has recently been developed and may help reduce some of these risks. A doctor can help a person figure out if a patch or a pill will work for him or her.

6.1.2. Common Side Effects of Medications taken for Attention Deficit/ Hyperactivity Disorder

Most side effects are minor and disappear when dosage levels are lowered. The most common side effects include:

- Decreased appetite. Children seem to be less hungry during the middle of the day, but they are often hungry by dinnertime as the medication wears off.

- Sleep problems. If a child cannot fall asleep, the doctor may prescribe a lower dose. The doctor might also suggest that parents give the medication to their child earlier in the day, or stop the afternoon or evening dose. To help ease sleeping problems, a doctor may add a prescription for a low dose of an antidepressant or a medication called clonidine.

- Stomach aches and headaches.

A few children develop less common side effects such as sudden, repetitive movements or sounds called tics. These tics may or may not be noticeable. Changing the medication dosage may make tics go away. Some children also may appear to have a personality change, such as appearing "flat" or without emotion.

6.1.3. Common Side Effects of Medications taken for Anxiety Disorders, including Post-Traumatic Stress Disorder

Antidepressants may cause mild side effects that usually do not last long. **Any unusual reactions or side effects should be reported to a doctor immediately**.

The most common side effects associated with SSRIs and SNRIs include:

- Headache, which usually goes away within a few days.
- Nausea (feeling sick to your stomach), which usually goes away within a few days.
- Sleeplessness or drowsiness, which may happen during the first few weeks but then goes away. Sometimes the medication dose needs to be reduced or the time of day it is taken needs to be adjusted to help lessen these side effects.
- Agitation (feeling jittery).
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex.

Tricyclic antidepressants can cause side effects, including:

- Dry mouth.
- Constipation.
- Bladder problems. It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected.
- Sexual problems, which can affect both men and women and may include reduced sex drive, and problems having and enjoying sex.
- Blurred vision, which usually goes away quickly.
- Drowsiness. Usually, antidepressants that make you drowsy are taken at bedtime.

People taking monoamine oxidase inhibitors (MAOIs) need to be careful about the foods they eat and the medicines they take. Foods and medicines that contain high levels of a chemical called tyramine are dangerous for people taking MAOIs. Tyramine is found in some cheeses, wines, and pickles. The chemical is also in some medications, including decongestants and over-the-counter cold medicine.

Mixing MAOIs and tyramine can cause a sharp increase in blood pressure, which can lead to stroke. People taking MAOIs should ask their doctors for a complete list of foods, medicines, and other substances to avoid. An MAOI skin patch has recently been developed and may help reduce some of these risks. A doctor can help a person figure out if a patch or a pill will work for him or her.

The most common side effects for benzodiazepines are drowsiness and dizziness. Other possible side effects include:

- Upset stomach
- Blurred vision
- Headache
- Confusion
- Grogginess
- Nightmares

Possible side effects from buspirone (BuSpar) include:

- Dizziness
- Headaches
- Nausea
- Nervousness
- Lightheadedness
- Excitement
- Trouble sleeping

Common side effects from beta-blockers include:

- Fatigue
- Cold hands
- Dizziness
- Weakness

In addition, beta-blockers generally are not recommended for people with asthma or diabetes because they may worsen symptoms.

6.1.4. Common Side Effects of Medications taken for Autism Spectrum Disorder

Children with ASD may not respond to medications in the same way as typically developing children or adolescents. Parents/caregivers should work with a doctor who has experience in the treatment of children with ASD. The doctor will usually start the child on the lowest dose that helps control problem symptoms. The prescribing doctor should be asked about side effects of the medication, and parents/caregivers should maintain a record of how the child reacts to the medication. The doctor should regularly check the child's response to the treatment.

More comprehensive information on medication side effects seen in individuals with ASD and other behavioral health disorders can be found at the website of the National Institute of Mental Health (NIMH). NIMH is part of the National Institutes of Health, a component of the U.S. Department of Health and Human Services.

http://www.nimh.nih.gov/health/publications/mental-health-medications/index.shtml

7. Appropriate Diversion of Youth with Behavioral Health Issues

In 2006, the Commonwealth of Pennsylvania issued a Mental Health/Juvenile Justice Joint Policy Statement (the "Joint Policy Statement") as a blueprint for creating a model system that responds appropriately to youth with mental health needs who may or do become involved in the juvenile court. The Joint Policy Statement, promulgated as part of Pennsylvania's participation in the Models for Change systems reform initiative, sets out a vision of a comprehensive model system that:

1) prevents the unnecessary involvement of youth who are in need of mental health treatment, including those with co-occurring substance abuse disorders, in the juvenile justice system;

2) allows for the early identification of youth in the system with mental health needs and co-occurring disorders; and

3) provides for timely access by identified youth in the system to appropriate treatment within the least restrictive setting that is consistent with public safety needs.[13]

The *"Guide to Developing Pre-Adjudication Diversion Policy and Practice in Pennsylvania"* offers the following definition of Pre-Adjudication Diversion:

> *"Pre-adjudication diversion is defined as providing opportunities for youth who would otherwise face formal processing in the court system so that they can avoid an adjudication of delinquency or conviction for a summary offense and instead directing them into an alternative program, including treatment when appropriate."*[14]

The document also provides guidance in the areas of:

- Statutory Basis and Role of Pre-Adjudication Diversion in the Juvenile Justice System
- Youth Eligible for Diversion
- Preventing Net-Widening
- Diversion Activities and Balanced and Restorative Justice
- Collaboration and the Identification/Development of Effective Diversion Programs
- Elements of Effective Programs and Written Agreements
- Family Involvement and Support Systems
- Special Considerations for Diversion by Law Enforcement
- Special Considerations for Diversion by Intake Juvenile Probation Officers

---

[13] *Guide to Developing Pre-Adjudication Diversion Policy and Practice in Pennsylvania*, Diversion Subcommittee of the Mental Health/Juvenile Justice state work group of the Models for Change Initiative in Pennsylvania, John D. and Catherine T. MacArthur Foundation, September 2010, p. 6.

[14] Ibid, p. 7

- Special Considerations for Diversion of Youth Who Commit School-Based Offenses
- Outcome Measurement

The consequences of a formal processing resulting in a juvenile adjudication of delinquency are significant. In the document entitled, *"The Pennsylvania Juvenile Collateral Consequences Checklist"*[15] areas in in which a juvenile's future may be affected both on the near-term and long-term if adjudicated delinquent are identified. These include areas such as future employment opportunities, access to public housing, entrance into the military, or access to schools, among others areas. The implication that an adjudication of delinquency can result in significant, sometimes long lasting effects, and if appropriate, diversion may be a viable option so as to not significantly limit the youth's ability to become a law-abiding, contributing member of the community.

The role of the family in providing necessary supports to enable successful diversion from an adjudication of delinquency is crucial. Juvenile justice professionals and other child-serving professionals have long struggled to effectively engage and involve families in supervision and treatment of their children. In the document, *"Family Involvement in Pennsylvania's Juvenile Justice System"* several areas are suggested upon which professionals can develop more effective partnerships and family supportive policies and practices including:

- Availability and Access to Effective Early Prevention and Intervention
- Communicating Respect
- Local Juvenile Policy and Practice
- State-wide Policy and Oversight

The frustration associated with accessing effective early prevention and intervention is often cited by families as an obstacle to preventing future delinquent behavior in their children.[16]

The "Guide to Developing Pre-Adjudication Diversion Policy & Practice", "Pennsylvania's Juvenile Collateral Consequences Checklist" and "Family Involvement in PA's Juvenile Justice System" can all be found at:

Guide to Developing Pre-Adjudication Diversion Policy and Practice in Pennsylvania

Pennsylvania Collateral Juvenile Consequence Checklist

Family Involvement in Pennsylvania's Juvenile Justice System

[15] *The Pennsylvania Juvenile Collateral Consequences Checklist*, Pennsylvania Juvenile Indigent Defense Network of the Models for Change Initiative in Pennsylvania, John D. and Catherine T. MacArthur Foundation, May 2010.
[16] *Family Involvement in Pennsylvania's Juvenile Justice System*, Family Involvement Subcommittee of the Mental Health/Juvenile Justice state work group of the Models for Change Initiative in Pennsylvania and the Family Involvement Workgroup of the Pennsylvania Council of Chief Juvenile Probation Officers' Balanced and Restorative Justice Implementation Committee, John D. and Catherine T. MacArthur Foundation, 2009.

13. Coordination of Services and Discharge Planning

Best Practices for Coordination of Services and Discharge Planning

Communication and coordination between the juvenile probation officer, behavioral case manager, service providers, clinical care manager (if MH/DA services are being funded), school district, family,and the youth are essential to effectively deliver behavioral health and other services. Behavioral health services may be critical part of a broader set of interventions ordered by the Juvenile Court to address the youth's criminogenic risks and needs. These interventions should be identified in the youth's case plan. It should be understood that psychotherapeutic treatments, psychiatric medications, and other clinical interventions may be elements in youth's case plan of a juvenile with mental health needs, but the case plan encompasses all domains relevant to supporting a youth's ability to live in the community without continued delinquent or criminal involvement. All of the elements of the case plan, including behavioral health intervention should support and operate in concert with one another.

In the publication, "*A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System"*[17]*,* the following recommendations are offered to Mental Health practitioners. The term, "rehabilitation" is used to describe the broader set of interventions that may be required to address the youth's criminogenic risks/needs.

- Assessments of youth involved with the juvenile justice system are most relevant when they address rehabilitation. The recommended services or interventions must specifically link to case-specific factors giving rise to delinquency and to factors that would reduce recidivism risk.

- The recommended services or interventions must actually be available, since rehabilitation cannot occur if the needed services cannot be accessed. The law in some jurisdictions further requires that services or interventions must be accessible through the juvenile justice system. Where the optimal services cannot be accessed, the clinician still articulates what the optimal services would be and why, but also provides an analysis of whether, or to what extent, accessible services are likely to have an impact upon rehabilitation as well as symptoms of mental health disorders.

- While solid clinical skills are essential, mental health practitioners must also be familiar with research regarding developmental trajectories of delinquent misconduct, and the psychiatric and/or cognitive impairments commonly found among delinquent populations.

- Mental health practitioners must also be familiar with and apply research regarding the efficacy of clinical assessments and interventions specifically relevant to reducing recidivism risk (rehabilitation) as well as symptoms and functional impairment arising from mental health disorders (treatment).

[17] Kinscherff, R. (2012). *A Primer for Mental Health Practitioners Working With Youth Involved in the Juvenile Justice System.*Washington, DC: Technical Assistance Partnership for Child and Family Mental Health. pg.4.

- In addition to the dimensions of mental health practice described above, clinicians must also be familiar with relevant law, policies, and practices of the specific juvenile justice system in which they are providing services, and the resources accessible through that system.

To aid and support in addressing the behavioral health needs of the youth in the context of the youth's obligations and requirements resulting from his/her involvement in the juvenile justice system the following the following best practices for juvenile probation officers are recommended:

- The assigned juvenile probation officer participates in development of the initial treatment plan and subsequent adjustments, which is included as part of the youth's juvenile justice case plan.

- Juvenile Justice goals and requirements are included in the treatment plan.

- An assigned juvenile probation officer maintains contacts/visits the youth and family while in the youth is in placement.

- Home passes are approved by Juvenile Probation.

- The assigned juvenile probation officer participates in the development of the aftercare/discharge plan.

- Juvenile Justice goals and requirements are included in the aftercare plan.

- The assigned juvenile probation officer provides aftercare supervision upon discharge.

Addressing the criminogenic risk/needs and the behavioral health needs of youth should be considered as complimentary as both are intended to support the youth in becoming a functioning, productive, law-abiding member of the community.

14. Abbreviations & Acronyms Related to Behavioral Health

A

AA — ALCOHOLICS ANONYMOUS
AAA — AREA AGENCY ON AGING
ACATA — AMERICAN COLLEGE OF ADDICTION TREATMENT ADMINISTRATORS
ACLD — ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES
ACMH — ASSOCIATION FOR CHILDREN'S MENTAL HEALTH
ACT — ASSERTIVE COMMUNITY TREATMENT
ACSW — ASSOCIATION OF CERTIFIED SOCIAL WORKERS
ADA — AMERICANS WITH DISABILITIES ACT
ADD — ATTENTION DEFICIT DISORDER
ADHD — ATTENTION DEFICIT HYPERACTIVITY DISORDER
AFDC — AID FOR DEPENDENT CHILDREN
AMA - AGAINIST MEDICAL ADVICE
AHEDD — ASSOCIATION FOR HABILITATION AND EMPLOYMENT OF DEVELOPMENTALLY DISABLED
AMI — ALLIANCE FOR THE MENTALLY ILL
AOPC — ADMINISTRATIVE OFFICE PENNSYLVANIA COURTS
APA — AMERICAN PSYCHIATRIC ASSOCIATION
APD — ADVANCED PLANNING DOCUMENT
APS — ADULT PROTECTIVE SERVICES
ARC — ADVOCACY AND RESOURCES FOR CITIZENS WITH COGNITIVE, INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
ARD — ACCELERATED REHABILITATION DECISION
ASAM — AMERICAN SOCIETY OF ADDICTIVE MEDICINE
ASCII — AMERICAN STANDARD CODE FOR INFORMATION INTERCHANGE
ASI — ADDICTION SEVERITY INDEX
ASU — ADULT SERVICES UNIT
AT — ASSISTIVE TECHNOLOGY

B

BDAP — BUREAU OF DRUG AND ALCOHOL PROGRAMS
BH — BEHAVIORAL HEALTH
BH-MCO — BEHAVIORAL HEALTH MANAGED CARE COMPANY
BHRS — BEHAVIORAL HEALTH REHABILITATION SERVICES FOR CHILDREN AND ADOLESCENTS
BIP — BEHAVIOR INTERVENTION PLAN
BNDD — BUREAU OF NARCOTIC DRUGS AND DEVICES
BSC- Behavioral Specialist Consultant
BSU — BASE SERVICE UNIT
BSW — BACHELOR OF SOCIAL WORK

C

CAC — CERTIFIED ADDICTIONS COUNSELOR
CADCA — COMMUNITY ANTI-DRUG COALITION OF AMERICA
CAO — COUNTY ASSISTANCE OFFICE
CAS — CHILDREN'S AID SOCIETY
CASA- CHILD APPOINTED SPECIAL ADVOCATE
CASSP — CHILD AND ADOLESCENT SERVICE SYSTEM PROGRAM
CAU — COUNTY ADMINISTRATIVE UNIT

CBT- COGNITIVE BEHAVIORAL THERAPY (OUTPATIENT)
CCC — CHILDREN'S COORDINATING COUNCIL
CCYA — COUNTY CHILDREN & YOUTH AGENCY
CDC — CHILDREN'S DEVELOPMENT CENTER
CDC — CENTER FOR DISEASE CONTROL
CER — COMPREHENSIVE EVALUATION RECORD
C/FST — CONSUMER/FAMILY SATISFACTION TEAM
CHADD — CHILDREN WITH ATTENTION DEFICIT DISORDERS
CI: CRISIS INTERVENTION
CIL — CENTER FOR INDEPENDENT LIVING
CMHS — CENTER FOR MENTAL HEALTH SERVICES
COB — COORDINATION OF BENEFITS
Complaint - A written or verbal expression of unhappiness or concern with Managed Care or a Provider. A complaint is a way of addressing your concerns.
CPS — CHILD PROTECTIVE SERVICES
CRNP — CERTIFIED REGISTERED NURSE PRACTIONER
CRR — COMMUNITY RESIDENTIAL REHABILITATION
CRR-HH- Community Residential Rehabilitation - Host Home
CSAP — CENTER FOR SUBSTANCE ABUSE PREVENTION
CSAT — CENTER FOR SUBSTANCE ABUSE TREATMENT
CSI — CONSUMER SATISFACTION INSTRUMENTS
CSP — COMMUNITY SUPPORT PROGRAM
CSR — CONTINUING STAY REVIEW
CST — CONSUMER SATISFACTION TEAM
CSW — CERTIFIED SOCIAL WORKER
CYA OR C&Y — CHILDREN & YOUTH AGENCY

D

D&A — DRUG AND ALCOHOL
DAP — DISABILITY ADVOCACY PROGRAM
DASPOP — DRUG AND ALCOHOL SERVICE PROVIDERS OF PENNSYLVANIA
DD — DEVELOPMENTAL DISABILITIES
DEA — DRUG ENFORCEMENT AGENCY
DESI — DRUG EFFICACY STUDY IMPLEMENTATION
DBT- DIALECTAL BEHAVIORAL THERAPY (OUTPATIENT)
DLP — DISABILITIES LAW PROJECT
DOH — DEPARTMENT OF HEALTH
DPH — DEPARTMENT OF PUBLIC HEALTH
DPW — DEPARTMENT OF PUBLIC WELFARE
DRN — DISABILITY RIGHTS NETWORK OF PENNSYLVANIA (Combination of the former Pennsylvania Protection and Advocacy and the Disability Law Project)
DSM-IV — DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4TH EDITION.
DUR — DRUG UTILIZATION REVIEW

E

EAP — EMPLOYEE ASSISTANCE PROGRAM
EAPA — EMPLOYEE ASSISTANCE PROFESSIONALS ASSOCIATION
EBP - EVIDENCE BASED PROGRAM
ECMH — EARLY CHILDHOOD MENTAL HEALTH
ECT — ELECTRO-CONVULSIVE (SHOCK) THERAPY
EI — EARLY INTERVENTION
ELC — EDUCATION LAW CENTER
EMS — EMERGENCY MEDICAL SERVICES

EPDST — EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT
ER — EMERGENCY ROOM
ESY — EXTENDED SCHOOL YEAR
EVS — ELIGIBILITY VERIFICATION SYSTEM

F

FA — FISCAL AGENT
FB — FAMILY BASED
FBA- Functional Behavioral Assessment
FBMHS — FAMILY BASED MENTAL HEALTH SERVICES
FCN — FAMILY CARE NETWORK
FDA — FOOD AND DRUG ADMINISTRATION
FD/FSS — FAMILY DRIVEN FAMILY SUPPORT SERVICES
FFS — FEE-FOR-SERVICE
FFT — FUNCTIONAL FAMILY THERAPY
FSIQ — FULL SCALE I.Q. TEST
FSS — FAMILY SUPPORT SYSTEMS
FST — FAMILY SATISFACTION TEAM
FTE — FULL TIME EQUIVALENT
FTP — FILE TRANSFER PROTOCOL
FY — FISCAL YEAR

G

GA — GENERAL ASSISTANCE
GAF — GLOBAL ASSESSMENT OF FUNCTIONING (AXIS OF DSM)
GAS — GLOBAL ASSESSMENT SCALE, GOAL ATTAINMENT SCALING
GME — GRADUATE MEDICAL EDUCATION
GPS — GENERAL PROTECTIVE SERVICES
Grievance - A formal procedure to address the denial of, reduction of, or substitution of a service requested by your Provider. It is put in writing for further investigation and decision is made within 15 days.
GS — GIFTED SUPPORT

H

HC — HEALTHCHOICES
HEDIS — HEALTHPLAN EMPLOYER DATA AND INFORMATION SET
HFW — HIGH FIDELITY WRAPAROUND
HIO — HEALTH INSURING ORGANIZATIONS
HIPAA — HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
HIPP — HEALTH INSURANCE PREMIUM PAYMENT
HLP — PENNSYLVANIA HEALTH LAW PROJECT
HMO — HEALTH MAINTENANCE ORGANIZATION
HAS — HEALTH SYSTEMS AGENCY
HSDF — HUMAN SERVICE DEVELOPMENT FUND
HUD — HOUSING AND URBAN DEVELOPMENT

I

ICF/MR — INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED

ICM — INTENSIVE CASE MANAGEMENT
ID — INSURANCE DEPARTMENT
IDD- Intellectual and Development Disability
IEA — INDIVIDUAL ENROLLMENT ASSESSMENT
IEAP — INDEPENDENT ENROLLMENT ASSISTANCE (PROGRAM)
IEP — INDIVIDUAL EDUCATION PLAN
IFA — INDIVIDUALIZED FUNCTIONAL ASSESSMENT
IMD — INSTITUTIONS FOR MENTAL DISEASE
I&R — INFORMATION AND REFERRAL
IOC — INVOLUNTARY OUTPATIENT COMMITMENT
IOM — INSTITUTE OF MEDICINE
IPS — INDIVIDUAL PLAN OF SERVICE
ISP — INDIVIDUALIZED SERVICE PLAN
IST — INSTRUCTIONAL SUPPORT TEAM
I-TEAM — INTERDISCIPLINARY TEAM
IU — INTERMEDIATE UNIT

J

JCAHO — THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
JDC — JUVENILE DETENTION CENTER
JPO — JUVENILE PROBATION OFFICE

L

LEA — LOCAL EDUCATIONAL AGENCY
LEA — LAW ENFORCEMENT AGENCY
LOCI — LEVEL OF CARE INDEX
LOF — LEVEL OF FUNCTIONING
LOS — LENGTH OF STAY
LPN — LICENSED PRACTICAL NURSE
LRE — LEAST RESTRICTIVE ENVIRONMENT
LS — LEARNING SUPPORT
LSS — LIFE SKILLS SUPPORT
LSW — LICENSED SOCIAL WORKER
LTC — LONG TERM CARE
LTSR — LONG TERM STRUCTURED RESIDENCE

M

MA — MEDICAL ASSISTANCE
MAAC — MEDICAL ASSISTANCE ADVISORY COMMITTEE
MADD — MOTHERS AGAINST DRUNK DRIVING
MAID — MEDICAL ASSISTANCE IDENTIFICATION NUMBER
MC — MIXED CATEGORY
MCO — MANAGED CARE ORGANIZATION
MDE — MULTIDISCIPLINARY EVALUATION
MDT — MULTIDISCIPLINARY TEAM
MDTFC — MULTIDIMENSIONAL TREATMENT FOSTER CARE
MEDICAL NECESSITY CRITERIA - The rules used by an MCO to decide if the services a Member's doctor wants them to get are necessary.
MH — MENTAL HEALTH
MHFA — MENTAL HEALTH FIRST AID
MHAP — MENTAL HEALTH ASSOCIATION OF PENNSYLVANIA

MI/DD — MENTALLY ILL/DEVELOPMENTALLY DISABLED
MISA — MENTAL ILLNESS/SUBSTANCE ABUSE
MOE — METHOD OF EVALUATION
MRCS — MATERNITY RATE CALCULATION SHEET
MST — MULTI-SYSTEMIC THERAPY
MSW — MASTER OF SOCIAL WORK
MT- MOBILE THERAPIST

O

OBRA — OMNIBUS BUDGET RECONCILIATION ACT
OBS — ORGANIC BRAIN SYNDROME
OCD — OBSESSIVE COMPULSIVE DISORDER
OCDEL — OFFICE OF CHILD DEVELOPMENT AND EARLY LEARNING
OCYF — OFFICE OF CHILDREN YOUTH AND FAMILIES
ODAP — OFFICE OF DRUG AND ALCOHOL PROGRAMS
ODP — OFFICE OF DEVELOPMENTAL PROGRAMS
OIP — OTHER INSURANCE PAID
OIS — OFFICE OF INFORMATION SYSTEMS
OMA — OFFICE OF MEDICAL ASSISTANCE
OMAP — OFFICE OF MEDICAL ASSISTANCE PROGRAMS
OMH — OFFICE OF MENTAL HEALTH
OMHSAS — OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
ONDCP — OFFICE OF NATIONAL DRUG CONTROL POLICY
OP — OUTPATIENT SERVICES
ORC — OTHER RELATED CONDITIONS
OSHA — FEDERAL OFFICE OF SAFETY/HAZARD ADMINISTRATION
OT — OCCUPATIONAL THERAPY OR THERAPIST
OTC — OVER THE COUNTER
OTR — REGISTERED OCCUPATIONAL THERAPIST
OVR — OFFICE OF VOCATIONAL REHABILITATION

P

P4P — PAY-FOR-PERFORMANCE
PACDAA — PENNSYLVANIA ASSOCIATION OF COUNTY DRUG AND ALCOHOL ADMINISTRATORS
PACT — PROGRAM FOR ASSERTIVE COMMUNITY TREATMENT
PAPSRS — PENNSYLVANIA ASSOCIATION OF PSYCHOSOCIAL REHABILITATION SERVICES
PARC — PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS
PARF — PENNSYLVANIA ASSOCIATION OF REHABILITATION FACILITIES
PASAP — PENNSYLVANIA ASSOCIATION OF STUDENT ASSISTANCE PROFESSIONALS
PATTAN — PENNSYLVANIA TRAINING AND TECHNICAL ASSISTANCE INSTITUTE
PAUD — PENNSYLVANIANS AGAINST UNDERAGE DRINKING
PBIS — POSITIVE BEHAVIORAL INTERVETIONS AND SUPPORT
PCAP — PENNSYLVANIA COUNCIL ON ALCOHOL PROBLEMS
PCBH — PERSONAL CARE BOARDING HOME
PCIT — PARENT-CHILD INTERACTION THERAPY
PCP — PRIMARY CARE PHYSICIAN OR PRACTIONER
PCP — PERSON CENTERED PLANNING
PDE — PENNSYLVANIA DEPARTMENT OF EDUCATION
PDR — PHYSICIAN'S DESK REFERENCE
PEN — PARENT EDUCATION NETWORK
PERP — PERPETRATOR OF CHILD ABUSE OR CHILD SEXUAL ABUSE
PH —PARTIAL HOSPITAL
PHLP — PENNSYLVANIA HEALTH LAW PROJECT

PH-MCO — PHYSICAL HEALTH MANAGED CARE ORGANIZATION
PIN — PARENTS INVOLVED NETWORK
PLCB — PENNSYLVANIA LIQUOR CONTROL BOARD
PMU — PSYCHIATRIC MEDICAL UNIT
POM — PERFORMANCE OUTCOME MEASURES
POMS — PERFORMANCE OUTCOME MEASUREMENT SYSTEM
PPO — PREFERRED PROVIDERS ORGANIZATION
PT — PHYSICAL THERAPIST

Q

QA — QUALITY ASSURANCE
QAPIP — QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM
QHP — QUALIFIED HEALTH PLAN
QI — QUALITY IMPROVEMENT
QM — QUALITY MANAGEMENT

R

RC — RESOURCE COORDINATION
REM — RAPID EYE MOVEMENT (OUTPATIENT)
RFP — REQUEST FOR PROPOSAL
RTF — RESIDENTIAL TREATMENT FACILITY

S

SA — SUBSTANCE ABUSE
SAMHSA — SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
SAP —STUDENT ASSISTANCE PROGRAM
SCA — SINGLE COUNTY AUTHORITY ON DRUG AND ALCOHOL
SD — SCHOOL DISTRICT
SED — SOCIALLY AND EMOTIONALLY DISTURBED (EDUCATION)
SED — SERIOUSLY EMOTIONALLY DISTURBED (MENTAL HEALTH)
SEP — SUPPORTED EMPLOYMENT PROGRAM
SHP — SUPPORTED HOUSING PROGRAM
SLP — SUPPORTED LIVING PROGRAM
SNU — SPECIAL NEEDS UNIT
SOC — SYSTEMS OF CARE
SSI — SUPPLEMENTAL SECURITY INCOME
STD — SEXUALLY TRANSMITTED DISEASES

T

TANF — TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
TC — THERAPEUTIC COMMUNITY
TCM — TARGETED CASE MANAGEMENT
TIC — TRAUMA-INFORMED CARE
TSS- Therapeutic Staff Support

U

UM — UTILIZATION MANAGEMENT
UM/QM — UTILIZATION MANAGEMENT/QUALITY MANAGEMENT
UR — UTILIZATION REVIEW

V

VA — VETERAN'S ADMINISTRATION
VNA — VISITING NURSE ASSOCIATION
VOC REHAB — VOCATIONAL REHABILITATION

W

WIC — WOMEN’S, INFANT’S AND CHILDREN (PROGRAM)

15. Online Resources

Parent Support

1. **Pa Parent and Family Alliance**-Podcasts, Parent Peer Support, Free Community parent support groups, school and family specific resources https://www.paparentandfamilyalliance.org/

2. **PA Families** Statewide Family Network providing support to families raising children and youth with emotional, behavioral, and special needs, as well as serving as an advocate in the different child serving systems PA Families Inc | Empowering families across Pennsylvania

3. **Understood**- Free website of resources and supports so people who learn and think differently can thrive — in school, at work, and throughout life. Find various tools and resources to support your child https://www.understood.org/

4. **Common Sense Media-** Recommendations on age-appropriate media for families including movies, TV, books, games, podcasts, and app https://www.commonsensemedia.org/

Education Supports

1. **PEAL Center** Educational Advocacy/Training 1-866-950-1040; https://www.pealcenter.org/

2. **Education Consult Line** Assists parents and advocates of children with disabilities or children 1-800-879-2301; ConsultLine (pa.gov)

3. **Pa Department of Education** Special Education (pa.gov)

4. **Pennsylvania's Education for Children and Youth Experiencing Homelessness (PA ECYEH)** Program Directory provides information that can assist you in ensuring students experiencing homelessness receive the services they require PA ECYEH Directory (center-school.org)

Various Disabilities Supports

1. **ASERT** List of community and resources specific to Autism- narrow down support groups, various topics on social stories, etc https://paautism.org

2. **Special Kids Network** assists providers and parents of children and youth with special health care needs access local services and supports for ages birth-21. Supports Education needs, transportation, housing, waiver programs, transition supports, employment, child care, etc. 1-800-986-4550 Special Kids Network (pa.gov)

3. **Disability Rights PA (DRP)** DRP helps people with disabilities in many areas such as abuse and neglect, access to community services, discrimination, ADA compliance issues, education, assistive technology, voting access, and access to Medical Assistance services. We help people with developmental disabilities, physical and sensory disabilities, brain injury, and people in mental health recovery. Disability Rights Pennsylvania | Protecting and Advancing the Rights of People with Disabilities (disabilityrightspa.org) **1-717-236-8110 or 1-800-692-7443**

4. **PA Health Law Project** non-profit legal services organization that represents Pennsylvanians who need help getting or keeping Medicaid (also known as Medical Assistance or MA) Pennsylvania Health Law Project | Helping People in Need Get the Healthcare They Deserve (phlp.org)

5. **Elks Nurse** no cost medical trained nurse supports children/adolescents in need of advocacy medical support such as access to equipment, education support, respite, community support What We Do – PA Elks Home Service Program

Grandparent Raising Grandchildren Supports

1. **Kin Connector** Providing guidance, advice, and support for kinship care families throughout Pennsylvania including resources and virtual support groups. Kinship caregivers are blood and non-blood relatives (ie teachers, coaches, and family friends) who care for children when their biological parents can't1-866-546-2111 https://kinconnector.org

2. **Aging Caregiver Support Program** Support for individuals age 55 and older, Not the biological parent of the child(ren), Related by blood, marriage, or adoption Has legal guardianship, or is raising the child(ren) informally and the dependent child under age 18. Alleviate the stresses associated with caregiving by providing access to respite care,

addressing the need for formal and informal supports, and providing financial reimbursement for out-of-pocket costs associated Caregiver Support (pa.gov)

3. **Statewide Adoption & Permanency Network (SWAN)**- Helpline that provide education, encouragement and follow up to assess how families are progressing in their journey to becoming a permanency resource and support and resources to families who have adopted or provide legal guardianship or kinship level care. Support groups, case advocacy, and respite are offered SWAN | Department of Human Services | Commonwealth of Pennsylvania 1-800-585-SWAN

Transition Supports

1. **Transition Checklist**- developed to assist schools in closing this gap of transition planning to adulthood for individuals with disabilities The FINAL Transition May 9 2013.pdf (pa.gov)

2. **Bureau of Supports for Autism and Special Populations (BSASP)** 1-866-539-7689 BAS Autism Programs | Department of Human Services | Commonwealth of Pennsylvania Autism-specific programs for adults with Autism Spectrum Disorder (ASD) for Pennsylvania The Commonwealth offers two programs specifically designed for adults with ASD: the Adult Autism Waiver (AAW) and the Adult Community Autism Program (ACAP)

3. **Youth MOVE PA** is a statewide youth & young adult advocacy organization dedicated to eliminating stigma surrounding mental health while promoting wellness and recovery for those seeking aid along their journey. Home (wildapricot.org)

Resource Guides/Basic Need Supports

1. **PA Navigate**- Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help starts here. This website permits the user to filter resources into any language PA Navigate by findhelp - Search and Connect to Social Care (pa-navigate.org)

2. **211-** Family Resources - PA 211 211 connects you to expert for various resources- basic needs, physical health, work support, etc