

**Quality Management Outcomes Team  
Meeting Minutes  
February 28, 2008 10:00 a.m. – 2:00 p.m.  
held at  
KY Department for Mental Health & Mental Retardation Services  
100 Fair Oaks Lane, Frankfort**

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**Meeting Overview:** The purpose of today's meeting is to discuss Department efforts to move the Evidence Based Practice agenda forward as well as Federal reporting requirements. Further, we'll have follow-up discussion on the group's idea of a toolkit for use in measuring functioning. Our chairperson will also address the use of the BPRS in mobile crisis units.

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**Attending Representatives:**

<p><b>ARC of Kentucky</b> Not Attending</p> <p><b>Brain Injury Association of KY</b> Not Attending</p> <p><b>KAPP</b> Not Attending</p> <p><b>KARP</b> Carl Boes Steve Shannon</p> <p><b>Kentucky Consumer Advocate Network</b> Not Attending</p> <p><b>Kentucky Department for Medicaid Services</b> Not Attending</p> <p><b>Kentucky Department for Public Health</b> Linda Lancaster</p> <p><b>KDMHMRS:</b> <b>Mental Health / Substance Abuse:</b> Phyllis Parker (<b>Acting Chairperson in Ms. Hillman's absence</b>) Anita Jennings Michele Blevins Rita Ruggles Tom Beatty</p> <p><b>Mental Retardation:</b> Kedra Fitzpatrick</p> <p><b>Administration &amp; Financial Management:</b> Hope Barrett: (<b>Facilitator</b>) David Smith</p>	<p><b>KDMHMRS:</b> <b>Commissioner's Office:</b> Not Attending</p> <p><b>KY Partnership for Families &amp; Children</b> Bill Hobstetter</p> <p><b>Kentucky Protection Advocacy Council</b> Not Attending</p> <p><b>Regional MH/MR Boards</b> <b>Four Rivers:</b> Dick Lovell Joseph Stambaugh <b>Pennyroyal:</b> Kecia Fulcher <b>River Valley:</b> Not Attending <b>Lifeskills:</b> Doug Bradley <b>Communicare:</b> Kelli Durrett Angela Mullins Terry Reams <b>Seven Counties:</b> Patricia Geftos Ron Van Treuen <b>Northkey:</b> Nan Genther <b>Comprehend:</b> Barbara Jefferson <b>Pathways:</b> Not Attending <b>Mountain:</b> Not Attending <b>Kentucky River:</b> Not Attending <b>Cumberland River:</b> Not Attending <b>Adanta:</b> Cathy Settle <b>Bluegrass:</b> Not Attending</p> <p><b>UK-Center on Drug &amp; Alcohol Research</b> Not Attending</p> <p><b>UK-Interdisciplinary Human Development Institute (IHDI)</b> Not Attending</p> <p><b>UK- Research and Data Management (RDMC)</b> Jeff Talbert</p>
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## 1. Introductions – Welcome

- The group welcomed Phyllis Parker, KDMHMRS. For today’s meeting, Phyllis Parker is acting Chairperson in Donna Hillman’s absence.
- The group also welcomed Rita Ruggles, KDMHMRS. For today’s meeting, Rita Ruggles will lead the discussion on EBPs in Lou Kurtz’s absence.

Previous Meeting Follow-Up:

- **GAF Score and its relevance to measuring client functioning - FOLLOW-UP**

Today, the group intended to briefly visit this topic and reach consensus on a direction for analyzing client functioning beyond the self-reporting surveys. This agenda item was put on hold since Ms. Hillman was unable to attend today’s meeting.

## 2. Training / Discussion

- **Evidence Based Practices (EBPs)**
  - Steve Shannon introduced the idea of a “Kentucky Center of Excellence for Evidence Based Practices”. Attached to these meeting minutes is the one-page handout “Kentucky Center of Excellence for Mental Health Systems Improvement”.
  - Ms. Rita Ruggles, KDMHMRS – Division of Mental Health & Substance Abuse, led this discussion in place of Lou Kurtz whose return travel was delayed. An overview was provided of the Department’s efforts during the past two years to move forward mental health evidence-based practices (EBPs).
  - The group explored Kentucky’s ability to meet the Federal reporting requirements on EBPs. (Definitions are attached) using the following chart as a guide.
    - The group agreed that they’d like to compile a list/description with associated costs of what EBPs are working in Kentucky. It was mentioned that the KDMHMRS Plan and Budget progress includes optional narrative reporting on programs/activities that are working at the CMHCs. The group agreed that numerical data should be reported only on services that maintain fidelity to the models (report the cleanest data possible).
    - The group named that we track Children’s Wraparound Services and Cognitive Behavior Therapy (CBT). The SAMHSA recently named CBT as one that may be added to the list for Federal reporting.
  - The following represents discussion about the individual EBPs:
    - **Integrated Treatment for Co-occurring Disorders (MH/SA)**  
The group agreed that the count of services should be only for services given when
      - 1) the providing staff member is dually-qualified or
      - 2) the providing staff members are single-program qualified (i.e. SA or MH) AND are simultaneously on the same treatment team.

Further, the group recommended a service code be added to the CMHC Event data set that is dependent on an “integrated service” which is reimbursable by Dept. for Medicaid Services.

- **Supported Housing**  
It was noted that this is not a billable service. The CMHC Event data set captures this under service code 43 which should include only services provided by housing specialists/coordinators. It should not include such services provided by case managers – these would be captured under the “Case Management” service codes.
  
- **Supported Employment**  
Services which are NOT Supported Employment includes (among others):
  - Sheltered work programs
  - Vocational rehab programs serving a multitude of services in the same setting.

The services that should be captured in this service code are those provided by vocational specialists. It was noted that a staff member of KDMHMRS Adult Branch is visiting CMHCs and compiling a report on Supported Employment service delivery; we could attain her final report when it is ready.
  
- **Assertive Community Treatment**  
The Federal definition has recently changed to not require a psychiatrist to provide this service. One unanswered question from the group was “does the fidelity include a requirement on caseload?”. Recommended follow-up for further discussion could include a look at
  - the fidelity scales,
  - the barriers and costs,
  - unbundled verses unbundled services. (Unbundled services allow payment some provided services even though the entire list of services is not provided.)
  
- **Illness Management / Recovery**  
Four Rivers has a consumer group that is developing a curriculum which could be used as a template and/or example for other rural areas of Kentucky. The noted outcome is that people move on – they “graduate”. It is a peer developed program which has incorporated attainable expectations of its graduates.
  
- **Family Psychoeducation**  
It was noted that this is not a billable service. Some interpret this as effort to integrate family members into treatment planning and education. Communicare works with their local NAMI on counting such services. Four Rivers mentioned a service, not reported to the Department, which is a Saturday curriculum for family members of a SA Residential client. The family members must attend the group meetings in order to visit the client.

- **Medication Management**  
The barriers named for this are money and power/control of decision. Pennyroyal is working with physicians in hospital and outpatient settings to try and overcome these difficult issues.
- **Overall Comments**  
The CMHCs could develop cost analyses which could feed QMOT's desired compilation of EBPs that are working in Kentucky.  
There simply isn't enough money to cover general services and bills experienced by CMHCs. Increasing EBP service provision asks a state to go beyond what we can't pay for.

*Lunch break*

### **3. Reducing Data Collections**

- **BPRS related to Crisis Events**  
The Chairperson, Donna Hillman, has addressed the question brought before the group: Is the BPRS the best tool to use in measuring client "improvement" when treated by a mobile crisis unit?  
  
On February 27, 2008, Donna signed a decision memo that states a change in requirements for only the mobile crisis programs. Copies of the decision memo were handed out at today's QMOT meeting and will be posted on the QMOT website in the section "Other Documents" for future reference  
<http://mhmr.ky.gov/cmhc/qmot.asp> .
- **Criminal Justice Arrest Data:** An update was given on efforts to report arrests associated with clients receiving mental health services as federally required.

### **4. Updates**

Today's updates on EBP activities are built into the meeting minute points above.

### **5. Next: Meeting Schedule....see next page**

5. **Next: Meeting Schedule**

Please check the QMOT web site for updated details on calendar events:

<http://mhmr.ky.gov/cmhc/qmot.asp>

The next meeting is:

**May 13, 2008** (*This meeting is moved from our regularly scheduled 4<sup>th</sup> Thursday due to other meeting conflicts.*)

(topic of interest: Emergency Services System of Care )

**10:00 a.m. – 2:00 p.m. with a brief networking/lunch break.**

**LOCATION: downtown Frankfort – Transportation Cabinet’s  
Conference Center room 107 – 200 Mero Street**

**Fiscal Year 2008 Meeting Schedule:**

This group meets bimonthly 4<sup>th</sup> Thursday 10:00 a.m. – 2:00 p.m. with a brief lunch break

- **June 26, 2008**
- **August 28, 2008**
- **October 23, 2008**

# Kentucky Center of Excellence for Mental Health Systems Improvement

## Background & Rationale

The Department for Mental Health and Mental Retardation Services (the Department) has been working with providers and other stakeholders over a number of years to improve the quality and variety of services and supports within the public mental health system. Key recent initiatives have included visits to each of the community mental health centers to catalog best practice efforts, the formation of an internal branch within the Department focused on training, technical assistance and research, and the implementation of an 18 month NIMH funded Evidence-Based Practice Planning grant. The most recent development (December, 2007) is the award of a SAMHSA Transformation Transfer Initiative (TTI) grant designed to further implement peer support services for adults with serious mental illness and the wraparound model for children with serious emotional disturbance in the public mental health system. These efforts, in concert with federal calls for systems transformation, have led to the recognition of a need for a state infrastructure to support the adoption, implementation and sustainability of evidence-based and other “best” practices.

The most critical recommendation made by the Evidence-Based Practice Planning Advisory Group was for the Department to “develop a singularly-focused program, through a collaborative partnership with consumers, families, and youth, that focused on developing the infrastructure necessary to support the identification, adoption, implementation, and sustainability of best practices”. This proposal is a direct result of this recommendation.

## Mission

The mission of the Kentucky Center of Excellence for Mental Health Systems Improvement is to promote excellence in public mental health services through training, technical assistance, research, and policy development.

## Plan

To develop a university-based Center of Excellence to disseminate and facilitate implementation of best practices, broker relationships among practitioners and researchers, provide training and technical assistance, identify and develop innovative services and supports, provide forums for the exchange of information and ideas around specific services and supports, seek external funding, and facilitate change management. The Center will be modeled after successful efforts in other states (see supplemental materials).

The Center of Excellence will be a collaborative partnership among the Kentucky Department for Mental Health and Mental Retardation Services, the Kentucky Association of Regional Programs, the University of Kentucky, and the National Alliance for the Mentally Ill - Kentucky.

## Advisory Board

An Advisory Board will be established to direct fund raising and Center planning efforts. Membership will be comprised of individuals from various sectors of the public mental health system including consumers, family members, providers, researchers (academia ?), and state employees.

## Resources

A request for a Center of Excellence for SFY 2009 and 2010 as part of the Department’s budget request was initiated at \$400,000 per year in each year of the biennium. If supported, a request for proposal would be developed and put out for bid to entities interested in creating a Center of Excellence that would support the proposed mission statement.

It is anticipated that each major partner would contribute some resources to the Center’s operation. This may include:

- Department for Mental Health and Mental Retardation Services (provides personnel and funding)
- Kentucky Association of Regional Programs (provides funding)
- University partner (provides space and support services)
- NAMI – Kentucky (provides funding)

## ASSERTIVE COMMUNITY TREATMENT

### I. DEFINITION

A team based approach to the provision of treatment, rehabilitation and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations, Lehman, Steinwachs and Co-Investigators of Patient Outcomes Research Team, Schizophrenia Bulletin, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (Mental Health: A Report of the Surgeon General, December, 1999, Chapter 4, "Adults and Mental Health, Service Delivery, Assertive Community Treatment"). Additionally, CMS (formerly HCFA) recommended that state Medicaid agencies consider adding the service to their State Plans in HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

### II. FIDELITY MEASURE

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/>

### III. MINIMUM REQUIREMENTS FOR REPORTING ACT

- Small caseload: Client/ provider ratio of 10:1 or fewer is the ideal.
- Multidisciplinary team approach: This is a team approach rather than an approach which emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, substance abuse specialist. For reporting purposes, there should be at least 3 FTE on the team
- Includes clinical component: In addition to case management, the program directly provides services such as: psychiatric services, counseling / psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.
- Services provided in community settings: Program works to monitor status, develop community living skills in the community rather than the office.
- Responsibility for crisis services: Program has 24-hour responsibility for covering psychiatric crises.

### IV. ACT IS NOT INTENSIVE CASE MANAGEMENT

**Note: If specific EBPs are provided as a component of ACT, they should be reported under ACT and not separately under other practices. In the revised version of the tables, please check off the EBPs that are provided under ACT. (Please note that to report these as EBPs; they should conform to the reporting guidelines for each EBP provided in this document.)**

## SUPPORTED EMPLOYMENT

### I. DEFINITION

Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client: staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

### II. FIDELITY MEASURE

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/employment/>

### III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED EMPLOYMENT

- Competitive employment: Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.
- Integration with treatment: Employment specialists are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.
- Rapid job search: The search for competitive jobs occurs rapidly after program entry.
- Eligibility based on consumer choice (not client characteristics): No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.
- Follow-along support: Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

### IV. SUPPORTED EMPLOYMENT IS NOT:

- Prevocational training
- Sheltered work
- Employment in enclaves (that is in settings, where only people with disabilities are employed)
- [If an employment specialist is part of an ACT team, this should be reported under ACT and not separately as supported employment.]

## SUPPORTED HOUSING

### I. DEFINITION

Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assists clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

### II. FIDELITY MEASURE (Not currently available)

### III. MINIMUM REQUIREMENTS FOR REPORTING SUPPORTED HOUSING

- Target population: Targeted to persons who would not have a viable housing arrangement without this service.
- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, supported housing provided for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.
- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

### IV. SUPPORTED HOUSING IS NOT:

- Residential treatment services.
- A component of case management or ACT.

## FAMILY PSYCHO-EDUCATION

### I. DEFINITION

Family psycho-education is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psycho-education programs may be either multi-family or single-family focused. Core characteristics of family psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

### II. FIDELITY MEASURE

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/>

### III. MINIMUM REQUIREMENTS FOR REPORTING FAMILY PSYCHO-EDUCATION

- A structured curriculum is used.
- Psycho-education is a part of clinical treatment.

### IV. FAMILY PSYCHO-EDUCATION IS NOT:

Several mechanisms for family psycho-education exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. For DIG reporting, do not include family psycho-education models not involving a clinician as part of clinical treatment.

**Note: Some states are providing NAMI's Family-to-Family program and not the family psycho-education EBP described above. If a state is providing NAMI's Family-to-Family program, this should be reported under family psycho-education with an asterisk and a note indicating that the numbers reflect the NAMI program and not the EBP described above.**

## INTEGRATED TREATMENT FOR CO-OCCURRING DISORDER (MENTAL HEALTH / SUBSTANCE ABUSE)

### I. DEFINITION

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

### II. FIDELITY MEASURE

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>

### III. MINIMUM REQUIREMENTS FOR REPORTING INTEGRATED TREATMENT

- Multidisciplinary team: A team of clinical, working in one setting provides MH and SA interventions in a coordinated fashion.
- Stagewise interventions: That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention)

### IV. INTEGRATED TREATMENT IS NOT:

- Coordination of clinical services across provider agencies

## ILLNESS MANAGEMENT / RECOVERY

### I. DEFINITION

**Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness, strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.**

### II. FIDELITY MEASURE

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/>

### III. MINIMUM REQUIREMENTS FOR REPORTING ILLNESS MANAGEMENT & RECOVERY

- Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

### IV. EVIDENCE-BASED ILLNESS MANAGEMENT IS NOT:

- Advice related to self-care but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

## **MEDICATION MANAGEMENT**

### **I. DEFINITION**

In the toolkit on medication management there does not appear to be any explicit definition of medication management. However the critical elements identified for evidence-based medication management approaches are the following:

1. Utilization of a systematic plan for medication management
2. Objective measures of outcome are produced
3. Documentation is thorough and clear
4. Consumers and practitioners share in the decision-making

### **II. FIDELITY MEASURE**

<http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/>

### **III. MINIMUM REQUIREMENTS FOR REPORTING MEDICATION MANAGEMENT**

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of antipsychotic medication and changes are based on clinical guidelines.

### **IV. EVIDENCE-BASED MEDICATION MANAGEMENT IS NOT:**

- Medication prescription administration that occurs without the minimum requirements specified above.

## MULTISYSTEMIC THERAPY (MST)

### I. DEFINITION

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

### II. FIDELITY MEASURE (Contact Jeanne Rivard at 703-682-9468 or [Jeanne.rivard@nri-inc.org](mailto:Jeanne.rivard@nri-inc.org) .

### III. MINIMUM REQUIREMENTS

- Services take into account the life situation and environment of the child / adolescent and involve peers, school staff, parents, etc.
- Services are individualized
- Services are provided by MST Therapists or masters-level professional
- Services are time-limited
- Services are available 24/7

## THERAPEUTIC FOSTER CARE

### I. DEFINITION

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed.”

II. FIDELITY MEASURE (Contact Jeanne Rivard at 703-682-9468 or [Jeanne.rivard@nri-inc.org](mailto:Jeanne.rivard@nri-inc.org))

### III. MINIMUM REQUIREMENTS FOR REPORTING

- There is an explicit focus on treatment
- There is an explicit program to train and supervise treatment foster parents
- Placement is in the individual family home

### IV. THERAPEUTIC FOSTER CARE IS NOT:

- An enhanced version of regular foster care.

## FUNCTIONAL FAMILY THERAPY (FFT)

### I. DEFINITION

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

### II. FIDELITY MEASURE (Contact Jeanne Rivard at 703-682-9468 or [Jeanne.rivard@nri-inc.org](mailto:Jeanne.rivard@nri-inc.org))

### III. MINIMUM REQUIREMENTS

- Services are provided in phases related to engagement, motivation, assessment, behavior change, etc.
- Services are short-term, ranging from 8-26 hours of direct service time
- Flexible delivery of service by one and two person teams to clients in-home, clinic, juvenile court, and at time of re-entry from institutional placement.