



**COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH  
MENTAL HEALTH SERVICES ACT  
PROGRAM SUPPORT BUREAU  
PREVENTION AND EARLY INTERVENTION DIVISION**

**FREQUENTLY ASKED QUESTIONS**

**ABOUT**

**PEI EVIDENCE BASED PRACTICES**

**REVISED SEPTEMBER 1, 2016**

# FREQUENTLY ASKED QUESTIONS ABOUT PEI EVIDENCE BASED PRACTICES

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For Outcome-related FAQs,  
please refer to PEI Outcomes FAQs at  
<http://dmhoma.pbworks.com/w/page/40360716/PEI%20Outcomes%20FAQ>  
or contact [PEIOutcomes@dmh.lacounty.gov](mailto:PEIOutcomes@dmh.lacounty.gov)

## **AGGRESSION REPLACEMENT TRAINING (ART)**

**1. What are the components of ART®?**

The components of ART® are based on social learning and cognitive behavior theories:

1. Skillstreaming

- The behavioral component
- *Teaches what to do*

2. Anger Control Training

- The emotional component
- *Teaches how to recognize and control anger*

3. Moral Reasoning Training

- The cognitive component
- *Teaches why to use pro-social skills*

**2. What is the age range for ART®?**

ART® (all 3 components) is for clients ages 12-17. Clients who are ages 5-12 are to be provided with **only** the Skillstreaming component of ART®.

**3. What is the focus of treatment for ART®?**

The focus of treatment for ART® includes children and youth with disruptive behavior disorders who are at risk of or involved with the juvenile justice system.

**4. What is the treatment modality?**

The treatment modality for ART® is group format. Individual sessions may be used to make up missed group sessions.

**5. What are the minimum and maximum clients allowed per group?**

The developer recommends 8 to 10 participants per group; not to exceed 12.

**6. How many group facilitators are needed?**

Model adherent ART® groups are conducted by 2 facilitators (co-facilitators).

**7. How often should ART® sessions be conducted?**

Model adherent ART® sessions are conducted in 3 group sessions (using each of the 3 components: Skillstreaming, Anger Control and Moral Reasoning) per week. When providing the Skillstreaming component of ART® only, for clients ages 5-12, sessions (in Skillstreaming only) are conducted 1 time per week.

**8. What is the length of treatment?**

The length of treatment for model adherent ART® is 10 weeks. When providing the Skillstreaming component of ART® only, for clients age 5-12, the length of treatment is also 10 weeks.

**9. What are the “Core Interventions” for ART®?**

The “Core Interventions” include:

- i. Assessment
- ii. Collateral
- iii. Group Psychotherapy
- iv. Group Rehabilitation
- v. Individual Psychotherapy (to “make up” a missed group session)
- vi. Individual Rehabilitation Service (to “make up” a missed group session)

**10. Do you have to be a licensed clinician to implement ART® under the PEI Plan?**

No. Please see Question #11. Please see current version of the County of Los Angeles – DMH, “A Guide to Procedure Codes” for specific Rendering Provider eligibility.

**11. What is the minimum amount of education required to be trained in and apply this evidenced based treatment, in order to stay within an appropriate “scope of practice?”**

The services listed under Core Interventions for each evidenced based treatment will determine the rendering provider’s scope of practice. For example, if one of the core services is Assessment, an AMHD must complete the Assessment. If the core service is Individual Rehabilitation (Rehab), anyone within their scope of practice can provide Rehab services.

As it relates to non-licensed staff (Medical Case Worker, Substance Abuse Counselor, and Community Worker) providing individual/group rehabilitation will be based on the supervisor’s discretion. This means that the supervisor has assessed the staff’s knowledge, experience, and reviewed staff’s documentation and decided that the staff is capable of providing and documenting Rehab services (with or without co-signature).

**12. Is there a “train the trainer” model for ART®? Yes. The**

“train the trainer” model for ART® includes:

- i. Completion of the ART® training protocol
- ii. Co-facilitate a minimum of 72 groups within a 12-month period, with at least 12 groups in each component
- iii. Rating of competency on each item of the Trainer Competency Rating Scale on at least one submitted videotaped session that occurred within 12 months
- iv. 2-day Agency Trainer training
- v. Participation in 15 consultation calls
- vi. Conduct and complete ART required training protocol with 2-6 trainees
- vii. Videotaped submission of excerpts of conducted trainings
- viii. Demonstration of trainer proficiency by videotape review of trainees

**13. What are the required Outcome Questionnaires for ART®?**

DMH PEI Outcome Measures Application Requirements: The outcome measures should be administered pre- and post-treatment. Additionally, if the ART® treatment extends beyond 6

months, an update for each measure is required every 6 months. The required outcome measures are the following:

- Youth Outcome Questionnaire (YOQ)
- Youth Outcome Questionnaire-Self Report (YOQ-SR)
- Eyberg Student Behavior Inventory (ECBI) or Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R), if parent is unavailable to complete the ECBI

Note: Even though the SESBI-R is required only when the ECBI cannot be obtained, both the ECBI and SESBI-R must be acknowledged in the PEI OMA. This is achieved by entering either the scores or an 'Unable to Collect Reason Code' for each measure.

CIHBS/Developer Requirement: The SkillStreaming Checklist is required to be administered pre and post Social Skills Training component of ART®. The developer highly recommends the Aggression and How I Think Questionnaires to be administered pre and post the Anger Control Training and Training in Moral Reasoning components of ART®, respectively.

**14. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs, YOQ-SR)?**

Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation can be completed by a person enrolled in a graduate degree program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waived staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

**15. What staff qualifications are required to administer, score/interpret, and input data for the ECBI and SESBI-R?**

Administration can be completed by a trained professional with a minimum of a bachelor's degree in psychology or related field. Scoring and interpretation can be completed by a person enrolled in a graduate degree program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waived staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

**CENTER FOR THE ASSESSMENT & PREVENTION OF PRODROMAL STATES (CAPPS)**

**1. What is CAPPS?**

CAPPS stands for the “Center for Assessment and Prevention of Prodromal States”. It is named after the agency and not the practice. CAPPS is a family focused therapy for youth at ultra-high risk for psychosis and their families. It is a manualized 18-session family focused treatment program. The actual name for this practice is called Family-Focused Therapy for Prodromal Youth (FFT-PY). However, in order to avoid any confusion with our existing Functional Family Therapy (FFT) EBP, DMH decided to call this EBP “CAPPS”.

**2. What is the population to be served under Los Angeles County’s PEI Plan?**

Our PEI plan serves individuals and their families for whom a short duration (usually less than one year) and relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation. This early intervention avoids the need for more extensive mental health treatment or services, and prevent a mental health problem from getting worse.

**3. What are the age range limits for implementing CAPPS under the PEI Plan at this time?**

CAPPS is currently being implemented for transition age youth and young adults, ages 16 – 25, and their families.

**4. What is the length of treatment?**

This is a structured manualized approach that is designed to consist of 18 sessions over 6 months. The length of treatment will depend on how many topics are covered, the number of sessions needed by the family to complete a topic, and the frequency of sessions.

**5. How often should CAPPS sessions be conducted?**

CAPPS family focused therapy sessions are conducted in 12 weekly sessions for the first 3 months, then 6 bi-weekly sessions over the next 3 months for a total of 18 sessions over a 6 months period to adhere to the fidelity of the model.

**6. Are there a maximum number of sessions?**

On average, each topic is covered in 1- 2 sessions. Therefore, if all 18 topics are completed, the number of sessions may range from 18 to 36.

**7. Does CAPPS have mandatory topics?**

Yes. This is a structured model with recommended sequencing of the specific topics. There are 18 specific topics that are to be covered depending on the family’s needs. The sessions will consist of 3 treatment modules with topics addressing Educational Sessions, Communication Enhancement Training, and Problem Solving Skills Training.

**8. How many topics are recommended for treatment? Is there a maximum or minimum?**

This model recommends the coverage of all 18 topic areas. There is some flexibility in terms of the order in which the later topics are covered based on the needs of the family.

- 9. What is the CAPPS therapy model staffing required?**  
This model requires a minimum of two clinicians and one clinical supervisor to implement the CAPPS practice.
- 10. Is CAPPS considered a crisis intervention?**  
No.
- 11. Since family sessions are a core service, what should the content of the family sessions be?**  
This model is based on the Family Focused Treatment Approach. The model is developed for 18 treatment sessions to be delivered within a 6 month period. These sessions will consist of 3 treatment modules that focus on Educational Sessions, Communication Enhancement Training, and Problem Solving Skills Training.
- 12. Is there a “train the trainer” for CAPPS practice?**  
Yes. Once the clinical supervisor has satisfactorily met the requirements listed for Therapist Competency and Adherence Scale (TCAS) and inter-rater reliability competency with the developer for supervisors, they are able to train new staff to the CAPPS practice for their assigned agency only.
- 13. Does the Department expect that agencies providing CAPPS treatment will have their staff complete the CAPPS Competency and Adherence Scale and Supervisory Trainings?**  
Yes, this training is required as part of the certification process. Additionally, this training also ensures fidelity to the practice model and sustainability of the practice.
- 14. Are Outcome Measures required and how often do they need to be completed?**  
Outcome measures are required to be administered at the beginning and at the end of treatment. The general measures include the Youth Outcome Questionnaires and the specific outcome measures are the Structured Interview for Prodromal Syndromes (SIPS) and Scale of Prodromal Symptoms (SOPS).
- 15. Does the CAPPS Supervisor have to be a Clinical Supervisor?**  
Yes. At minimum, each agency is required to designate a CAPPS Clinical Supervisor. This Supervisor is required to be a licensed mental health clinician that is trained in the CAPPS practice.
- 16. What are the “Core Interventions” for CAPPS?**  
Assessment/Psychiatric Diagnostic Interview  
Family Psychotherapy  
Collateral
- 17. What are “None Core Interventions” for CAPPS?**  
Individual Therapy  
Group Psychotherapy  
Targeted Case Management/Outreach and Engagement

Medication Support

- 18. Do you have to be a mental health clinician to deliver the CAPPS treatment services?**  
Yes.
- 19. What is the minimum amount of education required to be trained in and to provide CAPPS therapy services to clients in order to stay within an appropriate “scope of practice”?**

This clinical treatment model provides therapy that is based on family therapy and cognitive behavioral therapy treatment approaches. All therapy must be conducted by clinicians that are at least at the master’s level or higher and are licensed or license eligible.

There is a case management function that may be done by a Bachelors level case manager that includes outreach and engagement of clients.

## **COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)**

- 1. Can the principal or principal designee participate in place of the teacher?** Although principals and other administrators can participate in teacher in-service education on trauma, it is not recommended that they take the place of the teacher. Teachers are the primary point of contact for students and have much to benefit from understanding the many problems that can result from traumatic experiences.
- 2. Are the two-parent education sessions held in group format or are they with each parent and a participating child?**  
It is up to the Provider. However, individual sessions with parents appear to be the best way to involve them.
- 3. Is the Provider responsible for communicating and making arrangements for space (rooms) with the schools?**  
Yes. All experienced school-based mental health service Providers are well aware of how to negotiate with schools for space. Space is at a premium in most inner city schools. Some school-based clinicians do individual therapy in creative “found” space. CBITS presents a particular challenge because a school may not have the space to allocate for a group once a week for ten weeks.
- 4. What is the role of the DMH school-based coordinator?**  
This role may differ from Service Area to Service Area based on the unique needs of the population being served. Please consult with your service area lead District Chief or contract lead to discuss the role that your specific DMH school-based coordinator will play.
- 5. Is there a limit to repeating the group?**  
Many youth screened for CBITS have experienced multiple traumas. It is recommended that the youth and therapist select one trauma that can be worked on successfully. Other traumas may require other forms of treatment. It is hoped that the lessons learned in CBITS would generalize to other traumatic events. Repeating CBITS for any child should be discussed with Provider Supervisors/Managers and possibly with Service Area Program Administrative staff persons. The CBITS Child PEI Team lead can also be consulted.
- 6. Can CBITS be delivered in a setting other than a school site?\***  
Yes, however it is the provider’s responsibility to ensure that even if CBITS is NOT being delivered in a school site that there be clear documentation in the clinical record of ongoing coordination/communication/linkage by provider staff with school personnel regarding the client/family being served.

**7. Since high drop-out rates occur in groups, can one therapist conduct the CBITS group if it dropped to five students?\***

There is no absolute prohibition against one therapist running a group alone, although it is felt this might be taxing for that therapist. The problem is not solely the group count. It is important to remember that for this EBP each participant receives group therapy as well as 3 individual sessions, 1-2 collateral sessions and teacher education. The individual sessions occur in the early stages of the treatment targeting exposure before the group sessions, and the collateral sessions occur toward the end of the treatment.

## **CHILD-PARENT PSYCHOTHERAPY (CPP)**

- 1. What is the age range for the CPP model (what ages are included)?**  
Clients starting treatment can range from 0 months to 5 years, 11months. Treatment must begin on or before the 6<sup>th</sup> birthday. Once in treatment, CPP is validated for children ages 0 to 6 years.
- 2. Must my client have experienced trauma to qualify for CPP?**  
Yes, for the purposes of claiming to the DMH PEI Child Plan the child must have experienced trauma. You may use CPP to serve other populations with a different funding source.
- 3. How is “trauma” defined for babies/toddlers and what do I look for as far as symptoms in this young population?**  
If your agency is implementing Child Parent Psychotherapy, it is important that your agency has the ability to provide clinicians with supervision, consultation, and training in early childhood trauma. Please see Scope of Practice (below).
- 4. Must my client have a diagnosis of PTSD for the CPP model?**  
No, PTSD does not have to be the diagnosis in order to use the CPP model, but please use your clinical judgment to decide if CPP is an appropriate model for your client. As is always the case, in order to claim to Medi-Cal, your client must meet criteria for a Medi-Cal eligible diagnosis and the service provided must be claimable to Medi-Cal. Trauma screening is considered an important element of the CPP model. The CPP model strongly encourages screening for trauma prior to beginning treatment. Your agency is at liberty to select the screening tools of your choice. The developers recommend The Life Stressor Checklist-Revised (which screens for the caregivers trauma) and the Traumatic Events Screening Inventory – Parent Report Revised (parent report of the child's trauma). Both of these measures are free, were distributed at the CPP training, and are available on the CPP drop box link for trainees. It is recommended that as Trauma is the focus of treatment for providing CPP under PEI funding that your agency be mindful for how to route clients who are the best match for a treatment modality that focuses on trauma to CPP.
- 5. What are the outcome measures for CPP?**  
The outcomes are YOQ-Parent Report (ages 4+) and Trauma Symptom Checklist for Young Children (ages 3+).
- 6. What outcomes do I collect if my client is too young for the outcome measures? Do I collect outcomes for children under three years of age?**  
Please be consistent with normed age range for the outcome measures. You are not required to report outcomes for children under the age of 3.
- 7. What are the screening measures for CPP?**  
The CPP model strongly encourages screening for trauma prior to beginning treatment.

Your agency is at liberty to select the screening tools of your choice. The developers recommend *The Life Stressor Checklist-Revised* (which screens for the caregivers trauma) and the *Traumatic Events Screening Inventory – Parent Report Revised* (parent report of the child's trauma). Both of these measures are free, were distributed at the CPP training, and are available on the CPP drop box link for trainees.

- 8. The CPP model requires talking with the caregiver about the child's trauma and the caregiver's trauma. To do this, we have to meet with the caregiver alone prior to meeting with the child. Can we open the case without seeing the child?**  
No, you cannot open the case prior to seeing the client.
- 9. If I cannot open the case, can I claim for service prior to opening the case?**  
Yes, you can have a collateral session prior to having face-to-face contact with the client; HOWEVER, you must have face-to-face contact with the client within the same calendar month. Please refer to *Bulletin 09-07 Opening Date for Case Episodes* dated November 13, 2009 for guidelines.
- 10. As part of the CPP training, we need to complete process/narrative notes. Can we claim for that time?**  
No, the process/narrative note is not a service to the client; it cannot be claimed to Medi-Cal as a service to the client. The intention of the process/narrative note is to benefit the clinician's learning.
- 11. What kinds of trainings/resources might we seek out to build our clinicians' capacity to serve children ages 0-5?**  
Endorsement guidelines for Infant-Family and Early Childhood Mental Health Specialists for professionals serving children ages 0-5 in California have been developed. The guidelines can be found at <http://cacenter-ecmh.org/professional-development/>

Locally, you may also join the Los Angeles Infancy, Childhood, and Relationship Enrichment (ICARE) Network by e-mailing [ICARE@dmh.lacounty.gov](mailto:ICARE@dmh.lacounty.gov). The ICARE Network hosts quarterly meetings and sends e-mails regarding upcoming trainings and resources for working with children ages birth to five.

In addition, each Service Area has a DMH Birth to Five Coordinator. You may contact your lead district chief to find out who the DMH Birth to Five Coordinator is in your Service Area. Some Service Areas also offer regular Service Area Birth to Five Collaborative(s) that have presenters and resources for working with the 0-5 population in your Service Area of the county.

Seeking consultation and training in this specialty population is also recommended. Additionally, The National Child Traumatic Stress Network ([www.nctsn.org](http://www.nctsn.org)) has many resources available regarding childhood trauma in young children, which includes articles, screening tools, and free online courses with CEs. The Harvard Center for the Developing Child also has articles and videos on the impact of trauma on young children and early childhood brain development in English, Spanish, and Portuguese.

[\(http://developingchild.harvard.edu/\)](http://developingchild.harvard.edu/)

## **CRISIS ORIENTED RECOVERY SERVICES (CORS)**

**1. What is the goal of CORS?**

To provide immediate crisis intervention and increase adaptive coping strategies which the individual can utilize to manage stress and return to their previous or higher level of functioning. Specifically, CORS is designed for individuals who have experienced a recent event that has disrupted the person's usual equilibrium and created a vulnerable state.

**2. Which model is CORS based on?**

CORS is a Promising Practice based on the model developed at Didi Hirsch Community Mental Health's Benjamin Rush Center for short-term (up to six calendar weeks, or six sessions, whichever comes first) crisis intervention. Its origins are based on principles found in psychoanalysis, sociology, and life stress research. Any client receiving services in DMH who may have experienced a recent trauma, crisis or "hazardous event" may benefit from CORS.

**3. For whom is CORS appropriate?**

CORS is designed to serve children (ages 3+), transition-age-youth (TAY), adults, and older adults (OA) who have experienced a hazardous event within the previous three months. For children and families, the model allows for a 6 month timeline between the "hazardous event" and the request for help.

CORS is a Practice effective for clients presenting with Dysthymia, Anxiety disorders, and Adjustment disorders. However, other diagnoses, such as Acute Stress Disorder, Depressive Disorder Unspecified, PTSD, and even Major Depression are common and have been successfully treated with CORS. It is the presence of a stressful event and an inability to cope with the event that defines good candidates for this practice.

**4. When is CORS contraindicated?**

The model is not suited for individuals who are in a chronic state of crisis, individuals who are chronically using substances, or those who are persistently mentally ill and not able to identify a specific crisis. This Practice may be more effective for clients who voluntarily seek treatment, rather than those who are involuntarily participants. Additionally, court mandated treatment usually requires a long-term commitment (an average of 6 months to one year), and CORS is a short-term practice.

**5. What is considered a "hazardous event"?**

A "hazardous event" is an external life event that disrupts a person's usual functional equilibrium and creates or elicits a vulnerable state. The event occurs within three (3) months of the initial call or visit to the clinic for TAY, Adult, and OA and within six (6) months for children and families.

A "hazardous event" is defined as an external stressor, new to the individual(s), and has overwhelmed his/her previously successful coping strategies.

The external event signifies a loss or threat of loss, creating disequilibrium in a steady state. The possible losses include the loss of self-esteem, loss of role mastery, loss of nurturance, or loss of physical integrity (safety).

**6. What is the definition of a “crisis” in this Practice?**

A crisis is defined as “a state provoked when a person faces an obstacle (hazard) to important life goals. The obstacle is temporarily insurmountable through customary coping behaviors. A period of disorganization follows during which many attempts at solution are made. Eventually, some kind of adaptation is achieved which may be adaptive or maladaptive”.

**7. What are the key questions for clinicians in this practice?**

Based on the practice’s guidelines, clinicians should determine and document the following: “Why now?”, “How long has the hazardous event been going on?”, “What is different this time which motivated the client to contact them?”, “What coping mechanisms were used previously that are not now working?” “Who was the last contact for the person prior to asking for help?”

One of the key points in CORS is to facilitate the client’s understanding of and document the “meaning attached to the crisis” for the person or family. The meaning always involves a loss or threat of loss.

**8. What are some tools a clinician can use to determine if a client can benefit from CORS?**

The clinician can utilize a timeline to determine the specific details of the “hazardous event.”

**9. Does the clinician have to cover all three (3) phases of CORS**

Yes. The developer requires the clinician complete all three phrases:

- 1) Assessment Phase: (Session 1): The clinician assesses the client, develops a timeline of events, explores the meaning of the hazardous event, assesses for homicidal/suicidal ideation, and develops a reformulation of the crisis; including a cognitive understanding of the loss or losses involved.
- 2) Treatment Phase: (Sessions 2-5): In the treatment phase, the clinician assists the client to develop an affective understanding of the problem and establish new coping skills (Session 2-5). The clinician helps the client become aware of feelings regarding their loss or feared loss, which s/he may not have accessed during the crisis. The clinician works with the client to recognize maladaptive coping behaviors and develop adaptive coping strategies to manage the crisis. The work involves both insight on the part of the client regarding their feelings and associated responses, and behavioral change.
- 3) Termination Phase: (Session 6): The clinician summarizes the crisis, discusses possible future hazards and engages in anticipatory planning should another crisis arise, and addresses feelings related to termination. Evaluation for ongoing treatment in a different modality would also be done at this phase, however the department expects that many if not most cases will be closed.

**10. What type of treatment is generally offered through CORS?**

CORS consists of weekly individual therapy sessions for TAY, adult, and OA and weekly family therapy sessions for children.

**11. According to the practice, individual sessions can either be 60 or 90 minutes long. What is the Department's requirement?**

There is no Department mandate limiting the time frame of individual sessions. Clinicians can provide a 60-minute or 90-minute session on a weekly basis.

**12. What are the core interventions for CORS?**

The procedure codes for CORS core services are:

- Assessment (90791)
- Individual Psychotherapy (H0046,90832,90834,90837)
- Family Psychotherapy (for Children only, 90847)
- Group Psychotherapy (for Community at large, 90853)\*
- Targeted Case Management\*\* (T1017)

\*The use of Group Psychotherapy might be suitable for group members who have each experienced the same "hazardous event"; for example, a hurricane, fire, or other natural disaster. However, Group Psychotherapy is not usually indicated with this model as it applies primarily to people with individual hazards that have a particular meaning to them.

\*\*The use of targeted case management may be appropriate if providing these services will reduce the effects of the hazardous event, i.e. the client is unexpectedly homeless or unemployed, and needs to be linked to services.

**13. Who can provide CORS?**

CORS must be delivered by a trained therapist. Staff that may provide CORS include: licensed, registered, or waived MD/DO, Ph.D/Psy.D., LCSW, MFT, Psychiatric/Mental Health Clinical Nurse Specialist, a Psychiatric/Mental Health Nurse Practitioner, and student professionals in these disciplines with a co-signature.

**14. Does the Department require a clinician to maintain a certain number of CORS clients on their caseload?**

No.

**15. What role can paraprofessionals play with this Practice?**

The primary clinician can work with paraprofessional staff to ensure the client is provided linkage, case management, and care coordination.

**16. What role may a psychiatrist play within this Practice, and how are associated psychiatric services claimed?**

It is recommended by the practice that unless the client is already on medication, when possible, CORS be delivered without the initiation of medication support. This recommendation is based on CORS being time-limited (up to six calendar weeks, or six sessions, whichever comes first) in comparison to the various length of time it may take to schedule a psychiatric evaluation appointment followed by an additional time period

for the prescribed medication to reach a therapeutic level. When possible, the practice recommends medication support be provided after CORS is implemented in its entirety, if/when clinically necessary.

However, as part of the comprehensive assessment, the clinician may decide to refer the client for a psychiatric evaluation. For instance, a client presenting with symptoms of anhedonia, sleeplessness, loss of appetite, psychomotor retardation, and suicidal rumination, perhaps caused by a hazard, may respond well and quickly by the supplementation with psychotropic medication to the CORS practice.

If the CORS treatment team determines medication support is necessary, medication support can be provided in conjunction with the CORS therapy sessions. The clinician and psychiatrist can determine if continuing the medication support beyond the completion of six weeks of CORS psychotherapy is clinically indicated. The level of service that best addresses the consumer's continuing mental health needs should be documented.

**17. What is the length of treatment for CORS?**

CORS is limited to a maximum of six (6) consecutive calendar weeks, or six (6) sessions, whichever comes first. CORS is intended to address a crisis situation rather than an ongoing illness. A crisis is considered a time-limited event. Some crisis situations may resolve in a shorter period of time.

**18. Does the practice state a minimum number of weeks of treatment?**

No, there is no limit. However, a client has successfully completed CORS if the crisis the client originally came in for has resolved.

**19. Can CORS ever be extended past six weeks?**

Yes. According to the practice, the treating clinician can make the clinical decision to extend the practice for TWO weeks (i.e., 8 weeks total treatment duration) if the client experiences a second, distinct new crisis during the course of treatment.

Another possible reason for extending the treatment duration would be if the client expresses suicidal thoughts. In this case, the practice may be extended to stabilize the client and link the client to needed, ongoing mental health treatment and services outside of PEI.

**20. What should the clinician do if the client misses two or more sessions?**

Since CORS is time-limited to six calendar weeks, the practice does not recommend continuing CORS if the client misses two or more weeks. If the client misses one week of treatment, the clinician may complete two sessions in one week to make up for the missed week; however, the total time of treatment should not exceed 6 calendar weeks. Across all age groups, services claimed to a PEI billing plan must have a PEI-approved EBP code selected in the IS. The clinician will select the appropriate EBP code on the drop-down menu once s/he determines which EBP/PP/CDE best addresses the client's needs. For example, if at the initial assessment the clinician concludes the client is appropriate for CORS; s/he will select the corresponding code for "PEI CORS" (4D) in

the IS. If at the initial visit the clinician determines the client does not meet the PEI target population and, instead, refers the client to one of the MHSA CSS or non-MHSA programs, s/he will claim the services to the appropriate IS billing plan. No corresponding EBP code will need to be selected.

**21. Does the initial intake session count toward the six session limit?**

No. The week when the clinician completes the initial intake session is not included in the six allowable weeks of this practice. However, the six week session limit does begin during the week of the initial intake session, and clinicians are therefore encouraged to make efforts to schedule the first CORS session during that first week as well, whenever possible, to ensure that up to six sessions are available to the client if needed. Another option to ensure six sessions are held is to have multiple sessions held within one of the subsequent calendar weeks of the six week time frame.

**22. Can a client from one of the non-MHSA or MHSA Client Supportive Services (CSS) plans (Wellness, Field Capable Clinical Services, or Full Service Partnership) receive this Practice?**

Yes. Any client for whom CORS practice is clinically indicated can receive this CORS treatment. This is true of other PEI practices as well. The service is claimed to the MHSA plan/Level of Care in which the client receives their primary services—and NOT to PEI. For example, a CSS Wellness client can participate in CORS if the client experienced a hazardous event in the previous three (3) months which caused a crisis affecting their previous equilibrium. However, the client will continue to be billed under the "MHSA\_Fam\_Focused\_Wellness Svc" billing plan, not under the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "PEI-CORS" (4D), but no outcome measures are required when the EBP is administered to a client enrolled in a different plan (i.e., not PEI).

**23. What happens if the client successfully completes CORS?**

The client will be discharged and their case will be appropriately closed.

**24. What happens if the client continues to experience disruption in their level of functioning?**

The treating clinician should consider the following questions:

- 1) Why is the client's maladaptive response to the hazardous event still lingering? Has he/she not found an adequate alternative coping mechanism? Do we need to pull in some supportive persons in the client's life to assist?
- 2) Have we appropriately identified the hazard and the meaning of the hazard for the client, so they can understand their situation and find an alternative coping response?
- 3) Is the person experiencing unresolved grief which is now chronic?
- 4) Was CORS the most appropriate treatment to provide to this client based on the situation? If not, is there an intervention which would address the client's needs more effectively?

The treating clinician can link the client to continued care, via another non-MHSA or MHSA CSS level of service, such as FCCS or Wellness.

Some clients may be appropriately served in another PEI EBP for continued care.

**25. When should the clinician discuss the possibility of on-going treatment with the client?**

The developer recommends discussing referrals for on-going treatment during the 5<sup>th</sup> or 6<sup>th</sup> weekly session.

**26. Can a client receive CORS along with another PEI EBP?**

The goal of CORS is to help the client move forward quickly in coping with a crisis; using a brief and focused intervention and their own resources. Therefore, the Department expects that the use of multiple practices for PEI clients is occurring infrequently.

**27. What is the required training protocol?**

The CORS training protocol consists of a one-day, six-hour training. Some CORS trainers may provide additional on-site consultation support as needed to fully integrate the model into Practice.

**28. Is there a certification process?**

No. However, the model should only be practiced by clinicians who have received the full 6 hours of training in CORS.

**29. Is “train the trainer” available for CORS?**

Not at this time.

**30. Is there a Booster Training available for CORS?**

Yes. There is a CORS Booster training offered to all clinicians who have attended the initial six-hour training. The function of the Booster training is to provide a refresher of the basic tenants of the CORS model and to serve as a forum for clinicians to work active cases through the CORS model via consultation and group discussion, facilitated by the trainer. This Booster became available to all CORS-trained clinicians on a monthly basis since March 2015.

**31. Does CORS require a CORS-trained supervisor as part of the practice?**

A specific supervisor training in CORS is not available at this time. The Department does require a licensed supervisor to be available to assist the CORS clinician as needed. At a minimum, the department requires this supervisor be trained in the CORS model, and where possible, participate in an ongoing consultation group provided by DMH.

**32. What outcome measure should be used with this Practice?**

Clinicians will administer the Youth Outcome Questionnaire (YOQ) to parents of youth (ages 4-17) and Youth Outcome Questionnaire-Self report (YOQ-SR) for Children and younger TAY (ages 12-18).

Clinicians will administer the Outcome Questionnaire (OQ) (ages 19+) for older TAY,

Adults, and Older Adults.

There is no treatment specific outcome measure for this Practice for children under the age of 18, TAY, Adults, or Older Adults at this time.

**33. When should the outcome measure be completed?**

Outcome measures are to be completed within a 21 day window around the due date for that measure.

“Pre-measures” may be completed 1) on the date of the first PEI Practice Treatment Session, 2) up to 7 days before the date of the first PEI Practice Treatment Session, or 3) up to 14 days after the date of the first PEI Practice Treatment Session.

“Post-measures” may be completed 1) on the date of the last PEI Practice Treatment Session, 2) up to 7 days before the date of the last PEI Practice Treatment Session, or 3) up to 14 days after the date of last PEI Practice Treatment Session.

Updates may be done on any date between the Pre and Post Questionnaires.

**34. Can the clinician claim for administering the outcome measure?**

No, administering an outcome measure is not claimable to Medi-Cal.

## **FAMILIES OVERCOMING UNDER STRESS (FOCUS)**

**1. What is Families Overcoming Under Stress (FOCUS)?**

FOCUS is a promising practice (PP), which is a family-centered, resiliency training program designed to bridge communication and support in families contending with trauma, stress or loss. Initial implementation at the Department of Mental Health's (DMH) Directly Operated programs was dedicated to assisting service members and their families in successfully navigating through the stressors and troubles associated with military deployment(s). However, it has subsequently been adapted to provide resiliency training to civilian families who have suffered from the effects of traumatic events.

FOCUS teaches families core skills that will better equip them to deal with stresses and changes associated with wartime deployment, injury, illness, death and a range of other traumatic experiences. FOCUS assists families on increasing communication and family cohesiveness. By expressing and exploring different family members' perspectives of a traumatic event, the family is able to address associated problems and monitor the progress of future goals.

**2. Who is appropriate for FOCUS?**

FOCUS is intended for families with at least one child aged 5 and over, Transitional Age Youth (TAY) (ages 18 to 25), and Adults (ages 26 to 59) in our Directly Operated programs and school-based providers. This PP is appropriate for both military and civilian families who have experienced deployment(s), traumatic or loss event(s) resulting in a disruption of family functioning, personal adaptation, and related psychological difficulties.

**3. Does the client need to have a specific diagnosis to receive FOCUS?**

No. FOCUS is intended for military and civilian families who are having difficulties adjusting to and dealing with the stressors associated with deployment(s) and a range of traumatic event(s). The Department encourages clinicians to use their clinical judgment to determine if FOCUS is an appropriate model for the family being served. Furthermore, FOCUS is generally not the best practice for clients actively using alcohol or drugs, actively psychotic, actively manic, or at high risk for suicide or homicide. Clients presenting with any of the above issues should be referred to a higher level of care.

**4. What does the treatment consist of?**

FOCUS utilizes couple and family shared narratives about deployment(s) and/or traumatic event(s) to increase communication, resiliency, and to provide better support for one another. This is accomplished while family members express and explore their understanding of reactions to the deployment(s) and/or traumatic event(s). Families also work on identifying and building upon their existing strengths and positive coping strategies to work more effectively as a team.

**5. What is the length of treatment?**

FOCUS is an 8-session program designed to have each session used as a stand-alone intervention. This makes FOCUS flexible so military families can benefit from the intervention regardless of missed sessions or truncated time tables associated with pre-deployment, deployment and post-deployment issues.

**6. What are the eight sessions?**

FOCUS is divided into the following eight sessions:

- Session 1: Introducing Parents to FOCUS
- Session 2: Constructing Parent's Narrative Timelines
- Session 3: Introducing Children to FOCUS
- Session 4: Constructing Children's Narrative Map
- Session 5: Preparing Parents for the Family Session
- Session 6: Developing a Family Narrative
- Session 7: Building Family Resiliency Skills
- Session 8: Preparing for the Future

**7. What are the core interventions of FOCUS?**

The core interventions for FOCUS are:

- Assessment (Procedure Code 90791)
- Family Psychotherapy (Procedure Code 90847)
- Collateral (Procedure Code 90887)
- Individual Psychotherapy (Procedure Codes H0046, 90832, 90834, 90837)

Other interventions which may be appropriate during the course of the 8 sessions may include:

- Targeted Case Management (Procedure Code T1017)

The use of targeted case management may be appropriate if providing these services will assist in the reduction of the effects of the deployment(s) and/or traumatic event(s) on the family.

**8. Can FOCUS be used in individual treatment?**

Although some individuals may benefit from resiliency training, FOCUS was designed to assist the family as a unit. FOCUS can also be used for couples as well as single parent families who have a child between the ages of 5-18.

**9. What happens if the family misses a session?**

Ideally, all 8 FOCUS sessions should be completed without any interruptions. However, each session was designed as a separate intervention. Consequently, families who miss sessions due to pre-deployment, deployment, and post-deployment issues are allowed to interrupt treatment whenever necessary. Sessions may also be combined, offered multiple times per week or conducted with a co-therapist to allow maximum flexibility.

**10. Who can provide this PP?**

At this time the developer only allows clinicians (Masters level and higher, registered/waived and higher level clinicians) to be the primary leads in treatment. Paraprofessional staff can provide support with check-ins and case management.

**11. What role can a psychiatrist and medication play with this practice?**

Generally in this model, clients are not seen for a medication evaluation by a psychiatrist. On the other hand, there may be certain circumstances where a clinician may determine referring a client for a medication evaluation is appropriate. In these cases, not providing such services may be more harmful to the client's well-being and may prevent the client from returning to their previous level of functioning, especially when additional symptoms are resulting in severe impairments.

**12. Can a client from one of the Mental Health Services Act's (MHSA) Client Supportive Services (CSS) Programs (Wellness, Field Capable Clinical Services, or Full Service Partnerships) or non-MHSA programs receive FOCUS?**

Yes. Any client receiving services in one of our MHSA CSS or non-MHSA programs can receive this and any EBP. The service will be claimed to the current MHSA plan in which the client primarily receives his/her services, NOT to PEI.

**13. Can the client receive FOCUS along with other EBPs?**

Clients can receive 2 practices simultaneously only when clinically indicated. However, the use of multiple practices for PEI clients should happen very infrequently.

**14. What is the required training and certification protocol?**

The required training protocol has 4 parts. First, it begins with a six-hour, web-based program which is designed to provide an overview of FOCUS services, background information related to the impact of deployment on families, and to prepare the Resiliency Trainees for the live training component. Second, a three-day, in-person training or "Basic Course" is required which provides detailed instruction regarding how to conduct the full range of FOCUS services. Third, after the in-person training, weekly supervision by a FOCUS staff is required for at least 10 families. Fourth, the final step is a one-day, "Advanced Course" to be completed after the trainee has successfully provided FOCUS to 10 families.

**15. Is "train the trainer" available for FOCUS?**

No. The Department does not currently provide "train the trainer" as an option.

**16. What are the outcome measures for FOCUS?**

There are two outcome measures which are required for FOCUS:  
-McMaster Family Assessment Device (FAD)  
-Outcome Questionnaire (OQ)

**17. Can the clinician claim for completing the outcome measure?**

No. Administering an outcome measure is not a claimable service. There are two exceptions: (1) if the primary clinician closes the case as a result of referring the client to

another agency, and at discharge, completes the outcome measure; or (2) if the outcome measure is completed during a billable session, and not over the phone or at home by the client.

## **FUNCTIONAL FAMILY THERAPY (FFT)**

**1. What are the 3 Phases of treatment during FFT?**

The 3 Phases of treatment during FFT include:

1. Engagement and Motivation Phase
  - a. During the engagement and motivation phase of treatment the practitioner focuses on developing an alliance with the family, reduce negativity/blame and resistance, improve communication, minimize hopelessness, develop a family focus, increase motivation for change and reduce dropout potential.
2. Behavior Change
  - a. During the behavior change phase of treatment the practitioner focuses on development and implementation of individualized change plans, change presenting high risk behavior and build relational skills (e.g. communication, parenting, etc.).
3. Generalization Phase
  - a. During the generalization phase of treatment the practitioner focuses on maintaining/generalizing change, preventing relapses and providing community resources necessary to support change.

**2. What is the age range for FFT?**

FFT is to be provided to families where the identified client is between the ages of 10-18.

**3. What is the focus of treatment for FFT?**

FFT is intended for families where youth, ages 10-18, are experiencing severe behavior and/or conduct disorders.

**4. What is the treatment modality?**

FFT is provided in family group settings.

**5. Where can FFT be provided?**

FFT is primarily provided in the family home, but may also be provided in the community and in an office setting for the comfort of the family.

**6. How many family facilitators are needed?**

FFT family sessions are conducted by only 1 FFT practitioner.

**7. What is the average length of treatment?**

The average length of treatment is 12 sessions over a 3-4 month period.

**8. How often should FFT sessions be conducted?**

FFT sessions are conducted as often as need by the family; generally the first 3 sessions of engagement and motivation are conducted in the first 10 days of treatment, then sessions are typically conducted weekly. Session length is approximately 60-120 minutes.

**9. What are the “Core Interventions” for FFT?**

The “Core Interventions” include:

- i. Assessment
- ii. Collateral
- iii. Family Psychotherapy

**10. Do you have to be licensed clinician to implement FFT under the PEI Plan? Yes.**

Please see current version of the County of Los Angeles – DMH, “A Guide to Procedure Codes” for specific Rendering Provider eligibility.

**11. Is there a “train the trainer” model for FFT?**

No. Please see question below for internal agency training.

**12. What is the training protocol for new agency staff/when there is staff turnover?**

The training protocol for new agency staff/when there is staff turnover includes (Replacement Training Series):

- i. Initial Clinical Training (2.5 days)
- ii. Follow-Up Training #1 (2 days)
- iii. Follow-Up Training #2 (2 days)
- iv. Follow-Up Training #3 (2 days)

**13. What are the required Outcome Questionnaires for FFT?**

DMH PEI Outcome Measures Application Requirement: The outcome measures should be administered pre- and post-treatment. Additionally, if the FFT treatment extends beyond 6 months, an update for each measure is required every 6 months. The required outcome measures are the following:

- Youth Outcome Questionnaire (YOQ)
- Youth Outcome Questionnaire-Self Report (YOQ-SR)

CIHBS/Developer Requirement: Each clinician is required to enter information into the Clinical Services System (CSS). The CSS is available online through the developer’s website. The CSS includes:

- i. Progress Notes (for each session)
- ii. Counseling Process Questionnaire (administered every other session)
- iii. Client Outcome Measure (administered post therapy)
- iv. Therapist Outcome Measure (administered post therapy)
- v. YOQ (administered pre and post therapy)
- vi. YOQ-SR (administered pre and post therapy)
- vii. OQ (administered pre and post therapy)

**14. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs and YOQ-SR)?** Administration can be

completed by a trained non-clinical or clinical staff. Scoring and interpretation can be completed by a person enrolled in a graduate degree

program or has received a graduate degree in psychology, counseling, social work, or other related field. They are either graduate students at a clinical training program, or licensed or waived staff, who are registered with the appropriate governing body and are working towards licensure. Data entry can be completed by trained non-clinical staff.

## **GROUP COGNITIVE BEHAVIORAL THERAPY FOR MAJOR DEPRESSION** **(Group CBT)**

**1. Who is appropriate for Group CBT?**

The developer intended this Evidence Based Practice (EBP) to be used with individuals experiencing a depressive disorder.

**2. What is the age range for Group CBT?**

The Department has decided to use Group CBT for Transitional Age Youth (TAY, age 18-25), Adults (age 26-59), and Older Adults (OA, age 60+).

**3. Are the diagnoses of Major Depressive Disorder required for Group CBT?**

No, clients do not require a diagnosis of Major Depressive Disorder. However, the model is intended to treat symptoms of depression. The Department encourages clinicians to use their clinical judgment to determine if Group CBT is an appropriate model for the client.

Consistent with DMH policy, the client must meet criteria for an included eligible diagnosis in order to claim services to Medi-Cal.

**4. Can Group CBT be offered to all clients presenting with depressive symptoms?**

Group CBT is more successful with the PEI population versus the serious and persistent mentally ill (SPMI) population. Group CBT is generally not the best practice for clients currently abusing or addicted to alcohol or drugs, currently psychotic, those diagnosed with a mental health disorder other than a mood disorder (such as PTSD), or clients with personality characteristics which may alter the group dynamic.

**5. Who can provide Group CBT?**

The Department only allows trained psychotherapists to be the primary lead/clinician for the group. Trained psychotherapists include licensed, registered, or waived MD/DO, Ph.D/Psy.D., LCSW, MFT, Psychiatric/Mental Health Clinical Nurse Specialist, Psychiatric/Mental Health Nurse Practitioner, and student professionals in these disciplines with a co-signature. Paraprofessional staff can provide support with check-ins, homework, and case management. Paraprofessional staff can co-facilitate the CBT Group; however the primary clinician must take lead and, in this situation, the group can only be claimed as group rehab (H2015), not group psychotherapy (90853).

**6. What is the length of treatment?**

Group psychotherapy is offered one time per week for 12-16 weeks, depending on when the group completes all four sessions of the three modules. Ideally the client should commit to 12 weeks. The weeks do not have to be consecutive; thus the total time allowed is up to 16 weeks. The clinician should ensure that all 12 topics are discussed in the 12-16 week timeframe.

This model supports an orientation session at the beginning of treatment and a relapse prevention session at the end of treatment. These two sessions can be added so long as the entire course of treatment stays within the 16-week limit.

This practice may be extended up to 20 weeks if the Health module is added so long as the clinical appropriateness of extending the practice is clearly documented.

**7. According to the developer, group sessions can be either 1.5-hours or 2-hours. What is the Department's requirement?**

There is no Department mandate limiting the time frame of groups. Clinicians can provide a 1.5-hour or 2-hour group on a weekly basis.

**8. According to the developer, the groups can be open or closed. Does the Department mandate one or the other?**

The Department does not mandate that groups be open or closed; however an open group is recommended to allow new clients to enroll every 4 weeks upon the completion of a module. It is also recommended that the clinician orient new members to the group at start of each module. Clients are required to attend Session 1 of the module during which the client enters into the group.

Clinicians should be mindful that the open group format might influence the group's dynamics. Group structure should be based on your clinic and client needs; however an open group allows clients access to services more quickly as compared with a waiting list.

**9. Does the Department require a certain number of participants in each group session?**

There is no Department mandate regarding the number of participants; however there needs to be at least two clients in order to claim the procedure code for group psychotherapy.

The recommended ratio for Group CBT is 8-10 participants to two clinicians per group.

**10. Can the clinicians incorporate other topics and treatment modalities besides CBT in the groups?**

Group CBT therapy is limited to the treatment protocols contained within the Group CBT for Major Depression manuals. This EBP does encourage a "tailor approach" by allowing the group facilitator to use clients' life examples and illustrations to make CBT concepts applicable to the clients' lives.

**11. Is homework required between each group session?**

Yes. Clinicians should review the client's homework, weekly, in the group session.

**12. What procedure codes should be used for Group CBT?**

The procedure codes for Group CBT are:

- Assessment (Procedure Code 90791)
- Group Psychotherapy (Procedure Code 90853)

- Group Rehabilitation (Procedure Code H2015)\* (HE, HQ\*\*)

\*For paraprofessional co-facilitates the group with the clinician

\*\*For Contract Providers submitting electronic claims to the Department

Other services, including case consultation, medication support, collateral sessions, or crisis intervention, may be offered to address emergent client needs and individual therapy may be utilized if a client misses a group session; however the client should be referred to a higher level of care if they require ongoing services.

**13. When can you use Individual Psychotherapy (Procedure Code H0046, 90832, 90834, or 90837)?**

Individual psychotherapy should only be used to “make-up” a missed group psychotherapy session. Ongoing participation in individual psychotherapy is not part of the Group CBT model and could discourage group participation and negatively impact the benefits the client might otherwise gain from Group CBT. Individual psychotherapy with the same clinician to address the issues also discussed in group is discouraged by the Department while the client is participating in Group CBT.

**14. What about case management?**

Case management can be utilized to keep clients engaged in treatment or to connect them to other non-core services or community resources. For example, a client who is homeless will be more engaged in treatment if housing assistance is also provided. For those clients who may need long-term or more intensive treatment, the clinician can identify appropriate referrals. In these situations, the Group CBT clinician retains clinical responsibility over the case until it is successfully transitioned into the appropriate setting.

**15. Can the clinician claim for group preparation on Community Outreach Services (COS)?**

No. The Department does not permit use of COS to claim for group preparation.

**16. Can a client from one of the Mental Health Services Act (MHSA) Community Services and Support (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnership) or non-MHSA programs receive this EBP?**

Yes. Any client receiving services in one of our non-MHSA or MHSA-CSS programs can receive this EBP as well as other EBP interventions. In such instances, the service will be claimed to the MHSA plan/Level of Care in which the client receives their primary services—and NOT to PEI. For example, a CSS

Wellness client can participate in Group CBT if the client meets the criteria for this practice. However, the services for this client will continue to be billed to the "MHSA\_Fam\_Focused\_Wellness Svc" plan, not the "PEI Adult: Ages 26-59, Plan No. 2092". The clinician will identify the EBP as "Group CBT" (2J). PEI outcome measures are not required when the client is receiving EBP services in a different plan (i.e., not PEI).

**17. Can a client receive Group CBT along with another PEI EBP?**

The goal of PEI services is to help the client move forward quickly in coping with their mental health challenges. Therefore, the Department expects that the use of multiple practices for PEI clients would occur infrequently. The clinician would need to consider duplication of services, overwhelming the client with services/expectations, and, most importantly, the clinical necessity of adding another practice to meet the client's needs.

**18. What happens if the client successfully completes Group CBT?**

The client will be discharged and their case will be appropriately closed. They may return, if needed, should they benefit from another course of Group CBT or alternative interventions.

**19. What is the required training protocol?**

The Department requires the clinician to attend the two-day, Initial Adult Group CBT training. Upon completion of the two-day training, trainees participate in consultation calls with the trainer for the duration of their first 12-16 week group (depending on the clinician's level of training and demonstrated competence in Group CBT). The trainees will audio record their group sessions and download the recordings to the trainers secure website for their review. A minimum of a pass score on one recording for each of the three modules is required to complete the training. Clinicians must also attend the one-day Booster Training after completing the other components of the training protocol.

**20. Does Group CBT require a trained supervisor as part of the Adult CBT Team at a clinic?**

According to the EBP, formal supervision by a licensed clinician is required. The Department encourages each program to select a "champion" who will be trained in Group CBT and can provide implementation and clinical support for the EBP. The "champion" should have prior training in CBT, such as the course offered at Harbor UCLA.

**21. Are clinicians who completed the entire Ind CBT training protocol approved to implement Group CBT?**

Yes. Clinicians who have completed the entire Individual CBT training protocol are approved to implement the Munoz model for Group CBT.

**22. Is "train the trainer" available for Group CBT?**

The developer does not currently permit "train the trainer".

**23. Can interns get trained in and offer Group CBT?**

Yes, interns can be trained in Group CBT. Interns who complete all components of the training will receive provisional authorization to claim Group CBT services. Interns will require supervision by a licensed clinician to claim Group CBT services to the PEI Plan.

**24. How do I participate in the weekly phone consultation?**

Staff must complete the initial two-day training and the trainer must provide the individual access to the website to download the audio recordings of the group sessions. Staff

must log into the Group CBT Website, [www.adoptebp.com](http://www.adoptebp.com), to register. The website and the recordings uploaded to this site are used for the weekly phone consultation and to communicate and share information regarding CBT implementation and compliance. This website and the use of recordings should only be used during the training period. Clinicians should stop using the website and recording sessions once they have become certified in this EBP.

**25. Are Group CBT manuals available?**

There is a limited supply of Group CBT Manuals distributed as requested to our directly operated clinics. There is also a PDF version which can be emailed for print at the requesting clinician's agency. Please email [ASOCEBP@dmh.lacounty.gov](mailto:ASOCEBP@dmh.lacounty.gov) for the attached PDF.

**26. What are the required outcome measures for Group CBT?**

There are two outcome measures for Group CBT:

- Personal Health Questionnaire Depression Scale-9 for ages 18+
- Outcomes Questionnaire (OQ 45.2)-19 and older
- Outcomes Questionnaire (YOQ-SR 2.0)- 12 to 18

**27. Can the clinician claim for administering the outcome measure? No.**

Administering an outcome measure is not claimable to Medi-Cal.

## **Incredible Years (IY)**

### **Target Population**

**1. What is the age range for the IY model (what ages are included)?**

The age range depends on the specific component of IY that your agency is choosing to implement. A list of the potential components of IY that can be implemented (under PEI) and their respective age ranges are listed below:

- IY Babies (0-12 months, group for caregivers and infant)
- IY Toddlers (group for parents of children ages 1 to 3 years)
- IY Preschool (group for parents of children ages 3-6 years old)
- IY School Age Basic (group for parents of children ages 6-12 years old)
- IY Advanced (group for parents of children ages 6-12 years old)
- IY Dina Dinosaur School (group for children ages 4 to 8 years)

**2. May a parent and child group be run at the same time?**

Yes. The model was intended to be delivered with parents attending an IY Parenting Module while their children were attending IY Dina Dinosaur School group. This version of service delivery (with the parents and children receiving intervention simultaneously) allows for the IY EBP to be maximally effective and supportive to both the parents and children.

**3. What is the focus of Treatment for IY?**

The focus of treatment for Incredible Years under the Prevention and Early Intervention (PEI) Evidenced-Based Practices (EBP) is “Parenting and Family Difficulties.”

**4. Is there a Learning Network for IY?** Yes, there is a Learning Network for IY. The Learning Network provides quarterly meetings to discuss updates on IY implementation and data review. The IY Learning Network is facilitated by the DMH PEI Outcomes team ([PEIOutcomes@dmh.lacounty.gov](mailto:PEIOutcomes@dmh.lacounty.gov)) and the IY Practice Lead. You may email the PEI Outcomes team and ask to be added to their email distribution list in order to receive the email updates and invitations to the IY Learning Network. You should also email the IY Practice Lead and ask to be added to their email distribution list to receive IY clinical practice updates. Please email [MHSAP EI@dmh.lacounty.gov](mailto:MHSAP EI@dmh.lacounty.gov) for the current list of EBP Practice Leads.

### **Implementation of IY Groups**

**5. Is there a maximum number of children who can be seen in an IY Dina Dinosaur School Group?**

The developer recommends 5-6 children maximum per group. Agencies and clinicians may need to over recruit slightly to get to this number. For example, if your agency typically has a 1/3 "no show" rate, then you might take 9 children into a group, expecting that 6 will actually show up as the group progresses. However, it's important for your agency to track and be accurate about the “no show” rate because more than 6 children in a group can be very hard for clinicians to manage and if a group gets out of control, it's not a therapeutic experience for the children.

**6. Is there a minimum number of children that can be IY Dina Dinosaur School group?**

A minimum of 4-5 children are required for this group, with 6 being the ideal number.

**7. Is there a maximum number of parents/caregivers who can participate in IY Parenting Groups?**

The IY Parenting Groups should be limited to 15 parent/caregiver participants.

**8. What is the minimum number of group leaders who can lead an IY group?**

All of the IY groups have been designed to be led by 2 therapists. Each IY group (IY Baby, IY Dina, IY Parenting groups) needs to be staffed with 2 group leaders.

**9. What are the minimum group leader qualifications? Can a BA-level staff (i.e., Case Manager) co-lead an IY Group?**

When leading an IY group under PEI, it is required that both therapists for IY Baby and IY Dina Dinosaur School be at least masters-level clinicians who are registered with their boards or licensed. A BA-level staff (i.e., Case Manager) may co-lead an IY Parenting Group with a masters-level (or above) clinician who is registered with their board or licensed.

**10. Do supervisors who are overseeing IY clinicians need to be trained in IY?**

We do not require that supervisors attend an official IY training. However, it is highly recommend that the IY program manager, IY Lead, or IY supervisor be trained in IY. Many agencies find that having a supervisor trained in IY enhances sustainability of the model within their agency.

**11. How does our agency know if it has the most up to date videos offered for the IY Parenting and IY Dina Dinosaur School groups? Are the videos only available on DVD?**

If you have a DVD version of the videos, you have the most updated version. The videos are currently only available in DVD format, but the developer is considering a USB option in the near future. For specific questions about video vignette versions, please contact the developer at: [incredibleyears@incredibleyears.com](mailto:incredibleyears@incredibleyears.com).

**Outcomes**

**12. What are the outcome measures for IY?**

Under PEI, IY has required general and specific outcome measures. The general outcome measures include the YOQ (Parent) which is completed by the parent of children ages 4 to 17 and the YOQ-SR for children ages 12 to 18. The specific outcome measure includes either the ECBI (if parent is available) or the SESBI-R (a teacher report when parent is unavailable). ***Both the ECBI and the SESBI-R are for children ages 2 to 16. Please note that the age range for IY is for children ages 0-12.***

**13. What outcomes do I collect if my client is too young for the outcome measures?**

Please be consistent with the normed age range for the outcome measures. You are not required to report outcomes for children under the age of 2. If the child is age 2 years old and above, but not yet 4 years old, you would only administer the ECBI or SESBI-R. Once the child is 4 years old, you would administer both the YOQ Parent Report and the ECBI or SESBI-R. If the child is 12 years old then they would complete the YOQ and the YOQ-SR and either the ECBI or SESBI-R.

**14. Where can I find trainings for the IY Outcome Measures?**

PEI Outcomes provides free trainings for providers implementing IY under the PEI (Prevention and Early Intervention) Plan. You may find a list of the Outcomes Measures Trainings at:

[www.dmhoma.pbworks.com](http://www.dmhoma.pbworks.com) and then go to the right side of the screen under “Training” and click on “PEI Outcomes.” You will then be directed to the PEI Outcomes training page and there is a menu for “Outcomes Questionnaire Training for Clinicians/Clinical Team.” If you have specific questions about a PEI Outcome Measure training, please contact PEI outcomes directly at: [PEIOutcomes@dmh.lacounty.gov](mailto:PEIOutcomes@dmh.lacounty.gov)

**15. How do I order the IY Outcome Measures?**

The PEI Outcomes Division provides the outcome measures (YOQ-2.01 Parent Report, ECBI, & SESBI-R) for PEI providers who are approved to provide the IY EBP. Please contact PEI Outcomes directly for more information regarding ordering the IY Outcome Measures at: ([PEIOutcomes@dmh.lacounty.gov](mailto:PEIOutcomes@dmh.lacounty.gov)).

**Claiming**

**16. Must a child be identified for the parent to participate in the IY groups?**

Yes, there should be a specific identified child who has received an initial assessment and their chart has been opened. The parent receives the IY Parenting Group as an intervention to assist the parent with addressing the child’s noted symptoms. The parenting group is then billed to the child’s chart.

**17. How do we write goals for a child’s care plan when the parent is the one in the parenting group (not the child)?**

The parent participates in the parenting group to develop skills/strategies to address the symptoms and functional impairments expressed by their child. The parent is identified as the change agent to reduce their child’s presenting concerns and symptoms.

**18. What components of training protocol must be completed to bill PEI?**

The staff member leading the IY group must attend the initial training to begin claiming for PEI Services. However, in order to continue claiming for PEI services, it is expected, based on the PEI Training Protocol, that the staff member completes both:

- (A) an initial 3-day training (initial training for IY baby is 2-days) **and**
- (B) a consultation day within 12 months of when the 3-day training was completed.

**19. What if a staff member has previously attended the 3-day training and consultation day for IY Dina Dinosaur School, can that staff member now switch IY Modules and lead an IY School Age Basic Parenting group?**

In order to bill PEI for IY, each staff member must complete the initial training and the consultation day within the specific IY Module that the staff member is leading.

For example, to lead a Dina Dinosaur School group, a staff member must:

Attend IY Dina Group 3-day initial training + Consultation Day for IY Dina Group

To lead an IY School Age Basic Group, a staff member must:

Attend IY School Age Basic 3-day initial training + Consultation Day for IY School Age Basic

To lead IY Babies, a staff member must:

Attend the IY Babies 2-day initial training + Consultation Day for IY Babies

If a staff member has completed the protocol (initial training + consultation day) for IY Dina and now wants to lead an IY School Age Basic Parenting group, that staff member will then need to complete the IY School Age Basic Parenting group initial 3-day training and then

complete 1 Consultation Day for IY School Age Basic Parenting Groups within 12 months of the initial training.

### **Training**

#### **20. Is there a “Train the Trainer model available?”**

Yes there is “Group Leader Certification” offered by the developer, but this is not required by DMH PEI. However, the certification process from the developer may be a helpful way to enhance sustainability of the IY model for your agency. A staff member may become a “Within Agency Mentor,” which allows them to train your staff in the initial 3-day trainings and consultation days at no charge to the agency. Additionally a “Within Agency Mentor” maybe approved by Incredible Years to train clinicians and staff outside your agency. For additional information, please contact the developer directly or see their website: <http://incredibleyears.com/certification-gl/> or [incredibleyears@incredibleyears.com](mailto:incredibleyears@incredibleyears.com) .

#### **21. Where can I find additional information about training opportunities for the Incredible Years program?**

A) The Incredible Years website has a section dedicated to Training Opportunities. Many agencies have found it helpful to contact Incredible Years directly to ask if they are offering any on-site training in Los Angeles or nearby counties (i.e., Ventura County, Orange County, etc.).

##### **The information to contact IY Seattle is:**

- The web address for IY-Seattle is: <http://incredibleyears.com/>
- For upcoming workshop/training information: <http://incredibleyears.com/workshop-info/training-workshop-schedule/>
- To contact IY directly: <http://incredibleyears.com/about/contact/>

B) Children’s Hospital Los Angeles has two staff that are certified by Incredible Years as Within Agency Mentors, which allows them to train staff from outside agencies in the IY program that they are certified under. You may contact these staff directly as they regularly provide IY trainings in the Los Angeles Community.

##### **Dr. Dean Coffey: Parent Group Within Agency Mentor at CHLA**

Dean M. Coffey, Psy.D., Assistant Professor of Clinical Pediatrics  
Program Area Lead, Child & Family Mental Health  
Phone: 323.361.7741 Fax: 323.361.8342 e-mail: [dcoffey@chla.usc.edu](mailto:dcoffey@chla.usc.edu)

##### **Dr. Micah Orliss: Dina Group Within Agency Mentor at CHLA**

Micah Orliss, Ph.D., Licensed Psychologist, Project HEAL  
Children’s Hospital Los Angeles  
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## **INDIVIDUAL COGNITIVE BEHAVIORAL THERAPY (Ind CBT)**

**1. Who is appropriate for Individual CBT?**

Ind CBT is intended as an early intervention for individuals who are experiencing or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma which impact various domains of daily living.

**2. What is the age range for Ind CBT?**

Currently the Department supports utilization of Ind CBT for Transitional Age Youth (TAY, age 16-25), Adults (age 26-59), and Older Adults (OA, age 60+) at our Directly Operated clinics and Contracted Agencies serving clients under MHSA PEI or CSS plans (including FSP, FCCS, and Wellness).

**3. Are there specified diagnoses required for Ind CBT?**

No, clients do not require specific diagnoses to participate in Ind CBT. The model is intended to prevent or treat early onset of symptoms of depression, anxiety, and effects of trauma that may impact functioning in various domains of daily life. The Department of Mental Health (DMH) encourages clinicians to use their clinical judgment to determine if Ind CBT is an appropriate model for the client. Consistent with DMH policy, the client must meet criteria for an included eligible diagnosis in order to claim services to Medi-Cal.

**4. Who can provide CBT?**

Ind CBT may be provided by licensed, registered, or waived MD/DO, Ph.D/Psy.D., LCSW, MFT, Psychiatric/Mental Health Clinical Nurse Specialist, Psychiatric/Mental Health Nurse Practitioner, and student professionals in these disciplines with a co-signature provided they have had (or are currently receiving) specialized training in CBT.

**5. What is the length of treatment?**

Treatment length for Ind CBT ranges from 18 to 52 weekly sessions depending on client's clinical needs and treatment response. Clinical tasks, to be completed during a course of Ind CBT include: developing diagnoses, treatment planning from a case conceptualization perspective, and the provision of CBT intervention protocol.

**6. What is the length of treatment sessions?**

Ind CBT is provided during a 45 to 50-minute weekly session.

**7. Can the clinician incorporate other topics and treatment modalities besides CBT?**

Adherence to the treatment protocol is required for Ind CBT. For this intervention, treatment is limited to the use of CBT interventions and methods of conceptualization. Ind CBT allows for "tailoring" of CBT conceptualizations and interventions to address individual treatment goals.

**8. Is homework required between each session?**

Yes, homework is an important part of ensuring treatment generalization to the client's daily life. Homework is tailored to client's treatment goals and reviewed weekly during the therapy session.

**9. What procedure codes should be used for Ind CBT?**

The procedure codes for Individual CBT are:

- Assessment (Procedure Code 90791)
- Collateral (Procedure Code 90887)
- Crisis Intervention (Procedure Code H2011)
- Family Psychotherapy (Procedure Code 90847)
- Group Psychotherapy (Procedure Code 90853)
- Individual Psychotherapy (Procedure Code H0046, 90832, 90834, 90837)
- Plan Development (Procedure Code H0032)
- Targeted Case Management (Procedure Code T1017)

Other services; including case consultation or medication support may be offered to address emergent client needs. The client should be referred to a higher level of care if they require more intensive ongoing services.

**10. What about case management?**

Case management can be utilized to keep clients engaged in treatment or to connect them to other ancillary services or community resources. For example, a client who is homeless will be more engaged in treatment if housing assistance is also provided. For those clients who may need long-term or more intensive treatment, the clinician can identify appropriate referrals. In these situations, the CBT clinician retains clinical responsibility over the case until it is successfully transitioned into the appropriate higher level of care.

**11. Can the clinician claim for preparation on Community Outreach Services (COS)?**

No, DMH does not permit use of COS to claim billing for preparation of service delivery.

**12. What is the EBP code associated with Ind CBT for PEI billing?**

The clinician will identify the EBP as "Individual CBT" (8A) on the IS drop down menu when providing Ind CBT to a PEI client.

**13. Can a client receive Ind CBT along with another PEI Practice?**

The goal of PEI services is to help the client move forward quickly in coping with their mental health challenges. Therefore, DMH expects that the use of multiple practices for PEI clients would occur infrequently. The clinician would need to consider duplication of services, overwhelming the client with services/expectations, and, most importantly, the clinical necessity of adding another practice to meet the client's needs.

**14. What is the required training protocol for Ind CBT?**

DMH offers the following two options for the Ind CBT training protocol:

**Option 1**

- a. 3-day Initial Ind CBT training
- b. 16 weekly 55 minutes consultation calls. Clinician can miss up to 2 calls.
- c. Submission of 1 audiotape and 1 case conceptualization on 3 current CBT clients reviewed by CBT trainer or designated consultant. Trainee must receive a satisfactory rating score of 36+ on Cognitive Therapy Rating Scale (CTRS) on 2 audio recordings and a satisfactory rating score of 20+ on Case Review Rating Scale (CRRS) on 2 case conceptualizations.
- d. 1-day CBT Booster training.

**Option 2**

- a. 9-month Harbor UCLA CBT class
- b. Submit 1 audiotape and case conceptualization on 1 current CBT client reviewed by CBT trainer or designated consultant. Trainee must receive a satisfactory rating score of 36+ on Cognitive Therapy Rating Scale (CTRS) and a satisfactory rating score of 20+ on Case Review Rating Scale (CRRS).
- c. Additional information found in Question 15.

**15. I am a clinician who completed the 9-month Harbor UCLA Ind CBT training in the past. Can I provide Ind CBT for PEI, FSP, FCCS, or Wellness?**

To provide Ind CBT for PEI, FSP, FCCS, or Wellness, clinicians who have completed the 9-month Harbor UCLA Ind CBT training course may apply to and complete the Ind CBT Verification process. Applicants for the Verification process must meet the following criteria:

- i) Applicant must have completed a terminal graduate degree in the mental health field and be licensed or license eligible (receiving supervision from a licensed clinical supervisor)
- ii) Applicant must have completed the minimum number of sessions during the 9-month CBT class and have a certificate of completion form 9-month CBT course.
- iii) Applicants will be required to complete the verification application on a secure website ([www.academyofct.org/losangeles](http://www.academyofct.org/losangeles)) managed by The Academy of Cognitive Therapy.

Once an applicant has successfully passed through the CBT verification process, he/she can begin providing Ind CBT for PEI, FSP, FCCS, or Wellness.

**16. I took CBT training in the past. Can I provide Ind CBT to PEI, FSP, FCCS, or Wellness clients age 16 and older?**

In some instances, clinicians who have received specialized training in CBT treatment interventions and conceptualization may be verified to provide this Ind CBT within DMH. This training may have been received earlier at the graduated level or by attending advance CBT training. These situations will be approved on an individual basis by the Ind CBT Practice Lead. Once approved, the clinician will need to submit an audio recording and case conceptualization for rating to the Academy of Cognitive Therapy and receive a passing score of a 36 or higher on the CTRS and a 20 or higher on the CRRS.

**17. What devices are approved for recordings?**

Clinicians at DMH-operated clinics may ONLY use Phillips Records for audio recordings. Clinicians at county-contracted agencies are to adhere to recording devices and protocols as determined by their respective agencies.

The recordings are to be uploaded only to the secure website provided to the clinician during the training program in a DS2, WPA, MP3, or MP4 format.

**18. How do clinicians participate in the weekly phone consultation and upload recordings and case conceptualizations?**

Clinicians sign up for the consultation call during their initial 3-day training. The call is offered on a local or toll-free number each week and clinicians are provided an access code specific to the toll-free number. Clinicians will also receive the secure website address associated with their cohort upon completing the initial training. Submission of audio recordings and case write ups/diagrams can ONLY be accepted through the secure DMH approved website.

**19. When can a clinician start billing Ind CBT?**

Clinicians are able to initiate claiming Ind CBT to the PEI or CSS billing plan (including FSP, FCCS, and Wellness Programs) upon completing the initial 3-day training and throughout the entire training program and continue billing upon successful completion of the training program.

Clinicians must complete the remaining part of the training protocol (consultation calls, uploading of audio recordings/case conceptualizations to meet adherence, and booster training) within six (6) months of initiating the Ind CBT training protocol. Exceptions to length of training process will be made on an individual case by case basis; with a target date of completing the outstanding parts of the training program within one year of initiating the process to continue billing Ind CBT.

**20. Does Ind CBT require a trained supervisor as part of the Individual CBT Team at a clinic?**

No it does not. If possible, it is recommended to have one clinical supervisor trained in CBT available for ongoing support and supervision of trained staff.

**21. Is “train the trainer” a possibility with Ind CBT?**

For sustainability purposes, the Department will be implementing a Clinical Champion (CC) Training protocol.

Staff that have completed either Option 1 or Option 2 under the required Training Protocol are eligible to apply to become an Ind CBT Clinical Champion. The Clinical Champion Training Protocol is as follows:

1. Ind CBT CC must apply for certification through the Academy of Cognitive Therapy (ACT), paid by DMH

2. Initial 1-day training for Ind CBT CC (5 hr/day, 50 staff/training)
3. Consultation Calls: 1 time/week, 55 minute long, 1 consultant to 5 Ind CBT CC per call, 12 calls total. Calls to start 1-2 weeks after 1-day training.
4. During the 12 weeks, Ind CBT CC will provide individual supervision to a staff clinician in house providing CBT to at least 1 client at 16 and older.
5. Audio Recordings: each Ind CBT CC will submit 1 audio recording of a supervisory session with the staff clinician in house providing CBT to be rated by the CBT trainer or designated consultant. Ind CBT CC must receive a minimum score of 40 or higher on the CTRS.
6. During the 12 weeks, each Ind CBT CC will review and rate 2 case write-ups/diagrams (CCD) by a clinician providing CBT and rate the recording using the CTRS. An Ind CBT CC will pass if their CTRS score falls within a 5 point range of the assigned CBT trainer or designated consultant's CTRS.
7. During the 12 weeks, each Ind CBT CC will review and rate 2 case write-ups/diagrams (CCD) by a clinician providing CBT and rate the CCD using the CRRS. An Ind CBT CC will pass if their CRRS score falls within a 4 point range of the assigned CBT trainer or designated consultant's CRRS.
8. Personal Supervisory Model based on CBT Principles: Ind CBT CC will submit a personal supervisory model write-up for review. Must receive a minimum score of 20 on Supervisory Scale.

**22. What can a Clinical Champion (CC) provide after completing the training?**

Those who successfully complete the CC training protocol will only provide under Required Training Protocol Option 1 (as described in Question 14, bullet "b" and "c." Bullet "a" and "d" will still need to be provided by a DMH approved CBT trainer/institute.

**23. Can students and interns get trained in CBT?**

Yes, students and interns can be trained in Ind CBT. Those who complete all components of the training and are supervised by a licensed clinician will receive provisional authorization to claim Individual CBT services to the PEI Plan.

**24. What are the required manuals for the Ind CBT training protocol and the Ind CBT Clinical Champion training protocol?**

For Initial Training Process:

1. Clinician's Guide to Mind Over Mood – Greenberger & Padesky
2. Overcoming Resistance in Cognitive Therapy – Leahy
3. Mind Over Mood: Change How you Feel By Changing the Way You Think- Greenberger & Padesky

For Clinical Champion Process:

1. Teaching and Supervising Cognitive Behavioral Therapy- Donna M. Sudak, R. Trent Codd, Marci G. Fox, Leslie Sokol

**25. Is certification required for this EBP?**

No. Certification is NOT required.

A CTRS score of 36-39 and a CRRS score of 20+ achieves a level of competency in CBT meeting the DMH requirement to provide this EBP in LA County.

A CTS score of 40+ and a CRRS score of 20+ achieves a level of certification in CBT **IF** received by a national organization accredited to provide certification, such as the Academy of Cognitive Therapy (ACT).

Staff are welcome and encouraged but not required to become certified as a CBT trained therapist through a national organization such as ACT or the Beck Institute.

Only staff applying for the clinical champion training program will be required to become certified to participate.

**26. Should a clinician decide to become certified, what is the process?**

Clinicians who successfully complete the DMH Ind CBT training program are qualified for the fast track application process set up by ACT to become certified as a CBT therapist. Clinicians expressing interest in moving forward with the certification process will be provided information on how to proceed upon completing the Ind CBT training program.

**27. What are the required outcome measures for Ind CBT provided to a PEI client?**

Clinicians will administer the General Measure and symptom specific measures congruent with the client's presenting problem in treatment. The outcome measures for Ind CBT are as follows:

*General Measure:*

- Outcomes Questionnaire (OQ 45.2) – 19 and older

*General Measure:*

- Outcomes Questionnaire (YOQ-SR 2.0) – 16 to 18 years of age

*Focus of Treatment Specific Measure (for Depression)*

- Patient Health Questionnaire Depression Scale-9 (PHQ-9)- 16-65+

*Focus of Treatment Specific Measure (for Anxiety)*

- Generalized Anxiety Disorder 7-item Scale (GAD-7) 18-65+

*Focus of Treatment Specific Measure (for Trauma)*

- University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA PTSD-RI) for Child & Adolescent (6-20 years)
- Posttraumatic Stress Disorder Checklist-5 (PCL-5)- 21+

**28. What is the outcome measure for a 16-17 year old receiving CBT to address anxiety?**

According to PEI Outcomes, the 16-17 year olds being treated with anxiety do not need to receive a measure since it has not been set by DMH. Clinicians are welcome to provide the RCADs as a clinical tool; however, it does not need to be inputted into the PEI OMA at this time.

**29. Can the clinician claim for administering the outcome measure?**

No, administering an outcome measure is not claimable to Medi-Cal.

## **MANAGING AND ADAPTING PRACTICE (MAP)**

### **Training-Related Topics**

**1. What are the requirements to be trained as a MAP Supervisor?**

To qualify to become a MAP Supervisor, the individual must be 2-years post-licensure, have direct clinical control over the cases seen by their trainees, and must be in the role of supervisor.

**2. What is the timeline for training expiration and a therapist's ability to bill?**

Therapists may begin to bill after completing the first 8 hours of training. Therapists must complete all training protocol within 12 months or they will not be able to continue billing PEI for MAP services. However, the training for MAP never expires and clinicians may still submit portfolios for review if more than 12 months have passed.

- Certified Therapists have 3 years before needing to renew.
- Certified Supervisors have 2 years before needing to renew.
- Staff must maintain valid certificates in order to utilize and bill PEI for MAP. Agencies must maintain active subscriptions (PWEBS, Dashboards, and Practitioner Guides) in order for their staff to provide MAP at that agency.

**3. What is the suggested format for Agency Supervisor-Based Training?**

Below are suggestions from Providers:

- 3 days for the big concepts; after 6-8 weeks, a booster day; then break-out into 2-hour supervision format: a 6-month long process, one cohort at a time.
- 8 hours one day per week for 5 weeks. First 2 days are impactful, intense information to absorb.
- After 8 hours initial training, individual supervision every other week; available for drop-in consultations.
- Consider overlapping trainings so if someone misses a day, they can pick it up as the next wave come around.
- Spacing out training is optimal for better learning and retention of material.
- Consecutive 5-day trainings feel more laborious. Recommend to spread out trainings.
- DMH has a PEI Training Registry of who has been trained/certified. After the first 8 hours of training, please submit an updated EBPT Training Verification Form to [MHSAPEI@dmh.lacounty.gov](mailto:MHSAPEI@dmh.lacounty.gov)

**4. How do you notify DMH of clinicians' current training status?**

An EBP Training Verification Form must be completed and submitted to PEI Administration. Please contact PEI Administration at [MHSAPEI@dmh.lacounty.gov](mailto:MHSAPEI@dmh.lacounty.gov) for assistance with this form.

**5. Will agencies be able to certify their own clinicians in MAP?**

No. PracticeWise will always retain certification process.

**6. If we have MSW interns (still in school), can we train them?**

Yes. Bachelor's level staff and above can be trained and certified in MAP. However, it is the agency's obligation to ensure that these individuals complete the full practice protocol before leaving the agency.

**7. How often do you need to be recertified in MAP?**

- Recertification for therapists is required every 3 years.
- Recertification for supervisors is required every 2 years.
- Subscriptions to P-Web, Practice Guides, and PPMT Dashboard need to be renewed on a yearly basis.
- Recommended to not let certification lapse, even if you are not supervising, training, or seeing MAP clients.
- Active or inactive status options are available and have different costs for re-certification. "Inactive" status means that you are not currently seeing clients.
- 2 different portfolios:
  - Promotional review portfolio – For initial certification
  - Performance review portfolio – For certification renewal
- "Performance Review" has less client work and requirements than "promotional review."
- Make sure PracticeWise has your updated information (email, phone, street address).

**8. Are there DMH-sponsored MAP trainings being offered?**

No, not currently; however, PracticeWise will hold training for you if you have clinicians starting employment at your agency, or clinicians who have not yet been trained. Contact PracticeWise at [support@practicewise.com](mailto:support@practicewise.com) for information about purchasing a training. For direct service clinicians, the minimum cohort is 24. For supervisors, the minimum trainee cohort size is 12.

**9. Are there DMH-sponsored MAP Supervisor trainings being offered?**

No, not at this time. Contact PracticeWise at [support@practicewise.com](mailto:support@practicewise.com) and consider the cost-benefit: The cost of training a supervisor pays off after one cohort of clinicians. With renewal costs of \$250 every two years, and the cost of training replacement/new staff (with a general turn-over rate of 6 clinicians every 1-2 years), it may be worth certifying a supervisor.

**10. Is the MAP Agency Supervisor credential transferrable?**

Agency Supervisor credential is transferrable but can be maintained for only one agency at a time.

**11. Do new MAP Supervisors at small agencies have to train 6 clinicians?**

For small agencies that have difficulty finding 6 clinicians for a new supervisor to train, PracticeWise allows for a new supervisor to provide "skill enhancement" to currently certified staff as part of the training process for new supervisors.

**12. Can one agency's trained supervisor train another agency's staff?**

No. An agency supervisor is certified at only one agency at any time.

**13. We just hired a clinician trained at another agency in MAP, but his certification ends this month. He has not provided MAP in 2 years. How can he begin providing MAP again at our agency?**

A clinician trained by PracticeWise can provide MAP anywhere in LA. If trained by an agency supervisor, then complete an agency transfer packet with PracticeWise, and it is recommended that the supervisor reviews dashboard-building to confirm skills compared to your agency's standard.

- For a certificated clinician close to certificate expiration date, the clinician should review the Therapist's "Performance Review" Portfolio, which fully describes what is required.
- For a clinician new to an agency who does not have a case, look at the criteria in the "Performance Review" Portfolio as there is some flexibility as to how to complete. Contact PracticeWise to work with you to maintain a standard of quality.

**PWEBS-Related Topics**

**14. How do you determine which PWEBS results to use- One with few search criteria and many results or more search criteria but fewer results?**

- Practice Elements at the top of search results are referenced by more studies and may be of more relevance.
- Number of articles in PWEBS is limited by what PracticeWise has been able to code. PWEBS is a dynamic database which grows over time but is not exhaustive.
- Note on Culture-based Search results: Culture-based searches often return very few search results.
- In building a treatment plan, identify evidence that is important to you. E.g. age for developmental appropriateness; ethnicity if there is a compelling reason. What cultural adaptations do you need to make? Consider other cultural components not necessarily linked to ethnicity. Perform multiple searches with alternate criteria to see if the same elements are returned. Ethnicity will return few search results due to limited research of specific populations.
- When using PWEBS to create PPMTs remember client goals: helping reduce symptoms; helping client get better. Search results indicate what has been shown to be effective but may not work for every client.
- PWEB search helps therapist's conceptualization of therapeutic plan.

**15. How many practice elements should be returned by a "good" PWEBS search?**

There is no set number.

**16. Is it possible to incorporate other EBP elements not returned by PWEBS search with MAP?**

Yes. Remember, PWEBS is not exhaustive. If a clinician is trained in a different practice and is allowed by agency, it is possible to utilize other practice elements as part of MAP.

**17. How strict are the age ranges for MAP?**

MAP is adaptable. Current age ranges are determined by what PracticeWise has been able to enter into PWEBS, but MAP allows for additional elements to be utilized. For example, PWEBS trauma treatment currently goes down to age 3. But, if you have a 2-year old, and you have EBP trauma training for children younger than 3, then you can use elements from that EBP on your dashboard. PWEBS provides suggestions (practice elements) for treatment based on the available literature. The dashboard tracks delivery of practice elements and is used to monitor effectiveness of your intervention. Keep in mind that MAP is not an EBP and is a system used to organize and monitor treatment delivery.

Current ages for each MAP focus:

Depression 8-23

Anxiety 2-19

Disruptive 0-21

Trauma 2-18

**18. Are TAY Youth covered in PWEBS?**

The review underlying the PWEBS is only systematic through age 18 years, but it does include studies with participants over 18 years if youth under 18 are adequately represented in the study. This means that you may find results for youth above 18, but it will not be a thorough representation of the evidence base for those age groups.

**QA-Related Topics**

**19. Is it possible to utilize mood rating as a PPMT/SMART goal?**

- Advice is given against using mood rating as a goal; instead, you can monitor/count the number of times the intervention is used by a client to reduce symptoms.
- Level of “anxiety” and “depression” may be too vague.”
- One agency’s QA recommends that specific behaviors be counted/measured instead of mood rating, e.g. “amount crying.”
- Other agencies track mood rating on a weekly basis for some clients.
- Focus on integrating CCCP and PPMT to close the “clinical loop” of Initial Assessment, CCCP goals, and PPMT.
- Recommended to use strength based language and “positive behaviors” as goals.
- It is possible to use outcome measures for help in constructing goals. Use client responses to choose goals for reducing symptoms endorsed by client.

**20. How do you integrate clinical need with the demands of QA?**

There is no one right way. Create a system that works best for your agency based on size and resources.

**21. How do we monitor fidelity to the MAP model? How do we ensure QA, effective supervision, and effective clinical practice while maintaining fidelity to the model?**

Agencies are encouraged to create fidelity monitoring tools for use in supervision.

## **Electronic Health Record and Outcomes-Related Topics**

**22. How are agencies using Electronic Health Record Systems?**

Each agency is using a different EHR system.

**23. Are outcome measures for MAP entered in the OMA?**

On February 9, 2015, PEI OMA was ready to accept outcomes data for MAP, Triple P, and TF-CBT. Treatment cycles that were inactive/closed, or had fatal errors (i.e., malformed client IDs, incorrect D.O.B., etc.) were not integrated. CIMH Historical section in PEI OMA provides information on what was previously submitted to CIMH (i.e., demographic and outcomes data), and whether the record was integrated or not and reason(s) why it was not.

For more information, see link below:

<http://dmhoma.pbworks.com/w/page/55241527/CiMH>

**24. How do you appropriately maintain copies of outcome measures?**

Please contact [PEIOutcomes@dmh.lacounty.gov](mailto:PEIOutcomes@dmh.lacounty.gov).

**25. How can the supervisor ensure that data is correct on the PPMT if someone else is monitoring/collecting the outcome measure data? It seems hard for the responsibilities of MAP to be dispersed. Why can't we write the names of assessments/measures (i.e. ECBI, PHQ-) in case notes if it's such an integral part of treatment?**

It is the therapist's responsibility to administer, collect and monitor PPMT data and client progress. A MAP supervisor has the responsibility to ensure that the therapist is competent in capturing accurate data on the PPMT through chart review and supervision.

**26. I have not yet been trained in the outcome measures. If I do not have them completed within the first 30 days of treatment, should I administer them at all?**

MAP does not have the first 30 days of treatment policy when it comes to pretreatment data. Our interest in the completion of outcome measures has to do with assessing the functioning of the client, within the valid administration guidelines of each measure, for two purposes: (1) providing clinically useful information to guide treatment; and, (2) document treatment-related improvements in functioning.

From an outcomes perspective, the measures should be completed at pre-treatment, pre-MAP intervention. The farther one gets into treatment, the administration of measures no longer represents a pre-treatment assessment.

There is no absolute cut-off point. If the measures are not collected pre-treatment, they're not useful from an outcomes perspective. However, if the client was not seen within those 30 days, and the clinician feels as if the administration would still be pre-treatment, and be an accurate reflection of functioning before the MAP intervention, then it would be worthwhile. In terms of guiding clinical intervention, early and regular measurement is most useful, but even if pre-treatment assessment is missed, the "better late than never" rule applies.

## **Agency Staff-Related Topics**

**27. If staff transfer from other agencies will they need to redo the training process?**

**Specifically, what must new clinicians mid-way through their training do when they transfer?**

- Supervisor needs 12 total hours training in order to submit your portfolio.
- The 52 hours of supervision does not all have to be with the same person.
- Supervisor attests to the validity of performance portfolio, and that an adequate amount of training was given.
- Only current supervisor's documentation will be accepted by PracticeWise.
- New clinicians already trained need to submit a "Transfer Packet".
- New clinicians can begin billing based on submission date of "Transfer Packet".

**28. Is PracticeWise Staff Transfer Process PEI reimbursable as a training expense?**

Contact Olivia Sanchez at [osanchez@dmh.lacounty.gov](mailto:osanchez@dmh.lacounty.gov) to find out if the transfer is reimbursable.

**29. If therapist trained through PracticeWise at another agency, do we need to do a transfer packet?**

No. There are 2 types of certificates: Countywide and the agency-specific certificate. If PracticeWise conducted the training then the certificate issued is countywide as long as you have valid subscriptions to PWEBS and practice guides. If staff was trained by an agency supervisor, then you must complete transfer packet with PracticeWise. You can start billing DMH once the transfer packet has been submitted.

**30. Does a supervisor need to complete a transfer packet if they switch agencies?**

Only one agency per certificate; supervisors only supervise and provide trainings at one agency.

**31. Can you share some experiences from veterans who have gone through the Supervisors' Recertification process?**

- It was very simple and straightforward.
- Submit new Practice Elements.
- You don't have to have an active case – choose someone who you trained, and passed.
- The therapist is your case. You only need one, be sure they did the Eval.
- It took about 20 minutes.
- Minimum of sessions? Not an issue – chose a staff member who passed, demonstrating the skills.
- PracticeWise is looking for skill improvement. If in doubt, you can always call PracticeWise, it's factored into the fee you pay them, and they're prepared for that.
- Submit portfolio WITH payment.
- Evaluations: they're looking to see that they were done, not content. It's important for the supervisor to understand the relationship with the people you've trained.
- They want to see progression in elements; e.g. from skill to habitual, and add 1-2 new elements to change things up.

**32. Can you share some experiences from veterans who have gone through the Therapists' Recertification process?**

- Therapists have failed because practice element listed on portfolio did not have practice *guides*.
- Only requires 4 pages to submit. Double check that all required documents are

submitted for that portfolio (promotion or performance) review.

- Level 1 fail: you omitted basic information on page 1 of the form or their ID wasn't matched, pages are missing, documents not attached – may resubmit at no cost.
  - One report of neither supervisor nor therapists passed b/c “40 hours didactic + [hrs.] consultation = [total]” – because it didn't ask, she hadn't written “40 hours didactic +”
- Level 2 fail: One person submitted their portfolio and got a “proficient” grade but didn't check the box, “submitted dashboard” and received level 2 fail – need to wait 3 months before resubmitting with additional cost.
  - Recommendation- that you print the completed form and send the printed one because PracticeWise's form template may not save changes. If you submit PracticeWise's form, you'll be sending an incomplete form.
  - Failed b/c supervisor didn't count clinical events for recertification for promotion review, therapist submitted 9, and needed 10.
  - Forgetting to check a box on page 2: “Cultural Diversity” resulted in level 2 fail.
  - Recommendation- second set of eyes to review before submitting.
  - Recommendation- 2 measures even though 1 is enough. They're lowering points for the video graphic display if there's only 1.
  - Recommendation- Customize list of practice elements: delete the one(s) you're not using so presentation is cleaner.
  - Utilize “Treatment Planner” Guide to figure out focus (connect/care/cultivate. Map clearly how treatment is planned out from start of treatment, not after the fact. This also helps clinicians consider end-of-treatment from the start.
  - Focus Interference Framework = Treatment Planner Guide
    - (one agency) requires in paper charts

**33. Must one maintain MAP Therapist certification in order to maintain MAP Supervisor certification?**

No, maintenance of MAP Agency Supervisor status will not require renewal of MAP Therapist Status (The exception to this is that individual who achieve MAP Agency Supervisor status via “grandfathering” are required to successfully pass the MAP Therapist Portfolio when their initial 3-year “grandfathering” period expires).

Note: Grandfathering refers to people who were trained by PracticeWise as MAP therapists before the portfolio was in place. In those cases, people have a 3 year period from their initial training under which they can operate as a MAP therapist in LA County, but at the end of that period they will need to submit a full therapist portfolio.

**34. How does one maintain MAP Supervisor certification? Must you train 6 additional staff and have 2 more pass portfolio in that 2 year period?**

No. The renewal is basically an update not a retraining, so they will either need to (a) successfully complete a supervisee, (b) submit a case from a current supervisee, or (c) submit their own MAP direct service case, along with the other docs required. Please note that PracticeWise is currently working on policy documents for this and you will know what you need to do long before the time comes in two years.

**35. Once we have a MAP Supervisor, if they provided week long training and 6**

**months of consultation calls to staff, will those staff be “certified” MAP Therapists officially? Can they then take the Supervisor course?**

Those staff will have to successfully pass their portfolio review to be certified in MAP and obtain their MAP Therapist Status. Once MAP Therapist Status is achieved, staff are eligible to continue on to the Supervision and Consultation Series.

**36. Can MAP Supervisors supervise MAP staff that are already certified outside of the 10 max set by LACDMH?**

Yes.

**37. If an agency has two MAP Supervisors, can one do the training (in a formal 5-day sense) and the other do the follow-up consultation meetings? Will the training hours count toward the 15 the first person needs?**

We do not mind if agencies with multiple supervisors “tag team” on the training portion (e.g., three supervisors split up training duties, group their supervisees for a shared training event, and then each continue the supervision with their supervisees following the event) but a systematic “hand off” from one supervisor who does the training to others who do the clinical supervision is definitely not consistent with the spirit of the Agency Supervisor model. This issue is a little tough because therapists and supervisors do periodically get “reassigned” during the development period and if this is a rare event, we would not take issue, but if this is recurrent or systematic then it does violate the spirit of the model.

**38. Can a licensed therapist who received MAP training from a MAP supervisor be eligible for DMH sponsored MAP Supervision and Consultation Series training?**

Yes, as long as they successfully passed their Therapist Portfolio review and achieved MAP Therapist status, they are eligible for the MAP Supervision and Consultation series training.

**39. I read through the document on certification for PracticeWise and DMH but I'm not clear on which documents need to be submitted and to whom for MAP trainees receiving training from MAP Supervisors at the agency. Since they have not completed the 5 day training, they would not get a certificate, so what do I submit to PracticeWise and what do I submit to DMH?**

Upon completion of training, trainees must submit the portfolio to PracticeWise. Supervisors must also submit their trainee’s learning log along with their MAP Supervisor’s certificate to DMH for authorization to submit claims to MAP. Once the trainee has achieved MAP Therapist status, they must submit their therapist certificate to DMH.

**40. Which of the PracticeWise Online Resources services are required for a user to pursue or maintain MAP Therapist or MAP Agency Supervisor Status?**

The Progress and Practice Monitoring Tools (PPMT, a.k.a. Clinical Dashboards), Practitioner Guides, and PWEBS Database.

**41. Do those completing the MAP Supervision and Consultation Series have to submit all 6 trainees’ MAP therapist portfolios for review at the same time?**

No. It is not necessary to submit all of the Therapist Portfolios at the same time. Sometimes this is recommended to minimize confusion, but it is not necessary.

### **General MAP-Related Topics**

**42. Are there age restrictions for MAP? I have heard that the clients must be 4 yrs. old regardless of what data is available in the PracticeWise PWEBS database? If there are age range cut-off's both top and bottom of the range, what are they?**

With MAP, a key part of service planning and revision involves the use of the PracticeWise EBS Database (PWEBS). The PWEBS Database summarizes over 450 studies involving mental health treatments for participants ranging in age from 0 to 23 and currently focuses on treatments that target anxiety, attention problems, autism spectrum, depression, disruptive behavior, eating problems, mania, substance use, suicidality, and traumatic stress. However, that literature is not uniform across problems, gender, ethnic groups, etc. (e.g., the age range of established treatments for Attention Problems is 2 to 13 years) and the PWEBS literature review is not comprehensive for youth above age 18. Therapists are encouraged to probe the relevance of the available research to a given client or family and to use sound judgment in choosing a course of action. When therapists are operating outside the age range of the literature, they are typically expected to use best practices by adapting and extending approaches that work for groups of children “most similar” to the client in questions (in this case, closest in age). To the extent that there are departures from the literature, therapists should be aware that the uncertainty of achieving a positive outcome is increased, and thus especially conscientious use of outcome monitoring is warranted. MAP also incorporates a measurement plan into its direct service model, so that regardless of the strategies suggested by the literature, a MAP Therapist would be expected to measure and review the practices being used and the progress associated with those practices. (See document: Direct Service Workshop Overview)

**43. May I treat TAY youth with MAP?**

Under PEI, if you have TAY funding, you can treat TAY using MAP. When using MAP with clients over 18 years, it is very important to recognize the limits of the system. The review underlying the PWEBS is only systematic through age 18 years, so when going “beyond the literature” practitioners are encouraged to consider other sources of evidence that may be more directly relevant to the client’s characteristics (i.e., look at literature and literature review tools other than just the PWEBS). The PWEBS information is always about “similar” but not “identical” youth, so to the extent that the PWEBS does provide information about similar problem, gender, ethnicity, setting, etc. the generalization across age may be reasonable if not optimal. Also, we would encourage special attention to the “embracing diversity” issues to make thoughtful judgments about adaptations that may be necessary to the Practitioner Guide procedures to communicate them in a way that is appropriate for a young adult. Many of the other MAP components (e.g., PPMT, process guides) may translate more directly for use with older clients. Practitioners should be aware that the uncertainty of achieving positive outcomes is increased and especially conscientious use of outcome monitoring is warranted.

- 44. We are hearing from some of our MAP trained staff that clients with ADHD cannot be seen in MAP. Our understanding is that it is not diagnosis, but focus of treatment that drives the ability to use MAP. So, if you had a client with a diagnosis of ADHD but a focus of treatment of Disruptive Behavior, could you use MAP?**

Yes. The 4 target areas eligible for PEI are Anxiety and Avoidance, Depression and Withdrawal, Disruptive Behavior, and Traumatic Stress. The diagnosis of ADHD may or may not be eligible under PEI depending on the primary target area and focus of treatment. If the primary target area is one of the 4 target areas eligible under PEI, then the service and claim are eligible for PEI.

- 45. A number of the supervisors noted that they had recently heard through admin calls and LACDMH documentation that they are not able to claim for MAP for youth with depression issues under 8 years old. Likewise, their understanding is that they could not claim for MAP if kids fell under the lower age thresholds for the outcome measures. I am not sure if this is completely accurate, and wanted to be able to inform both my supervisees and our other training staff if this is in fact the case. Any insight into this issue would be much appreciated!**

Please see answer to question #37 above. In addition, on admin calls and LACDMH documentation, the age limits are specific to standardized measurement normative age range, which have implications for outcome data collection only.

- 46. Is there a website where archived webinars are stored to view for clinicians that have not gone through live-webinars for standardized measures?**

The Webinar is on both the CIBHS and PracticeWise websites.

- 47. If a client is in MAP, but the clinician feels that the parent would benefit from Triple P, would the clinician be able to allow the parent to do the Triple P Model and then resume MAP afterwards?**

Yes, If Triple P is the intervention suggested that will work for the client.

- 48. Will DMH accept MAP certificates for staff trained by in house supervisors that then move to another agency?**

PracticeWise has established a pathway for staff to maintain their MAP Therapist Status when moving to a new agency. Please contact PracticeWise for the transfer packet.

- 49. Can consultation by a MAP therapist with a non-MAP trained staff (e.g. MD) be claimed to MAP?**

Yes.

- 50. Staff is not clear about administering RCADS, so will there be training to help them?**

The Agency will have to train the staff on how the agency wants the RCADS done at their agency; however, there is a Webinar on the CIHBS and PracticeWise websites. Please contact Cricket Mitchell at CIHBS for further assistance ([cmitchell@cihbs.org](mailto:cmitchell@cihbs.org)).

**51. Has DMH established a protocol for agencies regarding utilizing case managers with MAP clients who are not trained in MAP with the changes to PEI claiming?**

Case Managers can claim for services provided within their scope of work as long as services are coordinated with the MAP Therapist, it is clinically appropriate, and there is documented justification of services.

**52. Will I fail my portfolio if I don't have baseline measures?**

No, baseline assessment is not specifically required to pass a MAP Therapist Portfolio review. A number of considerations are made in scoring dashboards for portfolio review. The score for the progress data availability criteria may receive a lower rating if multiple data points from multiple measures are not included. However, a low score on one criterion may be “offset” by a high score on another criterion.

**53. Must I include the PPMT in my final chart before termination?**

Yes, the PPMT (first page that shows the graph only) will need to be in your chart.

**54. Must my progress notes cite specific MAP Practice Elements in order to pass an audit?**

No.

**55. I heard that we are only allowed to use one or two practitioner guides per session. What happens if we use more?**

There is no “hard and fast” rule about the number of practitioner guides to use per session. The recommendation to limit use of multiple practitioner guides within a single session is designed to promote focus and depth in intervention. Ultimately, decisions about the number of guides to use and the depth to which each guide is addressed during a session is a clinical judgment. However, prior analyses of care patterns have identified a tendency toward use of many, lower “dose” practices, e.g., numerous practices endorsed for a single session, in actual care systems, whereas effective interventions tend to be characterized by fewer practices that are implemented with greater depth.

The MAP model guides but does not explicitly restrict or limit the number or ordering of practices used. However, MAP advocates that the selection of practices emphasizes a high degree of focus and that implementation of practices occur with sufficient intensity and depth to help clients develop expertise with the practice and effect change in their life as desired.

It is important to remember that the PPMT was created as a method for clinicians to keep track of their patterns of practice when numerous Practitioner Guides are endorsed for a single session. It can become hard to remember exactly what occurred in each session. The MAP Model emphasizes parsimony in selecting practices in sessions and on your PPMT so that you represent the things that were covered most thoroughly in the session. It is not necessary to endorse practices that were merely mentioned or reviewed in brief.

**56. Can I claim for MAP if I have youth with secondary problem areas including things**

**like bipolar, eating disorders, or autism?**

You can claim PEI as long as the primary focus of treatment is one of the four target behaviors: Anxiety, Depression, Disruptive Behaviors, or Traumatic Stress, regardless of the diagnosis. However, if the youth has more severe symptoms and/or requires more intensive treatment, he/she may not meet the criteria for the PEI target population and require services through a non-PEI Program.

**57. Is family therapy considered part of MAP? It comes up in my PWEBS searches but there are no practitioner guides.**

Yes, family therapy practices are included in MAP. Because the standard MAP terminology differs from that of the various family therapy literatures, learning the overlap and translations between terms may require a bit of extra initial effort. In MAP, family therapy structure, processes, and practices are represented in several ways.

One way that the MAP represents the structure of family therapy is through the “format” codes in the PWEBS, which indicate the patterns of participation in sessions. For example, interventions described as family therapy in the literature may have been tested in various formats such as conjoint family therapy which is coded as Family format, one-person family therapy which is coded as Family One format, dyadic family therapy which is coded as Parent Child format, or multifamily group which is coded as Multifamily format. Other formats such as Parent or Parent Group may also be coded as appropriate.

The various family therapy approaches also include numerous different practices that are coded into the standard practice elements wherever possible. For example, common family therapy techniques such as encouraging the family to speak directly to each other, encouraging interaction by asking the family to discuss something, etc. are addressed in the Communication Skills practitioner guide. The set of Cognitive practitioner guides incorporate family therapy techniques such as reframing, restructuring, or reconnection (e.g., recall and label positive feelings and thoughts about someone). The family therapy technique of validating changes with positive reinforcement is addressed as Therapist Praise/Rewards.

Family therapy strategies for working with boundaries and alliances are also covered in some of the standard practice elements, such as strengthening alliances by finding areas of common interest and encouraging their pursuit (e.g., Activity Selection, Attending), strengthening boundaries (weakening alliances) by collaborative rule setting between enmeshed and non-enmeshed adult with regard to an enmeshed child (Behavioral Contracting, Stimulus/Antecedent Control), opening up closed systems and detriangulation by focusing back on the parties in conflict, promoting direct address, labeling covert issues, and such (Communication Skills), etc.

Further, “other practice” descriptions are used in the PWEBS to provide additional specificity or to describe practices that are under consideration for inclusion in the standard practice element set. For example, aspects of the “Joining” technique are included in the Relationship/Rapport Building and Engagement practitioner guides but “Joining” is also explicitly identified as an “other practice” in the PWEBS.

The Family Therapy practice element itself has a few unique features. This practice emphasizes “shifting patterns of relationships and interactions within a family” and may be thought of as relational restructuring. As previously indicated, the specific practices and exercises for doing this are often characterized by the other practice elements mentioned above. The family therapy practice element is coded in addition to the other specific practice elements, when practices are applied to restructuring family relationship. Also, the practice descriptions in some of the family therapy literature are not detailed enough to code the specific practices used, so the family therapy practice element may be coded to indicate these interventions.

PracticeWise regularly re-evaluates how well the practice coding system reflects diverse literatures but also integrates these diverse literatures into a coherent set of common elements. The MAP system was designed to be a transtheoretical infrastructure that links to a common set of evidence, but part of the continual learning process of MAP is the ongoing translation from each professional’s preferred terminology to the common constructs and language of the MAP system.

**58. May I use other EBP materials when I am employing MAP?**

Yes. The MAP system provides tools and resources to promote high quality evidence-based practices, but there are many other good tools and resources available. When identifying and selecting appropriate alternative EBP materials for MAP, it is good practice to consult the PWEBS to identify those materials and models with the “best evidence” for similar clients and follow a structured decision-making process to guide generalizations as needed. When recording the use of these other evidence-based practices on your PPMT, you may either choose the practice element from your PWEBS search that best represents the generic concept of those materials you used. You may also write these practices in as an “Other” by using the name of the materials from the other EBP.

**59. What counts as a "clinical event" in MAP? Can I include collateral sessions or teacher meetings as clinical events?**

Clinical events may also be thought of a therapeutic interaction, clinical contacts, or intervention sessions during which components of the MAP system were used. If collateral sessions or teacher meetings include an active therapeutic practice then they may be “counted” as a clinical event.

**60. Do my PPMT measures have to align directly with my treatment goals?**

This is not technically required, but is strongly encouraged. Typically, PPMT target behaviors and measures should be closely related to CCCP goals since they both address client’s needs and impairments and measure progress of treatment. If a discrepancy between the CCCP and PPMT does exist, a compelling rationale should be apparent.

Sometimes clinicians write broad CCCP goals that encompass a variety of behaviors within a symptom cluster. For example, “Client will reduce depressive symptoms including crying, isolating, angry outbursts, and sulking from 10 times a week to 3 times a week.” When translating this goal to the PPMT, it may be helpful to break the

component behaviors down for individual measures or find a way to measure them as a Gestalt. In the above example, the therapist might measure: 1) caregiver report of youth's angry outbursts at home per week, 2) youth's report of crying episodes per week, 3) youth or caregiver reports of overall depression severity level that week.

Overall, your CCCP goals are best used to inform your PPMT measurements, consistency between these two should help to make it easier to keep track of progress of goals. They are meant to inform each other to benefit treatment planning and conceptualization.

**61. Can certified MAP Therapists lead "MAP Support Groups" at their agency to provide informal clinical and PRACTICEWISE Tool support without being a MAP Supervisor?**

Yes. Peer support, consultation, and review are encouraged and may be an effective and cost effective strategy for MAP quality assurance and improvement. Because this is different from MAP agency supervision and training, support groups will not qualify individuals for any advancement or promotion within the MAP Professional Development Program.

**62. How much are the fees if I have to resubmit my portfolio and how do I order a new portfolio review?**

Additional portfolio reviews can be purchased through the [www.practicewise.com](http://www.practicewise.com) website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to Purchase Portfolio Review. Current pricing and a group order form are also available on that web page. Email requests may also be addressed to [support@practicewise.com](mailto:support@practicewise.com).

**63. What should I do if I do not receive the MAP Update emails from Practicewise?**

This generally occurs either because the email address registered to your account is incorrect or the email is being screened as junk mail by your email provider. To verify that the correct email addresses listed for your account, go to [www.practicewise.com](http://www.practicewise.com), login to your account, click on your username in the upper right hand corner, and update the email address field. If the email address is correct, please check your junk mail folder or contact your system administrator to verify that email from PracticeWise are approved for receipt. If the problem continues, send a notice to [support@practicewise.com](mailto:support@practicewise.com) to request assistance.

**64. Is it required that I save my PWEBS searches into my PPMT notes page? I heard that if you don't do this you will fail your portfolio review.**

No. The PWEBS search may be submitted in the notes page of the PPMT, but it is also acceptable to submit it in another readable form (i.e., pdf .doc, fax, hard copy). During the review process, you will be notified if the submitted format is unreadable.

**65. Is there a telephone number where I can call the PRACTICEWISE Central Office?**

The phone and fax service number for the PracticeWise central office is 321-426-4109.

However, the best way to get a prompt response to a question is to send an email to [support@practicewise.com](mailto:support@practicewise.com).

**66. How many consultation calls must I participate in to pass my portfolio review?**

Twelve (12) direct service consultation calls are required to pass the MAP Therapist Portfolio promotion review and six (6) supervision and consultation calls are required to pass the MAP Agency Supervisor Portfolio promotion review.

**67. How long do the Training Event pages stay active?**

Training Event pages used to stay active for about 9 months, but due to repeated requests for extensions PracticeWise has extended these pages for several years.

**68. Will PracticeWise provide Training Event pages for MAP Supervisors when they lead trainings at their agencies?**

No. PracticeWise does not provide web support for internal agency training events.

**69. How do Supervisors determine the RSVP Code for tools subscription for their supervisees?**

Supervisors should contact the individual assigned as the group administrator by their agency. If you have difficulty identifying your agency's group administrator, you may send an email request to [support@practicewise.com](mailto:support@practicewise.com) and PracticeWise will try to assist you in identifying the assigned group administrator for your subscription.

**70. Do I have to hold 20 clinical events across at least two cases or for two individual cases to pass my portfolio MAP Therapist review?**

A total of 20 clinical events across at least two (2) cases is required. For example, two (2) cases with 10 events each would be sufficient experience.

**71. Must I achieve a positive outcome with my cases in order to pass my MAP Therapist portfolio review?**

No, it is not necessary to achieve positive outcomes with your cases to pass the MAP Therapist Portfolio promotion review.

**72. If I send in my portfolio via email, how do I provide a signature on the case record?**

An electronic signature is acceptable if the portfolio is submitted via email from the certifying account. You may create an electronic signature by typing your name on the line that reads "Signature" on the Case Record sheet of the portfolio.

**73. When is the Therapist Portfolio due?**

The Therapist Portfolio is due within one year of completing the Direct Services Training. Therapists are eligible to submit their portfolios for review as soon as they have completed 12 hours of consultation over a period of 6 months. The cost associated with the review of the Therapist Portfolio is included in the Direct Services Training contract which expires 1 year from the completion of the Direct Services Training. Submissions beyond that date will be accepted but there will be an additional cost for the review.

**74. What do Level 1 and Level 2 failure mean in the portfolio review process?**

Level 1 Review is performed to determine if the portfolio submission is properly completed.

- a. If results of the Level 1 Review are not satisfactory, then the submitter will be notified of problematic items and be allowed to resubmit within thirty (30) calendar days.
- b. If results of the Level 1 Review for the resubmitted items are not satisfactory, then the review will fail and a new review process will need to be initiated.

Level 2 Review is performed to determine if the portfolio meets quality standards.

- c. If Level 1 and Level 2 Reviews were completed successfully, the submitter will receive the appropriate Award of Status.
- d. If Level 2 Review was not completed successfully, then the submitter will be notified of the problematic items and be eligible to initiate a new review process for a resubmitted portfolio thirty (30) days after an initial review.
- e. If Level 2 Review was not completed successfully during the review of a resubmitted portfolio (i.e., upon second failure), then the submitter will again be notified of the problematic items. The submitter will be eligible to initiate a new review process for a second portfolio resubmission at least six (6) months after the failed resubmission review and following completion of an additional six (6) hours of consultation in the MAP System.

**75. I heard that I cannot use the word “Psychoeducation” in documentation. However, these are the words used in Practitioner Guides. How should I describe these MAP sessions?**

You can provide psychoeducation to youths and parents. For parents, make sure that you clearly demonstrate how the psychoeducation benefits the identified client and treatment goal(s).

**76. Do PPMTs work on both Macs and PCs?**

Yes, PPMTs can be used with both MAC and PCs if Excel is installed on the Mac or PC. (Note: Some macros on the PPMT may not be compatible with MACs.)

**77. Is the Focus Interference Framework required documentation that must be present in my client's file? Must I do a FIF for every case?**

No, the FIF is a process guide, not a required document. The FIF is intended to help develop a habit of mind and support integrative reasoning that should be applied to the analysis, understanding, and management of all MAP cases.

**78. How can a therapist or supervisor make up missed consultation calls?** Additional consultation calls can be purchased through the [www.practicewise.com](http://www.practicewise.com) website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to purchase additional MAP Direct Service or MAP Supervision consultation.

- 79. How can a therapist or supervisor make up missed consultation calls?** Additional consultation calls can be purchased through the [www.practicewise.com](http://www.practicewise.com) website. The therapist or supervisor will need to log in to the site and click on the link titled "Subscribe." Under this link the individual may choose to purchase additional MAP Direct Service or MAP Supervision consultation.
- 80. How does a therapist or administrator obtain verification of completed consultation calls?**  
Verification of attendance on a consultation call series can be requested by emailing [support@practicewise.com](mailto:support@practicewise.com).
- 81. How will renewals of the group subscriptions be handled?**  
Subscriptions are renewed on a yearly basis. The contact person listed as the Group Administrator on the PracticeWise Group and Custom Order Form will receive the renewal reminder. Each individual user will NOT be contacted about the expiration date. The first renewal reminders were sent to all of the Group Administrators on October 31st, 2011. A second reminder will be sent on November 30th to any agency that has not already completed its renewal. The most common reasons for a failure to receive the renewal notice is an invalid email address or automated screening of the reminder email by the Group Administrator's email system. If you would like to verify the email address for your account, please contact [support@practicewise.com](mailto:support@practicewise.com) to request information about the current Group Administrator record.
- 82. Are the subscriptions for the LAC DMH supervisor trainings separate from the original MAP Implementation subscriptions?**  
Yes, the supervisor subscriptions are established when the trainee attends a MAP Supervision and Consultation Series training event. As with the original subscriptions, the supervisor subscriptions are funded for the first year by LAC DMH. The renewals for the supervisor subscriptions will be sent out at least 30 days prior to the one year anniversary of the training dates.
- 83. Can I increase or reduce the number of subscriptions at the time of renewal?**  
Yes, an agency can increase or reduce the number of subscriptions it wishes to renew within the 30 days prior to the expiration. Any changes will be effective when the renewal is processed.
- 84. Can I get a list of the current users assigned to the group subscription? Yes, please send your request to [support@practicewise.com](mailto:support@practicewise.com) and you will receive the list of users and usernames currently assigned to the group subscription. My agency has multiple subscriptions from different training cohorts. Can I consolidate them into a single group subscription for my agency?**  
Yes if the multiple subscriptions are funded directly an agency and not a third party payor such as LACDMH. A single consolidated subscription may be established and a prorated credit applied for the unused portions of the multiple separate subscriptions. Please send your request to [support@practicewise.com](mailto:support@practicewise.com).

- 85. How do I know if my portfolio submission has been received properly?** You will receive an e-mail to the address listed on the submission within two business days confirming the receipt of the portfolio and including a unique tracking number for the submission.

## **PARENT-CHILD INTERACTION THERAPY (PCIT)**

**1. What are the components of PCIT?**

The model focuses on children who have externalized acting out behaviors. PCIT consists of two phases:

- a) **Child Directed Interaction (CDI):** Focuses on enhancing the child-caregiver relationship by promoting positive caregiver-child interactions.
- b) **Parent Directed Interactions (PDI):** Improves child compliance by teaching parents effective child management skills.

Both phases of treatment include didactic training, followed by 7-10 coaching sessions. During treatment sessions therapists coach caregivers via a “bug in the ear” during the caregiver-child play sessions.

**2. What is the age range for PCIT?**

It is for children ages 2 to 7 and their caregivers. PCIT targets dyads that are experiencing stress, or are at risk.

**3. What is the goal of PCIT services?**

The treatment goals of PCIT are to improve interactions and the relationship between caregiver and child, increase the caregivers’ ability to parent the child and decrease clients acting out behaviors.

**4. What is the length of treatment?**

The average length of treatment is 16-18 sessions for 50 minute sessions once a week in the office. Treatment should not exceed 25 sessions.

**5. Who can provide PCIT services?**

Clinicians can provide PCIT services once they have been approved by UC Davis Training Institute as a certified PCIT clinician. In order to achieve certification status clinicians must graduate 2 successful cases, as determined by UC Davis.

Additionally, untrained clinicians who are being supervised by appointed agency Trainer of Trainers (TOTs) are able to provide PCIT services.

**6. Are there facility requirements to conduct PCIT treatment?**

Appropriate space includes a stripped therapy room adjoining a separate observation room with a one way mirror and/or video monitoring. Additionally, there must be a communication system that allows the therapist to speak in real time to the parent during parent-child interaction. Additional materials include recommended age appropriate toys i.e. building blocks, play dough, colors, train set, etc.

**7. What are the outcome measures for PCIT services?**

The PCIT model will use the following measures at the beginning, midpoint and end of treatment:

- 1) Eyberg Child Behavior Inventory or Sutter–Eyberg Student Behaviors Inventory-Revised (ECBI or SESBI-R): for all children enrolled in PCIT
- 2) Youth-Outcome Questionnaire (Y-OQ): for children 4 years of age and older

**8. What other resources that can be used to build clinician’s capacity to serve PCIT clients?**

Additional clinical, training and outreach resources can be found at the UC Davis PCIT website: <http://pcit.ucdavis.edu>

## **PROBLEM SOLVING THERAPY (PST)**

**1. What is PST and who may use it?**

Problem Solving Therapy (PST) has been approved as a “promising practice” for older adult contract agencies providing PEI services. Problem Solving Therapy (PST) has been a primary strategy in such EBP’s as IMPACT/MHIP and PEARLS. PST has generally focused on the treatment of depression.

**2. How is PST used in LA County DMH?**

PST is to be used as an “early intervention” model intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally.

**3. What is the target population?**

Underserved Cultural/Ethnic Populations, Individuals with Early Signs of Mental Illness, Trauma – Exposed. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness (but who are not home-bound, isolated seniors for whom PEARLS would be the more appropriate treatment model.)

**4. What are the goals of PST?**

The goals of PST include: increasing the client’s understanding of the link between current symptoms and their current problems in living, increasing the client’s ability to clearly define their problems and set specific and measureable goals and finally to teach clients a specific structured problem-solving procedure that they can utilize throughout their lives.

**5. Can PST be used with diverse cultural backgrounds?**

This model is appropriate for both males and females and can be culturally and linguistically adapted to underserved cultural/ethnic populations.

**6. What are the components of PST?**

PST is a brief intervention model which involves 7 steps:

1. Clarify and define the problem
2. Set realistic goal
3. Generate multiple solutions
4. Evaluate and compare solutions
5. Select a feasible solution
6. Implement the solution
7. Evaluate the outcome

**7. What are the minimum requirements for a practitioner to be able to provide PST?**

Licensed and waived clinicians may offer PST consistent with their scope of practice.

**8. What are the Core services and codes that are provided as part of PST?**

- a. Assessment/Psychiatric Diagnostic Interview: 90791
- b. Individual Psychotherapy: H0046, 90832, 90834, 90837
- c. Targeted Case Management: T1017
- d. Individual Rehabilitation Services: H2015
- e. Team Plan Development: H0032

**9. What is the length of treatment?**

The number of sessions ranges from 6 – 10. The length of Initial session is 30-60 minutes; and should probably be guided by the client's capacity to actively engage in the various steps of PST. The frequency of sessions should also be guided by the urgency of the situation and the capacity of the client to have sufficient time and opportunity to implement each step of PST.

**10. What is the timing of sessions?**

Initial weekly sessions with increased time between sessions to bi-weekly sessions as client will have increased opportunities to practice skills. Initial session should last approximately 1 hour and the remaining sessions should last 30 minutes.

**11. What outcome measures are used for PST for older adults?**

The Outcome Questionnaire 45.2 (OQ) is the general measure used, and the Patient Health Questionnaire – 9 (PHQ-9) is the specific measure used. The OQ is designed to measure observed behavior change in a client from the beginning to the end of treatment. It should be administered at the beginning of treatment, possibly at the 6-month point, and at the end of treatment. The PHQ-9, the specific measure, should be administered every session to measure depressive symptom change throughout treatment. LAC DMH requires the use of the Outcome Questionnaire (OQ) and the PHQ-9 at the beginning of treatment to establish a baseline for all PEI programs for adults and older adults receiving PST. LAC DMH also requires that both of these measures be administered at the end of treatment to measure the effectiveness of treatment on symptom reduction and associated behavior change.

**12. What is the training protocol?**

Clinicians certified in PST, or trained in PEARLS, are qualified to implement this intervention model. PST Certification sessions are encouraged particularly when first learning this intervention model.

**13. What is the setting where PST can be practiced?**

PST services can be provided in any setting: outpatient clinics or field based.

**14. Is there an adherence scale for PST?**

Yes, there is a PST Therapist Adherence Scale called the PST Therapist Adherence Scale.

## **PROGRAM TO ENCOURAGE ACTIVE AND REWARDING LIVES FOR SENIORS (PEARLS)**

**1. What is the population to be served under PEARLS?**

PEARLS for Older Adults was designed to treat minor depression and dysthymic disorder in adults aged 55 and older.

**2. What are the age range limits for implementing PEARLS under the PEI Plan?**

PEARLS is designed for adults aged 55 and older.

**3. Are there exclusionary criteria?**

The PEARLS Program should not be used with clients who screen for Psychosis, Major Depression, Bi-polar Disorder, Alcohol or Substance Abuse or significant Cognitive Impairment.

**4. What screening tools are required?**

Patient Health Questionnaire – 9 (PHQ-9)

Dysthymia Screening

Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment

**5. What are the basic elements of the PEARLS Program?**

Focuses on teaching each client the skills necessary to move to action and make lasting life changes.

It is delivered in the client's home.

Takes a team-based approach, involving PEARLS counselors and supervisor or program manager.

Aims to improve quality of life as well as reduce depressive symptoms, and it is well-suited for individuals with chronic illness.

**6. What is the length of treatment?**

During six to eight in-home sessions that take place in the client's home and focus on brief behavioral techniques, PEARLS Program counselors empower individuals to take action and to make lasting changes so that they can lead more active and rewarding lives.

**7. How often should PEARLS sessions be conducted?**

The PEARLS depression intervention is typically conducted over six to eight sessions in a six-month period and consists of problem solving treatment (PST), behavioral activation, and pleasant activities scheduling. During the course of the PEARLS treatment, the counselor must pay attention to different ways of conducting sessions depending whether it is a first, middle or last session. Throughout the period during which sessions are conducted, there is ongoing clinical supervision on a weekly or biweekly basis for the PEARLS counselor.

**8. What are the required staffing patterns for PEARLS?**

PEARLS has identified four key roles: Manager, Supervisor, Counselor and Data Coordinator. (A single individual may serve in the role of Manager and Supervisor; but the PEARLS Counselor duties must remain clear and separate from the other roles.) In either case, it is important that everyone involved in the PEARLS Program work closely together.

**9. What is the staff-to-client ratio?**

PEARLS counselors can typically have a caseload of 20 clients, which includes a mix of clients having weekly, bi-weekly and month in-person session and client in follow up phone calls.

**10. Where can PEARLS be implemented?**

PEARLS was studied and proven to be effective as a home-based program. The developers of this model report there are some agencies who have modified it to be implemented as an agency-based program and have been very successful with it. While the developer cannot say that their research proves this is effective, there is some real-world evidence to encourage such an effort. Therefore, DMH will allow providers to implement PEARLS in other settings.

**11. Please describe the training model for PEARLS:**

After completing the two-day tailored PEARLS Training Program, participants will be able to:

- Identify depression using scientifically validated instruments
- Effectively assess depressed individuals and recommend steps to improve their mental health and overall quality of life
- Recognize the psychosocial needs and stressors particular to older adults
- Describe key elements of this comprehensive, multi-component depression management program
- Review the evidence base supporting the effectiveness of the PEARLS treatment program
- Demonstrate practical skills—such as problem-solving treatment, behavioral activation, and pleasant event scheduling—for treating depression in community-dwelling individuals
- Understand the key elements and personnel required to effectively implement PEARLS in their communities

**12. Is there a Fidelity Scale for PEARLS?**

There is a self-report questionnaire which may be used as a fidelity instrument called The University of Washington PEARLS FIDELITY INSTRUMENT that we have been granted permission to use and disseminate. Additionally, the toolkit does include an adherence scale which is a self-rating tool called The PST Therapist Adherence Scale.

**13. Are Outcome Measures required and how often do they need to be completed?**

Yes, outcome measures are required. The PHQ-9 is integral to the PEARLS model and used at beginning of treatment and re-administered at every session. Additionally, LAC

DMH requires the use of the Outcome Questionnaire (OQ) and the PHQ-9 to at the beginning of treatment to establish a baseline for all PEI programs for adults and older adults receiving PEARLS. LAC DMH also requires that both of these measures be administered at the end of treatment to measure the effectiveness of treatment on symptom reduction and associated behavior change.

**14. What are the CORE services and their codes that can be provided under PEARLS?**

Psychiatric Diagnostic Interview: 90791

Individual Psychotherapy: H0046, 90832, 90834, 90837

Targeted Case Management: T1017; (The client's assigned case manager may address the client's needs through targeted case management). Individual Rehabilitation

•Services: H2015

•Plan Development: H0032

**15. What are the goals of PEARLS treatment?**

The goals of PEARLS include: increasing the client's understanding of the link between current symptoms and their current problems in living, increase the client's ability to clearly define their problems and set specific and measureable goals and finally to teach clients a specific structured problem-solving procedure that they can utilize throughout their lives.

**16. What are the components of PEARLS?**

Three elements- Problem Solving Therapy, Behavioral Activation and Pleasurable Activity Scheduling

**17. Please describe "Wrap-Up" Activities.**

Following the last formal PEARLS sessions, the PEARLS counselor may provide periodic telephone "follow-up" calls for up to 60 days provided the following conditions are met:

- The follow-up phone calls are built into the treatment plan.
- There is discussion of skills used and what worked/didn't work.
- There is a clear plan, based on the of how the client will continue to use the skills
- There is some intervention to assist the client in continuing to use/start to use the skills learned. The conversation should involve an active role of the clinician.

## **PROLONGED EXPOSURE THERAPY FOR POST TRAUMATIC STRESS DISORDER (PE)**

**1. What is Prolonged Exposure for Post-Traumatic Stress Disorder (PE)?**

PE is an evidence based practice (EBP), which is theoretically based and a highly efficacious treatment for chronic post-traumatic stress disorder (PTSD) and related depression, anxiety, and anger. Based on basic behavioral principles, it is empirically validated, with more than 20 years of research supporting its use. PE is a flexible therapy that can be modified to fit the needs of individual clients. It is specifically designed to help clients psychologically process traumatic events and reduce trauma-induced psychological disturbances. PE produces clinically significant improvement in about 80% of patients with chronic PTSD.

**2. Who is appropriate for PE?**

PE is intended for Adults (ages 26 to 59) and Older Adults (OA, ages 60+) in our Directly Operated programs. This EBP is appropriate for those who are experiencing symptoms of chronic PTSD resulting from one or more traumatic events including but not limited to the following: rape, physical assault, combat, community violence, motor vehicle accidents, natural disasters, and history of child abuse.

**3. Does the client need to have a diagnosis of PTSD in order to receive this EBP?**

Yes. The client must be diagnosed with chronic PTSD.

**4. Who should not participate in PE Treatment?**

PE is contraindicated for clients who are actively suicidal, homicidal, psychotic, experiencing a panic or anxiety attack, and/or at high risk of being assaulted.

**5. What are the theoretical foundations of PE?**

This EBP is based on the Emotional Processing Theory of PTSD. Specifically, traumatic memories must be activated in order to be processed on an emotional level while simultaneously correcting erroneous cognitions about the “world” and “self.”

**6. What are the key components of PE?**

PE is divided into the following four components: 1) Exposure Therapy, 2) Anxiety Management, 3) Psychoeducation, and 4) Cognitive Therapy.

- (a) Exposure Therapy: a set of imaginal and in-vivo exposure techniques designed to reduce pathological, dysfunctional anxiety, and erroneous cognitions by encouraging the client to repeatedly confront trauma-related objects, situations, memories, and images which have been avoided in the past.
- (b) Anxiety Management: relaxation training, breathing techniques, positive self-talk, positive visualizing, social skills, and distraction techniques.
- (c) Psychoeducation: educating the client about common reactions to trauma.
- (d) Cognitive Therapy: identifying, challenging, and replacing dysfunctional thoughts and beliefs with positive ones.

**7. What is imaginal exposure?**

Imaginal exposure is repeated recollection of a traumatic event. Confrontation with traumatic memories enhances the processing of these events and modifies dysfunctional cognitions, such as “I cannot tolerate distress” or “What happened is my fault.” This consists of asking the client to recall every detail, including events, thoughts, and feelings, of a troubling traumatic experience in the present tense.

**8. What is in vivo exposure?**

In vivo exposure is repeatedly approaching trauma-related situations that have been avoided because of their association with a traumatic event. It is very effective in reducing excessive fear and unnecessary avoidance. It enables the client to realize that the avoided situations are not dangerous, thus modifying dysfunctional cognitions that the world is a dangerous place. This is accomplished by asking the client to gradually increase their physical participation in activities and situations, via a hierarchy from the least to the most anxiety provoking, that have been avoided since the traumatic event occurred.

**9. What are the treatment goals?**

There are five main treatment goals for PE.

- (a) Decrease avoidance of trauma-related situations (e.g., sleeping without a light or refusing to go out alone).
- (b) Decrease avoidance of trauma-related thoughts and images.
- (c) Decrease presence of dysfunctional cognitions: “The world is extremely dangerous” or “I am extremely incompetent.”
- (d) Increase ability to discuss thoughts and feelings related to the traumatic event.
- (e) Increase engagement in activities related to the traumatic event.

**10. What are the core interventions of PE?**

The core interventions for PE are:

- Assessment (90791)
- Individual Psychotherapy (Procedure Codes H0046, 90832,90834,90837)

Other interventions which may be appropriate during the course of the 10 individual psychotherapy sessions and may include-Targeted Case Management (Procedure Code T1017)

The use of targeted case management may be appropriate if providing these services will assist in the reduction of the effects of the traumatic event.

**11. What is the length of treatment?**

PE treatment consists of 10 weekly, consecutive sessions. The individual sessions are 90 minutes in length.

**12. How are the 10 sessions structured?**

The 10 sessions are divided into four distinct segments.

- (a) Introduction of the treatment program, in vivo hierarchy/exposure, and breathing training (Sessions 1-2).
- (b) Introduce and conduct imaginal exposure (Sessions 3-5).
- (c) Focus on “hot spots” (most distressing aspects of the recollected traumatic event; Sessions 6-9)
- (d) Final imaginal exposure (Session 10)

**13. Are more than 10 sessions allowed by the model?**

Yes. If clinically indicated, additional sessions, up to 8, are allowed for additional processing of the imaginal exposures.

**14. What happens if the client misses a session?**

Therapeutic progress may be lost if a client misses more than 2 consecutive sessions. This may be due to the client reinforcing the negative aspects of the trauma rather than using the tools necessary to overcome the traumatic event.

**15. Can this model be used in a group setting?**

No. PE was developed and designed for individual use only. Multiple clients going through in vivo exposure techniques and revisiting traumatic memories simultaneously in a group setting would be counterproductive.

**16. What happens if a client continues to experience disruption in their level of functioning?**

The client may need to continue with additional PE treatment, be hospitalized, and/or obtain additional mental health services. It should be noted that each case is unique and each client must be treated on a case by case basis.

**17. Who can provide this EBP?**

At this time the developer only allows clinicians (Masters level and higher, registered/waived and higher level clinicians) to be the primary leads in treatment. Paraprofessional staff can provide support with check-ins and case management.

**18. What role can a psychiatrist and medication play with this practice?**

Generally in this model, clients are not seen for a medication evaluation by a psychiatrist. On the other hand, there may be certain circumstances where a clinician may determine referring a client for a medication evaluation is appropriate. In these cases, not providing such services may be more harmful to the client's wellbeing and may prevent the client from returning to their previous level of functioning, especially when additional symptoms are resulting in severe impairments.

**19. Can a client from one of the Mental Health Service Act's (MHSA) Client Supportive Services (CSS) programs (Wellness, Field Capable Clinical Services, or Full Service Partnerships) or non-MHSA programs receive this EBP?**

Yes. Any client receiving services in one of our MHSA CSS or non-MHSA programs can receive this and any EBP. The service will be claimed to the current MHSA plan in which the client primarily receives his/her services, NOT to PEI.

**20. Can the client receive PE along with other EBPs?**

Clients can receive 2 EBPs or Community Defined Evidence Practices simultaneously only when clinically indicated. However, the use of multiple EBPs for PEI clients should happen very infrequently.

**21. What is the required training protocol?**

Training consists of a 4-day workshop followed by weekly consultation and supervision of 2 active clients in regular treatment with client consent. Weekly consultation is conducted via review of audio-taped therapy sessions, which are encrypted via electronic voice recorders, with certified PE Supervisors. Consultation will continue during the duration of active treatment for 2 clients.

**22. Is "train the trainer" an option with this EBP?**

No. The Department does not currently provide "train the trainer" as an option.

**23. What are the outcome measures for PE?**

There are two outcome measures which are required for PE:

- Post Traumatic Stress Diagnostic Scale (PDS) for ages 18-65 -
- Outcome Questionnaire (OQ) for ages 18+

**24. Can the clinician claim for completing the outcome measure?**

No. Administering an outcome measure is not a claimable service. There are two exceptions: (1) if the primary clinician closes the case as a result of referring the client to another agency, and at discharge, completes the outcome measure; or (2) if the outcome measure is completed during a billable session, and not over the phone or at home by the client.

## **SEEKING SAFETY (SS)**

- 1. What is the population to be served under PEI?**

Directed toward individuals and families for whom a short duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation, thereby avoiding the need for more extensive mental health treatment or services, or to prevent a mental health problem from getting worse.
- 2. What are the age range limits for implementing Seeking Safety under the PEI Plan?**

The age range begins at 13 years old and spans across all age groups.

  - Children (13-15)
  - Transition-Age Youth (16-25)
  - Adults (26-59)
  - Older Adults (60+)
- 3. What are the “Core Interventions” for Seeking Safety”?**

The “Core Interventions” are:

  - Assessment/Psychiatric Diagnostic Interview
  - Family Psychotherapy
  - Group Psychotherapy
  - Group Rehabilitation Services
  - Individual Psychotherapy
  - Individual Rehabilitation Services
- 4. What is the length of treatment?**

Length of treatment depends on how many topics are covered, the number of sessions conducted to complete a topic, and the frequency of sessions. On average, length of treatment will vary from 5 to 6 months.
- 5. How often should SS sessions be conducted?**

SS sessions (individual or group) need to be conducted at minimum once per week to adhere to fidelity of the model.
- 6. Is there a maximum number of sessions and who monitors?**

On average, each topic is conducted in 1 to 2 sessions. Therefore, if all 25 topics are conducted, number of sessions may range from 25 to 50.

It is recommended each provider monitors and tracks internal activities. Countywide and Service Area Administration will work collaboratively to monitor Seeking Safety services.
- 7. Does Seeking Safety have mandatory topics?**

Yes. “Introduction to Treatment/Case Management” and “Safety” to be covered first to

provide a foundation. “Termination”, when possible, at conclusion of treatment.

**8. How many topics are recommended for treatment? Is there a maximum or minimum?**

The more topics completed the better the outcomes. The developer reported a study consisting of a minimum of 6 sessions yielded positive outcomes.

**9. With a minimum of two clinicians, approximately how many clients can be served (caseload)?**

Dr. Lisa Najavits (developer) does not indicate a minimum or maximum number of clients to be served per caseload.

**10. What is the staff-to-client ratio?**

“Staff-to-client” ratio will vary depending on whether clients are seen in individual or group modality.

**11. Since Seeking Safety does not explore past traumas, how recent must the traumatic event be?**

Past traumatic events can either be recent or in the distant past, single events or multiple events. Please refer to “Principles of Seeking Safety” in the SS Manual (pages 5 to 15) for more information.

**12. Must my client have experienced trauma to qualify for SS?**

Yes. For the purposes of claiming to the PEI Plan the client must have experienced trauma.

**13. Do participants of Seeking Safety need to have any symptoms of PTSD? Yes.**

**14. Are the diagnoses of PTSD and Substance Use required for the SS model? No.** PTSD and Substance Use do not have to be the diagnoses in order to use the SS model, but please use your clinical judgment to decide if SS is an appropriate model for your client. As is always the case, in order to claim to Medi-Cal, your client must meet criteria for a Medi-Cal eligible diagnosis and the service provided must be claimable to Medi-Cal.

**15. Is Seeking Safety considered a crisis intervention?**

No. It is a stabilization model.

**16. Can a client do Seeking Safety and also attend AA or other substance abuse treatment?**

Yes. Part of treatment is to support and encourage clients to connect with resources in their community.

**17. Since family sessions are a core service, what should the content of the family session be?**

Including family member(s) during session(s) is not limited to any specific topic(s).

**18. Is there “train the trainer” model for SS?**

No. Please see question below for internal agency training.

**19. Can an “Adherence Rater” train new staff to SS instead of attending a developer approved training?**

The primary role of an Adherence Rater is to rate only internal agency staffs’ adherence to SS sessions. The Adherence Rater may also orient only internal agency new staff to SS instead of attending a developer approved training. Dr. Najavits, SS Developer, prefers to use “orient” instead of “train” to avoid any misrepresentation since there isn’t “train the trainer model”. Please see SS Fidelity and Adherence Guidelines for specific requirements and limitations.

**20. Does the Department expect that agencies providing Seeking Safety will have their staff complete the SS Adherence Rater and Supervisor Trainings?**

At this time, we are recommending Seeking Safety providers participate in the “SS Fidelity and Adherence Guidelines”. This will allow for sustainability and adherence to fidelity of the model.

**21. What staff qualifications are required to administer, score/interpret, and input data for the Outcome Questionnaires (YOQs, YOQ-SRs, and OQs)?**

Administration can be completed by a trained non-clinical or clinical staff. Scoring and interpretation should be completed by a trained clinician who possesses a master’s degree or higher. Data entry can be completed by trained non-clinical staff.

**22. Can we verbally translate an Outcome Measure from English to client’s language?**

No, this would invalidate the outcome measure because the person translating may not translate items exactly as they are meant by the outcome measure’s author. If an outcome measure cannot be completed due to language difficulties and there is no authorized translation in their native language available, then the appropriate “Unable to Collect” reason code should be indicated in PEI OMA for that outcome measure.

**23. How often do the required Outcome Measures need to be completed?**

Clinicians have 14 days from the date of the First EBP Treatment Session to collect the “Pre” measures, and 14 days from the date of the Last EBP Treatment Session to collect the “Post” outcome measures. PEI outcome measures should also be administered every 6 months (an “Update”) to clients enrolled in an EBP that lasts 6 months or longer.

**24. If I did not collect “pre” outcome measures then is it still required to collect “post” outcome measures?**

Each required outcome measure must be acknowledged in PEI OMA in one of two ways:

- The outcome measure’s score(s) is entered into the appropriate field(s) or
- “Unable to Collect” reason code is selected and entered into the “Unable to Collect” field.

**25. Does SS Supervisor have to be a Clinical Supervisor?**

Yes. At minimum, each agency at the Legal Entity or Directly Operated Clinic level is required to designate a “PEI SS Supervisor”. “PEI SS Supervisor” is required to be a licensed mental health clinician, meets agency’s requirements to provide clinical supervision, and trained in SS.

Please note “PEI SS Supervisor” is different from “SS Supervisor” as outlined in the SS Fidelity and Adherence Guidelines.

**26. Do you have to be a mental health clinician to implement SS?**

SS can be implemented by clinicians and non-clinicians (case managers, substance abuse counselors, etc.) operating within their “scope of practice”.

**27. What is the minimum amount of education required to be trained in and apply this evidenced based treatment, in order to stay within an appropriate “scope of practice”?**

The services listed under Core Interventions for each evidenced based treatment will determine the rendering provider’s scope of practice. For example, if one of the core services is Assessment, an Authorized Mental Health Discipline (AMHD) must complete the Assessment. If the core service is Individual Rehabilitation (Rehab), anyone within their scope of practice can provide Rehab services.

As it relates to non-licensed staff (Medical Case Worker, Substance Abuse Counselor, and Community Worker) providing individual/group rehabilitation will be based on the supervisor’s discretion. This means that the supervisor has assessed the staff’s knowledge, experience, and reviewed staff’s documentation and decided that the staff is capable of providing and documenting Rehab services (with or without a co-signature).

**28. Do non-clinicians (i.e. case managers, substance abuse counselors) need to be trained in Seeking Safety, if they are going to be providing services under Seeking Safety?**

SS trained clinicians and non-clinicians are able to deliver SS services within their scope of practice; which means they are able to deliver the identified SS “core interventions” (as defined below) and claim to the PEI Plan. Staff not trained in the SS model, may only deliver “non-core interventions” (as defined below).

- “Core Interventions” are those services intrinsic to the delivery of expected outcomes for each of the PEI Programs.
- “Non-Core Interventions” are to be provided on a short-term basis to meet emergent client needs.

## **TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)**

- 1. Does the model address client’s somatic response to threats, as well as boundary description in traumatized children?**  
Yes. It is worked through in therapy.
- 2. For TF-CBT, how long are the clinicians in training and participating in consultation calls?**  
Approximately one year. There is a two-day initial training and a booster training 6 months after.
- 3. When are the measurement tools administered? Is there a pre-test measurement?**  
Beginning (pre) and at the end of treatment (post.)
- 4. Is DMH PEI rolling out TF-CBT for ages 3-18?**  
Yes.
- 5. If clients score in the sub-clinical range in the pre-test for the PTSD-RI are they still eligible to receive TF-CBT?\***  
Sub-clinical pre-test scores alone do not preclude a client from receiving TF-CBT. It is possible that clients and/or their families under report on a measure and therefore, as with any intake, clinicians must consider other information gathering practices in addition to the measure, such as the assessment, observations, reports from others, etc., in determining functional impairment and medical necessity of a client.
- 6. Can a behavior specialist provide individual rehabilitation as part of the non-core services for TF-CBT?\***  
Yes.