MULTI-SYSTEMIC THERAPY

The provider agency must have a current license issued by multi-systemic therapy (MST) services to provide MST. The licensed entity has agreed to assume responsibility for this service under its license. The provider contracts with MST Services for training, supervision and monitoring of services. This occurs primarily through a MST national consultant. The provider will also have a contractual relationship with MST Services, allowing the provider to deliver the licensed MST model.

MST provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement. The MST model is based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. Services are primarily provided in the home, but workers also intervene at school and in other community settings. All MST services must be provided to, or directed exclusively toward, the treatment of the Medicaid-eligible youth.

Target Population Characteristics

MST services are targeted for youth primarily demonstrating externalizing behaviors, such as conduct disorder, antisocial or illegal behavior or acts that lead to costly and, oftentimes, ineffective out-of-home services or excessive use of child-focused therapeutic support services. Depression and other disorders are considered, as long as the existing mental and behavioral health (BH) issues manifest in outward behaviors that impact multiple systems (i.e., family, school, community). Youth with substance use issues may be included if they meet the criteria below, and MST is deemed clinically more appropriate than focused drug and alcohol treatment:

1. Referral/target ages of 12-17 years;

2. Youth exhibits significant externalizing behavior, such as chronic or violent juvenile offenses;

3. Child is at risk for out-of-home placement or is transitioning back from an out-of-home setting;

4. Externalizing behaviors symptomatology, resulting in a DSM-5 diagnosis of conduct disorder or other diagnoses consistent with such symptomatology (oppositional defiant disorder, other disruptive, impulse-control, and conduct disorders, etc.);

5. Ongoing multiple system involvement due to high risk behaviors and/or risk of failure in mainstream school settings due to behavioral problems;

6. Less intensive treatment has been ineffective or is inappropriate; or

7. The youth's treatment planning team or Child Family Team (CFT) recommends that he/she participate in MST.

MST services may not be clinically appropriate for individuals who meet the following conditions:

1. Youth referred primarily due to concerns related to suicidal, homicidal or psychotic behavior;

2. Youth living independently, or youth whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends or other potential surrogate caregivers;

3. The referral problem is limited to sexual offending in the absence of other delinquent or antisocial behavior;

4. Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism;

5. Low-level need cases; or

6. Youth who have previously received MST services or other intensive family- and community-based treatment.

Exception

Youth may be allowed an additional course of treatment if all of the following criteria are met:

1. MST program eligibility criteria are currently met;

2. Specific conditions have been identified that have changed in the youth's ecology, compared to the first course of treatment;

3. It is reasonably expected that successful outcomes could be obtained with a second course of treatment; and

4. Program entrance is subject to prior authorization by the managed care organization (MCO).

Criteria for Continuing Services

Youth receiving MST services must meet all of the following criteria for continuing treatment with MST:

1. Treatment does not require more intensive level of care;

2. The treatment plan has been developed, implemented and updated based on the youth's clinical condition and response to treatment, as well as the strengths of the family, with realistic goals and objectives clearly stated;

3. Progress is clearly evident in objective terms, but goals of treatment have not yet been achieved, or adjustments in the treatment plan to address the lack of progress are evident; and

4. The family is actively involved in treatment, or there are active, persistent efforts being made which are expected to lead to engagement in treatment.

Criteria for Discharge from Services

Youth who meet the following criteria no longer meet medical necessity criteria for MST and shall be discharged from MST treatment:

1. The member's treatment plan goals or objectives have been substantially met;

2. The member meets criteria for a higher or lower level of treatment, care or services;

3. The member's, family, guardian and/or custodian are not engaging in treatment or not following program rules and regulations, despite attempts to address barriers to treatment; and

4. Consent for treatment has been withdrawn, or youth and/or family have not benefitted from MST, despite documented efforts to engage, and there is no reasonable expectation of progress at this level of care, despite treatment.

Covered Services

Philosophy and Treatment Approach

The MST approach views individuals as being surrounded by a natural network of interconnected systems that encompass individual, family and extra-familial (peer, school and neighborhood) factors. The MST approach believes that it is often necessary to intervene in a number of these systems to achieve positive results. All interventions implemented during treatment come from evidenced-based treatment approaches. Through a combination of direct service contacts and collateral contacts, significant improvement in family functioning occurs, thereby reducing the need for continued professional services.

MST is based on the philosophy that the most effective and ethical way to help children and youth is by helping their families. MST views caregivers as valuable resources, even when they have serious and multiple needs of their own. One goal of MST is to empower caregivers to effectively parent their children. MST treatment reaches across all of the youth's life domains and is highly individualized around each case, as described below.

MST Treatment Principles include the following:

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context;

2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change;

3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members;

4. Interventions are present-focused and action-oriented, targeting specific and well-defined problems;

5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems;

6. Interventions are developmentally appropriate and fit the developmental needs of the youth;

7. Interventions are designed to require daily or weekly efforts by family members;

8. Intervention effectiveness is evaluated continuously from multiple perspectives, with the provider assuming accountability for overcoming barriers to successful outcomes; and

9. Interventions should be designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

These nine (9) principles guide treatment and the development of interventions to address referral behaviors. The treatment theory draws from social-ecological and family systems theories of behavior. Supervision and consultation to staff are focused on facilitating use of the MST model, and a variety of measures are in place to monitor a program's adherence to the MST model and ensure that fidelity to the model is maintained to the greatest extent possible (as described below).

Goals

MST is designed to accomplish the following:

1. Reduce the frequency of referral behaviors and increase pro-social behaviors, reduce symptoms, maladaptive and externalizing behaviors, so that the child/youth can be treated in a lower level of community-based care. Child/youth no longer demonstrating ongoing risk of deliberate attempts to inflict serious injury on self or others;

2. Decrease association with deviant peers and increase association with pro-social peers and involvement in positive recreational activities;

3. Help caregivers develop effective parenting skills and skills to manage the consumer's mental health needs, improve caregiver decision-making and limit setting;

4. Improve family relationships;

5. Improve school or vocational success, as indicated by improved grade point average, a decrease in disciplinary referrals, unexcused absences and tardiness and/or a decrease in job terminations;

6. Support involvement in restorative measures, such as community services, if involved with Juvenile Justice (Office of Children, Youth and Families resources will oversee and fund the participation in restorative measures, rather than the MST service provider);

7. Reduce likelihood of out-of-home placement and reduce the utilization of out-of-home therapeutic resources (i.e., therapeutic foster care, residential treatment facility, etc.); and

8. Develop natural supports for the consumer and family.

Specific treatment goals will always be individualized and tied to behavioral health needs.

Specific Design of the Service

On average, a youth receives MST for 3 to 5 months, but typically, no longer than five months. The therapist meets with the youth or family at least weekly but often multiple times per week, depending on need. Families typically see therapists less frequently as they get closer to discharge. On average, families receive about 60 hours of face-to-face treatment over a four-month period, as well as about 35 hours of non-direct contact provided to the ecology of the youth (e.g., consultation and collaboration with other systems). (Please note that these contact hours reflect averages only, and are not intended to specify a set number of family or member contacts. The MST model is intended to be a highly individualized treatment that is intensive and is delivered as frequently as is required to produce the outcomes desired for each specific youth). Services occur in the family's home or community at times that are convenient for the family. Staff members are expected to work on weekends and evenings, for the convenience of their members. Therapists and/or their supervisors are on call for families 24/7. Supervisors are available to therapists around-the-clock for support. Each therapist carries a small caseload (four to six families) at any one time.

MST includes the following:

1. Assessment;

2. Ongoing treatment planning;

3. Family therapy;

4. Parent counseling (related to empowering caregivers to parent effectively and address issues that pose barriers to treatment goals);

5. Consultation to and collaboration with other systems, such as school, juvenile probation, children and youth and job supervisors;

6. Individual therapy may occur but is not the primary mode of treatment; and

7. Referral for psychological assessment, psychiatric evaluation and medication management, if needed.

   NOTE: The term "counseling" throughout the MST section is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for the counseling and psychotherapy rendered by licensed mental health professionals (LMHPs) under their respective scope of practice license.

Unless it directly impacts the youth's treatment, MST therapists do not provide individual therapy to caregivers or other family members, or marital therapy.

MST is a practical and goal-oriented treatment that specifically targets the factors in a youth's social network that are contributing to the problem behaviors. Specific treatment techniques draw from therapies with the most empirical support, such as cognitive, cognitive behavioral, behavioral and pragmatic family therapies, such as structural family therapy. Interventions are developed based on an assessment of the "fit" for a specific behavior (specifically, what factors are driving the behavior, which are always individualized). Interventions always target specific, well-defined problems, focus on present conditions and are action-oriented. Families are often given "assignments" that require daily or weekly efforts, capitalize on strengths, build skills and encourage responsible behavior by the youth and family. By empowering caregivers to address their families' needs, MST interventions promote generalization and maintenance of positive changes. The help of natural supports, such as extended family or school, is often enlisted.

Therapists are totally responsible for engaging the family and other key participants in the youth's environment (e.g., teachers, school administrators, community members, workers from agencies with mandated involvement). MST requires a solution-focused, strengths-based orientation from therapists.

The effectiveness of interventions is closely monitored from week-to-week from multiple perspectives (e.g., caregivers, identified youth, teachers and the MST team). While overarching goals are established at the beginning of treatment, specific, measurable objectives are set each

week. Family members and therapists work together to design the treatment plan, which ensures family involvement. However, therapists and the provider agency are held accountable for achieving change and for positive case outcomes.

NOTE: The MST program has a hands-off policy and does not utilize any restraints or restrictive procedures.

Description of Individualization for Youth and Family

Treatment Planning

All treatment planning will be informed by an initial psychosocial assessment, which is completed by the MST Supervisor prior to entry into MST services. Use of the Child and Adolescent Level of Care Utilization System (CALOCUS) is not required for MST.

In the MST model, the MST therapist conducts treatment planning using the MST "Case Summary" process; for a member receiving MST services, the document titled "Initial Case Summary," and the documents which are updated each week as the "Weekly Case Summary," serve as the treatment plan for the member. The Initial Case Summary is developed by the MST therapist, based on the assessment, youth and family strengths, referral behaviors, and the goals of the youth and family. Goals of the youth, family, and other key participants in treatment (i.e., probation officer) are documented in the Case Summary as "Desired Outcomes of Key Participants," and these inform the "Overarching Goals" of treatment as documented in the Case Summary.

The Initial Case Summary is signed by the caregiver, and ideally signed by the youth as well. In the rare event that an MST treatment episode extended for over 180 days, the MST provider must obtain additional caregiver and youth signatures on the updated Case Summary at that time.

The Initial Case Summary is then continuously updated in the Weekly Case Summaries. Weekly Case Summaries are driven by continuous assessment, data collection and analysis, team and supervisory input, goal development, intervention development and implementation, outcome assessment, and ongoing plan revision.

Overarching goals are established at the beginning of treatment, while specific objectives are updated each week and closely monitored in the Weekly Case Summaries. In each Weekly Case Summary, the MST therapist reviews the Overarching Goals, and:

1. Develops Intermediary Goals that are specific, measureable action-oriented, realistic, and time-limited objectives;

2. Outlines intervention steps that will be taken to accomplish each Intermediary Goal;

3. Reviews previous Intermediary Goals; and

4. Documents advances in treatment, to indicate progress being made, and ongoing assessment of barriers, which leads to development of new intermediary goals.

MST provides LMHP oversight over treatment planning through MST supervision and consultation, which includes weekly review of treatment planning between the MST clinician, MST supervisor, and MST consultant. Supervisor and consultant feedback will be integrated into the Weekly Case Summaries and will be implemented into the upcoming week's intervention plan.

Cultural Concerns

MST treatment is attuned to the importance of ethnicity and culture for all members referred for services. Cultural values and concerns should be reflected in the MST therapist's assessment of the youth and family and incorporated into interventions, as appropriate. Weekly clinical supervision should include responsiveness to problems related to racism or discrimination. Cultural competence may be addressed in MST booster trainings if it is identified as an area of need by the MST supervisor and system supervisor.

Child Integration to Community

The treatment objectives must demonstrate that MST focuses on community integration by striving to reduce out-of-home placements, improve school attendance and academic success and build natural supports for the family and so on.

By maintaining the youth within the community, the least restrictive environment, MST treatment interventions strengthen the family and youth's relationship with community resources and the people managing them. This is important for creating sustainable treatment outcomes. Also, the MST model is strengths-focused and competency-based in its treatment approach. The general goal of MST is to promote increased emotional and social health in youth and families.

Provider Qualifications and Responsibilities

Agencies must be licensed to provide MST services by MST Services, Inc. or any of its approved subsidiaries. An MST agency must be a BH/substance use provider organization, which is a legally recognized entity in the United States and is qualified to do business in Louisiana and meets the standards established by the BHSF or its designee. MST agencies must be licensed

pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers. The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, certification by MST Services, Inc., staff criminal background checks, TB testing, drug testing and required training for staff employed or contracted with the agency. MST-only agencies are not required to be accredited due to the extensive nature of consultation by MST Services, Inc. These agencies must maintain good standing with MST Services, Inc., ensure fidelity to the MST model and maintain licensure through the Louisiana Department of Health (LDH).

NOTE: Agencies providing non-EBP rehabilitation and/or addiction services in addition to MST must be accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), or The Joint Commission (TJC).

The provider will provide all member services. MST therapists and supervisors are employees of the provider. Ultimate responsibility for services provided lies with the provider. The provider contracts with a network partner for training, supervision and monitoring of services. This occurs primarily through an MST system supervisor provided by the network partner. Network partner status, granted to the network partner's MST program by MST Services, allows for the development of MST teams supported and monitored directly by the network partner. The provider also has a contractual relationship with MST Services, allowing the provider to deliver the licensed MST model.

MST agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual.

Exceptions

1. Behavioral Health Service Providers (BHSPs) ***exclusively*** providing the evidence-based practice Functional Family Therapy (FFT/FFTCW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement to provide **medication management.** Such BHSPs shall develop policies and procedures to ensure:

    a. Screening of clients for medication management needs;

    b. Referral to appropriate community providers for medication management including assistance to the client/family to secure services; and

c. Collaboration with the client's medication management provider as needed for coordination of the client's care.

2. BHSPs **exclusively** providing the evidence-based practice Functional Family Therapy (FFT/FFT-CW), Homebuilders® or Multi-Systemic Therapy (MST) are excluded from the requirement of having a **Medical Director**. Such BHSPs shall have a **Clinical Director** in accordance with core staffing requirements detailed in this manual chapter under *Provider Responsibilities* in Section 2.3 – Outpatient Services – Rehabilitation Services for Children, Adolescents, and Adults.

Allowed Provider Types and Specialties

PT 12 Multi-Systemic Therapy Agency, PS 5M Multi-Systemic Therapy.

Staff Education Level/Qualifications and Training Topics

Education/Qualifications

The MST program at the provider consists of one or more MST teams, each with an MST clinical supervisor and two to four MST therapists. There is a system supervisor from the network partner, who is responsible for the clinical fidelity of the MST team. All staff will have background checks, tuberculosis (TB) testing, screenings and required training on file before working with youth and families.

MST Clinical Supervisor

The supervisor for an MST team is an independently licensed master's-level mental health professional with a graduate degree in a clinical mental health field and experience providing mental health treatment. A minimum of three years of experience is preferred. The supervisor facilitates weekly team supervision, reviews weekly case summaries in preparation for supervision and is available to therapists 24/7. The MST supervisor will, at times, take therapy cases, if needed, due to demand and staff availability. A full-time supervisor may supervise up to two teams; a half-time supervisor may supervise one team. Clinical services and supervision must be provided by LMHPs in accordance with their respective licensing board regulations. All practitioners must hold an unrestricted Louisiana license.

MST Therapist

Therapists are master's-level mental health professionals with graduate degrees in a clinical field, a background in family, youth and community service and a minimum of two years' experience

preferred. Highly skilled bachelor's-level professionals may be selected, with certain hiring conditions. These conditions include: (1) education in a human services field; (2) a minimum of three years' experience working with family and/or children/youth services; and (3) the provider has actively recruited for master's-level therapists but has not found any acceptable candidates or the bachelor's-level applicant is clearly better qualified than the master's-level applicants. Bachelor's level staff must have a degree in social work, counseling, psychology or a related human services field and must have at least three years of experience working with the target population (children/adolescents and their families). Therapists are responsible for providing direct service to a caseload of four to six families. The expectation is that the usage of bachelor's-level staff will not exceed one bachelor's-level staff person for every two master's-level staff persons per team.

NOTE: The term "therapist" is in keeping with the nomenclature of this evidenced based practice and should not be mistaken for LMHPs, who provide counseling and psychotherapy under their respective scope of practice license.

MST System Supervisor (MST consultant from the network partner)

The system supervisor is a master's-level, mental health professional with a graduate degree in a clinical field and experience as an MST clinical supervisor. The system supervisor provides weekly clinical consultation to the MST teams, monthly clinical consultation to the MST supervisors, quarterly booster trainings for the MST teams and monitors adherence to the MST model. A manager of network partnerships from MST Services is assigned to the network partner to monitor and train system supervisors.

Training

System supervisors are responsible for the training of MST therapists and MST clinical supervisors. All therapists and supervisors attend a 30-hour (five-day) MST orientation training within two months of hire. This training covers such topics as: engagement and alignment, parent–child interventions, marital interventions, school-based interventions, confidentiality and ethics, peer interventions, social supports, individual interventions, safety issues, substance use interventions and psychiatric consultation. All participants take a test at the end of the training week. Individual results of the tests are used to identify areas of strength and weakness for continued clinical development.

Booster trainings are conducted for one and a half days each quarter. The entire MST team attends a full day of booster training (minimum seven hours), while the half-day (minimum three and a half hours) may be attended by the entire team or only the supervisors. Topics for booster trainings are derived from planning discussions between the system supervisor and MST clinical supervisors

as they reflect on challenges over the previous months. Examples of booster trainings include family contracting, interventions for families affected by divorce, safety planning, preventing burnout, caregiver substance use and school-based assessment and intervention. Orientation and booster trainings are led by MST-licensed system supervisors.

Supervision

Intensive supervision and clinical consultation are an integral part of the MST model and are focused on promoting consistent application of the MST model to all cases. Training is monitored through the licensing agreements and contractual arrangement that the provider has with the network partner, and they with MST Services.

Supervision and consultation in MST includes the following:

1. MST therapists receive weekly team supervision with their MST supervisor, typically lasting one or two hours. If an MST supervisor has two teams, supervision is provided separately to each team. Prior to supervision meetings, the supervisor reviews weekly case summaries, makes notes and creates an agenda for the supervision meeting;

2. Each MST team receives weekly telephone consultation from an MST system supervisor, typically for one hour. Each week the system supervisor reviews case summaries and MST clinical supervisor notes, in preparation for the consultation session;

3. Each MST therapist has a clinical plan (professional development plan) to guide him/her to effective levels of MST adherence;

4. MST clinical supervisors are available around-the-clock to provide support to MST therapists; and

5. The MST clinical supervisors receive monthly telephone consultation from the system supervisor to monitor and develop their supervisory effectiveness. This supervision involves close review of audiotapes of supervision sessions and case reviews.

Weekly group supervision and consultation is documented on the MST Weekly Case Summaries, which document a weekly review of work on the case (goals, barriers, advances in

treatment, ongoing assessment, and new goals) along with questions for supervision and consultation, and feedback received by the MST therapist from supervision and consultation.

Individual supervision of MST clinicians is not a requirement for an MST license through MST Services; within the MST model, group supervision is the preferred modality. However, effective July 15, 2020, all non-licensed providers of rehabilitation services under LA Medicaid (inclusive of non-licensed MST clinicians) are required to have **no less than one (1) hour of individual supervision,** as part of the overall requirement for a minimum of 4 hours of clinical supervision per month for non-licensed staff.

Monitoring and Assessment of Service Delivery: The licensing agreement and contracts between MST Services, the network partner and the provider include monitoring activities to ensure fidelity to the MST model, as described below. Adherence to the model is monitored through the administration of two measures:

Therapist Adherence Measure-Revised (TAM-R): This is an objective, standardized instrument that evaluates a therapist's adherence to the MST model as reported by the primary caregiver of the family. It has been shown to have significant value in measuring a MST therapist's adherence to MST principles and to predicting treatment outcomes. The TAM-R has been validated in clinical trials with serious chronic, juvenile offenders and is now implemented by all licensed MST programs. The TAM-R takes 10 to 15 minutes to complete. It is administered during the second week of treatment and every four weeks thereafter. A staff person will contact the family in-person or by phone to complete the measure. Data is entered onto an online database managed by the MST Institute, and results are reviewed by the MST supervisor and therapist.

Supervisor Adherence Measure (SAM): This measure evaluates the MST clinical supervisor's adherence to the MST model of supervision. This 10 to 15-minute measure is completed by MST therapists, who are prompted to complete the SAM every two months and enter their responses directly onto the on-line database. Results are shared with the MST system supervisor, who then shares a summary of the feedback with the MST clinical supervisor during a consultation meeting.

The online database also collects case-specific information, including the percent of cases successfully completing MST and whether specific instrumental and ultimate outcomes have been achieved at discharge. The provider will ensure that the MST program collects TAM-R and SAM, as required by the model, and that this and other data is entered into the online database in a timely fashion.

Every six (6) months, a program implementation review is completed by the system supervisor and MST clinical supervisor for each team. This review includes completion of a program review form (a checklist of characteristics considered critical to the success of an MST program), a

narrative summary of the program's strengths and weaknesses and recommendations. This review is used to monitor the team's fidelity to the model and troubleshoot problem areas.

Exclusions

MST services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These services may be provided and billed separately for a member receiving MST services.

MST shall not be billed in conjunction with the following services:

1. BH services by licensed and unlicensed individuals, other than medication management and assessment; and

2. Residential services, including professional resource family care.

Medicaid will not reimburse for services provided to children who are residents of institutions for mental diseases (IMDs). These are institutions with greater than 16 beds, where more than 50 percent of the residents require treatment for BH conditions.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. MST may be billed under community psychiatric supportive treatment (CPST), but must be consistent with the CPST Medicaid State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved, and the child/youth receiving treatment does not need to be present for all contacts;

2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians or other individuals having a primary care relationship with the individual receiving treatment. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

   NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through

Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Time spent in travel, transporting children, documenting, supervision, training, etc. has been factored into the indirect unit cost and may not be billed directly;

4. Medicaid may not reimburse for children in the custody of the Office of Juvenile Justice (OJJ) who reside in detention facilities, public institutions or secure care, and are inmates of a public institution. =If the child is in OJJ custody, but not in a public correctional institution (i.e., is outpatient), Medicaid will reimburse for the MST, except for the oversight of restorative measures, which is an OJJ function; and

5. Medicaid does not pay when the vocational supports provided via MST qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.