Child and Adolescent Treatment Services Descriptions and Guidelines v3

TBS

Description of Treatment Service

Therapeutic Behavioral Services is intended to be a behaviorally focused intervention designed to assist a family unit with addressing and managing a specific behavior or behavior cluster. TBS should intervene to address new behavioral changes or to develop new skills and strategies, but not for habilitative issues or to teach activities of daily living. TBS is not intended to provide supportive therapy, mentoring, or social skills building.

TBS should generally be considered after less intensive services have been tried or determined to be inappropriate to meet treatment needs.[i] These might include, but are not limited to, individual therapy, family therapy, parental guidance and parenting skills development, as well as basic behavioral interventions within the context of individual, family and parental therapy. TBS treatment involves teaching and supporting the efforts of parents, guardians and other responsible adults to shape specifically identified behaviors, utilizing a contingency management behavioral plan, as opposed to serving as substitute caregivers. TBS is intended to teach families to independently manage their children. Treatment should always be part of a coordinated plan including all other involved therapeutic providers and natural supports (school, other involved adults, etc.). Children should continue in active treatment while receiving TBS services.

Typical Population Served

TBS would be considered appropriate for youth such as, but not limited to:

- a child with severe OCD, school phobia or social anxiety to help a family implement a clear behaviorally based plan designed to reintegrate into community and school settings.
- re-balancing parental authority in an early adolescent with acting out behaviors with the goal of supporting the parent taking back authority.
- in home, dyadic work with very young children to support healthy parental attachments
- in situations where an office based therapist cannot determine what triggers maladaptive behaviors in the child's natural home setting or community

Goals of Treatment

The TBS team comes into the "in vivo" setting, assesses the behavioral challenges and, in conjunction with any outpatient therapists/providers, develops a clear treatment plan to teach new strategies and skills within the available family unit. The behavioral support staff remains in the home to further assist with the development of this plan, to train the caretakers on how to implement the plan, and to address closely related behavioral issues as they arise. The goal of TBS should be educating the caregivers on how to independently manage and shape their child's current maladaptive behaviors, as well as imparting some general principles which can be applied to future challenging behaviors. A successful outcome is not total amelioration of symptoms, but rather a reduction in the most challenging of behaviors and empowerment of caregivers to the extent that less intensive services and informal supports can be planned and introduced.

MOB

Description of treatment services

Child and Adolescent Mobile Treatment services (MOB) are intended to be a short term, home-based engagement of a family unit by a multi-disciplinary treatment team. A mobile team includes a psychiatrist (or equivalent), a therapist and, when needed, nursing and/or other support staff. Use of a mobile team should be limited to situations which, by the nature of the behavioral health need, require the involvement of the entire treatment team and cannot be provided in an office setting.

Mobile services can be brought in to assist in the connection of a child and family to lower level of community supports when, as a result of either the illness of the child or the caregivers, this engagement has not been able to be made or sustained. The expectation of mobile treatment is transition to traditional outpatient care, and it is not intended for those who have transportation issues getting to an outpatient provider.

Typical Population Served

- Examples of when MOB services might be required include when parental mental illness prohibits consistent engagement into treatment of the child, where child's own SED is also requiring urgent and consistent treatment.
- MOB might also be utilized with an extremely traumatized or guarded/psychotic youth to help form the connection with the therapeutic team, assist in re-integration to the school and/or community, including routine outpatient facilities.
- MOB may be required after repeated inpatient hospitalizations where due to the nature of behavioral health issues routine engagement to outpatient services has not been achievable or sufficient.
- MOB services may be necessary to introduce a child or family to a supportive therapeutic relationship, when the youth or family are highly reluctant to accept treatment due to reasons of behavioral health needs, cultural issues, or past traumatic experiences; and the current clinical situation necessitates an escalated intervention.

Goals

- The goal of MOB services should be assisting and engaging the youth into outpatient therapy, other levels of care, and other supportive arrangements within the PBHS.
- MOB should incorporate many features of PRP and CM services and duplication of these services should only occur on a very limited case by case basis, to aid in the transition to lower levels of care.

TCM – I, II and III

General Description of Service

Targeted Case Management services are intended to focus on Care Coordination and Case Management. These services are not providing therapy, but are assisting families to identify resources to support therapeutic goals. Engagement into this process is an initial and essential purpose of care coordination, and includes building a support network for the family and advocating for the family with outside agencies (such as DSS, DJS, MSDE etc.) Other roles include helping families to identify needs and goals, be they therapeutic, educational, vocational, medical or otherwise, as well as being a resource to obtain additional supports (including those not part of the PBHS.)

The care coordinator, under the guidance of their supervisors, and in consultation with the primary therapist, the treating psychiatrist (and/or primary care physician if applicable) will develop a collaborative plan of care side by side with the family and other natural supports. While it is not the responsibility of the care coordination provider to provide treatment, it is their responsibility to own the collaboratively developed care plan and to support the family in their efforts to autonomously implement this plan. Treatment and services should be directed toward helping the child to remain integrated with his/her natural community and to prevent the necessity of a more restrictive or intensive service. For most families, the plan of care will include specific crisis strategies (beyond accessing available crisis services or an ER) designed to support the families through the expected challenges along the developmental path.

Care coordination should be delivered under a "wraparound" comprehensive and supportive philosophy of care. These communities delivered services are often identified as "wraparound services." Wraparound is a philosophy which promotes developmentally appropriate behavior, activities, skills, and social skills for the child in his/her natural setting by focusing on his/her individualized strengths and by promoting an inherent resiliency. More broadly, it promotes the opportunity for family independence from professional treatment and therapeutic supports. Providers and families need to be encouraged to work towards this goal. Autonomy may be enhanced by supporting the family in the development of their individualized, informal network of care, and ultimate transition away from any additional PBHS intervention.

All the levels of TCM support traditional treatment, but they also encourage the family's developmental process towards unassisted interventions and interactions. The therapeutic function and emphasis of each of the three levels depends strongly on the cohesiveness of the care coordination teams and the interaction between the behavioral health staff, the parents/custodians, and the child, for effective outcomes. Care coordination should also include a regular review of the plan of care with a focus on discharge preparation and planning on an ongoing basis.

Typical Population Served and Goals of Services

- **TCM I** – Basic engagement and assistance with obtaining entitlements and seeking services. Basic assistance with transportation to appointment when unable to access other options. Similar to adult TCM, this level offers the option to initiate engagement while still in higher level of care (1 transitional visit). Examples of appropriate families might include assisting a single mom for whom English is a second language who is struggling to find substance use services for her adolescent, as well as to engage this youth into treatment. Another example might be an MA eligible, but uninsured homeless family with a new infant and preschool aged child who is acting out both in preschool and in the shelter.

- **TCM II** – Beginning to incorporate the wrap around model. Identifying appropriate resources and engaging families to access these resource (within and beyond the PBHS). Examples include providing assistance with IEP process and referral to a family navigator. This level can provide support through specific challenges – youth who are expelled from preschools, families who need to find after school and summer options for youth with SED who are not fitting well in other systems. Providers should also consider this level of care for all youth upon initial DJS or DSS engagement when there is evidence of the need for additional behavioral health outreach. This level should focus on developing primary support teams around families to ensure compliance with treatment and treatment recommendations (such as medication compliance, school attendance etc.) Cases might include youth with multiple suspensions, repeated running away behaviors, youth with 1-2 legal charges, multiple episodes of police involvement, or multiple ER visits in a short period. This level is for youth, who without additional intervention, will rapidly be in acute crisis and needing much more intensive services. This level can also be used to initiate engagement and gather information and documents necessary to support a TCMIII request.

- **TCM III** – This is the highest level of community delivered care coordination and is intended to prevent an institutional level, residential treatment facility placement, and/or to help children to return to their natural home, school, and community after such a placement. This program works by directly associating the therapeutic process of the treatment team and the plan of care with effective adaptation to the social environment, including all available resources – both those readily available, and those which need to be identified and developed.