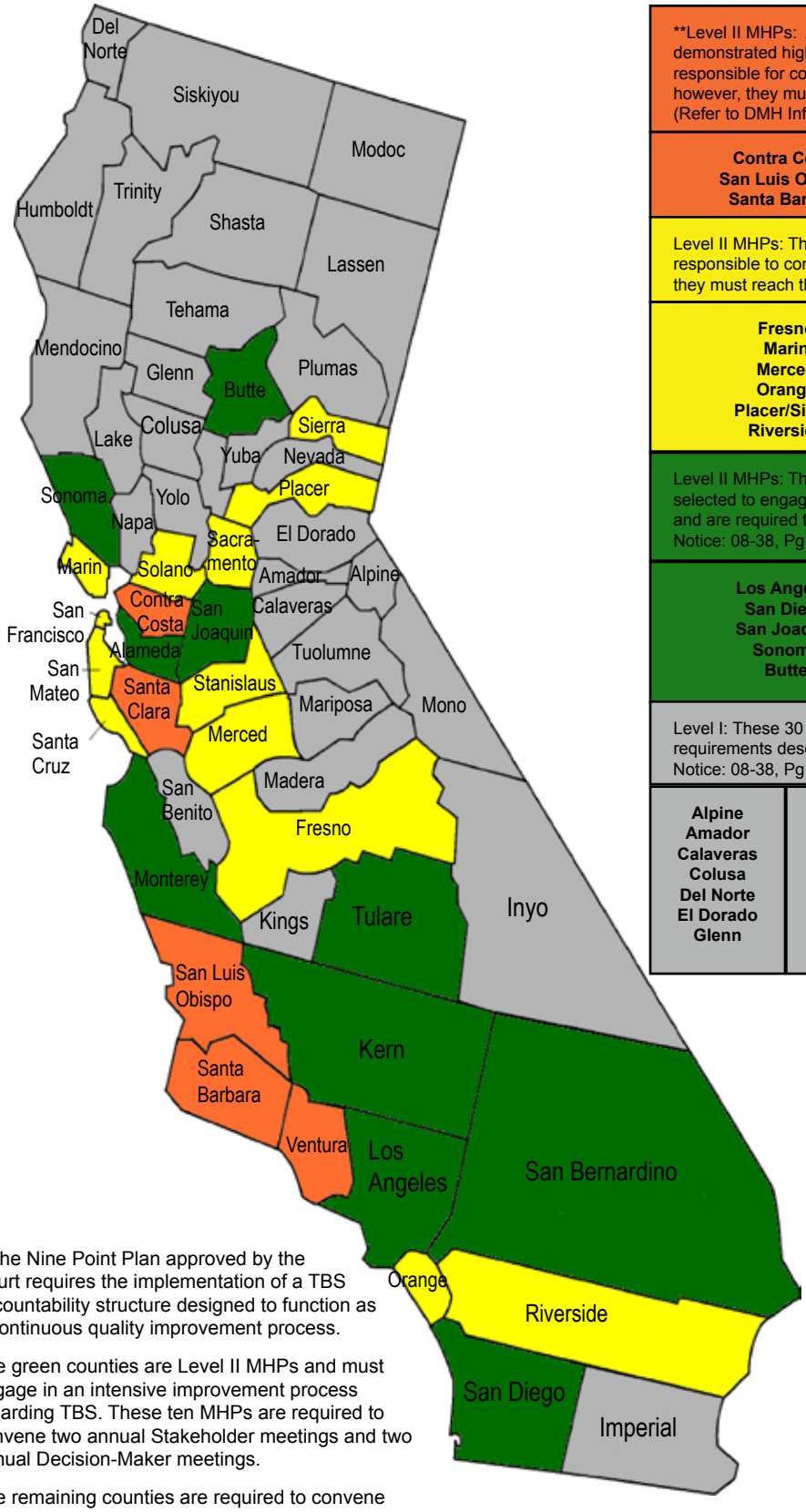
Therapeutic Behavioral Services (TBS) Coordination of Care Best Practices Manual

California Department of Mental Health

July 2010, Version 1.0



**Level II MHPs: As of January 1, 2009, these 5 MHPs have demonstrated high performance in TBS delivery. They are only responsible for completing Level I requirements at this time, however, they must remain above the 4% benchmark for TBS. (Refer to DMH Info. Notice: 08-38, Section IX, Pg. 9).

Contra Costa **San Luis Obispo** **Santa Barbara**	**Santa Clara** **Ventura**

Level II MHPs: These 12 medium and large MHPs are only responsible to complete Level I requirements at this time. However, they must reach the 4% benchmark for TBS.

Fresno **Marin** **Merced** **Orange** **Placer/Sierra** **Riverside**	**Sacramento** **San Francisco** **San Mateo** **Santa Cruz** **Solano** **Stanislaus**

Level II MHPs: These 10 medium and large MHPs have been selected to engage in an intensive practice improvement process and are required to meet Level II requirements. (Refer to DMH Info. Notice: 08-38, Pg 8, Level II, MHPs).

Los Angeles **San Diego** **San Joaquin** **Sonoma** **Butte**	**Alameda** **San Bernardino** **Kern** **Monterey** **Tulare**

Level I: These 30 small and rural counties must meet the requirements described in Section IX, A of DMH Info. Notice: 08-38, Pg 8, Level I, MHPs.

Alpine **Amador** **Calaveras** **Colusa** **Del Norte** **El Dorado** **Glenn**	**Humboldt** **Imperial** **Inyo** **Kings** **Lake** **Lassen** **Madera**	**Mariposa** **Mendocino** **Modoc** **Mono** **Napa** **Nevada** **Plumas**	**San Benito** **Shasta** **Siskiyou** **Sutter/Yuba** **Tehama** **Trinity** **Tuolumne** **Yolo**

**The Nine Point Plan approved by the Court requires the implementation of a TBS accountability structure designed to function as a continuous quality improvement process.

The green counties are Level II MHPs and must engage in an intensive improvement process regarding TBS. These ten MHPs are required to convene two annual Stakeholder meetings and two annual Decision-Maker meetings.

The remaining counties are required to convene one annual Stakeholder meeting and one annual Decision-Maker and increase TBS utilization rates.

All Level II counties are required to reach a 4% utilization rate for TBS by December 31, 2010.

Emily Q: Statewide Map of Level I and Level II MHPs Revised: 7/7/10

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EXECUTIVE SUMMARY

Version 1.0 note: In an effort to ensure that this training and education manual is of value to the field, the CDMH is circulating this as version 1.0 for practitioner and administrator review and comment.

If you have comments or concerns about the content in this manual, please advise CDMH by August 16, 2010. Your comments can be submitted electronically to TBS@dmh.ca.gov.

If you would like to discuss issues about this manual with a CDMH specialist, please contract Troy Konarski at (916) 654-2643.

The *Therapeutic Behavioral Services Coordination of Care Best Practices Manual* is designed to assist counties in their efforts to increase the use and quality of their Therapeutic Behavioral Services (TBS) programs.

The manual is intended for agency administrators, judges, social workers, probation officers, therapists, teachers, attorneys, family members, youth and other interested parties who may have little to no familiarity with TBS. They may use this information to collaborate locally and take advantage of TBS for children and families in their communities. The collaboration will be more successful with the commitment, willingness and trust of all community care providers (public and private) in furnishing services to children who are Emily Q class members. Emily Q class membership for TBS is described in the "TBS in Brief" section, under the heading "Who can receive TBS?"

Mental health, social services, juvenile justice, education and TBS providers and families must work together in supporting children who are eligible for TBS and giving them the best opportunity to succeed. Administrators of mental health plans (MHPs) will need to continually work with other government agencies to establish and maintain an effective working relationship across service delivery systems. Communication by all agencies and services is vitally important in responding to the multi-faceted service needs of the children who meet the class definition for TBS.

The manual is designed to improve understanding of TBS by defining and describing the various ways in which services are performed through professional disciplines outside of the traditional mental health services.

A brief explanation of TBS is followed by vignettes that illustrate the ways in which TBS is making a difference for children who receive services from various child-serving agencies. The reader may choose to focus upon the section devoted to a particular area of interest, such as child welfare, probation, schools or mental health, to use this manual as a focused education or reference tool.

Following the illustrative examples, the section titled *Strategies for Supporting Access to TBS* reviews successful approaches that communities have used to increase TBS utilization and quality, including interagency collaboration, training and outreach, easily accessible referral procedures, and proactive utilization guidelines.

The subsequent section, *Improving Outcomes through Coordination of Care: The TBS Decision-Maker Meetings Model,* describes the successful decision-maker meeting component of the Emily Q Nine-Point Settlement Implementation Plan.

Therapeutic Behavioral Services: Best Practices, contained in the manual's appendix, is a more detailed description of TBS, as presented in the Emily Q Nine-Point Settlement Implementation Plan (Nine-Point Plan), for professionals, care providers, and family members who are interested in a more detailed understanding of how to provide effective TBS. Additional materials from the CDMH website that can support coordination of care efforts are included in the appendices as well.

This *Coordination of Care Best Practices Manual* is one part of a multifaceted effort to support the federal court-approved *Emily Q v Bonta* TBS Nine-Point Plan. The California Department of Mental Health (CDMH) is committed to the performance improvement process as described in the Nine-Point Plan and to provision of support for the 56 MHPs with data, training and technical assistance to help increase access and utilization of TBS.

This manual complements another tool for MHPs and private providers, the California Department of Mental Health's 2009 *TBS Documentation Manual* http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/TBS_Documentation_Manual_10_26_09.pdf. The 2009 *TBS Documentation Manual* was developed to offer clear instruction about effective TBS Specialty Mental Health billing and claims administration practices that support access and utilization of this service.

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THERAPEUTIC BEHAVIORAL SERVICES (TBS)
DOCUMENTATION MANUAL

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By
California State Department of Mental Health

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Both of these manuals, as well as other helpful information and materials regarding Therapeutic Behavioral Services, can be found at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp on the California Department of Mental Health TBS website.

The CDMH TBS website includes court documents; CDMH letters and notices; TBS Data Reports; information from the Emily Q Settlement Team and the TBS Accountability, Communications and Training (TACT) Team; and a variety of other supportive materials. CDMH is adding new material regularly, and readers are encouraged to subscribe at the website to receive periodic updates. You may subscribe to the TBS website from the link at: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Apps/subscription/default.asp.

The CDMH gratefully acknowledges the work of the members of the multi-disciplinary team who collaborated for several months on this project, and likewise recognizes their sponsoring organizations, including:

- The Emily Q Settlement Team
- The TBS Accountability, Communications and Training (TACT) Team
- California Department of Education
- California Department of Social Services
- California Department of Alcohol and Drug Programs
- California Administrative Office of the Courts and selected judges
- APS Healthcare Inc.
- California Alliance of Child & Family Services
- California Mental Health Directors Association (technical assistance)
- California Institute for Mental Health (CiMH)
- Casa Pacifica (private TBS provider)
- Chief Probation Officers of California
- Child and Family Policy Institute of California
- JDT Consultants Inc. (private TBS provider)
- Napa County Special Education Local Plan Area (SELPA)
- California Court Appointed Special Advocates Association (CASA)

The CDMH welcomes suggestions or questions about these manuals or other TBS issues. Comments about TBS can be sent to CDMH at TBS@dmh.ca.gov. You also may contact either of the following CDMH staff members:
Sean Tracy, Assistant Deputy Director, Community Services, at Sean.Tracy@DMH.ca.gov
Troy Konarski, Staff Mental Health Specialist, Program Support Branch, at Troy.Konarski@DMH.ca.gov

Please visit the CDMH website for additional TBS information at www.dmh.ca.gov and go to TBS Updates on Emily Q v Bonta.

TBS IN BRIEF

What Is TBS?

Therapeutic Behavioral Services (TBS) is a one-to-one behavioral mental health intervention. TBS can help children, youth, parents, caregivers, foster parents, group home staff, and school personnel learn new ways of reducing and managing challenging behaviors, as well as strategies and skills to increase the kinds of behaviors that will enable children and youth to succeed in their current environment.

TBS behavior "coaches" or "specialists[1]" work intensively with a child in his or her home or community. No regulatory limitation is imposed on the intensity or length of TBS services; however, the service is guided by the needs of each child. TBS specialists may design, structure, model and support one-to-one interventions to modify target behaviors of concern or teach appropriate alternative behaviors, so that children or youths and their family members (caregivers) can manage on their own. Transition plans are developed to help each child and his or her family (caregivers) learn to use new skills by which to sustain improvements after TBS concludes.

How Can TBS Help?

TBS is designed to help children, youth, parents and caregivers (when available) manage challenging behaviors utilizing short-term interventions to achieve measurable goals based on the needs of the child or youth and family. TBS is never a stand-alone therapeutic intervention. It is used in conjunction with another mental health service, and can make the difference in averting need for a higher level of care or helping a child make a successful transition to a lower level of care.

TBS can effectively help children receiving child welfare services to attain permanence, or can help youth on probation to avoid subsequent law violations or detentions, or can help children and youth receiving mental health services to maintain their school placements.

Who Can Receive TBS?

TBS is available to children and youth under age 21 who have serious emotional challenges and who are eligible for a full array of Medi-Cal benefits without restrictions or limitations (full scope Medi-Cal).

In addition, to qualify, a child must be at risk of placement in a Rate Classification Level (RCL) 12 (or higher) group home (whether or not a RCL 12 or higher placement is available) or psychiatric hospital (whether or not a psychiatric hospital is available), or have a history of psychiatric hospitalization within the past 24 months, or be in an RCL 12 (or higher) group home and need TBS to prevent placement failure.

How Is TBS Started?

Children can be referred for TBS in many ways and each county has its own referral process. Parents, caregivers, foster parents, CASAs, social workers, probation officers, and mental health providers can ask for TBS services.

Each county mental health system has developed procedures for requesting a TBS assessment, providing the necessary documentation, and receiving TBS services[2]. The county mental health case worker will have more information on how to start the process for the child.

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[1] No standard title has been adopted for the practitioners who directly deliver TBS. The terms "coaches," "specialists" and "workers" are commonly utilized designations. These titles are used interchangeably in this document.

[2] For more information on TBS, including contact information for TBS coordinators from each MHP, see California Department of Mental Health (DMH) TBS Web site at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp

TBS WORKING FOR CHILDREN AND YOUTH

How TBS Makes the Difference

Half of all mental health disorders begin in childhood[3]. Mental health disorders are prevalent among children. Disorders commonly experienced during childhood include disruptive disorders (e.g., conduct and oppositional defiant disorders), attention-deficit/hyperactivity disorder, and depression and anxiety disorders (including those resulting from traumatic experiences).

In California, children who have Medi-Cal insurance have access to mental health treatment through county-operated mental health plans, including an array of services accessible through a combination of county clinics and private community-based organizations.

Numerous mental health treatments are available, including individual therapy, medication treatment and case management. These services often are fully effective in treating mental health disorders and in restoring personal and social functioning.

While productive treatments are available, the severity of disorders and, in turn, treatment success, varies among children and circumstances. In some cases, the severity of emotional and behavioral problems require treatment in a psychiatric hospital or in an out-of-home placement (i.e., foster care or group home). TBS is specifically intended to meet the needs of children and youth at risk of being placed in higher-level care (hospital or group home) or undergoing a transition to lower levels of care.

TBS is proving to be very effective in assisting children and youth with various severe emotional and behavioral difficulties, including children served by child welfare, probation and schools. As a result of TBS, children and youth are able to achieve permanence, avoid incarceration, and maintain school placements.

Children and youth being served by probation departments, receiving child welfare services and having serious difficulties in school may have mental health disorders that place them at risk of a psychiatric hospitalization or group home placement, or jeopardize their ability to remain in their current environment. TBS may be of assistance in all of these situations. Examples of behaviors that could benefit from TBS intervention include:

- poor impulse control;
- poor or impaired judgment;
- oppositional behaviors toward caregiver and/or teacher directions;
- extreme tantrums;
- aggression toward peers or adults;
- fighting with peers and teachers;
- extreme and unremitting anxiety or isolation; and
- unsafe or self-injurious behavior.

The four sections that follow highlight, with illustrative examples, how TBS has been used to support the goals of the child welfare system, probation departments, the courts, schools, and public mental health services.

[3] Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Co-Morbidity Survey Replication. *Arch Gen Psychiatry.* 2005 Jun; 62 (6):617-27.

Probation: TBS and Juvenile Justice Services

The courts and probation departments could consider using TBS at numerous stages in the delinquency process — for example:

- At the pre-disposition stage, to demonstrate to the court that a child can be managed safely outside of a detention or group home setting;
- After a youth has been assigned a suitable placement order, so that he or she can be placed in a lower level of care or return to his or her family's care;
- When youth are at home on community supervision, to prevent the need for a psychiatric hospitalization or group home placement; and
- A juvenile that is in a detention center and has a placement order signed by a judge is considered Medi-Cal eligible and can obtain TBS.

  If you would like additional information on TBS eligibilty and institutional status, please refer to the California Code of Regulations (CCR), Title 22, Section 50273.

  TBS can assist the youth during the transition phase from a juvenile detention center to a placement or the family home.

The following vignette illustrates how TBS was used successfully with one youth who was on probation.

A youth was experiencing emotional and behavioral difficulties at the group home where he resided. The major presenting problem was verbal and physical aggression and property destruction.

The client was a 17-year-old teenager on probation for grand theft auto and unsafe behaviors (alcohol and drug use, leaving home without permission, and setting fire to property). He was removed from his mother's home due to parental substance abuse, neglect and physical abuse, as well as sexual abuse by an adult neighbor. The youth was placed in an RCL 10 boys' group home and was at risk of a placement in RCL 12 or above. His probation officer made the TBS referral.

The youth was violating his probation regularly by leaving the group home without permission — absent without leave (AWOL) — and displaying verbal and physical aggression (regularly punching walls, throwing chairs, slamming doors, and threatening to harm peers and staff). The client was diagnosed with post-traumatic stress disorder (PTSD), major depressive disorder and conduct disorder.

The referring probation officer doubted that this youth would be able to maintain his placement and avoid incarceration if his behaviors failed to meet the terms and conditions of his probation within a reasonably short period of time. In consultation with administrators from the youth's group home, the court, and the county mental health department, the probation officer decided to refer this youth for TBS. His mental health assessment was updated, and a TBS treatment plan was added to the youth's mental health care plan.

An interagency team, utilizing the youth's strengths as a foundation, developed the TBS plan. A specific TBS coach was assigned to work with the youth, and to collaborate with group home staff that played important roles in nurturing and supporting the youth.

TBS treatment goals included the following two important steps: 1) develop coping skills to increase frustration tolerance and to discourage the youth from leaving the group home without permission

and using drugs; 2) increase anger management skills to decrease physical aggression.

TBS included three interventions to reduce the youth's target behaviors of unauthorized departure from the group home, aggression and drug abuse.

- *Relaxation.* — The TBS coach taught the youth relaxation techniques to reduce feelings of tension and anxiety that sometimes triggered his impulse to leave the group home without permission. The TBS coach modeled the repetition of slow, deep breathing "tense and release" exercises for the youth, and they practiced until the youth was able, without prompting from the worker, to engage in this process independently.

- *Reinforcement for participation in a drug/alcohol treatment program.* — The TBS coach developed a chart to keep track of the youth's attendance at the group home's drug/alcohol program meetings (three times per week). For each week in which the youth maintained attendance at all meetings he was given a token, which he could exchange for the privilege of choosing television programming at various times during the week. (The TBS coach consulted with the youth to determine how tokens would be rewarded.)

- *Replacement behaviors.* — The TBS coach helped the youth develop a list of behaviors to replace impulsive flight from the group home, drinking and drug use. With the TBS coach's assistance, the youth was able to recognize triggers and resolve them promptly, and practiced consulting the list (which he chose to post inside his desk); he also learned to choose an alternative behavior when he felt triggered to leave the group home without permission, drink or use drugs.

This youth received TBS for approximately four months, during which time he was able to meet his treatment goals and maintain his group home placement. The team of people working with the youth then determined that TBS was no longer needed, and the TBS coach receded and concluded his services. The probation officer reported this success to the court.

Social Services: TBS and Child Welfare Services

The courts and county social services departments could consider using TBS at numerous stages in the child welfare system, including:

- As a family maintenance intervention to safely maintain a child with his or her family (or a relative caregiver);
- As an intervention to support foster care parents, in order to prevent placement disruption to a higher level of care; and
- As a reunification intervention strategy, so that a child can be safely and successfully returned to his or her family's care.

The following vignette illustrates how TBS was used successfully with one youth who was served by Child Welfare Services (CWS).

A youth was experiencing emotional and behavioral difficulties in her foster home. She was very oppositional, failing to follow rules that her foster parents set, lying and throwing tantrums.

The client was a 13-year-old Caucasian female, who had been living in her foster home for 1 year and 10 months at the time of the referral to TBS. She had been removed from her mother's care two years earlier, following her father's suicide, because her mother had become unable to care alone for her and her siblings. She was living with her 9-year-old biological sister, 8-year-old half-sister, her foster mother's biological daughter, and her foster mother. The foster mother was a single parent.

The foster mother reported that the youth would not follow house rules and expectations, which included doing chores, bringing her grades home from school, doing her homework, and refraining from taking things without permission. The client was starting to lie about her violations of these rules, and when confronted became verbally aggressive (yelling at the foster mother, calling her biological mother offensive names and using profanity). The client was diagnosed with oppositional defiant disorder, adjustment disorder and bipolar disorder (provisional).

The referring CWS worker foresaw that this youth would lose her placement with her biological siblings if her behaviors did not improve, and the foster mother did not feel better equipped to handle the client's behavioral problems. In consultation with the client's individual therapist, the family's therapist, the client's psychiatrist, the county case manager, and the foster mother, the county mental health department decided to refer this youth for TBS. Her mental health assessment was updated, and a TBS treatment plan was added to the youth's mental health care plan.

An interagency team, utilizing the youth's strengths as a foundation, developed the TBS plan with family and youth involvement. A specific TBS coach was assigned to work with the youth, and to collaborate with the foster mother to support her in responding more effectively to the youth's behaviors.

TBS treatment goals included two important steps: 1) help the girl develop problem-solving skills to increase her compliance with adult directives and to enable her to meet household expectations while decreasing oppositional behavior; 2) support the youth's acquisition of anger management skills to decrease verbal aggression (yelling, cussing, name calling).

TBS included three interventions to reduce the youth's target behaviors of non-compliance, lying, and verbal aggression.

- *Impulse control.* — The TBS coach taught the youth problem-solving techniques (such as *stop-think-choose*) to help her make more positive choices. The TBS coach helped the client identify short- and long-term goals for herself, and plans to reach these goals. The intervention focused upon encouraging the client to experience being in charge of her own life, rather than feeling controlled and "ordered around" by her foster mother. The TBS coach frequently created an "outcome tree" with the client to help her think ahead about the different outcomes that would result from various choices she might make.

- *Clear system of rewards and consequences for the foster home.* — Working with the foster mother and the youth, the TBS coach developed a chart to keep track of the youth's daily and weekly tasks in the home, thereby reducing the need for the foster mother to remind the client daily about her responsibilities. In addition to making expectations clear, the system established the rewards the youth would earn for successfully meeting them. The foster mother opposed using tangible rewards (for example, money or music CDs); instead, the foster mother, youth and TBS coach identified privileges such as rewarding extra computer and TV time in the evenings, allowing the youth to choose foods for Friday night dinners, and permitting her to visit her friends more frequently. The client was responsible for taking her chart to her foster mother to get it "checked off" as she completed her assignments.

- *Conflict resolution skills.* — The TBS coach helped the youth develop a list of behaviors to replace the urge to lie about completing her chores. With the TBS coach's assistance, the youth was able to recognize triggers that influenced her to avoid her chores (e.g., feeling controlled by others) and developed the ability to use positive self-talk to remind herself of her goals and recognize the areas of her life in which she did have control. The girl and the TBS coach also practiced using assertive communication with the foster mother when the youth believed the chores were unfair. The TBS coach was able to introduce the conflict cycle, as well as collaborative problem-solving techniques, to help the two "hear" each other's concerns and find solutions.

This youth received TBS for approximately four months and met her treatment goals. The social worker reported the success to the courts, and the girl remained in her foster home. The team of people working with the youth determined that TBS was no longer needed, and the TBS coach gradually reduced her time until services ended.

Schools: TBS and Education

TBS also can be conducted in the context of a school program — for example, as part of a behavior plan or mental health treatment plan. The following vignette illustrates how TBS was used successfully to help a child maintain his school and foster care placement.

A child was experiencing serious emotional and behavioral difficulties both in school and at his foster home. The major presenting problem was aggressive and assaultive behavior.

The child was a 7-year-old boy enrolled in a special education class at a public school. His social worker made the referral for TBS in consultation with his foster parent and CASA volunteer. The referral was prompted by concerns, reported by his teacher at an interagency meeting, about aggressive behavior directed toward other children in the class and toward the teaching staff.

The foster mother already was well aware of the child's difficulties, which also were evident in the foster home. However, she did not know how to obtain support for his particular emotional and behavioral needs. She was feeling hopeless and desperate, and feared that she would need to ask to have him placed in another foster home.

The child's teacher reported that his school placement also was at risk. The child's behavioral difficulties had become too severe for him to be allowed to remain in the classroom without additional support. More specifically, both the child's teacher and his foster mother reported that his physical aggression, assaultive behaviors, angry outbursts, and oppositional defiance were overwhelming.

The foster mother, teacher and representatives from the child welfare and county mental health departments collectively decided to start TBS. The child's mental health assessment was updated, and a TBS treatment plan was added to the child's mental health care plan. The TBS plan was developed for the child by an interagency team that included the child's foster mother, mental health and school staff, his child welfare social worker, and the TBS specialist, utilizing the child's strengths as a foundation. TBS took place in the foster home and school, in collaboration with the teacher, foster mother, and others who played important roles in nurturing and supporting the child.

TBS encompassed four interventions to reduce the child's target behaviors of physical aggression, threats, angry outbursts, and instances of oppositional defiance. They focused not only on the child and his behavior, but also on assisting the child's teacher and foster mother, whose ongoing learning about TBS techniques and support would be vital to the success of the TBS interventions. The four interventions were:

- *Relaxation.* — The TBS specialist instructed the child in relaxation techniques to reduce angry and emotional outbursts and physical aggression. He modeled the repetition of slow, deep breathing "tense and release" exercises, and the child practiced until he was able, without prompting from the TBS specialist, to engage in this process independently. This occurred in both the foster home and at school.

- *Prompting.*— The child was motivated by "prompting" to comply with his teacher, foster parent and other adults who issued directives. The TBS specialist offered the child nonverbal (hand-up visual signals) as well as verbal prompts. This signaling occurred primarily in school, but also in the foster home, as needed. The child's foster mother and teacher also were instructed and encouraged to use this type of prompting.

- *Stop and think.* — The TBS specialist helped the child learn ways to "stop and think" before acting out or reacting inappropriately. The child's teacher and foster parent also were informed about the "stop and think" strategy, so that this technique of behavioral modification could be maintained in the absence of the TBS specialist.
- *Token economy.* — The TBS specialist implemented a token economy system to reduce oppositional defiance and provide positive reinforcement. As part of the token economy system, the TBS specialist recognized the child's compliance with teacher and adult directives by offering the child tokens to be exchanged for small rewards and privileges. The TBS specialist assisted and collaborated with the teacher and foster mother in using the token economy plan, with the goal of continuing this strategy after TBS concluded.

The child received TBS for approximately five months, during which time he was able to meet his treatment goals and maintain both his school and foster home placements. At the end of that five-month period, the interagency team decided that TBS services no longer were needed, and the TBS specialist withdrew from the school and home settings.

Mental Health: TBS and Mental Health Services

Children receiving mental health services often have serious emotional and behavioral disorders that place them at risk of a psychiatric hospitalization or group home placement. The following vignette illustrates how TBS was used successfully with one such child.

A child was experiencing serious emotional and behavioral difficulties both in school and at home. The major presenting problem was aggressive and self-injurious behavior.

The child was a 10-year-old girl enrolled in a county mental health program. The child's therapist, concerned that she would harm herself or a member of her family, contacted her parents to discuss using TBS.

Her parents shared similar fears about their daughter harming herself or another member of the family, and about their ability to maintain her in the home. When bored, tired or hungry, she frequently engaged in self-injurious behaviors, such as hitting her head against the wall, biting herself and deprecating herself. She was also aggressive with her younger brother and other family members. She engaged in fights with her older sister, who had been removed from the home but visited frequently. In addition to the physical aggression, she threatened and swore at her family members.

After consultation with the child, the child's parents and colleagues at the mental health program, the therapist decided to seek TBS services for this child. A TBS treatment plan, which the therapist developed in collaboration with the child, her parents and the TBS coach, was added to the child's mental health care plan. The plan matched TBS interventions to target behaviors, building upon the child's strengths (e.g., artistic skills, athleticism and desire to please others). TBS was provided to the child in her home and in collaboration with her family members.

TBS included the following three interventions to reduce self-injurious and assaultive behaviors. The strategies focused not only on the child and her behavior, but also on the family as a whole.

- *Trigger identification.* — The TBS coach and the child practiced identifying her thoughts and feelings when she engaged in self-injurious and assaultive behaviors. The TBS coach gave her art materials so that she could draw representations of her thoughts and feelings when she was frustrated, bored, and unhappy.
- *Developing coping skills.* — The TBS coach helped the child, through role-playing activities, to respond to triggering events in constructive ways that would help her achieve her goals. She learned how to use assertive language and "I feel" statements to communicate with her family members. In addition, the TBS coach modeled self-soothing techniques, such as deep breathing and muscle relaxation.
- *Parent education and support.* — The TBS coach helped her parents practice appropriate responses to her challenging behaviors, to set limits, to praise, and to use calming techniques. They also collaborated in establishment of household structure and rules.

The child received TBS for approximately four months, during which time she was able to meet her treatment goals and remain at home with her parents. After that four-month period, her parents, the TBS provider and her therapist agreed that TBS services no longer were needed, and the TBS coach gradually withdrew from the home.

STRATEGIES FOR SUPPORTING ACCESS TO TBS

Approximately 5,000 children throughout California are receiving TBS annually. They include recipients of child welfare services; youth on probation; and children with serious emotional and behavioral problems that jeopardize their ability to participate in school and remain at home. However, many more children who can benefit from TBS are not being referred and are not receiving these services.

Discussions with county mental health, probation and child welfare departments, schools, and TBS providers indicate that the use of TBS is greatly facilitated by the following key systems-level characteristics:

- strong interagency coordination
- streamlined referral procedures
- prompt eligibility determinations
- proactive TBS providers
- families and caregivers that are responsive and supportive of TBS.

Strong Interagency Coordination

Strong interagency coordination typically involves activities at multiple levels within and across the collaborating agencies that improve access to services, reduce fragmentation, and enhance outcomes for children and families. Components of successful strategies include:

1. Policy-level coordinating bodies, consisting of agency directors and administrators who routinely meet (e.g., monthly) for the purpose of establishing and sustaining policies conducive to coordination of children services across agencies;
2. Program-level coordinating bodies, consisting of agency managers and supervisors who meet frequently (e.g., weekly or monthly) to support interagency projects for the purpose of insuring the routine and successful implementation of one or more collaborative programs, such as interagency placement review committees;
3. Interagency programs, consisting of staff from two or more agencies, that collaborate daily in delivery of services and supports for individual managed care efforts — for example, mental health therapists collocated in child welfare or probation units to facilitate easy access to mental health assessment and treatment services;
4. Practical information consisting of presentations, program descriptions and easy-to-use referral instructions — specifically prepared for social workers, probation officers, teachers, therapists, judges and families — intended to support timely and appropriate access to needed services, including TBS;
5. Court leadership and education about TBS as an alternative to institutional placement is effective. (Judges have a unique ability to call together local administrators and leaders to support problem solving. They may encourage personnel from multiple agencies to collaborate in devising innovative solutions to complex and difficult problems.);
6. Routine communication and coordination between the county mental health department, TBS providers, families, and referring parties;
7. Collaboration between TBS providers, probation officers, and child welfare social workers such that the appropriateness of TBS for specific children can be discussed, and when indicated, recommendations can be prepared for consideration in disposition and suitable placement hearings;
8. School-based treatment planning meetings with participation by mental health clinicians, school staff, children, and parents;
9. Placement of mental health therapists in school, child welfare and probation settings to discuss the needs of individual children;

10. Local judges convening meetings with multiple child-serving agencies to support problem resolution and service delivery;
11. Outreach and involvement of judges and attorneys with responsibility for children receiving child welfare or probation services;
12. Routine consideration of the use of TBS in the context of wraparound child and family meetings or team-based decision-making meetings; and
13. Periodic review, by probation officers and child welfare social workers, of the children on their caseloads who are showing volatile or at-risk behaviors.

Streamlined Referral Procedures

Streamlined referral procedures, timely eligibility determinations and proactive TBS services are built upon a foundation of strong communication and collaboration between county mental health plans, their TBS providers, and the larger community of child- and family-serving agencies. Efficient TBS programs are characterized by:

1. Clear instructions and easy-to-use forms for making referrals;
2. Creation of simple, easy-to-complete TBS referral forms, tailored for probation officers, child welfare social workers, mental health therapists and school staff; and
3. Establishment of multiple gateways for referrals, from parents, therapists, schools, probation officers, child welfare agencies, and courts.

Prompt Eligibility Determinations

Streamlined eligibility determinations are extremely helpful for all stakeholders in providing timely and appropriate mental health services. They include:

1. Straightforward procedures for making eligibility determinations promptly using the streamlined TBS administrative requirements[4];
2. Routine consideration of TBS for children who are at risk of, or returning from, psychiatric hospitalization; and
3. Routine consideration, by the courts, of the appropriateness of TBS for children at risk of group home-level placement.

Proactive TBS Providers

Proactive TBS providers demonstrate:

1. The capacity and readiness to complete assessments and start TBS services, without delay, upon receipt of a referral and eligibility determination; and
2. Development of school-based TBS roles, responsibilities and classroom protocols.

Families and Caregivers that are Responsive and Supportive of TBS

County agencies and providers have reported success with outreach to families and numerous strategies for supporting access to TBS. These effective strategies include:

1. Preparation of briefing materials concerning TBS for courts, probation officers, child welfare social workers, teachers, therapists, families, and youth; and
2. Regular and recurrent trainings and outreach meetings to support the use of TBS involving the courts, probation departments, county social services, schools and mental health providers, and families and youth.

[4]See DMH Information Notice No. 08-38 at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/DMH_Documents.asp

IMPROVING OUTCOMES THROUGH COORDINATION OF CARE: THE TBS DECISION-MAKER MEETINGS MODEL

Successful interagency collaboration efforts are exemplified by TBS decision-maker meetings. In November 2008, the federal court-approved the Emily Q Nine-Point Settlement Implementation Plan (the Nine-Point Plan)[5]. This plan creates a comprehensive set of requirements for settling the Emily Q lawsuit, and increasing the utilization and quality of TBS. Recognizing that the children and youth who will benefit from TBS often are served by a variety of agencies, including probation departments, child welfare agencies, schools and the courts, the Nine-Point Plan specifically supports and calls for activities that will increase the coordination of care across child, youth and family-serving agencies. The TBS decision-maker meeting is a key component of this approach.

The Nine-Point Plan recognizes that optimal use of TBS will require participation at multiple levels and across the community; however, the decision-maker meeting capitalizes upon the understanding that the support and attention of agency leadership is essential for success. The Nine-Point Plan defines the membership of the decision-maker meeting as:

- Director of Mental Health
- Director of Child Welfare Services
- Chief Probation Officer
- Presiding Judge of the Juvenile Court local SELPA Director or Special Education Representative
- parent representatives
- TBS provider representatives
- other agencies that provide services to the Emily Q class members.

The first set of decision-maker meetings focused on four questions:

1. Are the children and youth in the county who are Emily Q class members, and who would benefit from TBS, receiving TBS?
2. Are the children and youth who receive TBS experiencing the intended benefits?
3. What alternatives to TBS are being provided in the county?
4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

Decision-maker meetings that follow will highlight different sets of questions or other priorities.

Participants in decision-maker meetings review the information provided by the CDMH, including TBS Data Reports. That review process creates opportunities for stakeholders to identify shared areas of interest, such as reducing group home placements and institutionalization of children and youth, as well as returning children and youth to their families and communities, and helping them remain in their homes.

These meetings also are helpful in identifying barriers that inhibit access to TBS. Through this process, participants in decision-maker meetings develop strategies to surmount barriers and create opportunities to increase use and improve the efficacy of TBS.

County mental health departments have completed reports documenting their decision-

[5]See the CDMH TBS website at: http://www.dmh.cahwnet.gov/Services_and_Programs/Children_and_Youth/docs/EPSDT_docs/Nine_Point_Plan_Total.pdf

maker meetings and highlighting their successful strategies. The CDMH TBS website has examples of these reports, and offers a variety of other practical resources to support local decision-maker meetings[8], including TBS brochures (available in 11 languages), helpful local meeting documents and forms, and sample county meeting announcements.

In March 2010, the CDMH presented to the federal court The 2009 TBS MHP Progress Report that helped to evaluate the strengths and best practices of MHP decision-maker meetings and stakeholder meetings. This progress report will be updated throughout 2010, and the reader may want to review local activities and programs relative to TBS and the Nine-Point Plan implementation:

http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/Exit_Plan_4-09-09.pdf

As a result of the 2009 experience with implementation of the Nine-Point Plan, CDMH, the Super TACT and the Emily Q Settlement Team (EQST) determined that there was a need for increased attention to family, consumers and youth participation and leadership involving TBS stakeholders and decision-maker meetings. The CDMH initiated a TBS Family and Youth Strategy that is being developed as this manual is published. We invite you to review this plan and offer opinions about ways to advance a consumer- and youth-centered focus in this local service delivery and coordination of care model, after it is posted to the CDMH website at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/docs/TBS_FamilyandYouthStrategy/FamilyYouth_Strategy_Update.pdf.

CONCLUSION

TBS is a one-to-one behavioral mental health service that is making a difference for children and families by helping to keep children in their homes and communities, and by preventing the need for high-level group home care and psychiatric hospitalization.

TBS is highly effective for children with a variety of severe emotional and behavioral difficulties, including children served by child welfare agencies, probation departments and schools. As a consequence, children and youth are able to achieve permanence, avoid incarceration and maintain school placements.

Despite this success, even more children can benefit from TBS, but they first need to be identified and referred for these services. Strategies for improving access to TBS are characterized by strong interagency coordination, streamlined referral procedures, quick eligibility determinations, and proactive TBS providers. Moreover, numerous specific strategies are being identified by counties, in TBS decision-maker meetings and other settings, and are being used with success throughout the state.

This *Coordination of Care Best Practices Manual* is one part of a multifaceted effort to support the federal court-approved *Emily Q v Bonta* TBS Nine-Point Plan, and to help increase access and utilization of TBS. CDMH is very committed to the performance improvement process as described in the Nine-Point Plan and to provision of corresponding supports, training, and technical assistance. To this end, helpful information regarding TBS is available at the California Department of Mental Health TBS website at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp.

Moreover, stakeholders are encouraged to share their suggestions or questions about TBS by contacting CDMH at TBS@dmh.ca.gov.

APPENDICES

Appendix 1

Therapeutic Behavioral Services: Best Practices

The following is reproduced, in its entirety, from Appendix D of the Emily Q Nine Point Settlement Plan, developed in response to Point 4 of the plan: Define TBS Best Practice to Promote Service Integrity.

Therapeutic Behavioral Services (TBS) is a one-to-one behavioral mental health service available to children and youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal. TBS is never a primary therapeutic intervention. It is always used in conjunction with a primary mental health service. TBS is available for children and youth who meet the requirements of being considered for placement in an RCL 12 or above (whether or not an RCL 12 or above placement is available) or who meet the requirements of at risk of hospitalization in an acute care psychiatric facility (whether or not the psychiatric facility is available). TBS is designed to help children and their parents or caregivers (when available) manage these behaviors utilizing short-term, measurable goals based on the child' and family's needs.

TBS can help children and youth, families, foster parents, group home staff and school staff learn new ways of reducing or managing challenging behavior as well as strategies and skills to increase the kinds of behavior that will enable success in their current environment. A TBS treatment plan will be developed by the treatment team to outline what the child, the family or caregiver and the TBS specialist will do during TBS, and when and where TBS will occur. The TBS plan will identify and describe the challenging behaviors that need to change and the replacement behaviors the TBS specialist will teach the child and family or caregivers. The plan will say when the TBS specialist will work with the youth and family or caregivers. The hours may be during the day, early morning, evening or night. The days may be on weekends, as well as weekdays. The TBS specialist can work with children in most places where they are likely to need help with challenging behaviors. This includes family homes, foster homes, group homes, schools, day treatment programs and many other areas in the community. The TBS specialist, the child and the family or caregiver will work together very intensely for a limited period of time, until a child has displayed improvement with behavioral goals and no longer needs TBS.

Service Philosophy

TBS is based on the research and philosophies of Behavior Modification. Evidence shows that the success of an intervention hinges on: 1) understanding why children behave in a certain way; and 2) replacing inappropriate behavior with a more suitable behavior that serves the same function (or results in the same outcome) as the challenging behavior. Intervention with challenging behavior begins with assessing and identifying the underlying needs being met by the maladaptive behavior. TBS is provided to children and their families or caregivers in the community through a well-trained interdisciplinary team of licensed and unlicensed staff. Services are provided working cooperatively and collaboratively with the youth, family or caregiver, community agencies and the TBS professional staff. The TBS mental health plan development and service delivery is based on the following tenets and values:

- The belief that when provided with useful therapeutic tools, a child can learn to manage their symptoms, yielding success in the home, school and community.
- The belief in the importance of cultural competence and sensitivity and multi-lingual mental health service delivery in meeting the diverse cultural needs of consumers.

- The belief that the parents and guardians of the child are an integral and valued member of the child's treatment team.
- The belief that youth that have experienced or are experiencing serious emotional distress during times of crisis, loss and transition will stabilize successfully when provided with competent and comprehensive short-term one-to-one support.
- The belief in providing children with specific, measurable and accomplishable short and long-term treatment goals specially focused on their areas of need.
- The belief in the importance of self-determination and the formulation of individualized Treatment Plans involving the child and family or caregiver in this process, highly valuing their input from the onset of service delivery.
- The belief in the importance of children being placed in the least restrictive environment with full inclusion in age and developmentally appropriate activities, peer groups and education.
- The belief in the commitment to youth wellness, creating well-being, obtaining balance in one's life and helping children to realize and reach their potential.

Family Engagement

The process of engaging the family or caregiver is a crucial component of providing TBS. It is the role of the TBS clinician and assigned staff to welcome and engage the family or caregiver. The caregiver engagement process builds trust and sets the stage for the work to come. It can ultimately make or break the partnership and affect the success of the child and family's outcomes. Engagement with the child and family or caregiver is an ongoing process and continues to need nurturing past the initial "getting to know you" phase.

Cultural Competence

TBS is committed to the recognition and appreciation of cultural diversity among service delivery staff, clients and community partners. Every effort will be made to provide the service to children in their primary or preferred language. It is also important that any forms, documents, and brochures be provided in multiple languages to reflect the cultural needs of the community. It is critical for TBS programs to employ from diverse cultural and language backgrounds similar to that of the counties that are served. As consumers are referred, their language and cultural needs should be matched with the appropriate Specialist(s).

It is equally important that TBS is committed to an atmosphere of inclusion, engagement, and supportive collaboration. Whenever possible, care givers should be encouraged to participate in the treatment plan implementation to promote understanding of the service and allow them to take ownership of the outcomes and an improvement in their child's functioning. Families who participate in TBS should feel non-judged, welcomed, and included in the process of helping their child. TBS should make every effort to meet the family or caregivers "where they are" and make any time, day, or environmental (location) adjustments that will help with the service be successful and limit the intrusiveness of the interventions.

Service Delivery

After receiving the TBS referral, the TBS clinician or TBS specialist will initiate contact to help coordinate a TBS Initial meeting with the referring clinician, social worker, or probation officer, the family or guardian, the client and other significant parties in the child's life to discuss treatment planning and service delivery. The TBS service delivery model should be based on a comprehensive assessment focusing on the children's strengths and needs. A licensed clinician (LPHA) should oversee the Initial Treatment Planning meeting to develop the TBS Treatment Plan and provide ongoing therapeutic supervision of services.

Initial Meeting of the Treatment Team

- The meeting is attended by a TBS clinician in conjunction with TBS staff, parent or caregiver, child, and the referring party (ie. mental health worker, probation officer, social worker). This group comprises the treatment team. Other participants in the treatment team may include family members, CASAs, teachers, therapists, partner agencies, support staff, etc.
- At this meeting, TBS is introduced and explained before any discussion of the youth's behavior occurs.
- It is very important that the parent or caregiver take as active a role in plan development and plan implementation as possible. It is advised that a caregiver be at home during home visits so the TBS staff can check in and out with an adult. The parent or caregiver is not required to sit down with the specialist at all visits, but may be asked to participate in a parent meeting, family meeting or youth meeting from time to time. By the end of services the parent or caregiver should be equipped in utilizing effective TBS interventions with their child. It is important to note here that TBS can still be an effective intervention for youths who may not have parental or caregiver involvement in their lives at the time of the service delivery. This is especially true for Transitional Age Youth (age 18 to 21).
- Team communication is very important. TBS specialists will be discussing the case with the clinician, teacher, parents, and caregivers to ensure that the entire treatment team knows what is working and areas that need more attention. It is recommended that a team should meet at least every 30 days to review the progress and adjust the plan as the goals are being met.
- TBS is not a crisis response service. In the event of a crisis the family or caregiver is encouraged to utilize a crisis stabilization service or follow a safety plan established in conjunction with their primary therapist or worker.
- The TBS team then has a discussion of challenging behaviors, narrowing the behavioral concerns and developing a TBS Treatment Plan in conjunction with the overall goals of the Mental Health Treatment Plan.

The TBS Treatment Plan

During the initial meeting process, specific and measurable data related to the frequency and duration of the child's challenging behaviors is obtained to enable comparison as services progress. To promote collaboration for client benefit, a signed release of information is requested at the time of the initial assessment so that communication can occur with the child's therapist or other members of the TBS team.

The individualized TBS Plan will identify specific target behaviors or symptoms that are jeopardizing the current placement or are presenting a significant barrier to transitions. A careful review of the presenting symptoms and subsequent behaviors to be targeted is prioritized, with the plan focusing on the behavior(s) that are most likely to disrupt the child's current living arrangement, inhibit the ability to transition to a lower level of care, or that will lead to placement in a higher level of care.

It is of utmost importance that goals in the individualized TBS Plan are clearly stated in specific and measurable terms. The goals reflect the child's baseline performance in targeted areas so that progress can be accurately recognized. Pre-test data is intended to offer accurate information related to the consumer's baseline performance and involves reports by both the child and their family or caregiver. Each target behavior is stated in descriptive and measurable means. Interventions to target each behavior are determined and specific measurable outcomes are identified.

An important factor is to determine antecedents and consequences to the youth's challenging behavior. Antecedents and consequences are not always apparent at the time of the Initial Meeting, and therefore determining antecedents and consequences to challenging behaviors is often incorporated into the child's TBS Treatment Plan as an early primary intervention.

TBS Initial Plan Implementation and Assessment Period

During the first 30 days of treatment, TBS is in an implementation and assessment phase. It is crucial to engage the family or caregivers and build trust during this phase. The TBS specialist should begin introducing the treatment plan and gather first-hand data in regard to the youth's challenging behaviors. This period at the beginning stage of TBS includes giving immediate assistance to the child and parent or caregiver to relieve stress and avoid crisis, while also gathering valuable information on the function and intensity of the behavior in the environment where it occurs. The TBS Specialist in conjunction with the TBS clinician should complete a Functional Analysis of Behavior, including: 1) identification of target behaviors, 2) frequency, intensity and duration of target behaviors, 3) antecedents and consequences of the behaviors (function), and 4) potential replacement or alternative behaviors, during this timeframe.

A child's progress toward goals and objectives offers valuable insight into the youth's ability to manage their symptoms, make appropriate choices in the future without TBS assistance, and their ability to incorporate skills and coping strategies learned into daily living.

A key component to behavior monitoring and overall success involves obtaining accurate baseline data related to the symptoms or behaviors to be targeted in the Treatment Plan. During the initial assessment process, the child's Treatment Team, i.e. licensed therapist, TBS Specialist, TBS supervising clinician, the child's CASA, family or caregivers and the child should carefully adhere to the following guidelines to ensure a meaningful and accurate baseline evaluation of behaviors:

- Careful documentation of the initial frequency and duration of the challenging behaviors to be targeted.
- In obtaining this baseline behavioral data, the clinician and TBS Specialist will gather this data from a variety of sources which may include observations by the TBS Specialist, parent or caregiver; the child's self-report; and the teacher or primary therapist.
- A careful review of environments (school, home, community) where the target behaviors are demonstrated will be completed. Specific information related to each domain will offer an ability to effectively monitor progress in each setting.
- During the assessment and beyond, identification of antecedents and consequences to target behaviors will be a focus of the behavior monitoring process, continuing to gather valuable information that assists in understanding the origins and precipitating events to challenging behaviors and symptoms.
- The ongoing assessment of the youth's behavioral changes will employ daily observations, reports and information obtained from family or care providers and the evaluation of the frequency of targeted behaviors.

Progress will be stated in measurable and specific terms throughout TBS involvement. Treatment plan modifications result from a review process between the Specialist, Clinician and Treatment Team.

TBS Interventions

TBS interventions are based upon the tenants of behavior modification, cognitive-behavioral therapy and supported by evidence-based practices. TBS interventions will be provided on-site between the child and TBS Specialist through therapeutic contact. TBS interventions are designed to help the youth develop improved emotional and behavioral skills and increase the child's ability to manage symptoms and behaviors once treatment goals have been met and services have been discontinued.

Interventions should be developed with the goal of parent or caregiver learning adaptive skills in order to successfully manage their child's behaviors once TBS has ended. It is critical that parents or

caregivers be able to watch, practice, role play, and implement interventions with the youth while TBS staff is present in the environment (home, classroom, etc.) to increase confidence, consistency, and sustainability.

Interventions will be stated clearly and concisely reflecting the methods that will be employed to meet the desired goals or outcomes. Interventions are designed to build skills and provide the child with tools to address their areas of difficulty; i.e. anger, threats, impulsivity.

Interventions are planned and implemented to increase the youth's ability to cope with situations that lead to behaviors and choices that jeopardize success in their home, school or community.

The TBS Specialist should be trained in providing behavioral interventions to emotionally or behaviorally challenged children and youth. TBS Treatment Plan goals are accomplished through planned interventions, which commonly include: role modeling, intermittent and planned reinforcements, teaching children and their parents or caregivers coping skills and strategies for symptom and behavior management and empowerment. TBS Specialists will focus on the strengths, talents and interests of the youth and their families or caregiver in developing intervention strategies. Through planned and systematic interventions, the child or youth will learn to exhibit self-control, act responsibly and feel empowered and successful. The development of a trusting one-to-one relationship with their TBS Specialist will help in acquiring and developing interpersonal skills.

Meaningful incentives and consequences to the child will be determined, and a plan for either intermittent or planned reinforcements will be included in the treatment plan to reinforce desired behavior. Parents and caregivers should take an active role in developing incentives and consequences and the interventions should fall within the general scope and ability of the parent or caregiver to fulfill after TBS is terminated.

The following are guidelines for respectful and successful TBS interventions:

- The purpose of TBS interventions is to teach, not control. Children need to learn how to make informed choices, weighing the potential consequences and rewards for their choices (behaviors).
- All children have a need and desire to be successful, liked and appreciated by adults and their peers. However, the manner in which they attempt to get their needs met is often not appropriate. Through one-to-one support and education, they can learn to meet their needs in a more successful manner.
- All behaviors are intentional and have a purpose to the youth. Through determining the outcome desired by the youth, successful interventions can be developed to achieve this outcome.
- The children and their families or caregivers are valued members of the Treatment Team and should be included in all aspects of service delivery.
- There is always hope for a positive outcome, regardless of the child's history or symptoms. The ability of the Treatment Team to maintain hope and faith in children and their positive outcome is imperative to success.
- Lastly, all youths and their families or caregivers deserve the best efforts of professionals to provide services in a competent, ethical and consistent manner.

TBS Supervision

TBS Supervision is recommended as a valuable means of monitoring the success of interventions to effectively meet the TBS Treatment Plan goals and objectives. It is important that all staff providing

direct service attend regular Supervision. For example, one TBS Case Model consists of weekly meetings held for two hours in duration and includes a team (max. 8 members) consisting of the TBS supervising clinician and the TBS Specialist(s) providing services to children. The focus of supervision is to discuss pertinent issues related to the child and services, which may include:

- Group discussion and updates on ongoing issues regarding safety and safety plans for youth, family, caregivers, and TBS specialists.
- Follow up discussion and processing of crisis events by the group.
- Discussion of youth's progress toward TBS goals. Emerging issues are also discussed.
- Discussion of behavioral intervention strategies as well as to work as a team to provide encouragement, ideas and feedback regarding interventions to individual specialists.
- Discussion of challenges in the provision of TBS services (i.e. rapport lapses, youth participation, level of parent or caregiver involvement, environmental factors, etc.)
- Discussion of and provision of group support for TBS Specialists' frustrations and personal challenges in the field.
- To inform the group of any changes to TBS scheduling, procedure or protocol.
- To provide training to the group regarding clinical issues such as boundaries and confidentiality.
- Discussion of upcoming TBS reviews, contact with primary clinician, frequency of services and fade out plan.
- To acknowledge the successes of the youth and family or caregivers.

Monthly TBS Review Meetings

Monthly TBS Review Meetings should be scheduled and all Treatment Team members be included. In addition to the TBS clinician, TBS Specialist, children, their parents or caregivers, members may include the child's primary therapist, care coordinator(s), the Case Manager and placement worker, CASA and any person who is significant to the youth and who has information that may be helpful to the TBS Treatment Plan. The focus of the TBS Review Meeting is to determine the effectiveness of the plan and the interventions and to adapt the plan as needed in order to facilitate progress toward the TBS goals. Treatment Team members should be encouraged to offer suggestions, observations and insight into TBS service delivery, progress and interventions employed. Parents or caregivers should be encouraged and supported in bringing up any concerns or issues with regards to TBS and how it is being implemented in their environment. The youth should be invited to this meeting to share their thoughts and experiences resulting from TBS involvement. Recommendations for changes in the level of services, interventions or modifications in the targeted behaviors should be discussed at this meeting.

TBS Termination

In response to the time limited nature of TBS, transition and termination procedures are thoroughly discussed with the child, family or caregivers and primary therapist during the Initial meeting and throughout the service. Criteria for decreases or increases in the intensity of TBS services and eventual elimination of these services are based on the youth's progress toward behavioral goals delineated in his or her Treatment Plan. Based on the child's progress, the frequency and duration of services are adjusted, transitioned or titrated. These transitions are discussed with the child, family or caregiver, and treatment team at regular (monthly) TBS Review Meetings. From the inception of services, the treatment team will be advised of the following to offer them a framework for transitioning TBS services:

- TBS services are not meant to "fix" a child or lead to a "perfect" child or perhaps an absolute elimination of all target behaviors. Rather, the goal of TBS services is to provide meaningful interventions to the child and familyor caregivers that lead to a significant reduction in the targeted behaviors.
- Through TBS service delivery, the youth and parent or caregiver will develop skills and strategies for coping with target behaviors.
- TBS involves a team, and the parent or caregiver and child are significant members of the team. In a family based or home environment, child and parent or caregiver involvement in TBS service delivery and TBS Review Meetings are critical to the success of services. It is highly probable that TBS services will not be successful, in this environment, without youth and family or caregiver involvement.
- TBS can be effective in working with Transition Age Youth (age 18-21) or children who do not have immediate adult support. But it is crucial that from the onset of TBS, informal supports (friends, coaches, clergy, co-workers, etc.) for the child be encouraged to take part on the Treatment Team (at the request of the child) to ensure that termination of services does not feel like abandonment.
- Decreases in TBS services are very exciting and represent an important accomplishment on the part of the youth, family or caregivers and significant support people in the child's life.

As transitions occur in the intensity of TBS services to the child, an addendum to their Treatment Plan will be made. Addendums will also be made if it is determined that additional behaviors are in need of TBS interventions. When the majority or all of the targeted behaviors have been decreased to a level where the child and parent or caregiver can maintain existence successfully in their current environment or the targeted behaviors have decreased to a level that can increase the possibility of a successful transition to a lower level of care, then TBS can be terminated.

Decreases and the successful elimination of services will be communicated to the child and family or caregivers as a very positive experience, as they have been successful for this to occur. Incentives, rewarding the success of the child's progress toward targeted behaviors will occur as services are decreased. When the successful completion of TBS services occurs, a celebration or graduation should be held for the family or caregiver to recognize the youth's accomplishments.

Toward the end of TBS service delivery, the TBS Specialist, child and family or caregivers should discuss a Setback Prevention and Response Plan. Factors to be discussed with the child and family or caregivers to prevent and respond to setbacks include the following:

- Attention to patterns, circumstances and antecedents to the youth exhibiting the targeted behaviors in setback prevention.
- Support systems available to the childand family or caregiver.
- Community resources and agencies that can provide support.
- Interventions learned that were successful for the child and family or caregiver to manage symptoms and behaviors.
- The importance of maintaining open communication between the youth and their primary mental health clinician.
- "Speaking up" right way when setbacks begin to occur, not allowing the behaviors to become extreme and frequent prior to getting help.

When TBS services are intensive and last for several months without observable improvement toward treatment goals, the appropriateness of the service to provide stabilization of the child's living situation

will be assessed. To prevent inappropriate changes in placement and to address a lack of the child's progress, strategies may include the following:

- The lack of the child's progress in response to the Treatment Plan should be discussed throughout the TBS Review Meeting process, both internally (TBS specialist and supervising clinician) and with the Treatment Team.
- When a youth is unresponsive to TBS services being delivered, continual weekly efforts should occur to locate interventions and strategies to elicit a positive behavioral response. Members of the Treatment Team should be consulted to obtain their feedback.
- Barriers to TBS service effectiveness should be explored and methods to counteract barriers are determined and implemented.
- If after extended TBS, a child's maladaptive behavior increases or progress toward target behavioral goals have plateaued, the Treatment Team should discuss possibilities that the child may need alternative mental health services or determine if further TBS may be counterproductive, placing the child at risk of an increased level of care.

Transition and termination of TBS is discussed with the youth and the family or caregivers throughout the service delivery. Given the intensity of the one-to-one relationship between the yough and Specialists, this can represent a significant loss to the youth. Specialists should receive training regarding the TBS termination process and termination principles when discontinuing services to the child. The focus of termination as a positive and necessary process in life should be related to the child by the Specialists. Teaching challenged childrento terminate in a positive way is very important and prepares them for these experiences throughout their life. The termination training for Specialists should address principles that include the following:

- Based on the intense, yet time-limited nature of this service, ongoing discussion should occur between the youth and Specialist about termination. Specialists should be advised not to promise contact with the youth and that it is important that the youth experiences termination (goodbyes) in a positive way, as it is a process that occurs throughout their life.
- Specialists should begin terminating with the child 30 days prior to the proposed elimination of services. The TBS program should provide training to educate Specialists how to role model and help children express their feelings about termination (goodbye) and not seeing their Specialist anymore.
- Specialists should plan a celebration or graduation from TBS with the child, making this transition a happy and meaningful one. Children should determine how they will say goodbye, who will be there and the activities that they will do to celebrate their success.
- Reaching behavioral goals should be addressed as a very positive accomplishment, and as decreases in services occur, the children should be complemented on their accomplishment and success.
- Specialists should receive training on positive methods of creating transitional objects to be given at termination that offer children a tangible possession that they can refer to and feel good about as a reminder of all their hard work.
- Specialists will also terminate with the family or caregivers and exchange comments with the parent or caregiver related to how the termination of TBS services is impacting their child.

Treatment Team communication during the last 30 days will be to discuss the termination, receive feedback as to how the child is responding, plans on responding to the child's reactions, and

development of the Setback Prevention Plan. The children may want some or all of the Treatment Team to attend their graduation celebration. The team will be encouraged to support the children, process the termination (goodbye) with their Specialist and to present this as an exciting accomplishment.

Following termination and graduation the TBS Specialist should complete a TBS Discharge Summary. The TBS Discharge Summary details the child's progress or lack of progress toward the target goals that were demonstrated at each TBS Review Meeting as well as the overall outcome of children maintaining their home or residential placement or successful transition to a lower level of care.

Appendix 2

DEPARTMENT OF SOCIAL SERVICES TBS LETTER

CDSS

JOHN A. WAGNER
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov

ARNOLD SCHWARZENEGGER
GOVERNOR

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

April 29, 2010

ALL COUNTY INFORMATION NOTICE NO. I-39-10

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY CWS PROGRAM MANAGERS
ALL CHIEF PROBATION OFFICERS
KARUK TRIBE

SUBJECT: THERAPEUTIC BEHAVIORAL SERVICES

REFERENCE: DEPARTMENT OF MENTAL HEALTH INFORMATION NOTICES 08-38 AND 09-10

This All County Information Notice provides important information regarding the availability of Therapeutic Behavioral Services (TBS), and strongly encourages counties to actively work with their local mental health partners to facilitate access to these services for children and youth in foster care who need them.

Background

In 1998 a class action lawsuit (Emily Q. v Bontá) brought against the State of California sought to have TBS included under Medi-Cal as an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) supplemental service. In 2001 the court ruled in favor of the plaintiffs and issued a permanent injunction against the State in which TBS was recognized as a Medi-Cal reimbursable EPSDT supplemental specialty mental health service. The court further ordered the California Department of Mental Health (DMH) to take specific steps to increase access and utilization of TBS.

These steps were formalized in a Nine Point Plan that was approved by the court in November 2008. The Nine Point Plan describes what DMH will do to improve TBS in California.

For example, the Plan significantly reduces administrative requirements related to the provision of TBS, clarifies definitions of eligible and "at risk" populations, and includes strategies to increase access and improve the quality of TBS, which is the Plan's primary goal. The nine points of the Plan are listed below.

Summary of the Nine Point Plan

1. Eliminates many administrative requirements that have burdened counties in the past and have reduced the use of TBS;
2. Presents simple and direct language to clarify TBS eligibility requirements;
3. Establishes an accountability process and structure that DMH will use to monitor and improve TBS utilization in every county;
4. Describes a TBS best practice approach from assessment through service delivery and termination;
5. Proposes a multiagency coordination strategy to engage Social Services and Juvenile Justice agencies at the state and county levels in order to increase and improve TBS service access and delivery;
6. Establishes a statewide TBS training program;
7. Outlines technical assistance manuals covering both TBS practice and chart documentation;
8. Outlines an outreach strategy to increase awareness of TBS and expand its utilization statewide; and
9. Defines a process that will result in Court exit from the Emily Q matter.

TBS Definition

TBS is defined as a one-to-one behavioral mental health service available to children and youth with serious emotional challenges who are under age 21 and who are eligible for full scope Medi-Cal benefits without restrictions or limitations. TBS is never a stand-alone therapeutic intervention, but rather is used in conjunction with another specialty mental health service.

Emily Q Class Members

Class members are all current and future beneficiaries of the Medicaid program below age 21 in California who:

- Are placed in a facility with a Rate Classification Level 12 or above and/or a locked treatment facility for acute psychiatric inpatient hospital services for the treatment of mental health needs; or
- Have undergone at least one emergency psychiatric hospitalization related to their current presenting disability in the past 24 months; or
- Are being considered for placement in these facilities as a result of behaviors that may benefit from TBS interventions, whether or not such a facility is available.

TBS Eligibility

For children and youth identified as meeting the requirements for class membership, the need for TBS is determined based on the following criteria:

1. The child/youth is receiving other specialty mental health services; and
2. The clinical judgment of the mental health provider indicates that the short-term support of TBS is needed to:
    a) prevent the child or youth from being in placed out of home care, or into a higher level of residential care; or
    b) address a change in behavior or symptoms that is expected as a child or youth transitions to a home, foster home, or lower level of residential placement.

Information Resources

DMH Information Notices 08-38 and 09-10 provide additional detail and clarification regarding a variety of issues, such as eligibility criteria, Medi-Cal reimbursement, administrative requirements, and training opportunities. The California Department of Social Services (CDSS) has links to these letters available on its website at CDSS Wraparound. In addition, there is a variety of information available on DMH's website at DMH TBS Information. In addition, a Coordination of Care for TBS Best Practices Manual is forthcoming and expected to be available soon. County welfare departments may also be interested in reviewing DMH's data regarding utilization rates for TBS. Data is available statewide and by individual county, however, it is not specific to children in the child welfare system. TBS data is found at DMH TBS Data.

DMH is highly committed to implementing the Nine Point Plan successfully, and providing counties with guidance and support that may lead to increased utilization of TBS. DMH is especially committed to improve TBS service delivery to the foster care population. In addition to receiving services through local county mental health departments, significant numbers of the Emily Q class members are served by Child Welfare, Probation, and the Juvenile Court. As a result, CDSS strongly encourages counties to work with local mental health departments to further align the interagency coordination of services. It is crucial that such coordination take place so that eligible children receive appropriate and timely services.

If you have any questions about this letter, please contact Cheryl Treadwell, Chief, Resources Development and Training Support Bureau at 916-651-6600.

Sincerely,

Original Document Signed By:

LINNÉ STOUT, Chief
Child Protection and Family Support Branch

Appendix 3

LOS ANGELES COUNTY MENTAL HEALTH PLAN SPECIALIZED FOSTER CARE AND TBS LETTER

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

Reply To: (213) 738-2147
Fax: (213) 639-1804

January 14, 2010

Dear Specialized Foster Care Provider:

Your agency is one of over 60 agencies in Los Angeles County that has contracted with the Department of Mental Health (DMH) to provide services related to the Katie A. Settlement Agreement. These programs include Wraparound, Multidisciplinary Assessment Teams (MAT), Intensive In Home Mental Health Services, Intensive Treatment Foster Care, and Basic Mental Health Services. These services are funded primarily through Early Periodic Screening, Diagnosis and Treatment (EPSDT) and are dedicated to children in the care of the Department of Children and Family Services (DCFS). Although the County has made a significant investment to serving foster care children, Specialized Foster Care (SFC) funding has been underutilized due to various challenges. It is critical that these resources are utilized in the most efficient and effective manner to serve as many DCFS involved children as possible.

In an effort to increase the utilization of resources and the services delivered, we will be adding the Basic Enhanced SFC Plan in the Integrated System (IS) to all SFC providers. This will allow our SFC providers flexibility to redirect remaining SFC EPSDT funding for any other mental health services provided to DCFS involved children and families. While we are in support of the flexibility this may provide, there are four important caveats to bear in mind:

1. Your agency must be able to direct SFC funds to the original contracted program as necessary to support the full implementation of the program;

2. Redirected SFC EPSDT funds must be used to serve DCFS involved children and their families;

3. Redirection of SFC funds is limited to EPSDT and does not include any allocations received from DCFS, such as MAT – DCFS, the case rate for Wraparound, or the case rate for Intensive Treatment Foster Care; and

4. You must work with your Lead District Chief to negotiate the funds that you plan to shift between services for the remainder of FY 2009-10 and for FY 2010-11.

We will also be adding the service function code for Therapeutic Behavioral Services (TBS) to all SFC providers for the Wraparound DCFS Plan, the Full Service Partnership Plan and the Basic Enhanced SFC Plan to support expansion of TBS as needed. If you are currently not a certified TBS provider, trainings for TBS certification will be offered in February and March 2010 with details to follow. If you have any questions about TBS, please contact Elizabeth (Betsy) Fitzgerald at (213) 739-2394.

Please contact your Lead District Chief to discuss a plan for redirection that will ensure full implementation of new and expanded programs without any disruption to services.

Thank you for your ongoing commitment to the children of Los Angeles County and support of the multiple Katie A. related initiatives now underway. Should you have any questions, please contact Olivia Celis at (213) 738-2147.

Sincerely,

Marvin J. Southard, D.S.W.
Director of Mental Health

MJS:OC:cb

c: DMH Executive Management Team
DMH District Chiefs

Appendix 4

TBS MARKETING POINTS

Therapeutic Behavioral Services (TBS)

What is TBS? TBS is a unique, short-term intensive intervention that may be included as one component of a comprehensive mental health treatment plan. TBS provides one-to-one support in helping children/youth replace inappropriate behavior with more suitable behavior.

What is the Emily Q settlement? In response to the Emily Q. v. Bonta class action lawsuit settlement, the California Department of Mental Health and local county Mental Health Plan agencies are working to increase utilization of TBS and ensure accessible, effective, and sustained TBS for children and their families in the Emily Q class in California.

Who is eligible for TBS under the Emily Q settlement?

Children and youth under age 21 receiving EPSDT mental health services who:

- are placed in or are being considered for RCL 12 or higher, or
- have received psychiatric hospitalization in the past 24 months, or
- are being considered for psychiatric hospitalization.

TBS can reduce the need for costly high-level group home placement, hospitalization, or incarceration.

Where can TBS be provided?

Family homes, foster homes, group homes, schools, day treatment programs, and many other places.

Who are the key partners in local TBS delivery?

Mental health agencies, child welfare services, juvenile probation, juvenile courts, schools, Court Appointed Special Advocates, service providers, parents, families, foster families—anyone who works with children or youth at risk of high-level placement because of their mental health behavioral needs.

Help increase TBS in your county.

County mental health departments are convening local TBS discussion and planning sessions with an array of agencies and people to discuss four main questions:

1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?
2. Are the children and youth who get TBS experiencing the intended benefits?
3. What alternatives to TBS are being provided in the county?
4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

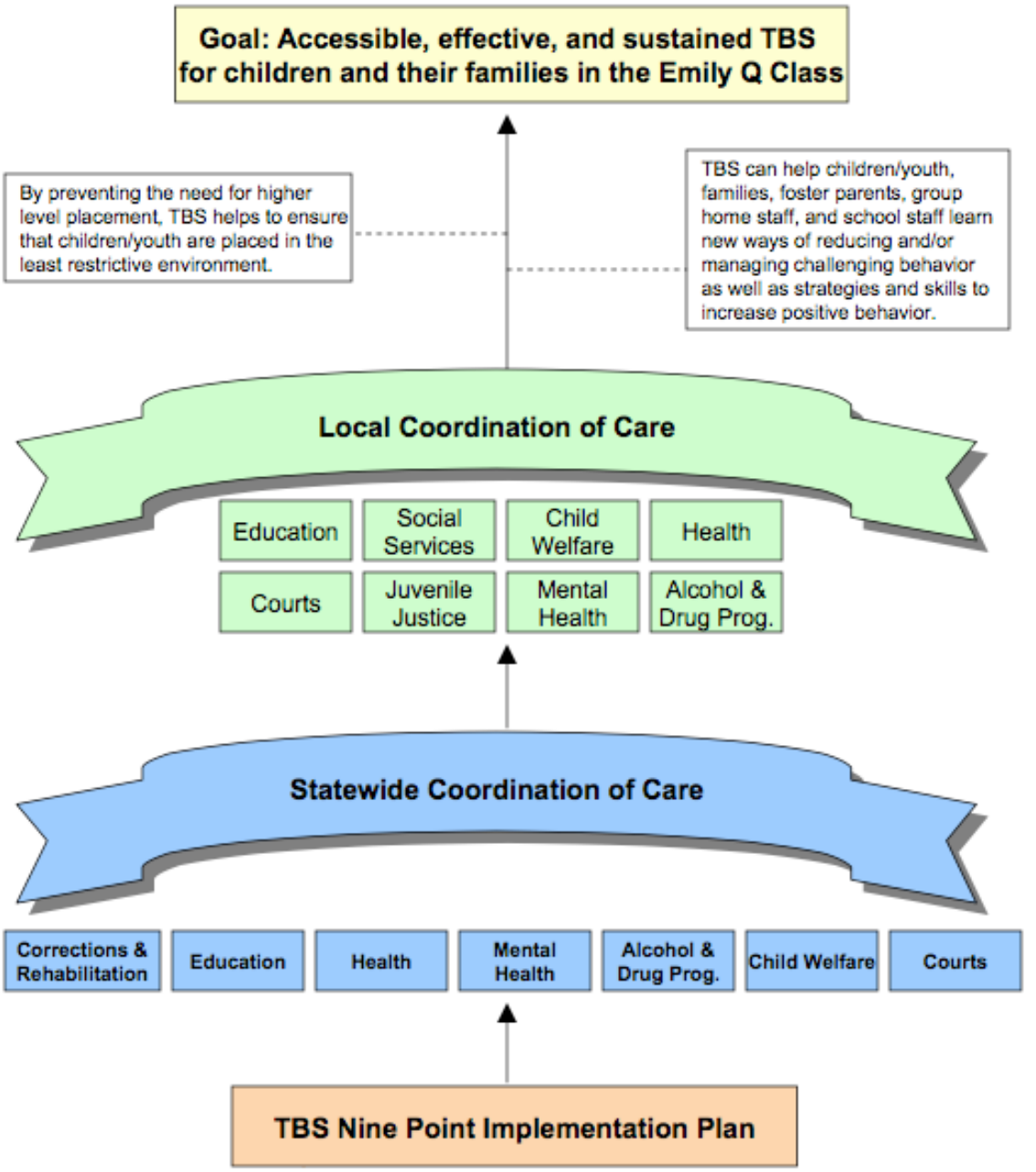
CONTACT YOUR COUNTY MENTAL HEALTH DEPARTMENT for more information about TBS and the TBS planning sessions in your county.

For Additional Information: Visit the California Department of Mental Health TBS website at: **http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp**

Prepared by California Department of Mental Health, March 2009

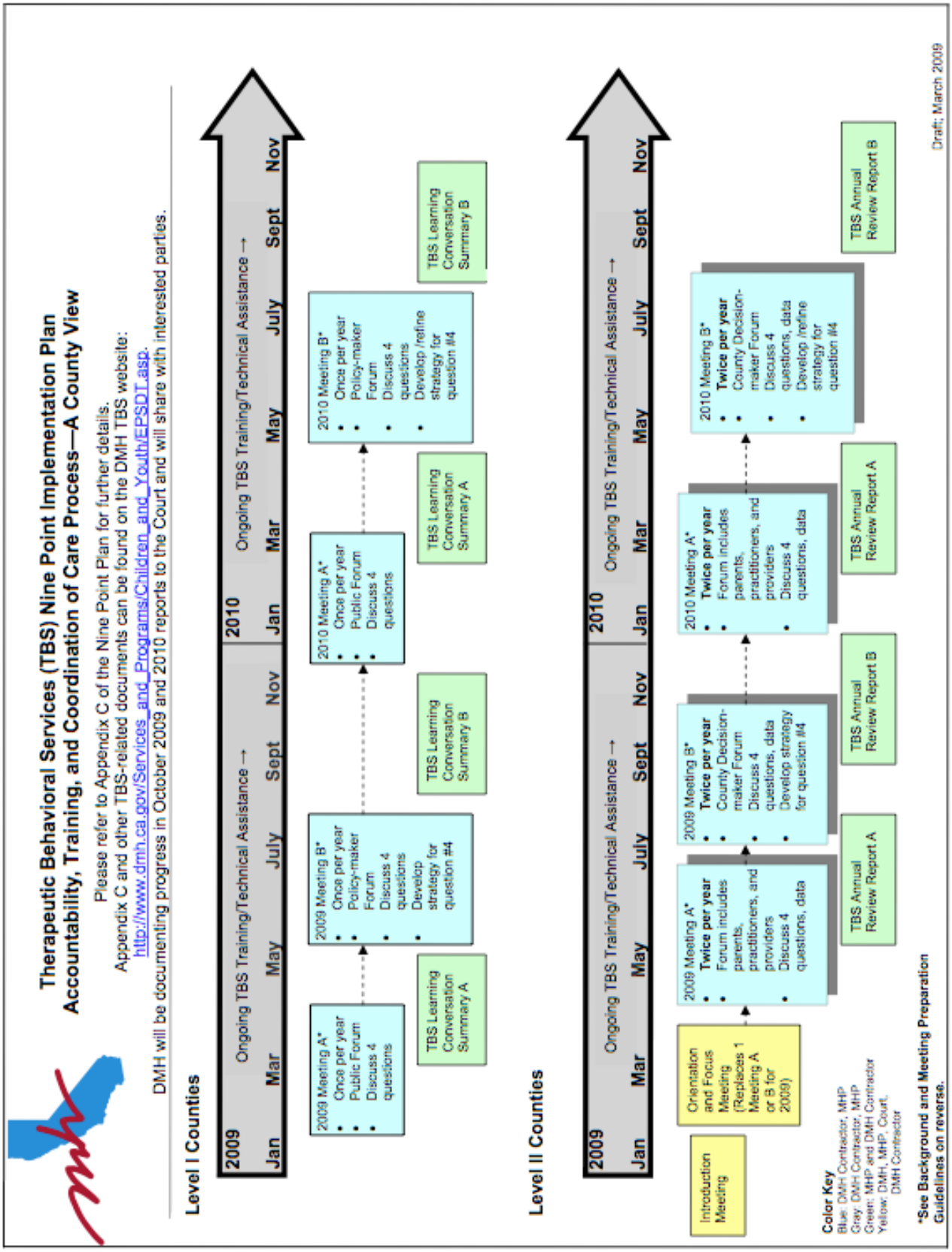
Appendix 5

Strategy to Increase Therapeutic Behavioral Services (TBS) utilization in California



Prepared by California Department of Mental Health, March 2009

How to prepare for successful Learning Conversations: Statewide Practice and Performance Improvement Structure:



- Please review the Nine Point Implementation plan and other important TBS documents posted on the DMH TBS website: http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp.
- Schedule meetings well in advance so that the appropriate policy makers and stakeholders are able to attend.
- Continue and/or expand your current coordination of care efforts with other local partners in TBS delivery who work with youth at risk of high-level placement due to behavioral health needs.
- Think about what actions your county can take to increase access and utilization of TBS by class members.
- As a part of the Statewide Practice and Performance Improvement Structure, Level I and Level II Learning Conversations are designed to bring together public and policy-making stakeholders to consider the following questions:
    1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?
    2. Are the children and youth who get TBS experiencing the intended benefits?
    3. What alternatives to TBS are being provided in the county?
    4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?
- These discussions will inform the TBS Annual Review Report (Level II MHPs) or the TBS Learning Conversation Summary (Level I MHPs) to be generated by the MHP. Report Templates will be posted to the DMH TBS website.
- This process:
    1. ensures TBS are accessible, effective, and sustained as ordered by the court;
    2. includes elements of data review, learning conversations, interagency coordination, and county-state cooperation;
    3. focuses on practice and service coordination rather than compliance and disallowances;
    4. uses a continuous quality improvement process; and
    5. includes outcome and utilization measures.

March 2009

Appendix 6

TBS EQUIVALENT GUIDELINES

Therapeutic Behavioral Services (TBS)

Equivalent/Alternative Certification Guidelines

Purpose: This is designed to assist county Mental Health Plans (MHP) in identifying their proposed services to be considered for certification as a "TBS-equivalent/alternative service" as outlined in the *Emily Q v. Bonta* Exit Plan (April 23, 2009). The Special Master is charged with the review, evaluation, and certification of these services and shall have sole discretion in determining whether these additional programs and services meet the TBS-like criteria. This process is an effort to reasonably account for all mental health services provided by the county MHP that are considered "TBS-like" services. These services will be used as a supplemental utilization rate that will assist counties in attaining the targeted 4% benchmark by June 30, 2012.

Class Eligibility: The TBS-like services must serve the *Emily Q* class. Class eligibility is defined as all current and future beneficiaries of full-scope Medi-Cal below the age of 21 in California who are placed in a Rate Classification Level (RCL) facility of 12 or above and/or a locked treatment facility for the treatment of mental health needs; are being considered for placement in these facilities; or have undergone at least one emergency psychiatric hospitalization related to their current presenting disability within the preceding 24 months.

Elements that must exist to be considered a TBS-Equivalent Service:

- Has a time limited focused on specific target goal attainment;
- Has individual treatment planning created with client, family, and treatment team (behavioral health staff, mental health representative, relatives, school personnel, parent partner, therapeutic aid, etc.);
- Establishes clearly defined measurable behaviors that are used to substantiate progress;
- Provides functional analysis of behaviors to understand needs the client is attempting to address in order to teach healthy replacement behaviors and decrease negative behaviors;
- Focuses on one to two behaviors at a time; and
- Has an intensive intervention schedule, with an emphasis on addressing parent/caregiver education and involvement whenever possible.

If counties have mental health services that are believed to be TBS-equivalent, that would assist your MHP in reaching the 4% benchmark, please contact the *Emily Q v. Bonta* Special Master Rick Saletta at rsalpham@sbcglobal.net.

For technical assistance or information regarding TBS or the *Emily Q v. Bonta* Court Orders, please visit http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp.

Appendix 7

EXIT PLAN for the EMILY Q. V BONTA case

Criteria for Performance and Termination of Jurisdiction

"Exit to Success"

Revised April 7, 2009

For the Court to terminate jurisdiction over the Emily Q. case, the California Department of Health Care Services (DHCS) and the California Department of Mental Health (CDMH) must demonstrate that the Nine-Point Plan approved and adopted by the Court on November 14, 2008, has been implemented and that Therapeutic Behavioral Services (TBS) utilization will be both increased and sustained. This requires performance by CDMH, the Mental Health Plan (MHP) counties that contract with CDMH to deliver TBS at the local level, and the Emily Q. Special Master.

Although the parties are in the early stages of implementing the Nine-Point Plan[1] and the effects of this new plan are as yet unknown, the effort needs an exit plan with specific measures that will guide CDMH and the MHPs through December 31, 2010, the proposed date for termination of jurisdiction. It is likely, as information is gathered and experience is gained, that the Emily Q. Settlement Team and the Special Master may submit to the Court for approval, improvements, modifications, and clarifications to this exit plan that will increase the prospects for successful implementation of the Nine-Point Plan.

During the period of this exit plan, oversight will be provided by the Emily Q.

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[1] A summary of the Nine Point Plan and the specifics of Points 1 through 8 are set forth as an attachment to the Second Quarterly Report in Response to Court's Order Appointing Special Master, filed on September 25, 2008 (Docket No. 544).

Settlement Team members, including the Special Master, and by an array of key stakeholders that are being mobilized for this effort including the Accountability Structure Implementation Strategy (ASIS) and Technical Assistance, Communication and Training (TACT) task groups formed by CDMH. To date, the first eight points of the Nine Point Plan have been developed through consensus among the various parties to the settlement. However, some elements of the exit plan that are essential to Point Nine were not developed through consensus, and the Special Master – building on elements where consensus was reached – has stepped forward to propose an exit plan. As the process moves forward, the Special Master encourages all parties to continue to strive for consensus in their understanding of the process and to remain engaged in this collaborative and cooperative effort to ensure that all children in the Emily Q. class who could benefit from TBS are able to receive the appropriate level of services.

The steps outlined in this exit plan meet the Emily Q. Settlement Team criteria that the plan must: be do-able; not let the perfect be the enemy of the good; be within the law and Court Order; increase utilization; decrease disproportionality between MHPs; show evidence of improvement, both quantitative and qualitative; be aligned with the parties' interests; demonstrate simplicity; be sustainable; and result in faster service access.

This exit plan breaks out areas of responsibility for CDMH, the MHPs and the Special Master according to three time periods: January 2009 through December 2010; January 2011 through December 2011; and January 2012 and forward. In brief, this exit plan describes the following:

Activities for the Period January 2009 through December 2010

- Performance Requirements for CDMH
- Performance Requirements for the MHPs
- Performance Requirements for the Special Master
- Small County Strategy
- Corrective Measures and Remedies
- Termination of Jurisdiction by December 2010

Activities for the Period January 2011 through December 2011

- Performance Requirements for CDMH
- Performance Requirements for the MHPs

Activities for the Period January 2012 and Forward

- Corrective Measures and Remedies
- Emerging Trends and Best Practices

For the Period January 2009 through December 2010

This section of the exit plan describes activities that will take place during the period January 2009 through December 2010, and addresses performance requirements for CDMH, the MHPs and the Special Master, along with corrective measures and remedies available to CDMH, and requirements for termination of jurisdiction to occur by December 2010.

Performance Requirements for CDMH – January 2009 through December 2010

CDMH shall be required to complete the following activities prior to termination of jurisdiction in December 2010.

Implement Points One through Eight of the Emily Q. Nine-Point Settlement Plan

CDMH must fully implement Points One through Eight of the TBS Nine-Point Plan, as follows:

1. Reduce administrative barriers to TBS and not replace them with additional barriers;
2. Clarify eligibility for TBS and not confuse eligibility at a later time;
3. Establish an accountability system capable of determining and documenting TBS services by the MHPs;
4. Establish a fidelity performance model for TBS;
5. Develop coordinated linkages with other state agencies that serve TBS class members, especially the California Department of Social Services, Juvenile Justice agencies, and the Administrative Office of the Courts;
6. Develop and implement a comprehensive training program for TBS providers and administrators at the local level;
7. Develop, publish and maintain training manuals consistent with the comprehensive TBS training program; and
8. Develop and implement a TBS outreach effort to children, families, providers and other stakeholders.

Implement Information Notices Regarding TBS

To inform the MHPs and other stakeholders about the Nine-Point Plan and their responsibilities, CDMH shall maintain communication through a series of information notices.

Implement the State TBS "Data Dashboard"

One key element of the Nine-Point Plan is development of a Web-based "data dashboard" that displays the on-going current progress of all 56 MHPs. CDMH

must establish and maintain this on-line data dashboard system.

Document the MHPs' Ability to Answer the Four Key Accountability Questions Identified in Point Three of the Nine Point Plan

Level I and II MHPs are required to convene meetings to discuss the four key questions regarding TBS service delivery in their respective MHPs. Level I MHPs and the Level II MHPs that are not among the ten Level II counties selected for the more intensive process shall convene two meetings per year. The ten Level II MHPs selected for the more intensive process shall convene four meetings per year. (Specific details regarding the types of meetings and required attendees are set forth in Point Three of the Nine Point Plan. For purposes of this exit plan, these meetings will be referred to as the "Local Meetings.") CDMH must ensure that all MHPs conduct these Local Meetings and that MHP answers to the four questions are publicly posted on the Web.

Sustain the ASIS and TACT Groups

CDMH must sustain the ASIS and TACT Groups, including convening monthly meetings of each group and posting meeting minutes on the Web.

Produce an Annual Assessment of MHP TBS Performance in October 2009 and October 2010

CDMH shall provide the Special Master and the public with two annual assessments describing overall implementation of the Nine-Point Plan, including assessment of MHP progress in meeting the performance requirements established in this proposed exit plan. These annual assessments will provide core information to the Special Master for his reports to the Court regarding overall plan progress as well as progress toward termination of jurisdiction.

Performance Requirements for the MHPs – January 2009 through December 2010

The 27 large- and medium-sized MHPs are required to engage in significant effort to fulfill the Court-ordered Nine-Point Plan. This effort will include striving to increase TBS utilization, implementing quality TBS, engaging policy leaders and other key local stakeholder agencies in the TBS effort, engaging with professional staff and contract providers for TBS training, and engaging with local family members and youth who must be involved in the local TBS effort in meaningful and influential ways.

Factors that the Special Master may consider to evaluate and certify MHP performance are outlined below. As new information and findings emerge over the next year through the Emily Q. Settlement Team, ASIS, TACT, and the support contractors hired by CDMH to work directly with the Level II MHPs, the Special Master may consider additional factors to evaluate and certify MHP performance. It is the Special Master's intention, through a consensus approach, to incorporate into the exit process any additional measures that offer direct or proxy indicators of MHP efforts to achieve and sustain the benchmark requirements. When the Special Master is satisfied with an MHP's performance based on the requirements of the Nine Point Plan and this exit plan as well as consideration of any additional factors, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine Point Plan applicable to that MHP. The Special Master shall send a letter to the Director of CDMH and the Director of the MHP informing them that the certification has occurred, and shall also notify the Court. The Special Master shall have discretion to certify an MHP prior to December 2010.

For the five MHPs that have been exempted from Level II because of current high TBS utilization (4% or above), the Special Master shall review their Level I reports and other documentation to ensure their continuing positive performance with TBS. When the Special Master is satisfied with an exempted MHP's performance, he shall notify the Court and send a letter to the Director of CDMH and the Director of the MHP that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

Each MHP that is certified will count toward the percentage of certified MHPs required by this plan for the Court to terminate jurisdiction.

Four Percent Benchmark for TBS Utilization

With this exit plan, the Court establishes a TBS utilization benchmark for the Level II and exempted MHPs of 4% as calculated by the number of children in an MHP receiving TBS divided by the number of children in that MHP who are receiving EPSDT Mental Health services in a given year. This TBS utilization benchmark will apply to the 27 large- and medium-sized MHPs, which represent all 22 Level II MHPs plus the 5 exempted MHPs; together, these 27 MHPs serve approximately 92% of the children who receive EPSDT Mental Health services in the State of California.

Strive to Increase TBS Utilization to the 4% Benchmark

All large- and medium-sized MHPs[2] are strongly encouraged to achieve the 4%

[2] The 27 MHPs that are classified as "large- and medium sized" for purposes of the Nine Point Plan are: Los Angeles, San Diego, San Joaquin, Sonoma, Butte, Alameda, San Bernardino, Kern, Monterey, Tulare, Fresno, Marin, Merced, Orange, Placer/Sierra, Riverside, Sacramento,

benchmark. For the Court to terminate jurisdiction by December 31, 2010, two-thirds (18) of the 27 large- and medium-sized MHPs must have reached the 4% TBS delivery threshold. If the Special Master determines that all other requirements are met, the Special Master shall certify an MHP that has achieved the 4% benchmark. If an MHP has met all other requirements, but has not achieved the 4% benchmark, the Special Master shall certify the MHP if the MHP demonstrates to the Special Master that it offers services equivalent to therapeutic behavioral services to Emily Q.. class members, and/or demonstrates that the MHP is on a trajectory to achieve the 4% benchmark no later than June 30, 2012. The Special Master shall have discretion to determine whether one or both of these additional criteria will be required in order to certify the MHP, and shall have discretion to look at TBS utilization rates prior to the start of the Nine Point Plan in determining the trajectory. Although being on a trajectory to achieve the 4% benchmark is one avenue for certification, it should be understood that an MHP would have to demonstrate through data and service integrity that certification is appropriate.

The Special Master anticipates that the successful implementation of the Nine-Point Plan will result in, at a minimum, 18 of the 27 certified MHPs achieving the 4% benchmark, and that these MHPs will represent a substantial percentage of all children in California who receive EPSDT Mental Health services. At this time the Special Master will not recommend a fixed percentage of children that must be represented throughout the state. The Special Master will instead wait 12 months and observe the overall impact of the Nine-Point Plan on the utilization benchmark.

San Francisco, San Mateo, Santa Cruz, Solano, Stanislaus, Contra Costa, San Luis Obispo, Santa Barbara, Santa Clara, and Ventura.

At that time it may not be necessary to recommend to the Court a minimum statewide percent of all children in California who receive EPSDT Mental Health services. Special Master Saletta places confidence in the commitment of CDMH, the California Mental Health Directors Association (CMHDA), and the MHPs to fulfill these expectations through the Nine-Point Plan process.

Implement Quality TBS to the Satisfaction of the Special Master

Quality of TBS will be determined by several factors including:

- Fidelity to Point Four of the Nine-Point Plan as a practice standard in the MHP;
- Participation of staff and providers in the TBS training and use of the TBS Manuals described in Points Six and Seven;
- Family and youth participation in the Local Meetings;
- Analysis and documented review of the TBS data dashboard as a required tool in the Local Meetings.

MHPs demonstrate their ability to accurately employ procedure codes, cost reports and CSI data reporting for TBS services.

The Nine-Point Plan includes a streamlined administrative process, which will involve some changes in administrative procedures associated with TBS. MHPs will demonstrate their ability to implement continuing and new procedures to the satisfaction of CDMH.

Engage Other Key Local Stakeholders

The MHP will demonstrate participation of key local stakeholders in the TBS effort, including county Child Welfare Services, Juvenile Probation, the Juvenile Court (dependency and delinquency), and the County Office of Education,

through:

- Stakeholder and policy leaders' attendance at the Local Meetings;
- Increased referrals from these stakeholders of Emily Q. class members for TBS;
- Increased TBS utilization by children referred from other county agencies.

Demonstrate commitment to outreach to, provide TBS training to, and engage with professional staff and contract providers in the MHP.

Outreach to, training of and engagement with professional staff and contract providers will be demonstrated by the following:

- Participation of MHP and contract provider staffs in local TBS trainings;
- Medi-Cal Quality Assurance activities that indicate inclusion of local TBS providers;
- Ad hoc meetings between the MHP and local TBS providers to promote the Nine-Point Plan and improve local TBS efforts.

Demonstrate commitment to outreach to, provide TBS training to, and engage with family members and youth in the MHP.

Outreach to, training of and engagement with family members and youth will be demonstrated by the following:

- Participation of family members and youth in local TBS trainings;
- Medi-Cal Quality Assurance activities that indicate inclusion of family members and youth;
- Ad hoc meetings between the MHP and local family members and youth to promote the Nine-Point Plan and improve local TBS efforts.

Performance Requirements for the Special Master – January 2009 through December 2010

The Special Master assumes oversight obligations in partnership with the various parties, and shall perform the following activities that lead to termination of jurisdiction in December, 2010. As noted above, there are three bases for MHP certification: meeting or exceeding the 4% benchmark, providing TBS and TBS-equivalent services to meet the 4% benchmark, and being on a trajectory to reach the 4% benchmark. The criteria for certification for each of these categories are as follows:

MHPs That Meet or Exceed the 4% Benchmark

The Special Master shall review progress by the 27 large- and medium-sized MHPs toward completing their requirements as described above and as detailed in the Nine Point Plan. Specifically, the Special Master shall determine whether or not an MHP has achieved the 4% utilization benchmark, implemented quality TBS, engaged other key local stakeholders and policy leaders, engaged with professional staff and contract providers, and engaged with local family members and youth as outlined above. When the Special Master is satisfied that an MHP has fulfilled these expectations, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

MHPs That Provide TBS-Equivalent Services to Meet or Exceed the 4% Utilization Benchmark

Some of the 27 large- and medium-sized MHPs may request that the Special Master consider certification based on a combination of TBS and TBS-equivalent services, such as one-to-one behavioral intervention programs that may be part of a

non-Medi-Cal full service partnership funded through the Mental Health Services Act (MHSA) or SB-163 Wraparound, etc., to Emily Q.. class members. The Special Master shall determine whether or not a proposed TBS-equivalent service is consistent with the best practice of TBS and, at his discretion, may count class members who receive a TBS equivalent service toward the total number of class members served. If the Special Master is satisfied that an MHP has met the 4 % utilization requirement through some combination of TBS and TBS-equivalent services, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

MHPs That Are on a Trajectory to Reach the 4% Benchmark by June 30, 2012

The Special Master shall work with MHPs to determine whether or not an MHP is on a trajectory to reach the 4% benchmark by June 30, 2012. The Special Master shall review progress by the MHPs toward completing their requirements as described above. Specifically, the Special Master shall determine whether or not an MHP has implemented quality TBS, engaged other key local stakeholders and policy leaders, engaged with professional staff and contract providers, and engaged with local family members and youth as outlined above. In addition to these requirements, the Special Master may take into consideration any or all of the following elements in determining if an MHP is on track to meet the 4% benchmark by June 30, 2012:

- The MHP has demonstrated a significant increase in TBS and/or TBS-equivalent services to Emily Q. class members, and can document that these percentage and numeric increases, if sustained, will reach the 4% benchmark by June 30, 2012. Specifically, and in measurable terms, the MHP must show that the rate of growth achieved during 2009 and 2010 will be sustained and will result in the MHP achieving the 4% benchmark by June 30, 2012.

- The MHP has demonstrated a significant increase in TBS and/or TBS-equivalent services to Emily Q. class members, but the existing percentage and numeric increases in TBS and/or TBS equivalent services will not reach the 4% benchmark by June 30, 2012. In that event, the Special Master may consider whether commitment of additional resources on the part of the MHP will result in increased services, so that the MHP will reach the 4% benchmark by June 30, 2012. The Special Master may consider certification in such a situation, provided the MHP: provides official documentation that adequate and appropriate resources have been committed for this purpose; the MHP demonstrates that the percentage and numeric increases, if sustained, together with the additional resources committed, will allow the MHP to reach the 4% benchmark by June 30, 2012; and the Special Master believes that with the commitment of these additional resources, the MHP will achieve the 4% benchmark by June 30, 2012.
- The MHP has documented budget and contract commitments that will lead to increased TBS or TBS-equivalent services.
- The MHP can demonstrate and document that it is giving class members priority access to TBS or TBS-equivalent services.
- The MHP documents working agreements that have led, will continue to lead, or will lead to an increase in TBS or TBS-equivalent services among county child welfare and probation agencies.

In order to ensure maximum flexibility for the Special Master to certify an MHP based on its trajectory, the Special Master reserves the right to consider additional measures and approaches.

When the Special Master is satisfied that an MHP has met these requirements, and

the other requirements of the Nine Point Plan and this exit plan, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP. Once an MHP is certified, it shall be counted toward the percentage of MHPs required for termination of jurisdiction.

For the five MHPs that have been exempted from Level II because of current high performance, the Special Master shall review their Level I reports, the data dashboards and other documentation to ensure their continuing positive performance with TBS. When the Special Master is satisfied that an MHP has fulfilled these expectations, he shall certify that CDMH and the individual MHP have succeeded in meeting the requirements of the Nine-Point Plan applicable to that MHP.

The Special Master shall utilize the CDMH October 2009 Report, experiences and perspective of the Emily Q. Settlement Team, and other factors, to make any necessary recommendations to the Court in January 2010.

Small County Strategy

By February 2010, CDMH, in consultation with CMHDA and the Special Master, shall convene a joint meeting with the 29 Level I small and small/rural county MHPs[3] to explore their experience to date with the Emily Q. Settlement Plan and to identify their needs for additional supports and services from CDMH. The goal of this meeting will be to develop, through a consensus approach, a small/rural

[3] The 29 small and rural MHPs are: Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Siskiyou, Sutter/Yuba, Tehama, Trinity, Tuolumne, and Yolo.

county-centered strategy to ensure the most appropriate utilization and quality of TBS in those regions. The Special Master shall have discretion to include participation of other appropriate individuals or organizations in this meeting.

Corrective Measures and Remedies

During the period January 1, 2009 through December 31, 2010, corrective measures and remedies will only be exercised for MHPs that are not participating in their respective requirements as outlined in the Nine-Point Plan. These measures and remedies are outlined in the next section of this exit plan.

Termination of Jurisdiction by December 2010

The Special Master shall recommend that the Court terminate jurisdiction when he finds that:

- CDMH has fully implemented Points One through Eight of the Nine-Point Plan; and
- Two-thirds of the large-and medium-sized MHPs (18 MHPs) have been certified by the Special Master as having fulfilled the benchmark requirements, and have established the necessary conditions in the MHP to ensure sustained commitment to utilization, quality, performance, training, and engagement.

For the Period January 2011 through December 2011

Performance Requirements for CDMH – January 2011 through December 2011

Upon termination of jurisdiction (December 31, 2010), CDMH shall assume responsibility for certifying MHPs as having completed their respective requirements as described in the Emily Q. Settlement Plan. CDMH shall maintain

the TBS or TBS-equivalent effort following termination of jurisdiction.

CDMH Support to MHPs that are Making Progress Toward Certification and Certified MHPs on a Trajectory to Reach the 4% Benchmark by June 30, 2012

During 2011, the first year following termination of jurisdiction, CDMH shall provide support to MHPs that are making progress toward certification. CDMH shall also provide support to MHPs that were certified by the Special Master because they were on a trajectory to reach 4% by June 30, 2012, if support is needed to help those MHPs to achieve the 4% benchmark by June 30, 2012. Support provided by CDMH through December 31, 2011, shall include assistance to the MHPs from CDMH's accountability contractor.

CDMH Review of Previously Certified MHPs

In October 2011, CDMH shall review the performance of MHPs that were previously certified by the Special Master. If an MHP that was previously certified because it reached the 4% benchmark or was providing TBS-equivalent services experiences a decline in services that causes it to fall below the 4% benchmark CDMH shall work with the MHP to increase either TBS or TBS-equivalent services to re-achieve the 4% benchmark. If an MHP that was previously certified because it was on a trajectory to reach the 4% benchmark is not making adequate progress to achieve the 4% benchmark by June 30, 2012, CDMH shall work with the MHP and provide support with the goal of bringing the MHP back in line with the expected trajectory. Through December 31, 2011, support to the MHPs described in this paragraph shall include assistance from CDMH's accountability contractor if such assistance is needed to help MHPs re-achieve the 4% benchmark, or to resume progress toward the trajectory to reach the 4% benchmark by June 30, 2012.

Corrective Measures and Remedies

MHPs that were not certified as of December 31, 2010, and are not making progress toward certification as described above during the January 1, 2011 through December 31, 2011 time period shall be subject to corrective measures and/or sanctions. CDMH shall impose an array of appropriate corrective measures including technical assistance and the remedies in the state mental health managed care regulations [Cal. Code of Regs., Tit. 9, § 1810.325, 1810.380 1810.385.], including site visits, Performance Improvement Plans, monitoring, imposition of corrective action plans, withholding Federal Financial Participation revenues, termination of the MHP's managed care contract and civil penalties against the MHP of up to $5,000.

Review and Revision of the TBS Plan

Following termination of jurisdiction, CDMH, with input from key TBS stakeholders, will review and revise the Nine-Point Plan to sustain and improve TBS utilization, quality, training and engagement as the TBS effort matures in California.

Performance Requirements for the MHPs -- January 2011 through December 2011

For the period January 2011 through December 2011, MHPs that were not certified as of December 31, 2010, and are not making progress toward certification (as described above) during the January 1, 2011 through December 31, 2011 time period shall be subject to corrective measures and remedies as outlined above.

For the Period of January 2012 and Forward

Corrective Measures and Remedies

Beginning January 2012, supports through a CDMH contractor to non-certified MHPs and to those previously certified but who fell below the 4% benchmark or failed to maintain a trajectory to reach the 4% benchmark by June 30, 2012 , (as described above) will end. The only intervention CDMH will offer to non-certified MHPs will be the corrective measures and remedies outlined above.

In the event that an MHP previously certified because it achieved the 4% benchmark or provided TBS-equivalent services reduces its TBS effort (or reduces TBS-equivalent services) such that it falls below the 4% benchmark, reduces the quality of its TBS services, disengages from its local agency partners, or disengages from its family members and youth, CDMH shall impose corrective measures and/or remedies outlined above that CDMH deems appropriate, with the goal of restoring the MHP to its former level of success in TBS.

With respect to MHPs previously certified because they were on a trajectory to reach the 4% benchmark by June 30, 2012, from January 1, 2012 through June 30, 2012, CDMH will continue to provide support and assistance to these MHPs as necessary to assist them in achieving the 4% benchmark by June 30, 2012. In the event that an MHP previously certified because it was on a trajectory to reach the 4% benchmark by June 30, 2012, fails to meet the 4% benchmark by June 30, 2012, reduces the quality of its TBS services, disengages from its local agency partners, or disengages from its family members and youth, CDMH shall impose corrective measures and/or remedies outlined above that CDMH deems appropriate, with the goal of restoring the MHP to its former level of success in

TBS. CDMH shall have discretion to determine which corrective measure(s) and/or remedy(ies) will be imposed.

Emerging Trends and Best Practices

CDMH shall continue to promote and develop TBS to members of the Emily Q. class with the intent of sustaining TBS utilization, quality, partner engagement, and family member and youth participation. It is expected that TBS will be developed and refined as more is learned about successful therapeutic behavioral supports and interventions. With regard to improvements in TBS, CDMH is encouraged to adopt promising trends and new best practices as these emerge, with the intent of continuously improving TBS and TBS-equivalent services to members of the Emily Q. class. It is the intention of this exit plan that CDMH will maintain a competent and effective statewide TBS program from January 2012 into the future that is sufficient to meet the ongoing needs of Emily Q. class children and prevent any recurrence of litigation for failure to serve members of the class.

If a new Medi-Cal behavioral intervention service is approved in the future, and it is determined by CDMH to be an equivalent to TBS that affords children, youth and families the same level of engagement, quality and effectiveness as TBS, CDMH should not be constrained by the post-jurisdiction requirements described above from providing the best possible behavioral services and supports.

Appendix 8

FAMILY AND YOUTH STRATEGY FOR TBS

Therapeutic Behavioral Services (TBS)
Development of the Family and Youth Strategy

CDMH Contact – Kathleen Carter Nishimura
(916) 651-6613

Background: In November 2008, United States Central District Court Judge A. Howard Matz approved a "TBS Nine-Point Plan" that establishes methods and measures to increase access and utilization of Therapeutic Behavioral Services (TBS) in California.

Important themes of the Nine-Point Plan are family and youth involvement and consistent application and awareness of cultural competency practices and services. The TBS Family and Youth Strategy supports implementation of:

- Point 3 – informing about TBS;
- Point 6 – encouraging and empowering family and youth to engage at the local level;
- Point 8 – training and building parent and youth capacity.

The plan was developed through an interest-based decision-making process facilitated by the Court's Special Master, Richard Saletta, to help resolve the issues of a decade-long lawsuit, Emily Q v. Bonta. The California Department of Mental Health (CDMH) continues to support the plan along with its contractors, the California Department of Health Care Services (CDHCS), the Emily Q Settlement Team, and a stakeholder-consultant group known as the TBS Accountability, Communications and Training (Super TACT) Team.

In 2009, CDMH recognized a need to promote strategies, identify models, and encourage counties to increase family and youth involvement and cultural competency through the stakeholder and decision-maker reports submitted as a result of the TBS Nine-Point Plan. Consequently, CDMH and the Super TACT Team began discussing various ways to address these needs and support counties and consumers in a productive dialogue and action plan for TBS.

2009–2010 Activities:

- In March 2010, CDMH presented to the Federal Court and public a *TBS County Mental Health Plan 2009 Progress Report*. Two of the applicable program report criteria for the counties in 2009 and 2010 include: 1) convening TBS Stakeholder meetings and 2) convening TBS Decision-Maker meetings. The meetings were evaluated on the content of the reports submitted to CDMH, including family and youth participation.
- Continued CDMH monitoring and offer for technical assistance to support the MHP TBS reports for family and youth Stakeholder and Decision-Maker participation in 2010;
- Development of a family/youth-focused marketing letter to support TBS and the Nine-Point Plan which was distributed to a statewide family partner network and TACT contact list;
- Addition of a "Family & Youth" icon on the CDMH TBS website to ensure materials are available in a user-friendly manner;

- Outreach and education for family and youth members will be a standard component of the CDMH e-newsletters;
- Release and marketing of a TBS Coordination of Care Best Practices Manual with the guidance of consumers, family and youth advocates/organizations;
- Presented at the May 2010 UACF Family Partner breakfast (California Mental Health Advocates for Children and Youth (CHMACY) Annual Conference) about team outreach/recruiting;
- Initiate conversations about creating family/youth action and network groups; and
- Submitted update to the Family and Youth Strategy Workgroup, Super TACT and Emily Q Settlement Team in April 2010 for feedback.

Strategy Development:

The CDMH and Emily Q Settlement Team are developing the "California TBS Family and Youth Strategy" in an effort to increase the meaningful involvement, outreach, and engagement with family and youth members in a culturally competent manner.

In January 2010, CDMH recommended that the Super TACT form a workgroup to develop a family and youth strategy. The goal of the Workgroup discussions was through a consensus approach, to engage family and youth in a culturally competent way to promote the Nine-Point Plan and to improve local TBS efforts.

The TBS Family and Youth Strategy Workgroup convened in February, March, and April 2010 and have developed a framework to design the strategy. CDMH is appreciative for the participation of those who were able to provide input at the April brainstorming meeting. Representatives of the major stakeholder groups have been invited to participate in this Workgroup to plan, develop and execute the release of a strategy.[1]

However, the Workgroup identified that in order for the strategy design to be successful and meet the needs of the TBS community, the input and participation from the following mental health consumer and county groups would strengthen the strategies and activities: United Advocates for Children and Families (UACF); National Alliance on Mental Illness (NAMI); the Client Network; County MHPs; California Mental Health Directors' Association (CMHDA); California Welfare Directors' Association (CWDA); and other key stakeholders may include the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, and other specific TBS private providers.

The CDMH is grateful for the support it has received from private providers who have experience working with families and youth and who have invested their expertise and time to help develop this strategy. Cindy Robbins-Roth, Amber Burkan of the California Youth Empowerment Network (CAYEN) and APS Healthcare were very helpful in pulling together their resources to work on the strategy and identifying valuable contacts during our initial spring 2010 meetings.

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[1]The following stakeholders were represented: Rick Saletta, Special Master; Melinda Bird, Disability Rights California; Amber Burkan, California Youth Empowerment Network (CAYEN); Kathleen Carter Nishimura, CDMH Community Services; David Gray, Facilitator; Troy Konarski, CDMH Community Services; Steve Korosec, Facilitator; Rita McCabe, CDMH Community Services; Mike Reiter, APS; Cindy Robbins-Roth, Parent/Family Partner; Gail Schifsky, CDMH Community Services; Nicette Short, Policy Advocate; Sean Tracy, CDMH Community Services; Melinda Vaughn, DOF and Barbara Zweig, CDMH Legal Services.

Proposed Workgroup Strategies:

In an effort to address the above mentioned challenges and assist the counties, CDMH is offering this framework for the Family and Youth Strategy which is designed to inform about TBS, encourage and engage at the local levels as partners in TBS, and training and building parent and youth capacity in all aspects of TBS. The proposed strategies include:

- Information and Communication
- Engaging with Parents and Parent Organizations
- Partnering with Other Service Agencies
- Family, Youth and MHP Training
- Evaluation

Next Steps:

In order for CDMH to finalize and implement the strategy, the next steps could include:

- Holding additional Workgroup meetings in Summer 2010 to develop the strategy and further engage key family and youth stakeholders to participate provide input to the strategies;
- Proposing the final draft strategy at the August 2010 Super TACT and Emily Q Settlement Team meetings;
- Releasing the strategy to the public and implement, as appropriate; and
- Providing a report to the Federal Court about Points 3, 6 and 8 of the Nine-Point Plan by or in December 2010.

Contact Information:

If you are interested in participating or learning more about this strategy, please contact Kathleen Carter Nishimura at Kathleen.Carter@dmh.ca.gov or (916) 651-6613.