Therapeutic Behavioral Services
2009 Community Stakeholder Meeting
Report

October 22, 2009

Submitted By:
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Child and Adolescent Program Chief
Contra Costa County Health Services
Mental Health Division

CONTRA COSTA
HEALTH SERVICES

CONTRA COSTA COUNTY TBS STAKEHOLDERS MEETING

OCTOBER 22, 2009

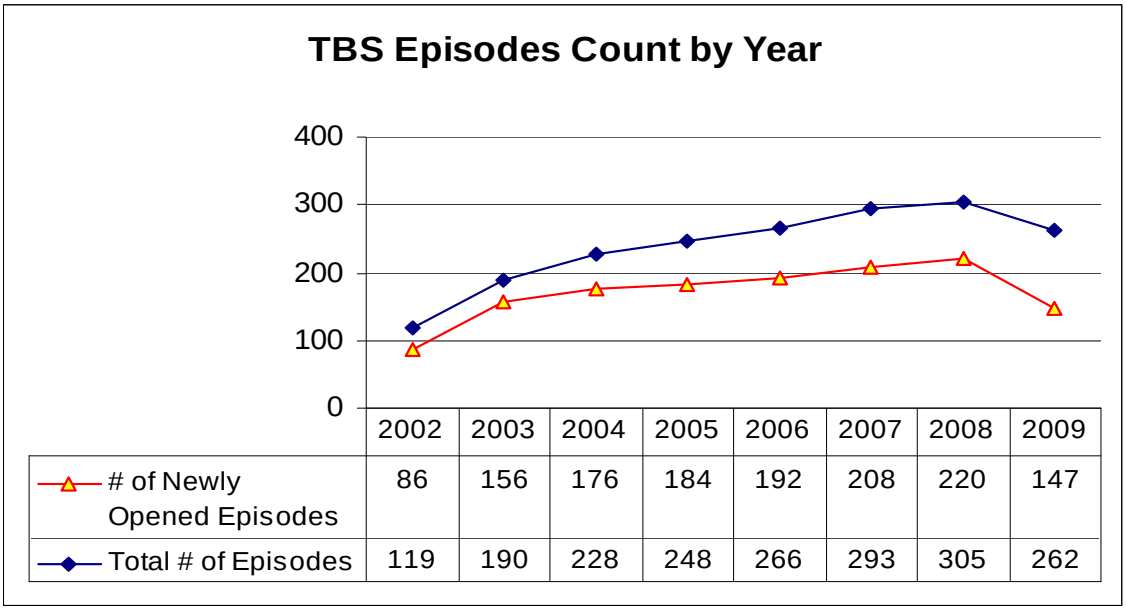
Submit completed form to: **TBS@dmh.ca.gov**.

Attendees numbered approximately 35. Four Hundred announcements were sent out to stakeholders. Information was also placed on the Mental Health Division Web site and at each of the Children's Services sites. Attending were TBS Supervisors, Coaches, Directors, clerical staff, a lawyer/advocate, consumers, new county staff and administration. Everyone was introduced and invited to share their favorite TBS story.

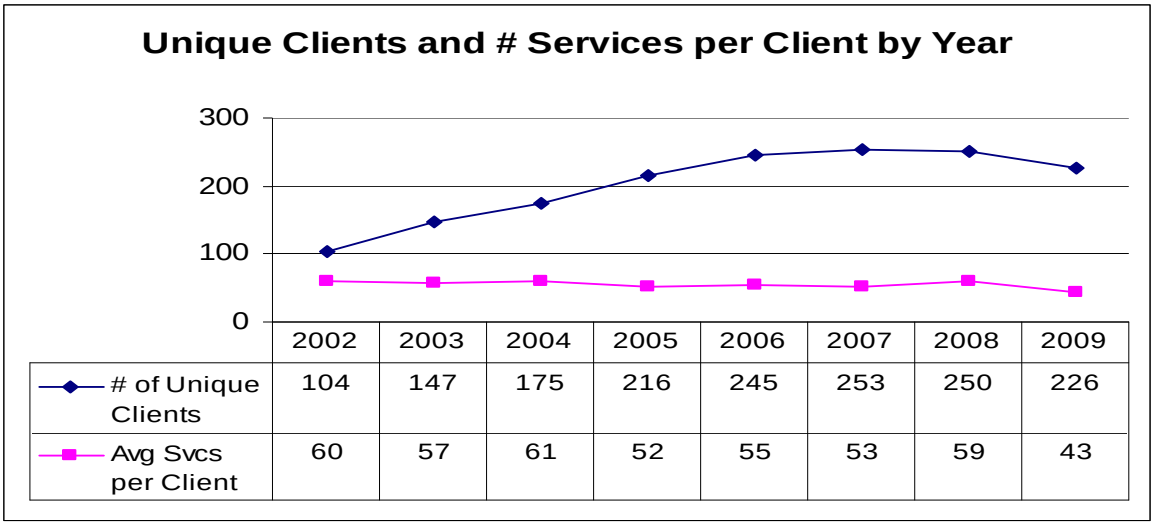
Agenda and Panel Participants
Introductions – Vern Wallace, Chief of Children's Mental Health
Assessment and Intake – Sharon Cuthbertson, LMFT, Team Leader of TBS
Eligibility and Authorization – Bles Surio, RN, Supervisor of Utilization Review
Interagency TBS – Rich Weisgal, Program Manager for TBS
Training – Dr. Sherry Burke, Consultant to TBS
TBS Outcomes – Vern Wallace

1. ***Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?***

Class beneficiaries are clearly receiving and benefitting from the service. Contra Costa County continues to reach a target population over the 5% requirement. Growth has been consistent each year from 30 cases in 2002 to 135-145 active cases now. Projection would put the actual client count at approximately 150-200 upon the completion of the fiscal year.



	2002	2003	2004	2005	2006	2007	2008	2009
# of Newly Opened Episodes	86	156	176	184	192	208	220	147
Total # of Episodes	119	190	228	248	266	293	305	262



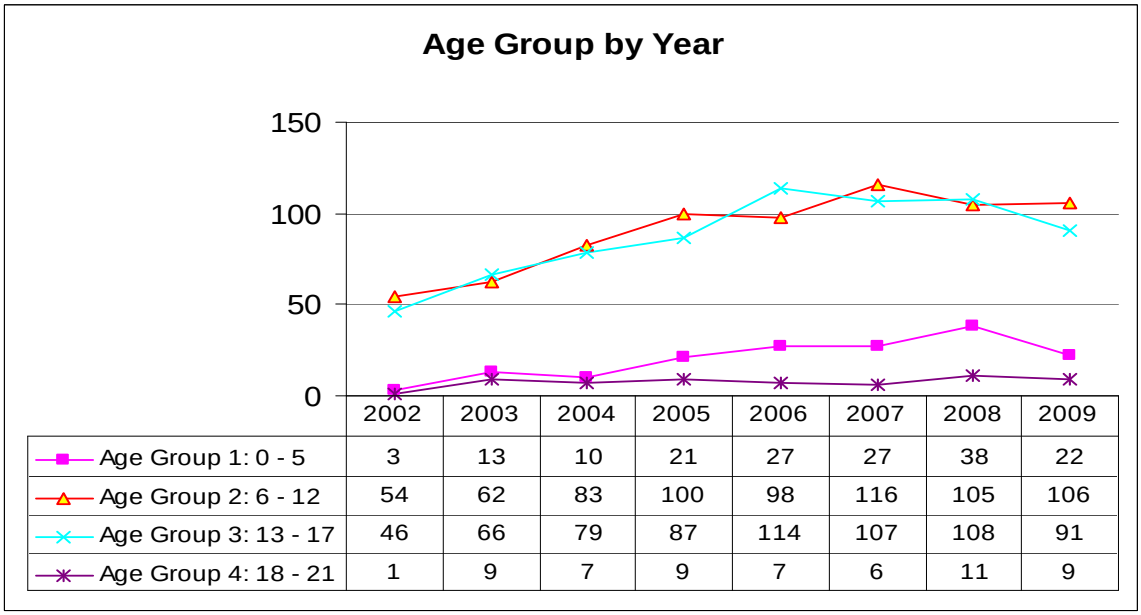
	2002	2003	2004	2005	2006	2007	2008	2009
# of Unique Clients	104	147	175	216	245	253	250	226
Avg Svcs per Client	60	57	61	52	55	53	59	43

POPULATIONS TARGETED

TBS Contra Costa serves youngsters who are Medi-cal beneficiaries and are at immanent risk of placement or hospitalization. Of active cases, our youngsters average over 72% in community homes including foster, adoptive, and biological homes. About 20% of active cases are in high level group placements. The remaining 8% are in board and care, TAY housing, or lower level group homes.

AGE

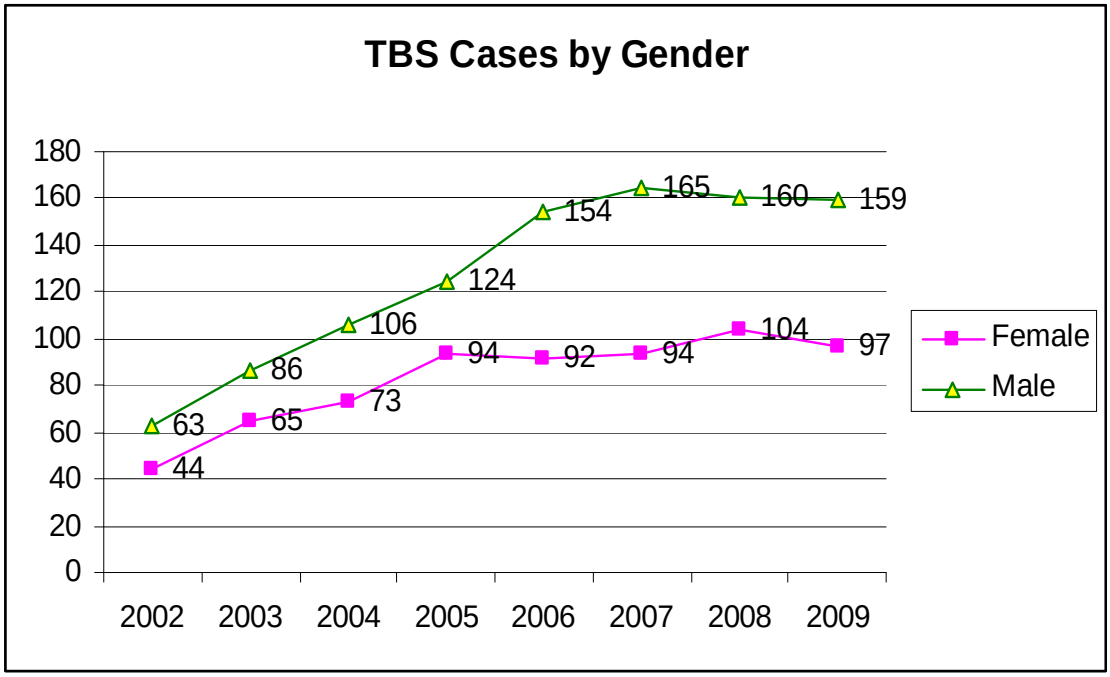
Age breakdown is 10-15% for the 0-5 age group. The latency group is 6-12%, and the teen group, from 13-17, varies from 40-45% of all cases. The remaining few consumers (usually 2-4% percent) are in the over 18 population. This is a pattern that is likely to continue given the large number of school based programs in the county at all age levels. Additionally, we also expect an increase in TAY participants in TBS as our TAY MHSA programming develops.



	2002	2003	2004	2005	2006	2007	2008	2009
Age Group 1: 0 - 5	3	13	10	21	27	27	38	22
Age Group 2: 6 - 12	54	62	83	100	98	116	105	106
Age Group 3: 13 - 17	46	66	79	87	114	107	108	91
Age Group 4: 18 - 21	1	9	7	9	7	6	11	9

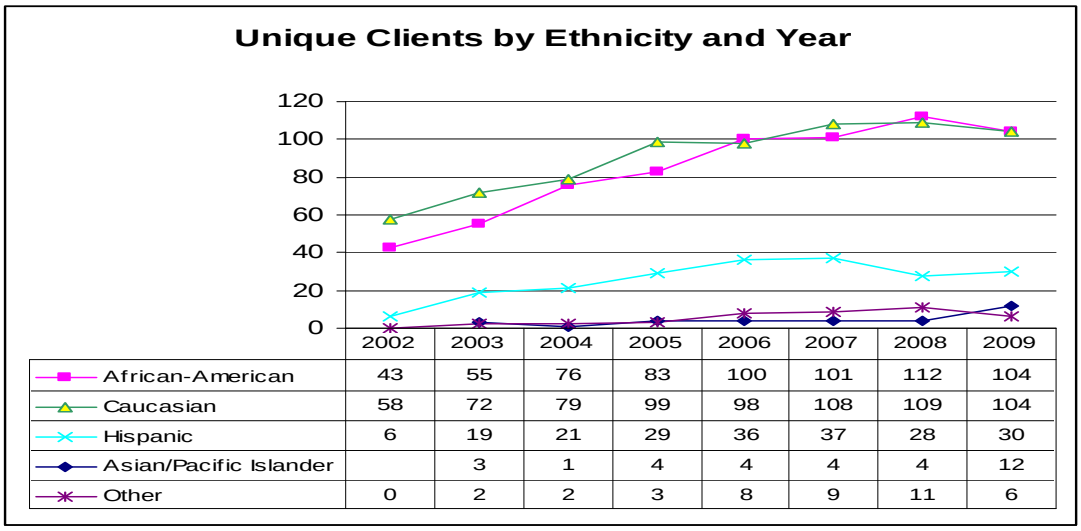
GENDER

Boys are usually represented 2:1 in most behavioral health programs. Not to change this tradition, boys are far more represented in the sample requiring TBS services. This is primarily due to the increased acting out behavior of young boys which comes to the attention of adults more readily. Girls exhibit more internalizing behavior and tend to go unnoticed for a longer period of time.



DIVERSITY

Race and Ethnic Diversity covers the county census, in terms of variation, and we have TBS coaches, in most cases, to match this diversity. Family Partners are part of the treatment team and are also matched, whenever possible, to the Family in terms of ethnicity, language capacity, family constellation, etc. Languages served included Spanish, Hindu, various dialects of Chinese and American Sign Language.

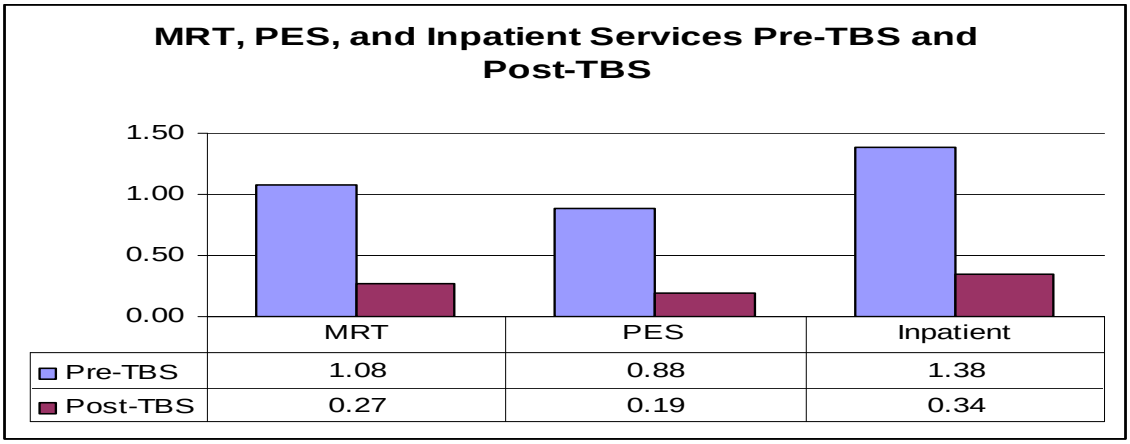


	2002	2003	2004	2005	2006	2007	2008	2009
African-American	43	55	76	83	100	101	112	104
Caucasian	58	72	79	99	98	108	109	104
Hispanic	6	19	21	29	36	37	28	30
Asian/Pacific Islander		3	1	4	4	4	4	12
Other	0	2	2	3	8	9	11	6

2. *Are the children and youth who get TBS experiencing the intended benefits?*

In the five TBS contracted agencies in county, over half of the workers have Master's degrees in progress or completed. We have 2 Coaches with completed doctorates and a few licensed coaches. All of our Supervisors are registered with the BBS and we had at last count 13 registered Interns. Attendance at the monthly trainings is 40-45.

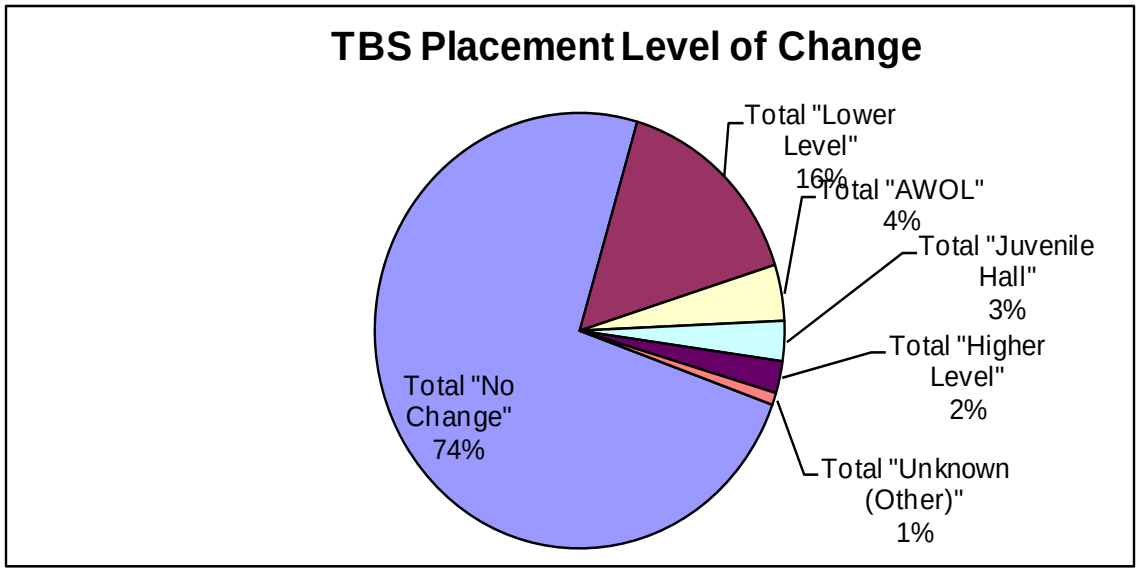
Emergency contacts, one measure of "benefit", were positively affected by TBS with a decrease in Mobile Response Team contacts, Emergency Room visits and actual in-patient hospitalizations after TBS compared to a similar time frame before TBS.



	MRT	PES	Inpatient
Pre-TBS	1.08	0.88	1.38
Post-TBS	0.27	0.19	0.34

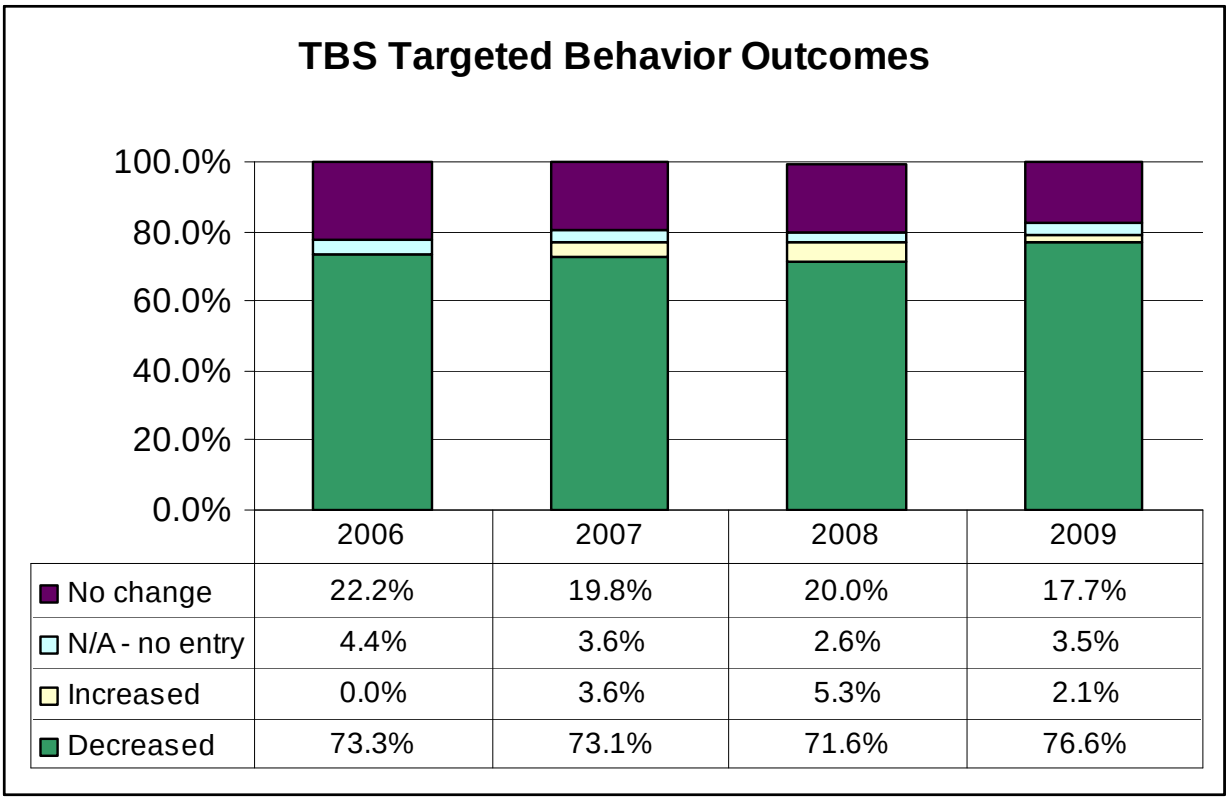
PLACEMENT

At termination of TBS 74% had maintained their placement.
Additionally over 15% had been moved to a lower level of placement.
The remaining cases ended in Juvenile Hall, AWOL, at a higher level of care, or "other".
Some cases had lost Medi-Cal.



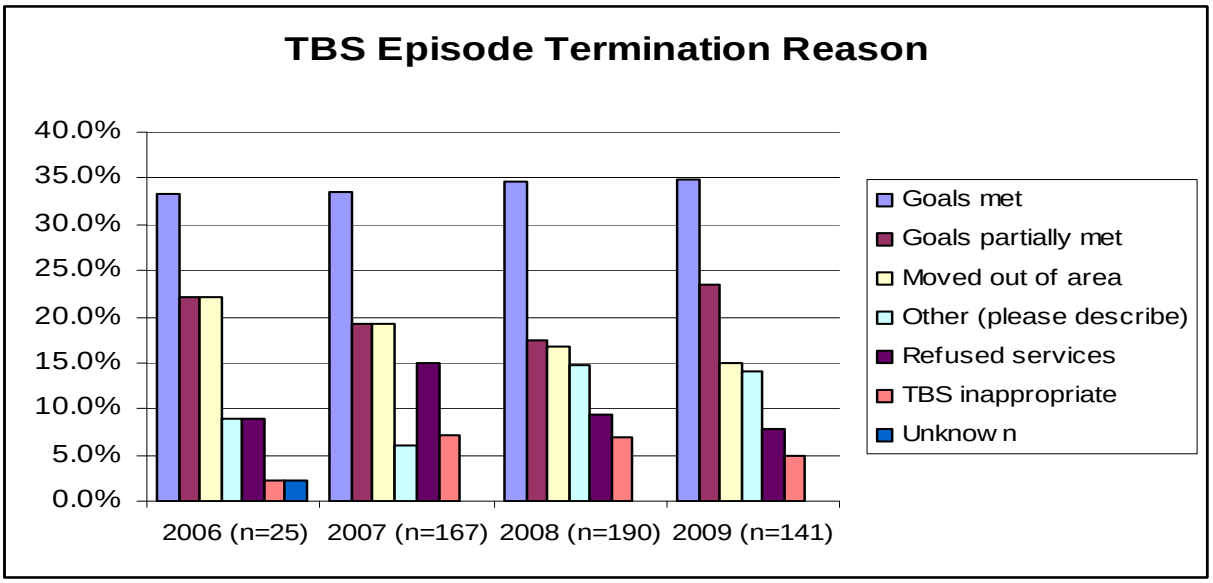
BEHAVIORAL GOALS

Outcome data indicates that over 30% of cases met their behavioral goals with over 20% more partially meeting goals. Over 70% of cases reported a decrease in the target behavior regardless of the reasons for termination.



	2006	2007	2008	2009
No change	22.2%	19.8%	20.0%	17.7%
N/A - no entry	4.4%	3.6%	2.6%	3.5%
Increased	0.0%	3.6%	5.3%	2.1%
Decreased	73.3%	73.1%	71.6%	76.6%

About 20% of youngsters ended TBS due to placement changes moving out of the area. Other terminations were due to family circumstance, placement in Juvenile Hall and most commonly the end of Medi-Cal eligibility.



3. What alternatives to TBS are being provided in the county?

Contra Costa County has made the choice to pursue TBS as the primary behavioral intervention service. TBS is now an integrated part of the collaboration with the Mobile Response Teams, Hospital Liaisons, WRAP teams, therapists, psychiatrists, and High Level Treatment Programs, school based services and contract providers. In the five TBS contracted agencies in county, over half of the workers have Master's degrees in progress or completed. We have two Coaches with completed doctorates and a few licensed coaches. All of our Supervisors are registered with the BBS and we had at last count 13 registered Interns. Attendance at the monthly trainings averages 40-45 provider staff. We will continue to focus on TBS in combination with other best practice methods of service delivery. The monthly training and administrative meeting will continue in order to provide support and a forum for continued quality improvement of this service delivery model.

4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

Stakeholder Comments and Input

Please include/address any sub-topics discussed in the learning conversation.
The attendees had the following suggestions.

- Make referral system more user friendly for parents.
- Increase Big Brothers and Sisters, respite and WRAP
- More School Involvement
- Reminders needed for awareness of Program
- TBS needed for non-Medi-Cal clients, i.e., AB3632, non-medical, etc.
- Develop Peer support groups
  Reminders are needed for Case Managers
- Past client reported that TBS had helped her focus. Made a difference.
- Current clients reported reduction in domestic violence better family relations

Ongoing Training and Supervision

Contra Costa continues to offer ongoing two-hour training monthly by Dr. Sherry Burke. This includes CEU's for licensed MFT, LCSW and Nurses. Training focuses on the functional aspects of behavioral intervention and its integration into the youngster's life. In the five TBS contracted agencies in county, over half of the workers have Master's degrees in progress or completed. We have 2 Coaches with completed doctorates and a few licensed coaches. All of our Supervisors are registered with the BBS and we had at last count 13 registered Interns. Attendance at the monthly trainings is 40-45. For example, topics have included***:***

2009	*2008*
Sensory Integration Dysfunction	*Oppositional Defiant Disorder;*
BEST PRACTICES; What's Working?	*Causes, Identification and Treatment*
CIRCLES; Understanding Social Skills.	*De-Escalation Technique*
EMOTIONAL INTELLIGENCE	*Understanding and Overcoming Resistance*

Providing TBS in a School Environment	*Monthly & Termination Reports*
PART I – TREATMENT PLANS	*Sensory Integration Dysfunction & ALERT*
Target Behaviors and Functions.	*Student Study Team & IEP Process*
PART II – TREATMENT PLANS	*Barriers, Fading & Transition Issues*
Factors Affecting Effectiveness of Reinforcer	Behavioral Goals/Measurable Outcomes & Data Collection
Self-Injurious Behaviors	Confidentiality
Part III- TBS TREATMENT PLANS,	
Increasing Consistency, Quality & Plan Fidelity	

FUTURE TOPICS
Periodic reviews on writing a good Treatment Plan
Interpreting testing results into behavioral interventions
Dealing with Processing Disorders
Resistance
Psychotic Depression and signs of prodromal psychosis

Summary and Comments

Based on Contra Costa's experience in the implementation and ongoing maintenance of TBS it is clear to see that it is a valuable and demonstrable success in keeping kids at home, in school, and out of trouble. The outcomes indicate that a significant number of youngsters benefit at least moderately, and most significantly, from the TBS intervention and Behavioral Planning process. It has maintained children in their homes, kept them in their current educational placement, and prevented unnecessary hospitalizations.

Opportunities for development and enhancement exist and of particular note is continuing the extensive training required to maintain a quality system of TBS Services. Additionally, opportunities to expand TBS like services to other non medi-cal beneficiaries in the System of Care need to be developed as noted by some of our consumer and advocate attendees.

In closing TBS in combination with other focused and planful Mental Health Outpatient services is a powerful intervention that can serve as a catalyst to exciting improvement and growth. When used strategically at the correct frequency intensity and duration it can, and does, prevent the continued traumatization of the child.

***Please find Attached the Power Point from presented at the meeting and the original meeting announcement attached.**