



**TBS Supervisor/Line Staff Training**  
**Los Angeles County**  
**June 21, 2010**  
**Agenda (Day 1)**



CALIFORNIA DEPARTMENT OF  
Mental Health



**Objective:**

1. To orient new and current TBS providers on a basic model of how to best implement TBS from referral of a case to the closing of that case
2. To give examples of how to measure and track TBS goals via functional analysis
3. To provide supervisors with a supervision strategy for direct care staff

9:00am -9:30am	Introductions & Overview of TBS 9 Point Plan
9:30am - 9:40am	Example of TBS Team Makeup
9:40am- 10:30am	TBS Coordination (between TBS, Family, and other treatment team members)
10:30am - 10:45am	BREAK
10:45am - 11:15am	TBS Coordination (continued)
11:15am -12:00 pm	Functional Analysis Exercise
12:00pm - 1:00pm	LUNCH
1:00pm -1:15pm	Answer questions from morning training
1:15pm - 2:30pm	Phases of TBS
2:30pm - 2:45pm	BREAK
2:45pm - 2:55pm	Parent Partner Testimony
2:55pm – 3:10pm	Monthly Meetings
3:10pm – 3:20pm	Supervision
3:20pm -3:30pm	Working with other providers
3:30pm - 3:40pm	TBS Coordination of Care Manual/TBS Distribution List
3:40pm - 4:00pm	Questions, comments, suggestions, feedback



**TBS Supervisor/Line Staff Training  
Los Angeles County  
June 22, 2010  
Agenda (Day 2)**



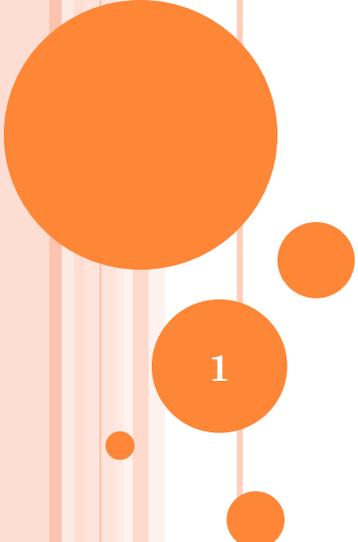
CALIFORNIA DEPARTMENT OF  
Mental Health



**Objectives:**

1. To provide a comprehensive overview of a best practice model on how to effectively deliver TBS services as a direct line staff
2. To demonstrate how to measure and track progress of identified behavior goals via functional analysis and progress notes
3. To provide direct line staff with examples and illustrations of various interventions and approaches to service delivery

9:00am -9:20am	Introduction of TBS services
9:20am - 9:40am	Starting a case
9:40am - 10:20am	Phases of TBS/Interventions
10:20am - 10:35am	BREAK
10:35am - 11:10am	Phases of TBS/Interventions (continued)
11:10am -12:00pm	Engagement and Approach (vignettes)
12:00pm - 1:00pm	LUNCH
1:00pm -1:15pm	Answer questions from morning training
1:15pm -2:30pm	Functional Analysis Exercise
2:30pm – 2:45pm	BREAK
2:45pm - 3:15pm	Reviewing Sample Progress notes
3:15pm - 3:30pm	Monthly meetings
3:30pm -3:40pm	TBS Coordination of Care Manual/TBS Distribution List
3:40pm- 3:50pm	Working alongside other providers (and EBP)
3:50pm - 4:00pm	Questions, comments, suggestions, feedback, evaluations



# **TBS SUPERVISORS/LINE STAFF TRAINING**

1

**Elizabeth Fitzgerald LCSW - Clinical Program Head LAC/DMH**

**Kim Nguyen Pierce, PhD - LAC/DMH TBS Coordinator**

**Todd Sosna, PhD - California Institute of Mental Health**

**Jeffrey Jamerson - Assistant Director of Community Based Service Five Acres**

**Chad Beckman MFT - Clinical Supervisor TBS Five Acres**

**Elisa Quintero - TBS Coordinator Five Acres**

**Jim Preis - Mental Health Advocacy Services, Inc.**

# OVERVIEW OF THE TBS NINE POINT PLAN

- [http://www.dmh.ca.gov/Services\\_and\\_Programs/Children\\_and\\_Youth/Court\\_Documents.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Court_Documents.asp)
- **Point 1:  
Streamline the TBS Administrative Requirements**
  - Eliminates many administrative requirements that have burdened counties in the past and have reduced the use of TBS.
- **Point 2:  
Clarify Criteria for TBS Eligibility**
  - Presents simple and direct language to clarify TBS eligibility requirements.
- **Point 3:  
TBS Accountability Structure**
  - Establishes an accountability process and structure the California Department of Mental Health (CDMH) will use to monitor and improve TBS utilization in every county.

# OVERVIEW OF THE NINE POINT PLAN

- [http://www.dmh.ca.gov/Services\\_and\\_Programs/Children\\_and\\_Youth/Court\\_Documents.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Court_Documents.asp)
- **Point 4:  
Define TBS Best Practice to Promote Service Integrity**
  - Describes a TBS best practice approach from assessment through service delivery and termination.
- **Point 5:  
Create TBS Coordination of Care Process**
  - 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.
- **Point 6:  
TBS Training**
  - Establishes a statewide TBS training program.

# OVERVIEW OF THE TBS NINE POINT PLAN

- [http://www.dmh.ca.gov/Services\\_and\\_Programs/Children\\_and\\_Youth/Court\\_Documents.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Court_Documents.asp)

- **Point 7:**

## **TBS Manuals**

- Outlines technical assistance manuals covering both TBS practice and chart documentation

- **Point 8:**

## **TBS Outreach**

- Outlines an outreach strategy to increase awareness of TBS and expand its utilization statewide.

- **Point 9:**

## **Termination of Court Jurisdiction**

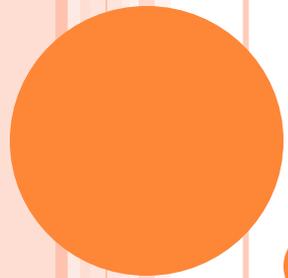
- Defines a process that will result in Court exit from the Emily Q matter.

# EXAMPLE OF A TBS TEAM



## TEAM MAKEUP (EXAMPLE)

- TBS Supervisor(s)
- Clinical Supervisor
- Case Manager
- TBS Specialist(s)



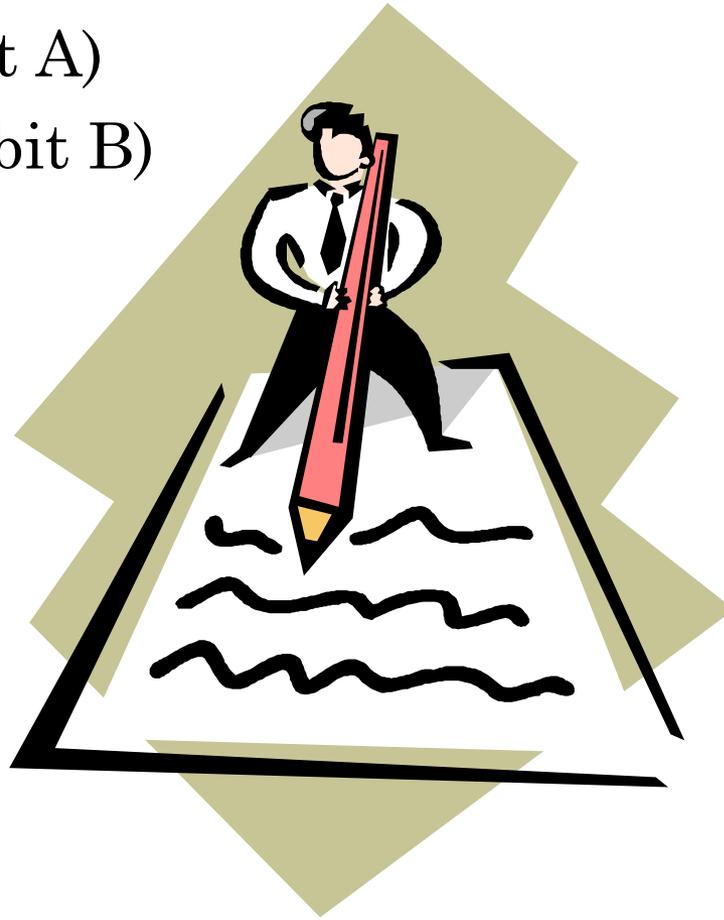
# TBS COORDINATION

# WHAT IS TBS & WHO QUALIFIES?

- 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.
- Child/Youth is transitioning from a RCL12 or higher to a lower level of care; or
- Child/Youth is placed in a group home facility or RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; or
- Child/Youth is being considered by the county for placement in a facility described above; or
- Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; or
- Child/Youth has previously received TBS while a member of the certified class; or
- Child/Youth is at risk of psychiatric hospitalization.
- Child/Youth is full scope Medi-Cal beneficiary

# THE TBS REFERRAL

- DMH Version (exhibit A)
- Agency Version (exhibit B)



# INTAKE (PROCESS FOR LA COUNTY)

- Who submits a referral?
  - Submitted by therapist who has an open case with Client
  - Submitted by DCFS CSW, Probation or Hospital, Caregiver & LA County DMH Personnel



# INTAKE

- Who accepts the referral?
  - Received by the TBS Clinical Oversight and/or TBS Supervisor
- Prioritizing Referrals
  - Prognosis (exhibit C)
  - Referral list (exhibit D)



# INTAKE

- Requesting additional Paper work from Therapist
  - Copies of 9pg. Initial Assessment
  - Payer Financial Information (PFI) (ex. E)
  - Copy of Medical Card
  - Copy of CCCP (exhibit F)
  - Copy of Transfer of Coordinator (exhibit G)
  - Consent for Service form (exhibit H)
  - Release of Information form (exhibit I)

# CLINICAL OVERSIGHT

- Provides TBS Referral  
(also obtained on the TBS website)
- Completes the TBS supplemental Assessment (30 to 60 days after a case opens) (exhibit J)



# PRE-CASE PLANNING

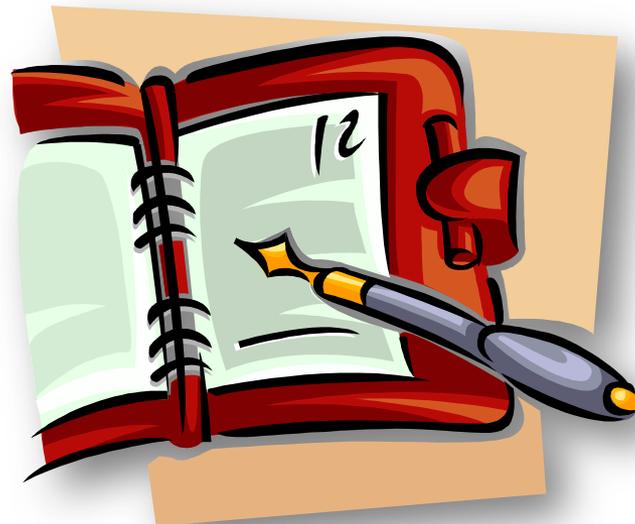
- (Clinical Oversight) assigns temporary goals derived from referral and additional paperwork
- In Adm. Meeting a TBS Coach is assigned to case, by matching client & caregiver interests with TBS Coach

# PRE-CASE PLANNING

- Schedule Start-Up Meeting
- Start-up Form Questions/gather information (exhibit K1)
  - Participants: therapist, caregivers, client, TBS coach, TBS supervisor
  - If a Wrap case, the meeting can take place in the CFT meeting
  - Solidifying TBS time and days of service

# PRE-CASE PLANNING

- Start-up Packet – (Forms)
- Notice of Practice (HIPPA) (exhibit L)
- Parent Agreement (exhibit M)
- DMH Patient Rights (exhibit N)





**LUNCH BREAK 12:00PM – 1:00PM**

# PHASES OF TBS (EXHIBIT O)

- Phase I - Observation, assessment, and orientation of services
  - Assist specialist in creation of a Safety Plan (exhibit P)
  - Assess “honeymoon period” of child/caregiver specialist
  - Help specialist to identifying lagging skills & unsolved problems using tool assessments
  - Monitor/oversee start of functional analysis this is key in measuring how client is doing and for gathering information



# PHASES OF TBS

- Phase I (continued)
  - Identify with specialist what's working both with client and caregiver
  - Engage and build rapport with caregiver and client as supervisor of case from inception (\*attend start up meeting and monthlies)
  - Begin to prepare Caregivers and Client for discharge (show movie clip)
  - Meet regularly in supervision with specialist(s) (exhibit Q)
  - Begin supervisor field shadow(s) use shadow log (exhibit R)
  - Case consultation 1x/week with referring Therapist
  - Communication with CSW from inception of case

# PHASES OF TBS

- Phase II - Plan Creation & Implementation
  - Assist specialist with creation of plans – crisis response plan, intervention plan, incentive plan etc.
  - Research skill building - purposeful activities with caregiver and client (exercises and interventions)
  - Assist specialist in identify and creating opportunities to practice skills
  - Help to create a “tool kit” – worksheets, skill building exercises, vision boards, etc.

# PHASES OF TBS

- Phase II (continued)
  - Supervisor field shadow(s) use shadow log
  - Meet regularly in supervision with specialist(s) and review functional analysis



# PHASES OF TBS

- Phase III -Transition, Discharge & Follow-Up
  - Assessment of client and Caregiver success in utilizing skills and intervention
  - Reminding specialist to reinforce the positive - Coaching and praising the caregiver and client for doing well
  - Assisting specialist to “tweak” plans/interventions
  - Assess when client and caregiver have experienced success in implementing planned interventions and skills to begin use of “planned absences”

# PHASES OF TBS

- Phase III (continued)
  - Reinforcement of plans developed in Phase II
  - Setting up a TBS transition plan (exhibit S) and termination ie: intervention list (exhibit T), connecting to community supports
  - Surveys completed by client and caregiver (exhibits U1 & U2)
  - Client follow up form after 3 month (exhibit V)
  - Client follow up form after 6 month (exhibit V)

# MONTHLY MEETINGS

- Review progress (every 30 days) (exhibit W)
- Feedback –presenting functional analysis from TBS coach, client, caregiver, therapist, Wrap, FSP : what works, and what doesn't work
- Discuss and outline next 30 days
- Brainstorm what's working and encourage buy in from treatment team

# SUPERVISION

- Individual Supervision
  - Shadowing
  - Monitoring and Reading Notes
- Clinical Group Supervision

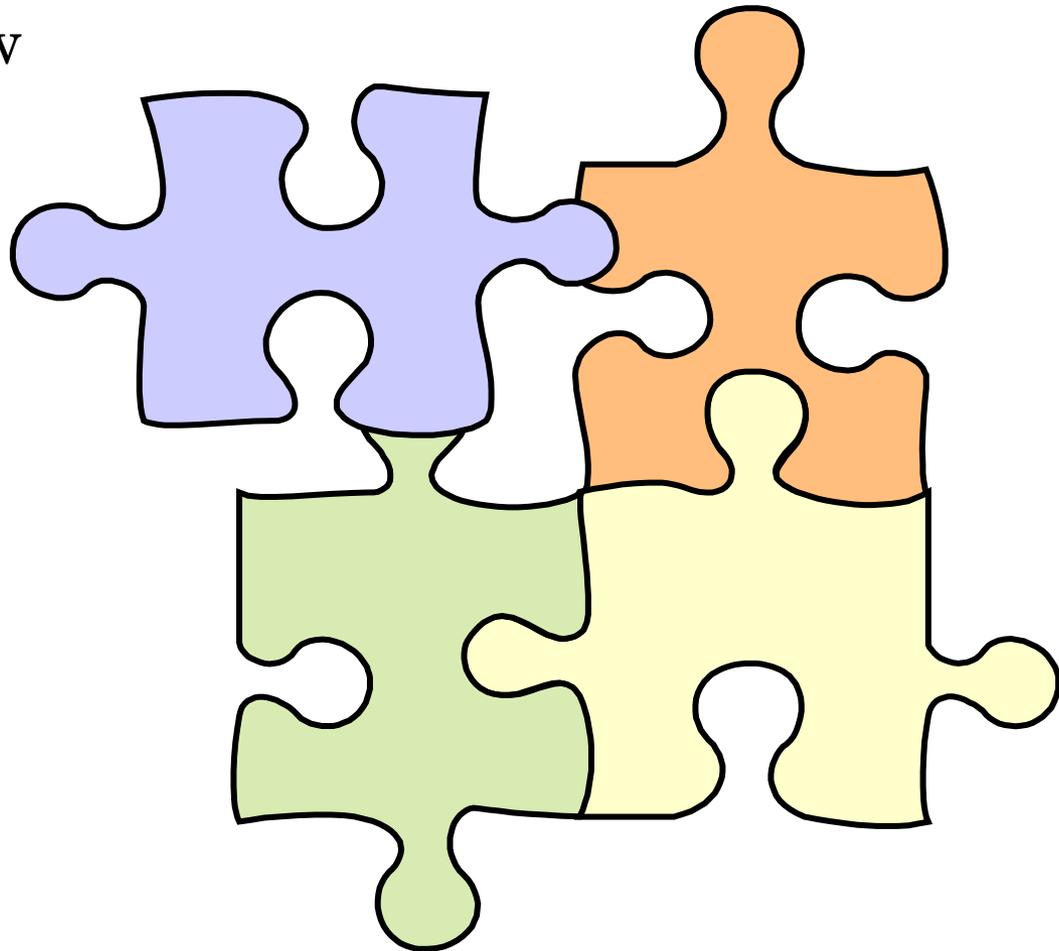


# WORKING WITH OTHER PROVIDERS

- Wraparound, FSP, ITFC
  - Communication
  - Identifying roles
  - Pre-start up meetings
- Evidence Based Programs
  - demonstrated effectiveness
  - intended populations and outcomes
  - time limited
- Schools
  - MOU's
  - Start up meetings with school staff

# COORDINATION OF CARE MANUAL

- Brief Overview



# DEPARTMENT OF MENTAL HEALTH TBS DISTRIBUTION LIST

- Participant sign up for the TBS Distribution List
- [http://www.dmh.ca.gov/Services\\_and\\_Programs/Children\\_and\\_Youth/Apps/subscription/default.asp](http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/Apps/subscription/default.asp)



# OVERVIEW OF BEHAVIORAL FUNCTIONAL ANALYSIS (EXHIBIT X)

- Tracks client progress with regard to each TBS behavior goal
- Measures over 30 day period whether ct. met goal or not
- Identifies patterns (days and times of incidents)
- 4 questions – Antecedents, Behavior, Response, Outcome (use as teaching tool for caregivers/clients, what to look for and notice how they are responding)
- Should be kept even in absence of TBS specialist (get caregiver reported incidents since last TBS shift)
- Present at monthly review meetings (to show progress on chart)

# TBS PROGRESS NOTE DOCUMENTATION

- GIRP format – Goals, Intervention, Response, Plan (exhibit Y)
- Quantification of incidents (info from functional analysis)
- Structure of writing a note
- What to include?

# DISCHARGE SUMMARY

- Summarize the entirety of services (should not exceed 2 pages)
- Explain why services ended
- Example Discharge Summary (exhibit Z)

# VIGNETTE EXERCISES

- Boundaries
- Safety
- Non receptiveness to service
- Out of scope practice

COUNTY OF LOS ANGELES  
REFERRAL FOR THERAPEUTIC BEHAVIORAL SERVICES (TBS)

- 1. Date Referred: \_\_\_\_\_
- 2. Name of Child: \_\_\_\_\_ 3. IS #: \_\_\_\_\_
- 4. Birth Date: \_\_\_\_\_ 5. Age: \_\_\_\_\_ 6. Gender: \_\_\_\_\_
- 7. Ethnicity: \_\_\_\_\_ 8. Medi-Cal #: \_\_\_\_\_
- 9. Social Security #: \_\_\_\_\_
- 10. Child's Address: \_\_\_\_\_
- 11. Child's Phone #: \_\_\_\_\_
- 12. Parent/Guardian Name: \_\_\_\_\_
- 13. Address: \_\_\_\_\_
- 14. Phone #: \_\_\_\_\_
- 15. Child currently residing with  
 Parent     Foster Home     Group Home     Other (specify): \_\_\_\_\_  
 If Group Home, Name & RCL #: \_\_\_\_\_
- 16a. Child's primary language: \_\_\_\_\_ 16b. Language spoken in home: \_\_\_\_\_
- 17. TBS is needed to: (*check one*)  
 \_\_\_\_\_ Prevent placement in a higher level of care  
 \_\_\_\_\_ Enable transition to a lower level of care
- 18. TBS Class Membership (*check all that apply*):  
 \_\_\_\_\_ Child in RCL 12 or above, and/or a locked treatment facility for the treatment of mental health needs.  
 \_\_\_\_\_ Child is being considered for RCL 12 or above, and/or a locked treatment facility for the treatment of mental health needs.  
 \_\_\_\_\_ Child has had one or more psychiatric hospitalization within the past 24 months  
     If yes, give date(s) \_\_\_\_\_  
 \_\_\_\_\_ Child previously received TBS  
     If yes, give date(s) \_\_\_\_\_
- 19. Describe child's current situation and reason for requesting TBS:  
 I  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

COUNTY OF LOS ANGELES  
REFERRAL FOR THERAPEUTIC BEHAVIORAL SERVICES (TBS)

20. Current Diagnosis:

AXIS I \_\_\_\_\_

\_\_\_\_\_

AXIS II \_\_\_\_\_

AXIS III \_\_\_\_\_ AXIS IV \_\_\_\_\_

AXIS V Current GAF \_\_\_\_\_

21. Is child prescribed medication? Yes \_\_\_\_\_ No \_\_\_\_\_

Medication & dosage: \_\_\_\_\_

22. List risk factors, special needs: \_\_\_\_\_

\_\_\_\_\_

23. Current mental health service provider:

Name and Title: \_\_\_\_\_

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

24. DCFS/CSW (if applicable):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

25. Probation Officer (if applicable):

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

26. List current behaviors for TBS to address (include frequency of occurrence):

1. \_\_\_\_\_

2. \_\_\_\_\_

27. Referring Party:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

28. Signature \_\_\_\_\_ 29. Date: \_\_\_\_\_

**TBS Referral**

**PLEASE TYPE ALL INFORMATION**

CLIENT'S INFO			
CLIENT'S NAME	MIS#	DOB	AGE
		GENDER <input type="checkbox"/> M <input type="checkbox"/> F	
SOCIAL SECURITY #		MEDI-CAL #	ETHNICITY
MENTAL HEALTH PROVIDER			
CLINICIAN'S NAME		PHONE /extension	FAX
AGENCY		REPORTING UNIT	E-MAIL
CURRENT SFPR NAME	ANNUAL CYCLE DATE (Ex. 4/23/09 to 3/31/10)	TRANSFERRING TO SFPR	AGENCY & REPORTING UNIT
REFERRING PARTY (If different from above)			
NAME		PHONE	FAX
RELATIONSHIP to CLIENT		E-MAIL	REFERRAL DATE
NEED FOR TBS/ CERTIFIED CLASS (Please check box for each area)			
<input type="checkbox"/> To prevent higher level of placement		<input type="checkbox"/> To ensure transition to lower level of care	
<input type="checkbox"/> Psychiatric hospitalization in the past 24 months related to current presenting disability. Most recent from _____ to _____ Location: _____ <input type="checkbox"/> In danger of being removed to RCL 12 or above. <input type="checkbox"/> Previously received TBS while a member of the certified class. <input type="checkbox"/> Currently placed in a rate classification level (RCL) home 12 or above/and or locked treatment facility for the treatment of mental health needs.			
CURRENT RESIDENCE			
<input type="checkbox"/> Bio Hm <input type="checkbox"/> Foster Hm <input type="checkbox"/> Grp Hm/RCL _____ <input type="checkbox"/> Residential/RCL _____ <input type="checkbox"/> Relative's Home <input type="checkbox"/> Psychiatric Hosp. <input type="checkbox"/> Juvenile Hall <input type="checkbox"/> Transitional Living <input type="checkbox"/> Other: _____			
CURRENT CAREGIVER'S INFO			
CAREGIVER	RELATIONSHIP	CAREGIVER	RELATIONSHIP
ADDRESS:			
PHONE #	ALTERNATE PHONE #	LANGUAGE SPOKEN	
TRANSITIONAL CAREGIVER'S INFO (If transitioning to a lower level of care or other caregiver, indicate transitional caregiver's info below.)			
<input type="checkbox"/> Bio Hm <input type="checkbox"/> Foster Hm <input type="checkbox"/> Grp Hm/RCL _____ <input type="checkbox"/> Residential/RCL _____ <input type="checkbox"/> Relative's Home _____ <input type="checkbox"/> Psychiatric Hosp. <input type="checkbox"/> Juvenile Hall <input type="checkbox"/> Transitional Living <input type="checkbox"/> Other: _____			
CAREGIVER	RELATIONSHIP	CAREGIVER	RELATIONSHIP
ADDRESS:			
PHONE #	ALTERNATE PHONE #	LANGUAGE SPOKEN	
SCHOOL INFO			
SCHOOL NAME		PHONE	STATUS
SCHOOL ADDRESS		DISTRICT	GRADE
OTHER CONTACTS (Please include address)			
CSW NAME & ADDRESS		PHONE /extension	FAX
ATTORNEY NAME & ADDRESS		PHONE /extension	FAX
PROBATION OFFICER NAME & ADDRESS		PHONE /extension	FAX





**TBS Referral****PLEASE TYPE ALL INFORMATION**

# **TBS Referral**

## **Supporting Paperwork Checklist**

The TBS Department, would like to thank you for your interest in TBS services. **In order for us to process your TBS referral we need the following documentation along with the completed TBS referral:**

- 8 Page Initial Assessment**
- Change of Diagnosis form (If the diagnosis from the TBS referral request form does not match that of the Initial Assessment)**
- Assessment Addendum, with current client issues. (If the Initial Assessment is more than one year old).**
- Copy of Current Coordination Plan (With current cycle date)**
- Copy of Medi-cal Card**
- Copy of Current Day Rehab. Care Plan (Only if client is in Day Treatment)**
- UMDAP/PFI(Cannot open case without one)**
- Consent for service form**
- Authorization release of information form**

Determining Prognosis for TBS referrals

When a referral is submitted, the clinical oversight for the TBS program reviews all of the clinical documents (e.g. Initial Assessment, CCCP, etc.). Once these have been reviewed, the referring clinician is consulted with to determine the level of need for TBS services, resulting in a prognosis for each case. The prognosis' are as follows:

-Good

-Fair

-Guarded

-Poor

All cases that are "To prevent higher level of placement" should fall into the categories of Guarded or Poor. While most cases that are "Ensuring transition to a lower level of care" generally fall into Fair or Guarded. On a rare occasion, a case may be considered a Good prognosis if the client is functioning at a high level with minimal acting out behaviors.

A Poor prognosis generally includes current behaviors of physical and/or verbal aggression, recent hospitalization, history of multiple hospitalizations, caregivers actively seeking out residential treatment placement, or previous TBS services provided to client.



**LOS ANGELES COUNTY  
DEPARTMENT OF MENTAL HEALTH  
PAYOR FINANCIAL INFORMATION**

**UMDAP EXHIBIT E**  
CONFIDENTIAL CLIENT INFORMATION  
See W & I Code, Section 5328

**CLIENT INFORMATION**

<b>1</b> CLIENT NAME	SS #	CLIENT ID #
<b>2</b> MAIDEN NAME	DOB	MARITAL STATUS M S D W SP
SPOUSE NAME		

**THIRD PARTY INFORMATION**

<b>3 NO THIRD PARTY PAYOR</b> <input type="checkbox"/>			
<b>4</b> MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-CAL COUNTY CODE /AID CODE/ CLAIM #	MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR ELIGIBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REFERRED
<b>5</b> SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE
IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON			
<b>6</b> MEDI-CAL HMO <input type="checkbox"/> YES <input type="checkbox"/> NO	CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO
HEALTHY FAMILIES <input type="checkbox"/> YES <input type="checkbox"/> NO		HEALTHY FAMILIES CIN #	OTHER FUNDING
<b>7</b> MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO	VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO
PRIVATE INS <input type="checkbox"/> YES <input type="checkbox"/> NO		HMO <input type="checkbox"/> YES <input type="checkbox"/> NO	CLAIM #
<b>8</b> NAME OF CARRIER		GROUP/POLICY/ID #	NAME OF INSURED
<b>9</b> CARRIER ADDRESS			ASSIGNMENT/RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO

**PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)**

<b>10</b> NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS M S D W SP	PAYOR CAL/CL ID
<b>11</b> ADDRESS	CITY	STATE	ZIP CODE	TEL #
<b>12</b> SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER:				PAYOR SS #
<b>13</b> EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
<b>14</b> EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
<b>15</b> SPOUSE		ADDRESS (Include City, State & Zip Code)		SPOUSE'S SS #
<b>16</b> SPOUSE'S EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
<b>17</b> SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)		TEL #

**UMDAP LIABILITY DETERMINATION**

<b>19 LIQUID ASSETS</b>	<b>20 ALLOWABLE EXPENSES</b>	<b>21 ADJUSTED MONTHLY INCOME</b>
Savings \$ _____	Court ordered obligations paid monthly \$ _____	Gross Monthly Family Income \$ _____
Checking Accounts \$ _____	Monthly child care payments (necessary for employment) \$ _____	Self/Payor \$ _____
IRA, CD, Market value of stocks, bonds and mutual funds \$ _____	Monthly dependent support payments \$ _____	Spouse \$ _____
<b>TOTAL LIQUID ASSETS</b> \$ _____	Monthly medical expense payments \$ _____	Other \$ _____
Less Asset Allowance \$ _____	Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____	<b>TOTAL</b> \$ _____
Net Asset Valuation \$ _____	<b>Total Allowable Expenses</b> \$ _____	Add monthly asset valuation \$ _____
Monthly Asset Valuation (Divide Net Asset by 12) \$ _____		<b>TOTAL</b> \$ _____
VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO	Subtract total expenses \$ _____
		<b>Adjusted Monthly Income</b> \$ _____

<b>22</b> Number Dependent on Adjusted Monthly Income	<b>ANNUAL LIABILITY</b>	<b>ANNUAL CHARGE PERIOD</b> FROM _____ TO _____	Payment Plan \$ _____ per month for _____ months.
<b>23</b> PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

**OTHER**

<b>24</b> PRIOR MH TREATMENT (Only applicable to current Annual Charge Period) <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
<b>25</b> ANNUAL LIABILITY ADJUSTED BY	DATE		REASON ADJUSTED
ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
<b>26</b> An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER			PROVIDER NAME AND NUMBER
<b>27</b> I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON			
			DATE

*① MATCH DATE w/ SCREEN*  
*② SHOULD COVER TIME TBS WAS PROVIDED*

EXHIBIT  
F

Annual Cycle Month: (Due prior to the 1<sup>st</sup> day of the Month)

- Jan  Feb  March  April  May  June  July  Aug  Sept  Oct  Nov  Dec

Client Long Term Goals: (use client direct quote)  
"don't want to be in trouble in school, home and the community"

**Short-term Goals / Objectives:** Must be SMART: Specific, Measurable/Quantifiable, Attainable within this year, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology in the Assessment.

**Objective #1** Effective Date: 3/01/10  
The client will reduce oppositional behaviors (refusing to follow caregiver's/staff's directions by arguing, power struggling, ignoring, walking away) from 7x/day to 5x/day and replace with appropriate coping/anger management skills.

**Clinical Interventions:** Must be related to the objective and achievable within the time frame of this plan. Describe proposed intervention and duration (specify if time frame is less than 1 year)

**Type of Service:**  MHS\*  TCM  Med Sup  Crisis Res  Trans Res  Long-term Res  CalWorks  TBS  Other: \_\_\_\_\_  
When the frequency of oppositional behaviors (refusing to follow caregiver's/staff's directions by arguing, power struggling, ignoring, walking away) changes from 7x/day to 5x/day, TBS will reduce to 3 days/week, 5 hours a day to terminate. Utilizing incentives, increasing open communication, encouraging client to verbalize feelings, giving client achievable goals, redirecting and prompting client, linking client to community outlets, utilizing therapeutic worksheets and art projects, validating client's concerns, and positive praise

<b>Client Involvement</b> Client agrees to participate by: Utilizing coping skills, verbalizing feelings, utilizing community outlets, accepting responsibility for actions, following directives from caregivers, utilizing learned communication skills.	<b>Family Involvement:</b> <input type="checkbox"/> Biological <input type="checkbox"/> Other (If other, please specify below) Family is available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Client consents to family participation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Family agrees to participate? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify) Utilizing interventions introduced by TBS such as planned ignoring, support from treatment team, giving client alternative choices, encouraging client to verbalize feelings.
--	---

**Outcomes:** To be completed either when the objective is obtained or prior to the beginning of the next cycle month. If not met, please specify what was or was not met and adjust objective accordingly.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Short-term Goals / Objectives:**

**Objective #2** Effective Date: 3/1/10  
The client will reduce physical aggression (hitting, property destruction, kicking, punching, invading personal space, threatening, posturing) from 5x/day to 3x/day and replace with appropriate coping/anger management skills.

**Clinical Interventions:** Must be related to the objective and achievable within the time frame of this plan. Describe proposed intervention and duration (specify if time frame is less than 1 year)

**Type of Service:**  MHS\*  TCM  Med Sup  Crisis Res  Trans Res  Long-term Res  CalWorks  TBS  Other: \_\_\_\_\_  
When the frequency of physical aggression (hitting, property destruction, kicking, punching, invading personal space, threatening, posturing) changes from 5x/day to 3x/day TBS will reduce to 3 days/week, 5 hours a day to terminate. Utilizing incentives, increasing open communication, encouraging client to verbalize feelings, giving client achievable goals, redirecting and prompting client, linking client to community outlets, utilizing therapeutic worksheets and art projects, validating client's concerns, and positive praise

<b>Client Involvement</b> Client agrees to participate by: Utilizing coping skills, verbalizing feelings, utilizing community outlets, accepting responsibility for actions, following directives from caregivers, utilizing learned communication skills.	<b>Family Involvement:</b> <input type="checkbox"/> Biological <input type="checkbox"/> Other (If other, please specify below) Family is available <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Client consents to family participation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Family agrees to participate? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify) Utilizing interventions introduced by TBS such as planned ignoring, support from treatment team, giving client alternative choices, encouraging client to verbalize feelings.
--	---

**Outcomes:**

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Additional Client Contacts/Relationships:** Refer to the "MH525: Contact Information" form. **Interpretation**

<input checked="" type="checkbox"/> DCFS <input type="checkbox"/> Probation <input type="checkbox"/> DPSS <input type="checkbox"/> Health <input type="checkbox"/> Outside Meds <input type="checkbox"/> Regional Center <input type="checkbox"/> Substance Abuse/12 Step <input type="checkbox"/> Consumer Run <input type="checkbox"/> Education/AB3632 <input type="checkbox"/> Other _____	Prefer a language other than English: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No This plan was interpreted: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Language: English
--	--

\*MHS includes therapy/rehab (individual, family, or group), psychological testing, collateral and team conference/consultation services

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Name: \_\_\_\_\_ IS#: \_\_\_\_\_  
Agency: \_\_\_\_\_ Provider #: \_\_\_\_\_

Los Angeles County – Department of Mental Health

CLIENT CARE  
COORDINATION PLAN

- Signator or Co-Signator must be consistent with Scope of Practice.
- Signatures must be obtained when objectives are created (both initial and additional) and at each review period.
- One signature block can be used for multiple objectives created on the same day if the objectives are within the scope of the signator.

Objective Number(s)  <u>X &amp; Y</u>	Unlicensed Staff/Title	Used if Staff does not hold one of the licenses or registrations below. Second signature required.
	PhD/PsyD, LCSW, MFT, RN, CNS	Required for all Objectives without MD/DO signature. Includes licensed or registered and waived PhD/PsyD, licensed or registered/waived LCSW & MFT, Licensed RN, Certified CNS.
	MD/DO, NP	MD/DO Required for Medicare Clients/Private Insurance. MD/DO or NP required for Medication Support goals.
	Client*	Document reason for lack of signature below. Signature should be obtained as soon as possible with regular updates in Progress Notes until obtained.
	Other*	Parent, Authorized Caregiver, Guardian, Conservator, or Personal Representative for treatment.

Objective Number(s)  <u>1 &amp; 2</u>	Unlicensed Staff/Title	TBS SPECIALIST SIGNATURE	Date:
	PhD/PsyD, LCSW, MFT, RN, CNS	SIGNATURE	Date:
	MD/DO, NP		Date:
	Client*	CLIENT'S SIGNATURE	Date:
	Other*	CAREGIVER'S SIGNATURE	Date:

Client was offered a copy of this objective:  Accepted  Declined Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s)  _____	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective:  Accepted  Declined Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

Objective Number(s)  _____	Unlicensed Staff/Title		Date:
	PhD/PsyD, LCSW, MFT, RN, CNS		Date:
	MD/DO, NP		Date:
	Client*		Date:
	Other*		Date:

Client was offered a copy of this objective:  Accepted  Declined Staff Initials: \_\_\_\_\_ Date: \_\_\_\_\_

If the required Client/Other's signature is not above, please justify/explain the refusal or unavailability of the Client/Other and the plan for obtaining signature in the future.

\*The signature of the individual signing the Consent for Services is required. If unavailable, the signature of the caregiver may be obtained instead.

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	Agency: _____	Provider #: _____
<i>Los Angeles County - Department of Mental Health</i>		





CONSENT FOR SERVICES

EXHIBIT H

The undersigned client or responsible adult consents to and authorizes mental health services by

\_\_\_\_\_ TBS  
Name of Facility and/or Program

These services may include psychological testing, psychotherapy/counseling, rehabilitation service, medication, case management, laboratory test, diagnostic procedures, and other appropriate services. While these services may be delivered at different locations, all services provided within the Los Angeles County mental health system will be approved and coordinated by the staff of a single agency.

The undersigned understands:

1. he/she has the right to
  - a. be informed of and participate in the selections of evaluation, treatment, rehabilitative, and case management services which will be provided;
  - b. receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
2. all of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or service coordinator or withdraw this consent at any time.
3. information from a client's service record relative to service delivery needs may be shared with any agency within the Los Angeles County mental health system (county-operated and contract) with obtaining the consent of the client.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Adult

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

Witness attests:        Client is willing to accept services, but unwilling to sign the Consent.

Witness Attest:        I have completed or have caused to be completed the Consent of Minor form for any client under the age of 18 signing without parental/guardian consent.

This Consent was translated into \_\_\_\_\_ for the client and/or responsible adult.

\_\_\_\_\_  
Signature of Witness/Translator

\_\_\_\_\_  
Date

\*Responsible Adult = Guardian, Conservator, or Parent of Minor when required (see Minor Consent).

Signator  was given or  refused a copy of this consent on \_\_\_\_\_ by \_\_\_\_\_

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Name: _____	MIS#: _____
Agency: _____	Rept Unit: 7286
<b>Los Angeles County – Department of Mental Health</b>	

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
AUTHORIZATION REQUESTING RELEASE OF INFORMATION AND/OR RECORDS

TO: Facility or Agency Street/City

Name of Person Birthdate

Has requested services of the Los Angeles County Department of Mental Health and thereby is authorizing the release of records and information to:

Five Acres
Name of Facility/Program Person Requesting Information
(626)798-6793 2055 Lincoln Avenue, Pasadena, Ca. 91103

For the purpose of: REFERRAL and TREATMENT PLANNING

Information requested is checked below:

- ( ) Diagnosis Only ( ) Pathology Report ( ) DPSS
( ) Course of Psychiatric Treatment ( ) Diagnostic Examination, Specify ( ) Probation
( ) Course of Medication treatment ( ) School Reports, Specify ( ) Other
( ) Discharge Summary ( ) Laboratory Reports, Specify
( ) History and Physical ( ) Consultation(s) Specify
( ) Operative Report ( ) Other, Specify

Dates Requested
Include:

We understand that the release or transfer of the specified information to any person or entity not specified herein is prohibited. An additional written authorization must be obtained for a proposed new use of the information or for its transfer to another person or entity.

This authorization shall become effective \_\_\_/\_\_\_/\_\_\_ and is subject to revocation by the undersigned at any time except to the extent that action has already been taken. If not earlier revoked, this authorization shall terminate on \_\_\_/\_\_\_/\_\_\_.

Signature of Client Date

Witness Signature of Parent or Guardian/Conservator

\*CONSENT REVOKED \_\_\_/\_\_\_/\_\_\_ Signature of Client/Parent/Guardian/Conservator

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION IF I SO REQUEST

# SUPPLEMENTAL THERAPEUTIC BEHAVIORAL SERVICE ASSESSMENT

MH 661  
Revised 04/30/09

**I. Provider Information**

**TBS Rendering Provider**

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Single Fixed Point of Responsibility**

Agency: \_\_\_\_\_

Name: \_\_\_\_\_ Discipline: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**II. Client Identifying Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Ethnicity: \_\_\_\_\_ Medi-Cal:  Yes  No

Current Living Situation: \_\_\_\_\_

Parent/Caregiver: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

CSW/Probation Officer: \_\_\_\_\_ Phone: \_\_\_\_\_

Regional Center/Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Other: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**III. Child/Adolescent Initial Assessment**

Completed by (name of agency and provider): \_\_\_\_\_ Reviewed on (date): \_\_\_\_\_

Additional Information/Changes to Initial Assessment:

**IV. TBS Class Eligibility**

The child/youth is currently placed in Rate Classification Level (RCL) facility of 12 or above and/or locked treatment facility for the treatment of mental health needs

Child/youth is being considered by the County for placement in one of the facilities described above

Child/youth has undergone, at least, one emergency psychiatric hospitalization related to his/her current presenting disability within the preceding 24 months

Child/youth previously received TBS while a member of the certified class

**V. Criteria for TBS Eligibility**

To prevent out-of-home placement or a higher level of care

To ensure transition to home, foster home, or lower level of care

**VI. TBS Assessment**

1 a. Identify the specific behaviors and/or symptoms that jeopardizes continuation of the current placement or the specific behaviors and/or symptoms that interfere with the child or youth transitioning to a lower level of care:

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Name: \_\_\_\_\_ IS#: \_\_\_\_\_

Agency: \_\_\_\_\_ Provider #: \_\_\_\_\_

Los Angeles County – Department of Mental Health

# SUPPLEMENTAL THERAPEUTIC BEHAVIORAL SERVICE ASSESSMENT

## VI. TBS Assessment (continued)

Describe child or youth's behaviors and/or symptoms in terms of intensity, frequency, and duration in support of TBS, note when and/or where behaviors and symptoms occur:

2a. What other specialty mental health service(s) is client currently receiving? Indicate why child or youth needs TBS in addition to current service(s):

2b. List previous less intensive services that have been tried and/or considered and describe why these less intensive services are not or would not be appropriate:

3. Identify skills and adaptive behaviors that the child or youth is using now to manage the targeted behaviors and/or symptoms and/or is using in other circumstances that could replace the targeted behavior and/or symptom:

4. Identify what changes in behavior and/or symptoms TBS is expected to achieve and how the child's therapist or treatment team will know when these services have been successful and can be reduced or terminated:

5. (Optional) Provide any additional clinical information supporting the need for TBS:

## VII. Diagnosis

- Diagnosis is the same as on the Child/Adolescent Initial Assessment
- Diagnosis is different from the Child/Adolescent Initial Assessment (Complete MH 501 Diagnosis Information Form by an LPHA)

## VIII. Signatures

Signature & Discipline	Date	Co-Signature & Discipline (if required)	Date

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Name: \_\_\_\_\_ IS#: \_\_\_\_\_  
 Agency: \_\_\_\_\_ Provider #: \_\_\_\_\_  
 Los Angeles County – Department of Mental Health

Start up Meeting Assessment/Summary

Client: \_\_\_\_\_ Clinician's email: \_\_\_\_\_

CCP Quote" \_\_\_\_\_"

<b>Date of meeting:</b>	<b>Participants:</b>				
<b>Diagnosis:</b>					
Hospitalizations?					
Any self-injurious behaviors?					
Presenting Problems/ Barriers Primary Symptoms/Behaviors When did these behaviors start? What triggers these behaviors?					
Names, ages and title of others in the home Current family issues identified (substance abuse, domestic violence, divorce, removal from home, recent losses, etc.)					
Behaviors that the client/family/clinician would like to reduce?  Please confirm or replace with correct ones.	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Behavior #1</td> <td style="text-align: center;">Frequency</td> </tr> </table>	_____	_____	Behavior #1	Frequency
	_____	_____			
	Behavior #1	Frequency			
	Examples				
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; text-align: center;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">Behavior #2</td> <td style="text-align: center;">Frequency</td> </tr> </table>	_____	_____	Behavior #2	Frequency	
_____	_____				
Behavior #2	Frequency				
Examples					

Client strengths and interventions that currently work for them:	<b>Strengths:</b>  <b>Interventions:</b>
Medical Concerns: History of sexual or physical abuse	
Hours and Days of Service: Address/Phone/cell phone of caregivers/school staff:	
Caregiver's/Client's receptivity:	
Weekly time for TBS and Clinician to communicate:  Progress Notes for Charts?	
Set Monthly Meeting Time	<b>Date:</b>  <b>Time:</b>

What are some things that are working right now?

What would you like support/help with?

What do you expect from TBS services?

What are some ways you currently cope to deal with your child's behavior?

What are some of your strengths, interests?

What areas do you find most challenging in dealing with child's behavior?

EXHIBIT L

**NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT OF RECEIPT**

The Five Acres Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child/client, \_\_\_\_\_ . By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Five Acres. We encourage you to read it in full.

If you have any questions about our *Notice of Privacy Practices*, please contact Privacy Officer, Five Acres, 760 W. Mountain View St, Altadena, CA 91001.

I acknowledge that I have received the *Notice of Privacy Practices* of Five Acres.

\_\_\_\_\_  
Signature of Parent/Client Representative

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**TBS PARENT/GUARDIAN AGREEMENT**

Therapeutic Behavioral Services (TBS) is based on the philosophy of teamwork. There will be several "team players" working with you and your family, each having a distinctive role, which involves a commitment to the goals that were developed for your child by the treatment team. TBS specialists in particular will be responsible for focusing on the specific goals that have been developed on the TBS service plan and to pass on successful interventions to you as a caregiver. Your main responsibilities throughout the course of TBS will be to be available at scheduled service times and to be open to learning new interventions and tools that are successful in guiding your child's behavior. Your participation is an essential part of the success of your TBS team. In addition, you will be expected to communicate any concerns with the case supervisor (as identified on the safety plan that will be provided to you by a specialist) should they arise.

It is important to know that TBS specialists will maintain the same boundaries of privacy, respect and professionalism that you can expect from your child's therapist. TBS specialists will follow appropriate rules of conduct such as reporting to your home on time and working with your family on the specific goals that have been developed. TBS specialists are also expected to comply with California Child Abuse Reporting laws, to protect your privacy and confidentiality. Since the TBS specialist will be meeting in your home and community, it is significant that you understand that there are specific rules that limit what can and cannot be done. For example, TBS specialists may not work with a client (in the home) without a caretaker present or provide transportation to and from doctor's appointments or therapy visits. It is important that you understand and respect the professional relationship between the TBS specialist and your family.

By signing this document, you are consenting to TBS services and acknowledging that you agree to fully participate in the treatment plan designed for your child. In addition, you acknowledge that TBS services may be discontinued, at our discretion, if you have excessive cancellations or if TBS seems to be a poor match for you or your child's needs. Lastly, please remember that TBS is a short term, intensive mental health intervention that works in conjunction with yourself and other treatment team individuals towards accomplishing the behavioral goals outlined and that TBS services generally terminate within a number of weeks, rather than months.

\_\_\_\_\_  
Parent/Guardian                      Date

\_\_\_\_\_  
Parent/Guardian                      Date

\_\_\_\_\_  
TBS Case Supervisor                  Date

\_\_\_\_\_  
TBS Specialist                                  Date

**Name:**  
**Agency:**

**MIS#:**  
**Rept Unit:**

**DMH Patients Rights**

Every Medi-Cal beneficiary has a right to receive the **Guide to Medi-Cal Mental Health Services**. This Guide can also be obtained on LA County Department of Mental Health website: <http://dmh.lacounty.gov/index.html>

As a person eligible for Medi-Cal, you have a right to receive medically necessary specialty mental health services from the Mental Health Provider. When accessing these services, you have the right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Receive information on available treatment options and alternatives; and have them presented in a manner you can understand.
- Participate in decisions regarding your mental health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, punishment or retaliation as specified in federal rules about the use of restraints and seclusion in facilities such as hospitals, nursing facilities and psychiatric residential treatment facilities where you stay overnight for treatment.
- Request and receive a copy of your medical records, and request that they be amended or corrected.
- As a beneficiary you have the right to receive information in accordance with Title 42, CFR, Section 438.10 which describes information requirements.
- Be furnished healthcare services in accordance with Title 43, CFS, Sections 438.206 through 438.210, which cover requirements for availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization services.
- You may have additional rights under state laws about mental health treatment and may wish to contact your county's Patients' Rights Advocate (call your county mental health department listed in the local phone book and ask for the Patient's Rights Advocate) with specific questions.

**The undersigned client or responsible adult\*acknowledges receipt of The Guide to Medi-Cal Mental Health Services**

Signature of Client	Signature of Staff	Date
Signature of Responsible Adult	Relationship to Client	Date

**The Guide to Medi-Cal Mental Health Services:**

Given     Declined    Date: \_\_\_\_\_    Staff Initials: \_\_\_\_\_

**\*Responsible Adult = Guardian, Conservator, or Parent of Minor**

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	Agency: _____	Provider#: _____
	<b>Los Angeles County – Department of Mental Health</b>	

## Phases of TBS

### **1. Orientation, Observation & Assessment (2-4 weeks) varies**

TBS staff begins by gaining an understanding of the child's behavior. TBS starts by identifying lagging skills that are contributing to challenging behavior and begins use of functional analysis/information gathering. TBS creates an outline (with child and caregiver) of potential interventions/replacement behaviors for the child to use as alternatives to the undesirable behaviors (keeping in mind strengths and interests.) Strategies may include the development of a behavioral plan, such as a step-by-step process in which caregivers follow a guideline to manage a specific behavior as they occur. It could also include setting up an incentive plan where the child is rewarded (externally motivated) to practice using new replacement behaviors, for applying new skills and for engaging in skill building exercises with caregiver(s).

### **2. Plan Creation and Implementation (2-3 months) varies**

Next, TBS staff works directly alongside child and those who care for the child. During this time, TBS staff, the child and child's caregivers are developing, learning and applying new skills and interventions together and taking responsibility for their part in the child's behavior plan. Interventions and strategies focus on skill building between child and caregiver (coping, problem solving, anger management, communication etc.) and plan development (after school routine/plan, incentive plan, crisis plan, etc.) Proactive planning for purposeful activity/intervention/skill building during service time is essential during this phase. Moving away from external motivators to internal motivators typically occurs during this phase. Functional analysis is continued throughout phase 2 to track progress and is utilized for continued assessment by TBS, clinician and other treatment team members to help guide case (i.e. length of service, reducing of frequency, change in goals, etc.)

### **3. Transition and Follow up (4-6 week) varies**

During the final phase, planned absences are implemented (as one way of gauging if it is appropriate to reduce services) once the child and caregiver experience success in utilizing new interventions/skills. As services are being reduced, more support/coaching over the phone is utilized by TBS (to ensure implementation of devised interventions/skills/plans from phase 2 and assess caregiver's ability to manage behaviors in absence of TBS as well as clients ability to implement learned replacement behaviors/skills in absence of TBS.) TBS staff oversees/develops a transition plan with treatment team to ensure that the positive behavioral changes will continue. A child graduates from TBS once the frequency, duration and intensity of the 1 or 2 targeted behaviors has been reduced and interventions and strategies are being utilized consistently by caregivers/support persons. \*\*TBS may also need to stop services if the child does not appear to be benefiting from service for progress has reached a plateau of benefit effectiveness.



# TBS Safety Plan

<b>Helping Hands</b>	<b>Cottage staff (advocate)/Trabajador de cuidado de niños</b>	(213) 111-5555
<b>Mrs. Tough</b>	<b>Mother/Madre</b>	(626) 441-1234

<b>Anticipated Crisis</b> Crisis Anticipado	<b>Proactive Intervention Plan</b> Plan de Accion	<b>Reactive Intervention Plan</b> Plan de Reaccion
1. The client will reduce physical aggression (throwing objects, slamming doors, property destruction) and replace with appropriate coping/anger management skills.	Identify triggers related to client's physical aggression. Explore replacement physical outlet with staff for client to engage in (based on his interests). Work on developing collaborative problem solving skills with client, staff and peers through use of activities and exercises.	Assist client in redirecting him to take a self time out while encouraging client to Stop, think and choose. Use calm and firm tone to give no more than 2 word prompts to redirect. Give client space and assist in removing any potentially harmful objects that can be thrown and peers out of area. Follow up with client (when ready) to review his actions and brainstorm new alternative courses of action to use in future.
2. The client will reduce verbal aggression (yelling, profanity, cussing, posturing) and replace with appropriate coping/anger management skills.	Develop "5 things I can do" coping list with client to help reduce verbal aggression (and update as needed). Build communication skills between client, peers and staff through use of games and therapeutic worksheets. Begin developing list of replacement language/phrases for client to use.	Redirect client in calm firm tone and use close proximity to support him. Remind client of using his coping skills (5 things I can do) list in the moment. Praise client for his efforts <b>immediately</b> if he applies skills. Give client space to calm down and review actions of client and come up with new alternative courses of action to verbal aggression.

**Other Vital Information / Otra información importante**  
**(Medication, unusual circumstances, hints, tips, etc)**  
 (Medicamentos, circunstancias especiales, sugerencias)

**No Medications being taken by client at this time.**

**Map and Directions / Mapa y dirección**

Include precise locations of residence

**Sign for every month of service. Update as needed.**

Date/Fecha:	Signature/Firma:

# TBS Safety Plan

Date/Fecha:	Signature/Firma:
Date/Fecha:	Signature/Firma:

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Name: Tough, Tommy      MIS#: 333333

Agency:                      Rept. Unit #

Keep it Behavioral, Simple and Success Focused!

Supervisee:

Date:

**The Goal of Supervision**

The purpose/goal/outcome of supervision is for the supervisor to

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**Agenda**

Supervisee's topics

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Supervisor's topics

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**Follow Up Items**

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Supervision Note Form

EXHIBIT Q

Staff:

Date:

Topic		Follow Up Needed
Staff Needs		
Information for Program Supervisor/Director		
Caseload Headliners/ Significant Case Issues		
Staff Issues/ Potential Disciplinary Actions/ Acknowledgements		
Other		

DMH Status					
Liability Issues	Productivity status	Empty Note status	Therapeutic Content status	Anniversary paperwork status	Audit Status

DCFS Status					
Liability Issues	Treatment Plan Report status	Case Activity Notes status	Content status	Intake & Discharge Paperwork status	Audit Status

Staff Signature: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_

Staff: \_\_\_\_\_

Date of Supervision: \_\_\_\_\_

Information to pass along:

Positive feedback and observations:

Suggestions for improvement:

Corrective feedback

Issues brought by employee:

Disciplinary Actions:

# SITE VISIT LOG

Date of Visit: \_\_\_\_\_ Specialist: \_\_\_\_\_

Time of Supervisor visit: from \_\_\_\_\_ to \_\_\_\_\_

Length of Shift: from \_\_\_\_\_ to \_\_\_\_\_

**Observations:**

**Strengths** (Important; do not omit.)

**Check any areas that may need additional training:**

- \_\_\_ Tardiness and/or \_\_\_ leaving early
- \_\_\_ Rapport building with \_\_\_ client and/or with \_\_\_ caregiver(s)
- \_\_\_ Staying within scope of practice
- \_\_\_ Coaching of or directness with caregiver(s)
- \_\_\_ Focusing on goal-related behaviors
- \_\_\_ Consistency with interventions
- \_\_\_ Transferring of Skills
- \_\_\_ Handling crisis situations: \_\_\_ child abuse reporting, \_\_\_ deescalating violent behaviors, \_\_\_ other: \_\_\_\_\_
- \_\_\_ Communication with \_\_\_ Lead, \_\_\_ TBS Clinician, \_\_\_ Referring Therapist
- \_\_\_ Other: \_\_\_\_\_
- \_\_\_ Other: \_\_\_\_\_

**Plan if required:** (Further training, discussion with clinician, etc.)

\_\_\_\_\_  
Signature of Specialist Date

\_\_\_\_\_  
Signature of Supervisor Date

**Tommy Tough's Projected Transition Plan:**  
(as of February 18<sup>th</sup>, 2007)

**\*\*\*Last day will be Monday, 4/2/07\*\*\***

**Week 1: 4 days of service at home; T W Th F**

**Week 2: 4 days of service at home; M T W F**

**Week3: 3 days of service at home; M W F**

**Week 4: 3 days of service at home; M W F**

**Week 5: 2 days of service at home; M W**

**Week 6: 2 days of service home; M W**

**Week 7: 1 day of service home; M**

## Sample INTERVENTION LIST FOR TOMMY TOUGH

1. Tommy responds well to praise and encouragement for doing well. If you are able to build rapport through identifying his positive efforts he is more likely to listen to redirects or prompts to stop a particular behavior.
2. Tommy enjoys playing basketball and football and these outlets are often best used proactively to release some energy he has throughout the day. This outlet can also be used as a reactive response if ct. has just become physical with someone in efforts to de-escalate him while processing what happened.
3. Calling Tommy's mother or special friend via phone when he becomes upset can help to de-escalate him in the moment as he responds well to both natural supports. Tommy also responds well when staff call mother and special friend to report his positive efforts or to invite them to RTC events (i.e. Family and Friends Picnic)
4. Keeping Tommy enrolled in some kind of physical outlet (team basketball, etc.) helps to encourage positive peer interaction and fosters appropriate coping skills through coach and group interaction.
5. When addressing Tommy for inappropriate peer interaction (i.e. posturing, making threats) he responds better to few word firm redirects in calm tone while walking within close proximity. He also responds well to positive touch (hand on back) and being reminding to make a good choice and referencing a time when he did make a good choice (i.e. Come on Tommy, keep making good choices like you did yesterday when Johnny provoked you, what did you do then?)
6. Tommy's identified triggers are: peers/staff talking about his mother or special friend not being able to come to a visit, or holidays when he is not going on home visit. Peers who provoke him or call him names often can trigger him as well to approach them in posturing manner.
7. Proactively seating Tommy away from identified peers who he may be having difficulty with can help to reduce negative interactions and prevent physical aggression.

8. What do you like the most about your TBS? How has your TBS helped you?

9. What do you like the least (what's least helpful) about your TBS?

10. How could TBS improve?



**YOUTH SURVEY**

Instructions: Please take a few minutes to fill out this survey. Your opinions are very important and will help improve the program. Your survey answers are confidential and will be reviewed only by the Research Department. Thank you!

**Please return the survey in the envelope provided.**

Please circle the best answer for each question. Please add comments to explain your answers.

EXHIBIT U1

**How much do you like ...?**

1. The number of hours or days per week that you meet with your TBS?

Very Much	Pretty Much	Not Sure	Not Much	Not At All
5	4	3	2	1

(comments) \_\_\_\_\_

2. The activities that you and your TBS do?

Very Much	Pretty Much	Not Sure	Not Much	Not At All
5	4	3	2	1

(comments) \_\_\_\_\_

3. The relationship that you and your TBS have?

Very Much	Pretty Much	Not Sure	Not Much	Not At All
5	4	3	2	1

(comments) \_\_\_\_\_

4. The things that your TBS teaches you?

Very Much	Pretty Much	Not Sure	Not Much	Not At All
5	4	3	2	1

(comments) \_\_\_\_\_

5. The way your TBS deals with problems?

Very Much	Pretty Much	Not Sure	Not Much	Not At All
5	4	3	2	1

(comments) \_\_\_\_\_

**How much is your TBS helping you...?**

6a. get along better with family members?	Very Much	Pretty Much	Not Sure	Not Much	Not At All
	5	4	3	2	1
b. get along better with other kids?	5	4	3	2	1
c. get along better with other adults	5	4	3	2	1
d. with self-control/making good decisions	5	4	3	2	1
e. feel good about yourself	5	4	3	2	1

(comments) \_\_\_\_\_

7. TBS is helping me do better...

at home	Very Much	Pretty Much	Not Sure	Not Much	Not At All
	5	4	3	2	1
in school	5	4	3	2	1
in the community	5	4	3	2	1

(comments) \_\_\_\_\_

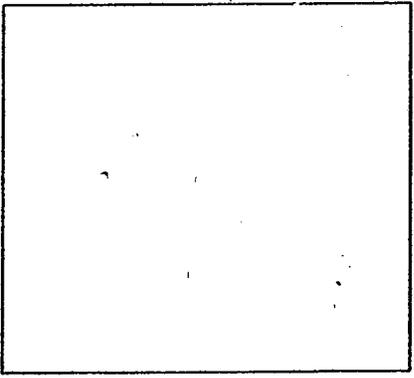
Turn Over →

5. What do you like the most (what's most helpful) about TBS?

6. What do you like the least (what's least helpful) about TBS?

7. How could TBS improve?

*Therapeutic Behavioral Services (TBS)  
Parent/Family Satisfaction Survey*



Instructions: Please take a few minutes to fill out this survey. Your opinions are very important and will help improve the program. Your survey answers are confidential and will be reviewed only by the Research Department. Thank you!

Please return the survey in the envelope provided.

Please circle the best answer for each question. Please add comments to explain your answers.

1. How satisfied are you with the amount of improvement your child has made with the help of TBS services?

Very Satisfied 5	Satisfied 4	Neutral 3	Dissatisfied 2	Very Dissatisfied 1
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(comments) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is your child...

Getting along better at home with family members?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Getting along better at school?	<input type="checkbox"/>	<input type="checkbox"/>
Learning to control his/her behavior when upset?	<input type="checkbox"/>	<input type="checkbox"/>
Feeling better about him/herself?	<input type="checkbox"/>	<input type="checkbox"/>

(comments) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. TBS worker(s) had a positive relationship with your child and family?

Strongly Agree 5	Agree 4	Undecided 3	Disagree 2	Strongly Disagree 1
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(comments) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. TBS worker(s) helped you deal with your child's behavior?

Strongly Agree 5	Agree 4	Undecided 3	Disagree 2	Strongly Disagree 1
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(comments) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Turn Over →

## CLIENT FOLLOW-UP FORM

(Follow-up is mandatory once a month for 6 months after the client's case terminates.)  
 (Turn this form in at the end of every month to the TBS Director.)

<b>Client's Name:</b>	
<b>TBS Specialist:</b>	
<b>Date of Admission:</b>	
<b>Date of Discharge:</b>	
<b>Date of Follow-up:</b>	
<b>Contact:</b> (Client, Caregiver, Clinician, Group Home Staff, CSW, PO, Other)	<b>Name:</b> <b>Address:</b> <b>Phone Number:</b> (Our Research Department requires this information.)
1. Behaviors TBS focused on and progress:  2. Current placement:  3. Agencies involved with client at his time (Mental Health, DCFS, Probation, etc):  4. Progress with therapy:  5. Consistency with taking medications:  6. Relationship with caregiver and peers:  7. School Status:  8. Current extra curricular activities:  9. Any current conflicts/concerns:  10. Future plans:  11. Other:	
<b>TBS COMMENTS/ INTERVENTIONS/ASSISTANCE/REFERRALS:</b>	
<b>TBS specialist made an attempt to follow-up on the following date but was unsuccessful because...</b>	
<b>DATE OF ATTEMPT</b>	<b>REASON (no answer, disconnected #, etc)</b>

**TBS**  
**Monthly Review/Update Form**  
**Therapeutic Behavioral Services Component**

Date of Review: 12-1-08

Client Name: Tommy Tough MIS#: \_\_\_\_\_

TBS Admission Date: 11-1-08

**Goals:**

1. Reduce verbal aggression (cursing, threatening, posturing, provoking) from 5x week to 3x week and replace with appropriate coping/anger management skills.

**Review of Progress**

During this first month of TBS, services were provided 3 times per week. Ct. had a total of 16 incidents of VA during the month of November. Behaviors included: posturing towards peers, threatening to hit, threatening language in the form of cursing, arguing with staff. Interventions utilized this month were: separating ct. from peers, redirects, positive touch, reminding ct. of making good decisions, close proximity, using calm voice, supporting direct care staff in redirecting ct., coaching peers not to respond and walk away from ct., utilized therapeutic worksheets, encouragement and praise, creating coping list "5 things I can do". Caregivers (unit staff) and client are currently receptive to services. Goals will not be changed as this is first month of service and TBS is still in rapport building/observation phase. Ct. is currently on Ritalin 10 mg. Ct.'s mother visits sporadically with ct. currently.

**TBS Transition/Discharge Plan:**

TBS will continue to provide services 3x per week in efforts to continue building rapport and assess ct.'s behavior and build coping skills/anger management skills. Ct. will continue to see therapist 1x per week.

Plan approved by clinical supervisor

Participants:	Name	Relationship and/or Agency	Date
TBS Specialist			
Caregiver			
Client			
Therapist			

TBS Specialist Signature: \_\_\_\_\_

TBS Clinical Supervisor Signature: \_\_\_\_\_

Date of Next Review: \_\_\_\_\_

**Behavior Chart**

Client Tommy Tough

Month NOVEMBER

Specialist Miracle Worker

X = # of VA incidents that occurred

Goal 1. Reduce VA from 5x – 3x p week

Yellow Times Bx. Specialist was working  
Highlight

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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Comments:

11-5-08 Ct. had cancelled visit with mother – no show - ct. accepted and had no VA incidents

11-11-08 Ct. visit with mother – good visit - no VA incidents

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Behavior Analysis

<b>Duration &amp; Date</b>	<b>Antecedents:</b> What was happening just before the behavior	<b>Behavior:</b> Describe the exhibited behavior looked like, i.e. kicking, biting, whining, etc.	<b>Interventions/Response:</b> Describe the interventions attempted and how client responded.	<b>Outcome:</b> Did client received a consequence; or what action was taken...explain.
11-6 1 incident 10 mins.	Ct. was eating lunch w peers; peer made comment "your mom never visits"	Ct. responded to peer by: standing up, posturing, threatening to hit, cursing	Bx. Spec. intervened by: Standing b/t ct. and peer, giving 2 word redirects (stop, calm down), Positive Touch (shoulder)	Ct. did not earn points from unit staff for + peer relations; Bx. Spec reviewed alternative courses of action when feels triggered and praised for not hitting peer
11-14 1 incident 5 mins	Ct. was seated w peers at dinner, peers were dialoguing about upcoming holiday	Ct. responded by: Cursing at peer "shut the f*** up" "damn be quiet" (same peer as before)	Bx. Spec. intervened by: Redirecting ct. to ignore w non verbal cue (brush of shoulder) and shaking of head	Ct. did not earn points for + peer relations; Bx. Spec. role played w ct. "what if" situations, reviewing ignoring, informing staff, moving to different seat
11-22 1 incident 15 mins	Ct. was playing outside during rec. w peers – football – call was made ct. did not like	Ct. started cursing, arguing w staff, not willing to play anymore	Bx. Spec. intervened by: Close Proximity, walked w ct., in calm voice redirected to "calm down", "let it go", "lets practice", walked ct. back to unit	Ct. had to take TO in unit in separation room; ct. took 10 minutes to scream loudly, sing, and release energy before returning back to program
11-23 3 incidents 7 mins + each	Ct. was eating lunch w peers and engaged in appropriate dialogue w peers; ct. was in living room during transition time dialoguing	Ct. yelled out "who gives a f****" "just shut up already" "damn you talk too much" at lunch 2 diff. x's (diff peers); ct. cursed at peer "nobody gives a sh**" walked out of unit	Staff reported intervening by: sitting in b/t ct. and peers at lunch, redirecting ct. verbally to stop, coached peers not to respond to ct., encouraged ct. to move to different table	Ct. did not go on evening outing w unit; ct. did not earn points for + peer relations
11-26 6+ incidents Off and on 12-4pm	Ct. was in unit w 1 staff and was arguing w staff when told to do any chores, tasks, or direction – general non compliance	Ct. was cursing, laughing "f*** no I'm not doing that sh**"; client was walking out of unit on grounds, visiting other units, cursing at bx. spec "get the f*** away"	Staff tried to redirect ct., gave choices, gave ct. space to decide Bx. spec kept eye's view of ct. while giving space, notified other units to redirect ct. back to us, ignored ct.'s cursing while asking ct. if he was ready to go back	Ct. went to separation room on his own 3 different times; was singing loudly w headphones on, screaming inappropriate lyrics to songs, dancing around



**Behavior Chart**

Client Tommy Tough

Month DECEMBER

Specialist Miracle Worker

X = # of VA incidents that occurred

Goal 1. Reduce VA from 5x – 3x p week

Yellow Times Bx. Specialist was working  
Highlight

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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Comments:

- 12-6-08 Ct. had cancelled visit with mother – no show - ct. accepted and had no VA incidents
- 12-13-08 Ct. had cancelled visit with mother – no show - ct. accepted and had no VA incidents
- 12-15-09 Ct. started new meds today – Zolof 10mg

Behavior Analysis

<b>Duration &amp; Date</b>	<b>Antecedents:</b> What was happening just before the behavior	<b>Behavior:</b> Describe the exhibited behavior looked like, i.e. kicking, biting, whining, etc.	<b>Interventions/Response:</b> Describe the interventions attempted and how client responded.	<b>Outcome:</b> Did client received a consequence; or what action was taken...explain.
12-8 1 incident 5 mins	Ct. was finishing up eating w peers ; peer mumbled something under breathe to ct.	Ct. responded by threatening "say it again f***er and I'll whoop you're a***"	Bx. Specialist cued ct. to ignore peer (non verbal) and walk away; Using CP and PT to help ct. move away	Ct. did not escalate; no + peer relations points; other peer was also consequenced
12-20 1 incident 15 mins	Staff reported during lunch peers were discussing how excited they were to go home for holiday	Staff reported Ct. responded by cutting peers off; changing subject, talking loudly, then "shut the f*** up already" "don't nobody want to hear that sh***"	Staff reported ct. was walked down to unit away from peers as ct. escalated verbally towards peers; ct. was allowed to continue to yell loudly in room, cursing in general; given space to de escalate	Ct. had early bed and earned no + peer relations points;
12-22 2 incidents 10 mins each	Staff reported Ct. was eating lunch w on call staff today; staff were dialoguing about taking trip out of state to visit family	Staff reported Ct. Commented "who gives a f***" and laughed; continued to target staff verbally "shut the f*** up, shut the f*** up"	Staff reported ct. was sent to separation room; ct. was allowed to curse and yell in room by self on 2 separate incidents during lunch	Ct. did not earn special snack; ct. did not earn + adult relations points
12-24 6+ incidents Off and on 1030-530p	Staff reported ct. woke up refusing to follow directions; staff was giving redirect; staff turned TV off; staff was giving directions	Staff reported ct. ignored staff, was cursing in general and at staff; ct. threatened and pushed staff when staff turned off TV; ct went to room and screamed, yelling	Staff reported they: reminded of conseq., gave warnings, turned off TV, redirected, gave choices, called support staff when ct. became physical, gave space for ct. to de esalate	Ct. spent most of shift w support staff off and on; did not earn + adult relations points; early bed
12-25 6 + incidents Off and on 10-3p	Staff reported ct. woke up targeting same staff about previous day turning off TV	Staff reported ct. called staff names: "punk b****" "f*** you go home" "I hate you" Threw books at staff; attempted to kick	Staff reported they: Gave space, redirected ct., reminded of coping skills (take TO, listen to music); moved away from ct.; when new staff came used fresh face w ct for remainder of shift	Ct. spent most of morning in room by self; did not earn + adult relations points; spent rest of afternoon 1 on 1 w fresh face staff without further incidents

**Behavior Chart**

Client Tommy Tough

Month JANUARY

Specialist Miracle Worker

X = # of times incident occurred

Goal 1. Reduce VA from 5x -3x p week

Yellow Times bx. specialist worked  
Highlight

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
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Comments:

1-7-09 Ct. mother cancelled visit – no show – no bx. incidents

1-17-09 Ct. mother visited – no bx. incidents

1-2-09 Ct. started having therapy 2x per week starting this month

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Behavior Analysis

<b>Duration &amp; Date</b>	<b>Antecedents:</b> What was happening just before the behavior	<b>Behavior:</b> Describe the exhibited behavior looked like, i.e. kicking, biting, whining, etc.	<b>Interventions/Response:</b> Describe the interventions attempted and how client responded.	<b>Outcome:</b> Did client received a consequence; or what action was taken...explain.
1-1-09 4 incidents Off and on 2-500p	Staff reported: during staff change ct. began targeting incoming on call staff, verbally provoking; when given directions	Staff reported ct. saying "oh great, now we get to watch football all day" "are you going to work today or sit on you're a****" etc	Staff reported they: explaining what days activities entailed did not address cursing; reassured ct. football was not on agenda for day; gave ct. space to go to room alone	Ct. went to room on own, listened to music, came back out around 5pm when other peer returned; began to participate back in program; ct. did not earn + adult relations points
1-14-09 1 incident 5 mins	Ct. was engaged in outdoor activity w peers - kickball	Ct. objected over being "out" and argued w staff and peer; cursed out loud 1 time and walked away to sit on bench	Bx. Specialist gave ct. space and time to calm down giving thumbs up for self TO; reviewed expectations for re-entering game; praised ct. verbally and encouraged to play again	Ct. took self TO for 5 mins; returned to game without further incident; no consequences
1-24-09 1 incident 5 mins	Ct. was playing video game w peer as group activity - ct. lost	Ct. threw control down and said "dammit" and walked away to room abruptly	Bx. Specialist gave ct. space initially; gave ct. thumbs up for going to room; supported ct. by sitting outside of door; told ct. 5 mins were up; gave hi five to ct.	Ct. took self TO for 5 mins; returned to video game and waited for turn; staff praised ct. for taking self TO; no consequence

11-14-08 Tommy Tough

1. Ct. will reduce Verbal Aggression from 5x per week to 3x per week and replace with appropriate coping/anger management skills.

G: Ct. had 1 incident of VA in the form of cursing at peer today during dinner. Staff reported 0 incidents of VA since last service shift.

I: Bx. Specialist praised ct. (hi five) for being in unit program upon arrival. Bx. Specialist gave ct. space to assist ct. in following routine for day. Bx. Specialist gave ct. non verbal cues throughout the day to show approval for appropriate bx. (thumbs up, wink, pat on back, sitting by ct. during transition silently.) Bx. Specialist helped ct. create a "5 things I can do" list/plan for when ct. becomes upset because of peer comments (ignore, inform staff, move away, take self TO to calm down, go to room). Bx. specialist role played with ct. "what if" situations that centered on peers provoking or talking about mother in efforts to practice using newly identified coping skills. Bx. specialist created non verbal cue (brush of shoulder with fingers and shaking of head in "no" manner) as reminder for ct. to practice ignoring peer in the midst of frustration.

Bx. Specialist redirected ct. to ignore via non verbal cue (brush shoulder off with fingers and shaking of head) when ct. began cursing at peer. Bx. Specialist positioned himself between ct. and peer at dinner table. Bx. Specialist reviewed "what if situations" again with ct. and "5 things I can do" before ending shift.

R: Ct. gave Bx. Specialist hi five and smiled. Ct. was able to stay in program when given space, occasionally checking to see if Bx. Specialist was watching him. Ct. responded well when given non verbal cues (smiled, gave head nod, gave thumbs up back.) Ct. participated in making "5 things I can do" list when he gets frustrated with peers comments. Ct. hung list up in room as visual reminder. Ct. was receptive to role play and participated with Bx. Specialist (laughing and acting out each coping skill). Ct. was receptive to learning new non verbal cue to ignore (brush shoulder off with fingers) and client likened it to Jay Z song "Get that dirt off your shoulder." Ct. was able to ignore peer after redirect with non verbal cue and when Bx. Specialist repositioned himself. Ct. was able to repeat verbally what his options are when he gets frustrated with peers.

P: Plan will be to continue to reinforce and practice newly identified coping skills. Plan will be to try and identify other possible triggers of ct.

12-8-08 Tommy Tough

1. Ct. will reduce Verbal Aggression from 5x per week to 3x per week and replace with appropriate coping/anger management skills.

G: Ct. had 1 incident of VA in the form of cursing at peer when peer mumbled something to ct. Staff reported 0 incidents of VA since last scheduled shift.

I: Bx. Specialist arrived and praised ct. for doing well in class (thumbs up.) Bx. Specialist gave ct. space and sat in back of room to allow ct. to remain in class program. Bx. Specialist used close proximity and positive touch (side hug) with ct. when ct. lined up to go to lunch and praised ct. verbally for his efforts. Bx. Specialist sat in between ct. and rest of peers at table (in efforts to set ct. up for success.) Bx. Specialist participated in conversation with peers and ct. and stimulated conversations about movies, new video games and favorite meals (in efforts to proactively steer away from comments arising about ct.'s mother.) Bx. Specialist cued ct. to ignore peer (non verbal) and walk away. Bx. Specialist stood up and used positive touch to help ct. move away from peer to take TO. Bx. Specialist informed staff of peer mumbling comment to ct. under breathe. Bx. Specialist listened to ct. vent and explain while walking what peer said ("Tommy don't remember what his mom's meals taste like cause he never goes home.") Bx. Specialist praised ct. for walking with this Bx. Specialist and not escalating and rewarded ct. with on the spot incentive \$2 McDonald's coupon (for practicing coping skill successfully.)

R: Ct. smiled upon seeing this Bx. Specialist. Ct. participated in class without incident and needed minimal cues from this Bx. Specialist. Ct. was receptive to side hug and praise given (smiling and telling Bx. Specialist about his good grades.) Ct. was receptive to Bx. Specialist sitting between himself and peers, with no objection. Ct. was listening mostly during lunch time conversation with peers, just eating food. Ct. yelled out cursing abruptly ("say it again and I'll whoop you're a\*\*") towards peer who mumbled something. Ct. was able to stop cursing and allowed Bx. Specialist to use positive touch to steer away from peer towards room to take TO. Ct. explained to Bx. Specialist what peer had mumbled. Ct. was able to calm down once Bx. Specialist reported incident to staff and other peer received a consequence. Ct. was receptive to earning on the spot incentive of \$2 coupons for McDonald's and agreed to continue practicing using coping skills.

P: Plan is to immediately address provoking peer to reduce ct.'s chances of becoming VA. Plan is to continue to use non verbal cues, seating arrangement at lunch/dinner time to sit between ct. and peers. Plan is to continue to use on the spot incentives with ct. as he practices using new coping skills.

1-14-09 Tommy Tough

1. Ct. will reduce Verbal Aggression from 5x per week to 3x per week and replace with appropriate coping/anger management skills.

G: Ct. had 1 incident of VA in the form of yelling out loudly 1 curse word when getting "out" in kickball game. Staff reported 0 incidents of VA since last scheduled shift.

I: Bx.Specialist greeted ct. upon arrival with side hug. Bx.Specialist reviewed expectations of the day with ct. verbally, explaining how Bx.Specialist was going to give ct. many opportunities today to practice using coping skills without being cued. Bx.Specialist had ct. repeat coping skills without looking at visual aide in room. Bx.Specialist gave ct. space throughout the day in efforts to allow ct. to practice using coping skills without being prompted. Bx.Specialist praised ct. non verbally each time ct. accepted directions and doing tasks without objecting. Bx.Specialist encouraged ct. during playing of kickball game ("let's go Tommy, you can do it"). Bx.Specialist used planned ignoring when ct. cursed out loud and gave ct. space to practice using coping skill. Bx.Specialist gave ct. thumbs up when ct. took self TO on bench. Bx.Specialist went to sit by ct. after 1 minute and praised ct. verbally, reviewing with ct. expectations for getting back in game (and accepting getting out). Bx.Specialist encouraged ct. to re-enter game.

R: Ct. gave Bx.Specialist side hug and listened as Bx.Specialist reviewed expectations. Ct. repeated verbally all his coping skills aloud. Ct. was in program, following directions, doing chores without prompting from Bx.Specialist for most of day. Ct. occasionally glanced up at Bx.Specialist to see if Bx.Specialist was noticing and gave thumbs up back to Bx.Specialist. Ct. was non responsive to encouragement during game. Ct. let out loud curse "Sh\*\*" when peer caught ct.'s kicked ball and ct. was out. Shortly thereafter, ct. walked himself over to bench to take a TO without prompting by staff or Bx.Specialist. Ct. was able to remain in self TO for 1 minute on his own. Ct. was receptive to Bx.Specialist noticing his efforts and praising him. Ct. was able to stay in TO for full 5 minutes. Ct. apologized to staff and peers for cursing and was allowed back in game without further incident.

P: Plan is to create intervention list to pass on to current and future caregivers. Plan is to prepare for upcoming holiday (MLK) and assign special friend to take ct. on outing. Plan is to provide TBS services on holiday as well and assess if ct. does well off unit on holiday with planned activity.

DISCHARGE SUMMARY

	Date	Time
Admission	_____	_____
Last Contact	_____	_____
Discharge*	_____	_____

\*Date of last contact or last cancelled or missed appointment

**Presenting Information:** Ct. was referred for TBS services to prevent higher level placement. Ct. engages in verbal aggression in the form of cursing at staff and peers, threatening to hurt and posturing, provoking peers.

**Course and Response to Treatment:** During the 1st month of service ct. and caregiver were receptive to services. Ct. had a total of 19 incidents of VA. Ct. was receptive to the following interventions: separating ct. from peers, redirects, positive touch, reminding ct. of making good decisions, close proximity, using calm voice, supporting direct care staff in redirecting ct., coaching peers not to respond and walk away from ct., utilized therapeutic worksheets, encouragement and praise, creating coping list "5 things I can do". TBS provided 3-4 days of service per week.

During the 2nd month of service ct. and caregiver were receptive to services. Ct. had a total of 18 incidents of VA. Ct. was receptive to the following interventions this month: close proximity, seating arrangement (lunch and transition time), positive touch, self time outs, coaching client to inform staff when peers provoke, on the spot incentive (McDonald's coupon), praise and encouragement, reviewing expectations, practice using replacement language in "what if" situations. Identified triggers this month: peers comments about mother and being left on unit during holidays (not going home to visit mom.) TBS provided 3-4 days of service per week.

During the 3rd month of service ct. had a total of 6 incidents of VA. Ct. was receptive to the following interventions this month: giving ct. space to practice using coping skills without being prompted, reviewing expectations, practice repeating coping skills without use of visual aide, self time outs, arranging planned outings or activities for ct. during holidays (as ct. struggles with being left alone when peers are gone), staff responding immediately to peer provoking decreases ct. responding verbally aggressive to peers. Identified triggers: losing in game and being bored. Services were reduced this month to assess caregivers ability to implement interventions and plans to manage ct.'s behavior in absence of TBS, and caregivers reported they were able to manage behaviors this month. TBS services continued to be reduced as ct. continued to meet TBS goals. TBS provided 2 days of service per week (except during holiday this month, provided extra service) and discharged on 2-5-09.

**Medication:** (Include Dosage & Response) None  
Risperdal 2.5 mg

**Disposition and Recommendations:** (If referred, include name of agency(s) or practitioner(s)) \_\_\_\_\_  
Ct. was able to remain in current placement and did not move to higher level of care. Ct. continues to be on medication and see therapist 1x per week upon discharge of services.

\_\_\_\_\_  
(Signature and Discipline) Date

\_\_\_\_\_  
(Reviewer's Signature and Discipline) Date

This confidential information is provided to you in accord with applicable Welfare and Institutions Code Section. Duplication of this information for further disclosure is prohibited without the prior written consent of the patient/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is

Name:	Tommy Tough
MIS #:	
Agency:	
Reporting Unit:	7286A