Therapeutic Mentoring Practice Guidelines

Therapeutic Mentoring Practice Guidelines

Table of Contents

Purpose of These Guidelines 1

The Children's Behavioral Health Initiative (CBHI) 2

- Mission 2
- Values (Systems of Care Philosophy) 2
- Vision 2
- Strategic Priorities 2

Overview of Therapeutic Mentoring 3

- Eddie 3
- The TM process from beginning to end: Amy 6
- What Therapeutic Mentoring is 12
- What Therapeutic Mentoring is not 12

The Therapeutic Mentoring Process 13

- Referral 14
- Initial contact and engagement with family and youth 14
  - José 16
- Assessment 16
- Planning 17
  - Developing the Therapeutic Mentoring Action Plan 17
  - Jenny 17
- Lesson Plan Development 17
- Safety Plan Development 19
- Ongoing cycle of implementation and collaboration 20
- Implementing the plan 20
  - Developing a relationship with the youth 20
  - Best Practices for building a relationship as a Therapeutic Mentor 22
  - Examples of skills that youth may need to develop 24
- Preparation and Transition Out of Therapeutic Mentoring 26
  - Transition vignette: Jillian 29
  - Transition vignette: Shaun 30
  - Transition vignette: Josefina 30

Documenting Progress 30

Working with Hubs and Other Services 32
Working with Parents 33
Providing Therapeutic Mentoring to Siblings 34
Culturally Relevant Practice 34
Staffing, Training, and Supervision Requirements 36
Supervision Requirements 36
Staff Training 37
Credentialing Requirements 37
Credentialing Waiver Requests 38
Use of Interns 38
Staff Transitions 38
Medical Necessity Criteria for Admission 40
Service Definitions 40
Access to Care 41
Timeframes and Documentation 42
Waitlist Activities 42
Medical Necessity Criteria 43
Criteria for Admission 43
Criteria for Continued Services 44

Bibliography 45

Appendices 46
Appendix A: Availability of CBHI Services to Members in Various Benefit Plans 46
Appendix B: Suggested Resources for Building Social Skills with Youth 47
Appendix C: Therapeutic Mentoring Service Definitions 48
Appendix D: Therapeutic Mentoring Performance Specifications 48
Appendix E: Therapeutic Mentoring Medical Necessity Criteria 48
Appendix F: Managed-Care Entity CHBI Health Record Documentation Standards 48
Appendix G: CBHI Clinical Pathways Grid 49
Appendix H: Tip Sheet for Outpatient Clinicians: Roles and Responsibilities as a CBHI Hub Provider 49

Appendix I: Crisis-Planning Tools 49
Appendix J: Managed-Care Entity CBHI Waiver Request Form 49
Appendix K: Guidelines for Ensuring Timely Access to CBHI Services 50
Appendix L: Access to Care Protocol 50
Appendix M: CBHI Referral Log Waitlist 50
Appendix N: Managed-Care Entities Therapeutic Mentoring Initial and Subsequent Authorization Processes 50
Appendix O: Managed-Care Entities Websites 50
Appendix P: Definition of Terms 51

Acknowledgements 56

Purpose of These Guidelines

These guidelines detail professional standards, expected practices, and quality considerations for Therapeutic Mentoring (TM) services for the Children's Behavioral Health Initiatives (CBHI). The intent of these guidelines is to provide guidance on best practices for staff providing the service on a day-to-day basis so that their interactions, activities, and interventions with youth and their families result in the achievement of intended outcomes. This document is **not** intended to restate what is described in other governing CBHI documents; rather, it describes best practices in implementing those standards and protocols.

The primary audience for this document is providers of TM. All TM providers and their staff should read, reflect upon, and use these guidelines on a regular basis. [1]

In addition, the guidelines may be useful to youth and families in understanding, choosing, and evaluating services; and to other stakeholders, including providers of other behavioral health services and child-service state agencies. We strongly recommend that all stakeholders also consult Practice Guidelines for other MassHealth behavioral health services—not just to understand those services, but also because insights from those documents may illuminate TM.

Many documents referenced throughout the guidelines are found in the Appendices section and are available as a resource to providers in the Children's Behavioral Health Initiative section of the Massachusetts Behavioral Health Partnership website at www.masspartnership.com.

We welcome feedback on all the Practice Guidelines for future revisions. Please address questions and comments to cbhi@state.ma.us, or call the Assistant Director of Children's Behavioral Health Interagency Initiatives at 617-573-1791.

[1] In this document, the term "provider" is used to refer to the provider agency or program. When referring to a Therapeutic Mentor, terms such as "TM," "TM staff person," or "practitioner" are used.

The Children's Behavioral Health Initiative (CBHI)

Mission

The Children's Behavioral Health Initiative is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care to ensure that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success in home, school, and community.

Values (Systems of Care Philosophy)

- Child-Centered and Family-Driven

  Services are driven by the needs and preferences of the child and family, developed in partnership with families, and accountable to families.

- Strengths-Based

  Services are built on the strengths of the family and their community.

- Culturally Responsive

  Services are responsive to the family's values, beliefs, and norms, and to the socioeconomic and cultural context.

- Collaborative and Integrated

  Services are integrated across child-serving agencies and programs.

- Continuously Improving

  Service improvements reflect a culture of continuous learning, informed by data, family feedback, evidence, and best practice.

Vision

Massachusetts places the family and child at the center of our state's service delivery system and has a coordinated system of behavioral health services that meets the individual needs of the child and family. Policies, financing, management, and delivery of publicly funded behavioral health services are integrated so that families can find and use appropriate services. The system ensures that all families feel welcomed and respected, and that they receive services that meet their needs, as defined by the family.

Strategic Priorities

1. Increase timely access to appropriate services
2. Expand array of community-based services
3. Reduce health disparities
4. Promote clinical best practice and innovation

5. Support positive outcomes for children and families
6. Establish an integrated behavioral health system across state agencies
7. Strengthen, expand, and diversify workforce
8. Mutual accountability, transparency, and continuous quality improvement

Overview of Therapeutic Mentoring

Therapeutic Mentoring (TM) is a home- and community-based service of structured, one-to-one mentoring sessions between a Therapeutic Mentor and a youth, designed to support a specific goal on the youth's behavioral health treatment plan developed by a hub service. The service takes place in the locations most conducive to the youth's acquisition of skills, including the youth's home and a wide variety of community sites. Typically, TM is performed by a paraprofessional Therapeutic Mentor who is supervised by a qualified clinical professional.[2] TM is a hub-dependent service; therefore, TM always unfolds in the context of one or more behavioral health services, including the hub service.

TM is designed to give youth the opportunity for skill building through experiences in his or her natural environment. Therapeutic Mentoring addresses one or more goals on a youth's existing Outpatient Therapy or In-Home Therapy treatment plan (for youth not in Intensive Care Coordination), or on an existing Individual Care Plan (for youth in Intensive Care Coordination). To help the youth develop the target skills, the TM works to model and educate the youth about the use of the skills, motivate the youth to practice the skills, coach the youth to overcome obstacles, and help the youth and family evaluate and celebrate the youth's progress.

Target skills usually fall into the categories of interpersonal (i.e., social) skills and self-management (i.e., executive functioning) skills. Since self-management is necessary in social situations, and since successful self-management often relies on getting support from others, youths will often need to work on skills in both categories at once.

Eddie [3]

> *Eddie, age 15, receives individual outpatient therapy (his hub) and medication management. He is making progress on treatment goals related to depression and conflicts with his parents. However, he is not successful at making friends with other youth as part of a larger positive peer group. He lacks confidence to try new activities and then withdraws quickly to home and other places where he feels comfortable. This frustrates his parents, which has led to more conflict at home.*

---

[2] The term "paraprofessional" is drawn from the performance specifications. It refers to a person whose education does not include an advanced degree in a clinical discipline. It does not imply a lack of role-specific training or of a professional attitude. These are essential!

[3] As with all examples in this document, this vignette is based on a composite of real stories rather than a specific individual, and all names are fictional.

The Outpatient therapist consults with Eddie and his parents and, with their agreement, initiates a referral to Therapeutic Mentoring to work on the goal of developing peer skills and persistence for new tasks. TM is written into the outpatient treatment plan to augment the therapist's work through direct "in vivo" coaching.[4] *The youth, family, therapist, and Jake, the TM, agree that Jake will spend time with Eddie practicing effective social interactions and that they together will select a new community activity that interests Eddie.*

Jake develops an action plan that builds on the strengths that Eddie has shown in interactions with adults. They use techniques that have worked at home, such as keeping a calm tone of voice and an appropriate interpersonal distance, to role-play conversations with peers. They also discuss how turn taking with peers is different than with adults, who may be more tolerant than peers of Eddie's long-winded way of speaking. They practice various topics, and they come up with a list of phrases to use to initiate conversation with a peer. After some time, Jake and Eddie go to a video game industry show where Eddie can converse with other youth who share his gaming interests.

To develop persistence, Eddie would like to try an individual sport, as he feels sure that he is not ready for a team environment. Another task for Jake is to explore possibilities such as jogging, swimming, or rock-climbing with Eddie and to participate with him while encouraging Eddie to gain confidence to try on his own. Eventually, they set up a plan for Eddie to try jogging and report on how he liked it. They gradually add intervals and distance to keep Eddie challenged without being discouraged. They explore possibilities for Eddie to join a Meetup group of local runners to begin making social connections.

Jake communicates regularly with the outpatient therapist to ensure that TM actions continue to fit the scope and progress of therapy. Jake's observations about Eddie's interactions in hands-on situations strengthen the therapist's understanding of Eddie's challenges. The therapist's sharing of her strategies in building Eddie's communication skills and confidence enhances the impact of Therapeutic Mentoring.

While there is no formal credentialing requirement for the role of Therapeutic Mentor, the best TMs bring an array of interpersonal skills, common sense approaches, creative learning experiences, and organizational ability to the work of mentoring. Under the supervision of a trained and licensed clinician, and in collaboration with the hub team, the youth, and family, a TM must be able to translate the identified hub treatment plan goal for which TM is involved into concrete, practical steps for the youth's skill development.

The Therapeutic Mentor works directly with the youth, family, and referring hub provider (Intensive Care Coordination, In-Home Therapy, or Outpatient Therapy) in the continuing process of gaining insight into the youth and family's needs and strengths, developing an understanding of the family's culture, and helping the family carry out options that have been identified with their treatment team. The TM addresses the youth's needs in a manner that is strengths-based and sensitive to and respectful of the family's culture. The TM collaborates with other supports, when appropriate and with the family's consent, and integrates all Therapeutic Mentoring activities with other behavioral health services provided to the youth.

---

[4] *In vivo* (in life) is a term from biological research referring to experimental phenomena observed in living organisms rather in than *in vitro* (in glass), in Petri dishes. Psychology uses these terms to refer to phenomena in real-life settings versus those that occur in artificial settings (such as a therapist's office).

Therapeutic Mentoring services include supporting, coaching, modeling, and training the youth in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and relating appropriately to other youth and adults while engaged in community-based services and programs. In addition to guidance from the hub team, a TM clinical supervisor provides guidance in developing a TM Action Plan to address the overarching goals. The clinical supervisor has a perspective, honed through training and experience, which helps the TM to map the overall plan as well as "lesson plans" for each mentoring session.[5]

As long as a youth continues to meet Medical Necessity Criteria, youth and family agree to the service, and the hub provider supports the intervention, there is no restriction on length of time that a youth may engage in Therapeutic Mentoring. The frequency and duration of each session as well as the service as a whole are determined by the individual needs of the child and family in the context of the hub treatment plan. There is no arbitrary time limit on TM services.

Finally, TM provider organizations participate in the service area's System of Care (SOC) Committee, which works at a system level to promote collaborative problem solving about barriers to services; scarce resources; the need for enhanced coordination among school systems, state agencies, and providers; and other regional concerns. The SOC Committee is hosted by the local Community Service Agency and invites participation across the system, including representatives of state agencies, school districts, Courts and Probation, all CBHI service providers, hospitals, and other 24-hour levels of care, medical practices, Managed-Care Entities, family members and young adults, and the wide array of community resources. Participation in the SOC promotes positive relationships among resources and regular information sharing, which benefits families who need support.

Therapeutic Mentoring has a clear purpose and scope different from general mentoring programs, such as the Big Brothers Big Sisters. The Therapeutic Mentor always works in the context of a behavioral health treatment plan to support, coach, and guide the youth to develop the skills necessary for him or her to make use of community-based services and programs, such as Boys and Girls Clubs, YMCAs, town recreational programs, faith communities, afterschool programs, health and wellness programs, job training, and employment. Skill building may include helping youth to engage in effective self-advocacy with existing treatment providers, Care Planning Team meetings, System of Care Committee meetings, and other resources.

---

[5] We use the term "lesson plan" to convey the kind of prior planning of goals, setting, activities, and materials that are necessary for effective TM sessions. TM does not replace educational services, including special education services that must be provided under an Individualized Educational Plan.

The TM process from beginning to end: Amy

As a hub-dependent service, Therapeutic Mentoring always comes into a process that is already underway. In this case, Amy is in Intensive Care Coordination (ICC).

> *According to the Intensive Care Coordination (ICC) assessment, and ongoing Care Plan Team meetings, Amy is a 12-year old girl with a history of trauma, depression, and out-of-home placement who overeats to soothe her emotional distress. Her parents (Suzette and Jeff) and her pediatrician are worried about her health. She has gained so much body mass in the past year, since returning to live with her birth parents, that she is showing early stages of diabetes. Amy defiantly denies that her weight gain is a problem, and she has so far refused to discuss her eating habits. However, the school is alarmed that she has for months been skipping gym class and sometimes missing school altogether. Suzette reports that Amy refuses to weigh herself or go shopping for clothes and complains of feeling tired most of the time. On weekends, Amy barely leaves the apartment. She "sneaks" snacks throughout the day and eats alone in her room.*
>
> *Suzette and Jeff are both concerned for Amy's health. Suzette admits to being angry with Amy for not taking better care of her appearance. Jeff alternates between saying it is "just a pre-teen stage" and that Amy "should know better" than to let her health suffer. He says that he ridicules Amy sometimes so that she will "snap out of it." Both parents are fearful that DCF will remove Amy from their home again, if the school absences continue. Suzette reports that they have "tried everything" to get Amy to stop overeating and they are frustrated with the ensuing fights.*
>
> *The ICC team has explored the family strengths, including times when Amy is able to use calming tactics other than eating to soothe her. When her grandmother is visiting, Amy takes walks with her around the neighborhood; they do errands together, and Amy can talk with her about feeling depressed and about how much she "hates herself." Suzette notes that Amy sometimes asks her to buy fruit "because it's healthy," but that if Suzette suggests it, Amy will balk. Suzette also says that she and Amy can joke around together when they are not talking about health issues and that Amy likes the one-to-one attention.*
>
> *The family and ICC clinician have pulled together a Care Planning Team of the many stakeholders in Amy's situation—Amy, her parents, grandmother, pediatrician, school adjustment counselor, school attendance officer, In-Home Therapy clinician, individual outpatient therapist, and Department of Children and Families worker. They have clarified roles among the team members, and they have developed both a Safety Plan (some of Amy's remarks to her grandmother have raised concerns about suicidality) and an Individual Care Plan that prioritizes Amy's health and her family's need to support her healthy choices without arguments. The Plan weaves together all the strands of strength and support.*
>
> *The Care Planning Team agrees that a Therapeutic Mentor would be an asset in working on the Care Plan goal of improving Amy's eating and exercise habits as part of the plan to overcome depression. The ICC makes the referral to the family's preferred agency for Therapeutic Mentoring, and when a cheerful young woman named Carol is assigned, the ICC provides (with family consent) the assessment and Care Plan.*

At the start of service, the TM prepares his or her engagement with the family through conversations with the hub-referral source, review of the relevant clinical documents, with family consent, and initial conversations with the youth and family as they engage together. The Therapeutic Mentor does **not** complete a comprehensive assessment or a CANS, as these are the responsibility of the referring hub. The hub shares the most up-to-date Comprehensive

Assessment, including the CANS at the start of service, except in those rare situations where the family declines consent.[6] The documents and related discussion give the TM an understanding of the goals and issues that are a priority for the youth and family. The CANS can be an especially useful tool for the TM, as it is written in a clear, direct format; it addresses current behavior, and its ratings prioritize areas of need.

The hub also provides and discusses with the TM the most recent hub treatment plan to which the TM work applies. Based on the goals identified for intervention by the hub team and conversations with the youth and family, the TM develops an Individual Action Plan (IAP) that is clearly and specifically linked to the identified goal(s) in the hub Treatment Plan. The TM also fits the Action Plan into the parameters of the hub Safety Plan with the hope that successful skill development in the identified areas of risk may help to avert crisis altogether. The hub team and the TM's clinical supervisor offer input.

> *Carol plans to meet with Amy and her family to develop the Individual Action Plan that derives from the Care Plan goal and guides the TM work. The ICC and Carol agree to weekly check-in times. They make a plan for Carol to attend the next Care Plan Team meeting to make sure that TM is incorporated into the team's decisions about strategies and next steps.*
>
> *Carol recognizes that her role addresses one important goal, but that there are many more challenges that the family encounters. These include Amy's emotional distress over past abuse, her blaming herself for being placed out of home, the struggle to re-engage as a family unit after Amy's out-of-home placement, the parents' overall parenting styles, their distrust of state agency involvement, and their need for education about emotional health. Carol uses supervision to guide her through the potential hazards of intervening in areas addressed by others on the team.*

A Therapeutic Mentor must be able to direct his or her work to the identified scope without being tempted to intervene independently in areas of the work that are the responsibility of other team members.

The TM must provide anticipatory guidance with youth before beginning activities, especially in new or unfamiliar circumstances. The TM may teach alternative strategies to youth for making friends and interacting positively with peers and adults. To assist the youth in developing pro-social communication skills, the TM may be called on to teach/coach conflict resolution skills to youth, and model effective communication in various interactions, including those with emotional charge. Within the context of the Action Plan, the TM may guide the youth in rehearsing how to deal with social pressures to engage in risky or unwise activities (such as substance use, sexual activity, illegal behavior, or associating with negative peers).

---

[6] This is the family's right. However, if a family declines consent for providers to share information, it signals a need to explore the reasons. This is primarily the responsibility of the hub and secondarily that of other providers. It is important to know, for example, if a family has had bad prior experiences with providers sharing information, or if they have misconceptions about how information may be used. Sometimes it is necessary to build trust before families feel safe sharing information, so it makes sense to revisit the family's concerns over time.

In order to provide this guidance, the Therapeutic Mentor needs to practice new skills with the youth in a safe, controlled setting as a behavioral rehearsal before testing them in "real world" situations. After the behavioral rehearsal, the TM finds (or creates) naturally occurring experiences in the community for the youth to practice new skills. The TM thoughtfully and gradually exposes youth to social situations to exercise age and developmentally appropriate skills, and supervises the youth's practice of new or enhanced skills in different settings and situations. The TM must provide timely, encouraging feedback to the youth on how she or he demonstrates the practiced skill.

> *In Amy's situation, with the goal of improving Amy's eating and exercise habits, Amy, her parents Suzette and Jeff, and Carol draft an Individual Action Plan that starts with the strengths that Amy has demonstrated and will evolve as she progresses. For example:*
>
> - *Amy and Carol will take a walk around the block together twice each week.*
> - *Amy will eat a fresh fruit snack with Carol after each walk.*
> - *Amy and Carol will practice using the communication techniques–such as "I-statements" and words that identify strong feelings–, which the outpatient therapist has suggested to Amy.*

Helping the youth build motivation and commitment to the mentoring tasks is part of the TM's job. Youth are likely to be ambivalent about the activities laid out in the Action Plan—they may lack confidence in their ability, be fearful of failure and well-practiced in avoiding or diverting attention away from tasks that are challenging. The TM Action Plan should recognize the need to build motivation through engagement of the youth in planning goals and activities, through development of a positive relationship with the youth, through careful grading of the difficulty of the planned activities, and through frequent opportunities to reward work with fun and celebrations of progress.

> *Carol and her supervisor talk over possible ways to incentivize Amy. Carol works with the In-Home Therapy team and family to identify small ways that Amy and her mother can have fun together (a game of cards for the two of them, a funny movie rental), as well as non-food rewards that Suzette and Jeff can give to their daughter each time she reaches a milestone in her treatment, such as completing three walks without complaint or stepping on the scale to weigh herself at home. In support of the family's Safety Plan, Carol reminds Amy when she gets stressed and uncommunicative that she can call her grandmother as a support.*

Each meeting between the TM and the youth follows a purposeful, individualized "lesson plan" that reinforces the overall goal through clear, planned activities that build in increments from previous sessions. The lesson plans teach, model, and coach skills related to each identified goal on the Individual Action plan. Lesson plans guide the meetings with the youth so that they have a defined purpose related to treatment and are not simply an activity or social occasion to enjoy.

The TM provides feedback to the family, with the youth, about progress and skills the youth continues to practice. When the youth needs to develop or practice skills in the context of his or her family relationships, the Therapeutic Mentor collaborates with the hub team and works

with youth and family together to implement strategies in the home that are consistent with the youth's IAP and goals.

For the first few meetings, Carol reminds Suzette before the meeting to have fresh fruit on hand for Amy's snack, but Carol also brings apples "just in case." When she arrives, Carol and Amy walk together around the block. Carol makes the walks engaging by appealing to Amy's interests—noticing the signs of spring that are appearing, chatting about celebrity news, and sharing amusing stories about silly escapades. At the end of each walk, she asks Amy to describe one feeling about the walk using an I-statement. Carol keeps both the outpatient therapist and the In-Home Therapy team apprised of these meetings and learns from them that the IHT team is helping the parents to back away from nagging and teasing Amy, as they had sometimes done, and to understand Amy's condition more fully.

After the first few sessions of building the walking habit, Carol flexes the meeting time to add elements to the lesson plan. She still walks with Amy, but she also starts each meeting by asking Amy and her mother for examples of positive changes: Have there been times when Amy has not felt tired? Were Amy and Suzette able to spend some pleasant, one-to-one time over the weekend? Has Suzette noticed a time that she was able to stay calm with Amy?

Carol introduces the plan for rewards, and they agree that Amy will get to download one song from iTunes for each time that she chooses a fruit snack, takes a walk with Suzette, or voluntarily uses an I-statement instead of a blaming statement to express her distress. Carol anticipates bumpy progress and leaves room for setbacks; she sets modest goals with Amy (can she earn two songs this week?) but not deadlines.

Again, communication with the other team members helps to mutually reinforce the work and keep everyone aware of Amy's progress, Suzette's challenges in making time for Amy, Jeff's struggle with his angry responses to Amy, and so on.

Carol communicates with the IHT team and the individual therapist every week after the second meeting with Amy. Carol also attends the Care Plan Team meeting every month to make sure that her work remains firmly fixed in the context of the entire team effort.

Therapeutic Mentoring **does not directly provide** formal social, educational, artistic, athletic, recreational, or vocational services. The Therapeutic Mentor may engage youth in **existing** social, educational, artistic, athletic, recreational, or vocational services as part of a therapeutic plan when a youth's emotional/behavioral deficits prevent him or her from doing so alone and when participation supports a goal on the behavioral health plan. A TM does not act as a tutor, individual sports coach, or a music teacher, for example.

When a Therapeutic Mentor chooses to use a community event or activity as a way to teach or practice new skills with the youth in order to meet their treatment goals, such occurrences must always serve the purpose of addressing the needs of the specific youth with whom the TM is working. In the event that multiple Therapeutic Mentors are working with their respective youths at the same community event or activity, every effort must be made to maintain the confidentiality of each youth.

In general, it is NOT appropriate for Therapeutic Mentors to **arrange to meet together** with their respective youth at the same community event or activity.[7] Therapeutic Mentoring is not an occasion for TM staff to socialize together. A TM's decision to attend the event should always be based on maximum benefit to his or her youth, independent of other youth attendance.

> *As the positive relationship between Amy and her parents gradually strengthens, and as Amy slowly gains healthy self-soothing techniques (walking on her own, talking more openly with her therapist), the Care Plan team sees other signs of progress. At last, at a check-up with the pediatrician, Amy's health indicators show positive improvement. Suzette reports a reduction in family conflict, and Amy says she has had some good times with Suzette "just hanging out."*
>
> *Carol—in consultation with the Care Plan Team—can consider another level of challenge with Amy. The next increment might be to build on Amy's interests and strengths to plan an activity in a social setting. They might decide to attend an outdoor health fair to learn about community groups. The purpose of Carol going with Amy is to provide encouragement for Amy in an interactive community setting and to help her explore possible future opportunities.*
>
> *Alternatively, they may explore animal shelters to find a place where Amy can volunteer to walk dogs; or take advantage of a free workout in a promotion for a fitness club. Other challenges might include increasing the number of walks per week and gradually replacing Carol's participation with a school companion or family member. In all cases, next steps depend on individual strengths and needs, the behavioral health treatment goals, and team and supervisor consultation. Every activity has a specific, youth-centered purpose.*

Therapeutic Mentors must receive training to understand community safety principles for themselves and the youth when attending community outings. It is imperative that the TM anticipate and plan ahead for the type of supervision that the youth will need, taking into consideration the age, developmental level, and gender of the youth; the environments in which the youth needs extra support; and any potential risk factors inherent in the situation.

Many youths in TM will have a Safety Plan developed by the Hub. Therapeutic Mentors, in this case, must be familiar with each youth's Safety Plan prior to going out into the community with responsibility for the youth and must have adequate access to reach a supervisor, a primary member of the treatment team, and an emergency service provider in the event of a crisis.

Therapeutic Mentors provide transportation at times in connection with a therapeutic activity. Providing transportation to a community activity or doctor's appointment, for example, without a clear therapeutic intent **is not** part of the TM service. The TM must be prepared to follow all state requirements for safety restraints (car seats, seat belts) and to stop if the youth removes a seat belt or becomes agitated to a degree that risks safety.

---

[7] On rare occasions, it may make sense to arrange a conjoint Therapeutic Mentoring session in which two mentored youths meet with their TMs in order to foster relationships that may serve as informal supports for both youths. Ensuring youth and family informed consent over release of private information in such a circumstance requires careful thought and discussion on the part of the families, the providers, and the hubs. We recommend that no TM undertake such a plan without prior discussion with the youth's MCE.

Therapeutic Mentoring does not provide childcare or respite. TMs do not meet with youth in the family home without a parent or guardian present in the home, unless the treatment team has identified and approved an appropriate substitute caregiver to be present.

Sometimes treatment team members who do not understand the medical necessity criteria for TM will urge the TM to fill an unmet need for supervision or transportation of the youth. If this occurs, the TM provider must educate the team about the medical necessity criteria for TM and be firm about appropriate use of the service.

Transitioning from a CBHI service is a team effort. Transition from TM occurs when the goals on the Individual Action Plan have been substantially met and/or when the youth no longer meets Medical Necessity Criteria for the service. Planning for transition should occur long in advance, and should involve the youth and family, the TM provider, and the hub, as well as any other services or stakeholders who are centrally involved as members of the Care Planning Team or treatment team.

Sometimes TM continues through a transition in hubs, such as ICC stepping the hub function down to IHT or outpatient, or IHT transferring to outpatient. The transition can also go in the other direction as team members identify a need to "step up" the hub function. In this case, it is the responsibility of the outgoing and incoming hubs to ensure continuity for hub-dependent services like TM. An alert TM provider will always monitor an upcoming hub transition to ensure that the outgoing and incoming hubs, in fact, are collaborating in planning the transition with the family, with each other, and with hub-dependent services.

> *As Amy and her family are successful in achieving the treatment goals developed in their Care Plan Team, the team may decide together that ICC is no longer needed, but that the family would continue to benefit from In-Home Therapy and individual outpatient therapy for Amy. Since they also agree that Therapeutic Mentoring is an important part of continuing with Amy's treatment, the hub responsibility shifts from ICC to the IHT team, and Carol continues to work with Amy without interruption, as long as Amy meets the Medical Necessity Criteria.*

When the needs that required TM have been met and the treatment team and hub agree, Therapeutic Mentoring prepares for transition.

> *As with all CBHI services guided by Wraparound principles, the transition is carefully planned, celebrates Amy's successes, and occurs with agreement from the full team. In Amy's case, transition planning takes place when Amy's health indicators are stable, she has been able to verbalize her distress according to treatment goals, she is engaging in regular healthy exercise and social interaction, and she is spending quality time with Suzette on a regular basis.*

Therapeutic Mentoring, as with all CBHI services, is based on System of Care and *Wraparound* principles. Therefore, it is a flexible, individualized service that has no specified limit on the duration of services. The length and intensity of service as well as the transition out of TM is based on the youth, family, and treatment team determination of youth and family needs and a team agreement that the youth no longer needs the one-to-one support offered by TM.

What Therapeutic Mentoring is

- A hub-dependent CBHI service that works on goals established in a hub's plan
- A service that creates a positive relationship with a youth in order to accomplish activities that build skills, knowledge and confidence related to the youth's goals
- An opportunity to enhance skills both in relation to others (social skills) and oneself (self-management)
- Collaborative with family and team members
- Culturally informed according to the unique nature of each family
- Continually informed by outcome data, revising plans as needed based on their outcomes
- Capable in transitioning youth in a planned fashion to other supports and activities in place of Therapeutic Mentoring

What Therapeutic Mentoring is not

- A way to meet a youth's need for long-term relationships with caring adults—TM is available for as long as is medically necessary to address the youth's treatment needs, but it is not intended to take the place of a long-term adult relationship[8].
- An intervention designed primarily to provide a positive adult role model—While the TM should be a positive model for the youth, an individualized plan for Therapeutic Mentoring should involve active teaching and rehearsal of skills, and not just modeling of appropriate behavior by the TM.
- The best place for a young person to "open up" with disclosures not shared with others—While the TM should be a "good listener" and respectful of the youth's need for privacy, and while conversation can be both a way of building a relationship and a way of practicing needed skills, TMs also need to recognize times when it is necessary to redirect or reframe a conversation. In particular, the TM cannot be a keeper of secrets. (This is an area where the supervisor can provide helpful guidance to the TM.[9]) While a

---

[8] If a young person needs additional, long-term adult supports—and many youth in CBHI services do—Therapeutic Mentoring should bring this need to the attention of the hub so the team can plan for development of additional formal or natural supports. This could include strengthening family relationships, finding community resources such as volunteer mentors (e.g., Big Brothers Big Sisters), or developing other natural supports.

[9] Note that the TM is a mandated reporter under MGL Chapter 119 Section 51a. In addition, the TM needs to be able to share with her or his supervisor anything that occurs in the interaction with the youth. Additionally, parents generally need and have a right to a certain level of information about their minor child, including access to the child's medical record. Limits to confidentiality should be discussed with the youth and caregiver as part of their initial orientation to TM and should be reviewed subsequently as needed.

youth may sometimes feel more comfortable talking with a Therapeutic Mentor than with a psychotherapist, if "talk therapy" is needed, the Therapeutic Mentor should encourage and support the youth to do that work with a clinician.

- An independent service that sets its own goals with the youth or family – TM collaborates with the hub service in setting TM goals and interventions, and plans for transitioning out of TM.
- A method for working with more than one identified child or youth at one time—A TM may support an individual youth in developing skills in a group context but may not provide the TM service to two youths at one time.
- A service that supplants regular parental responsibilities of supervision and support for a child or youth—If a child has unmet needs outside the scope of TM, it is the responsibility of the TM provider to bring these needs to the attention of the family and the hub provider so that they can develop an appropriate plan to meet those needs.
- A provider of tutoring, sports coaching, music lessons (for example), nor a transportation service.

The Therapeutic Mentoring Process

Amy's story illustrates the TM process from beginning to end. The TM process includes the following stages.

- Referral
- Initial contact and engagement with family and youth
- Assessment
- Planning
- Ongoing cycle of implementation and collaboration
- Preparation and transition out of TM

Note that one stage does not always end as subsequent stages begin. Assessment, planning, and implementation roll into an ongoing cycle, while preparation for transition begins (gently) during early discussions with the family.

In the following sections, we discuss each stage in more detail. Since every youth and family is unique, implementation of the guidelines for each stage should always be individualized in terms of the youth's and family's strengths and needs, culture, and informed choices.

Referral

Therapeutic Mentoring agencies have a complete referral when the following are obtained.

- Comprehensive Assessment, including the CANS
- Consent from the family or legal guardian via the hub to initiate services
- Hub Treatment Plan or ICC Care Plan
- Safety Plan, if applicable

Sufficient information in the assessment to document relevant medical information (i.e., pre-existing medical conditions, food allergies, asthma, prescribed medications, preferred medical providers, most recent physical).

The TM provider must have contact information for the youth and family. The absence of any other pieces of the complete referral is NOT sufficient reason to delay the offer of services to a family. The TM provider must actively follow up with the hub and/or other team members (with family consent) to acquire any missing pieces of the assessment, treatment plan, and Safety Plan (as applicable).

Note: The Hub and TM providers generally communicate well. Typically, the TM does not have to exert pressure to acquire the necessary referral information, as hub providers generally meet their responsibilities in this area. TM should not be delayed unnecessarily while waiting for documentation—the youth and family should not bear the consequences of the occasional lapse by a hub.

Providers should check at the time of referral (and throughout the duration of service) to ensure the youth's MassHealth eligibility. At referral, agencies should verify the spelling of the youth's name and demographic information for billing purposes.

When a referral is received, the Therapeutic Mentoring agency assigns a staff person who best matches the specific needs of the youth, and that match may involve race, gender, language, or Therapeutic Mentor skill set. The TM agency must offer an initial meeting with the family, whether or not the referral is complete; every effort must be made to obtain complete information as soon as possible after the referral is received.

The Therapeutic Mentor schedules an initial engagement visit with the family and youth. This will be the occasion to secure any other consent that is needed.

The TM provider agency creates a clinical record for the youth that includes all the referral and insurance information, as well as ongoing documentation.

Initial contact and engagement with family and youth

Direct contact with the family typically takes the form of one or more phone calls followed by an initial face-to-face meeting. Common sense as well as research evidence suggests that the quality of early contact has a significant effect on outcomes.

While the referral process is weighted heavily with administrative duties, the initial meetings (often called "intake" by providers) represent an important opportunity for the Therapeutic Mentoring provider to establish an effective therapeutic relationship with the youth and family, as well as researching, preparing, and organizing the path for quality services. The administrative parts of the TM intake process may offer relatively neutral ground—forms to review rather than a story of difficulty to relate—on which to initiate positive engagement.

The key to a successful initial engagement process is to establish mutual respect and trust with the youth and family. The TM needs to review the referral material thoroughly prior to the first meeting in order to build upon that information without having to ask redundant questions or expect the youth and family to repeat their "story." The TM makes sure to have his or her agency's intake materials ready on hand so the encounter can be effective and efficient.

Best practice is to

- Be on time to appointments
- Show gratitude for being allowed to meet with the youth and family
- Introduce yourself to both the youth and the caregiver and ask what they would like to be called
- Give honest compliments when you can
- Be humble and respect the youth and family, including their values, culture, and traditions
- Explain the purpose of the meeting
- Ask how you can help, then listen
- Talk directly to the youth, as well as the family; do not talk about the youth in the "third person" when she or he is present
- Explain how you can or cannot help
- Begin initial engagement, if time allows, around the youth's goals and his or her expectations of Therapeutic Mentoring. Depending on the youth's level of cognitive maturity, she or he may or may not have the insight needed for a discussion of therapeutic goals. In this case, it makes sense to engage first around activities rather than motives and goals. Even for young children, however, it is important to be able to frame the TM process as helping them get better at certain important tasks.

It is very likely that the initial engagement work will take more than one meeting, and the pacing of the work should match the youth and family capacity for participating. When a youth or parent shows signs of losing focus or becoming stressed by the discussion, the TM needs to adjust the time and content of the meeting accordingly. For example, a youth may be reluctant to set a goal before developing more rapport with the TM; or a youth may be unsure what setting a goal means in practical terms. Be patient and gently persistent.

The youth's goal needs to match the intent of the hub treatment plan. The family should already be familiar with the hub treatment plan and the goal(s) that need additional support from the Therapeutic Mentoring service. The family will have given consent for the referral. This means that the Therapeutic Mentor is starting with a sketch of the work, rather than a blank slate. The TM has responsibility for ensuring that the goals set by the youth and family fit the "big picture" of the hub plan.

José

> *José, age 10, is struggling to find ways to manage situations that make him angry. This is the hub treatment plan goal for which TM has been engaged. The TM has in mind the need to support José in replacing his threats of physical violence toward his mother with behaviors that express frustration without harming anyone. José might express a goal of "getting on the baseball team." While this would not be a sufficient goal alone, the boy's interest in baseball could become part of a plan to help develop skills—such as teamwork, patience, and respect for rules—that are required in baseball and that are transferrable to a more patient and respectful relationship with his mother.*

Upon establishing the goal in context—in a single meeting or multiple meetings—the TM works with the youth and family to

- Brainstorm steps towards achieving goal
- Prioritize steps
- Document who will take responsibility for each step toward the goal
- Close all meetings on a positive note

Assessment

The TM provider does not conduct a Comprehensive Assessment—that is the responsibility of the hub. However, it is still necessary to develop a mental picture of the youth and a narrative of his or her situation by integrating information obtained from the Hub with the first-hand experience of being with the youth and family. Everyone who works with the youth and family is likely to have a slightly different experience and perspective. Over time, the TM will have unique experiences with the family and especially with the youth. With consent of the family, the TM becomes an important contributor to the team's ongoing process of understanding the youth and family.

While the Hub is responsible for developing and refining the comprehensive assessment, the TM provider needs to gather information specifically related to Therapeutic Mentoring. This involves learning more about the details of the youth's daily functioning, particularly regarding target skills. Some of this information can be obtained from records and from conversations with the family and youth, but you will learn a lot during initial sessions spent with the youth in the home or community.

Planning

Developing the Therapeutic Mentoring Action Plan

The Therapeutic Mentor develops an Individualized Action Plan (IAP) that addresses the hub provider's goal(s) for Therapeutic Mentoring by identifying measurable, individualized actions aimed at the skill development needs that emerged in the youth's assessment process (see Appendix F). The youth and family, hub provider, and TM together agree on the priority goals and actions. The TM Action Plan describes clinically driven, skill-building interventions that the TM will use to help the youth develop the target skills.

Some interventions may be similar to those for other youth with whom the TM has worked. However, each youth's plan and its interventions must be individualized according to the particular strengths, needs, and preferences of the specific youth and family.

Because treatment is individualized, each child, youth, and family receives flexible services over time to meet their changing needs. Treatment typically involves the teaching of adaptive, pro-social skills and responses that equip young persons and their families with the means to deal effectively with the unique conditions or circumstances that created the need for treatment.

Treatment accountability requires that goals and objectives have clear timelines and that outcomes are systematically monitored by quantitative data. Plans need to be adjusted regularly, based on what is working and what is not. Therefore, each TM IAP must also spell out the measures for progress.

Jenny

> *Jenny is working on making friends in her fourth-grade class at school, and initial progress will be measured as "Jenny will practice positive verbal interactions with the TM playing the role of the classmate two times per week." When this goal is met (data collected from TM, team in agreement), the next measure might be "Jenny will have one positive interaction with a classmate every day for one week, as reported by her teacher." When this goal is accomplished (data collected from teacher and team in agreement), the frequency might be increased or the duration of positive interactions extended. At some point, a measure might be "Jenny will have a schoolmate to eat lunch with every day."*

In all cases, the incremental steps must be clearly articulated and measured so the next step can build on the previous progress in a coordinated manner.

The TM IAP is developed with the meaningful participation of the youth, parent/caregiver and hub provider, and all three parties should concur with the final plan. The plan is written in nontechnical language that is understandable to the youth, and should identify all the people who were involved in the development of the plan. The plan is signed by the parent, youth (if age appropriate), and TM.

Lesson Plan Development

Acquiring new skills through planned activities is the primary aim of Therapeutic Mentoring services. The lesson plan for a TM session requires answers to three questions.

- What are the youth's goals?
- What skills does the youth need to learn in order to achieve goals?
- What activities/resources are needed to teach the skills?

Lesson planning is an organized and intentional approach to planning, teaching, and practicing skills that the youth needs in order to achieve his or her treatment plan goals. Lesson plan development is key to creating a safe, meaningful, and deliberate therapeutic intervention. Examples in the previous sections illustrate how being prepared with a plan for each session allows the Therapeutic Mentor to make best use of time each week. Lesson plans break down the skill development into specific tasks that can be taught and reinforced during each TM session. Lesson plans also provide concrete information for the family and other treatment team members about what the Therapeutic Mentors are doing with the youth and what progress is being made.

While a variety of formats can be used, a quality lesson plan will contain the following elements.

1. Hub treatment plan goal
2. Related skill name (description)
3. Rationale for skill (how it relates to the goal)
4. Identification of the skill components, both positive (behaviors that are part of the skill) and negative (behaviors that conflict with the skill)
5. Modeling the skill (through a game or activity)
6. Behavioral rehearsal (role play)
7. Practice the skill (in real-life situations)
8. Independent use of the skill (help youth and family identify time and venues)
9. Continuation of use of the skill with increasing mastery

Being prepared with meaningful lesson plans each week will allow the Therapeutic Mentor to use the environment that is presented, often starting with home and later moving to community as a place of learning.

TM staff work with their supervisors to identify materials and resources for the identified skill development needs. Please refer also to Appendix B for more resources on building interpersonal and executive functioning skills. For another perspective on skill building, we also recommend resources related to Positive Behavior Intervention and Supports (PBIS), readily found online, and the CBHI Service Guidelines for In-Home Behavioral Services (IHBS).

Safety Plan Development

The Therapeutic Mentor is not required to complete a Safety Plan for the youth. When the youth's hub is Intensive Care Coordination or In-Home Therapy, a written Safety Plan is the responsibility of the hub provider.[10] The TM provider should obtain the Safety Plan from the Hub and should be familiar with it. If the Hub is ICC or IHT, the Hub also provides 24/7 crisis availability in person or by phone.

Additionally, the Hub is responsible for ensuring that the family understands how and under what circumstance to use Mobile Crisis Intervention (MCI). The Hub also may ensure that a crisis plan for the youth is on file with the local MCI team. The Therapeutic Mentor is not required nor expected to provide urgent response to the youth and family when there is an emergency or a crisis. If safety issues arise during a TM session, the Therapeutic Mentor must follow the youth's safety plan and any emergency protocols established by their agencies. This may include contacting emergency resources and/or the hub provider.

Within the context of the youth's TM goals, TM can be an important element in helping youth and families avoid crises and in assisting them to manage escalating crises more effectively. At a minimum, the TM over time may provide insight into how the youth responds to frustrations and stressors, stimuli, and situations that challenge the youth's self-control and strategies that have worked *in vivo* to help a youth manage his or her emotions in an escalating situation. In addition, the Hub's goals for TM may include coaching and practicing the skills the youth will need to avoid crisis altogether. Examples could include

- Coaching the youth on observing her or his own level of stress and arousal
- Helping the youth learn to identify and steer clear of situations that are likely to be overwhelming
- Practicing strategies that help the youth calm down when feeling stressed, such as listening to music, using relaxation techniques, or beneficial self-talk or talking with the TM about how he or she is feeling[11]
- Reflecting afterwards on how the youth managed the situation in order to reinforce positive behaviors and identify plans for dealing with future stressors

---

[10] When Outpatient Therapy is the Hub, the outpatient therapist should develop a Safety Plan when clinically appropriate.

[11] Practicing relaxation techniques provides a good example of the need for collaboration between services. Teaching relaxation techniques to the youth would in most cases fall to a clinician (in IHT or outpatient, for instance), while supporting the youth's practicing the techniques in real-life settings would be the work of the TM. Together the two components can be very powerful, but only if the clinician, the youth, and the Therapeutic Mentor share the same understanding of what the techniques are and when, where, and how they are used. Otherwise, the TM and clinician may be working at cross-purposes, inadvertently confusing the youth and undermining his or her efforts.

The Therapeutic Mentor can also role-play the approaches that have worked in the past to keep them ready at hand, and the TM and youth may practice new approaches that have been established in the Safety Plan. Development and practice of interventions for safety should always be done with full communication between the TM and the Hub. Whenever possible, it is helpful for the hub clinician and TM to practice safety strategies together with the youth and family.

Please refer to Appendix I for the crisis planning tools, including the Safety Plan, the Advance Communication to Treatment Providers, Supplements to the Safety Plan and Advance Communication, and Companion Guide for Providers on the Crisis Planning Tools for Families.

Ongoing cycle of implementation and collaboration

Implementing the TM Action Plan will lead to a deeper understanding of the youth's needs and capabilities. The Therapeutic Mentor uses and shares this knowledge so the team can support the youth's progress and revise the overall plan as needed. As a result, the Hub may revise the goals in the hub plan, amending or adding to the goals that TM should address. Even if the overall goals do not change, the TM Action Plan should change based on the youth's use of TM and his or her progress. The TM process becomes an ongoing cycle of learning.

Implementing the plan

Developing a relationship with the youth

Developing a positive relationship is a necessity in Therapeutic Mentoring. Without such a relationship, it is virtually impossible to engage in any sort of therapeutic work with a child or adolescent. How a TM works with a youth is as important as what they do together.

Some young people will be able to understand the goals and methods of TM and welcome the relationship with the Therapeutic Mentor. The relationship will develop naturally over time as the youth and TM get to know each other and enjoy successes in working together. For others, the process will be less straightforward. Some youth, for example, will relish the attention of the TM but will need a lot of help understanding the goal-setting and skill-building process. Others may have difficulty entering into the relationship in a collaborative way.

There can be many reasons for this. A youth may have a longstanding habit of using oppositional behavior with adults, which has been reinforced over time by success at getting needs at least partially met in this way. Alternatively, a young person may have a history of trauma and or abandonment, so it is difficult for him or her to enter into a trusting relationship. For some youths with language learning difficulties, adults seem to talk too much and put young people on the spot by expecting them to answer questions and explain themselves, so one-to-one interactions with adults tend to be painful and frustrating. For these and many other possible reasons, the youth may be ambivalent about working with you: happy to get attention and to enjoy some pleasant activities, but wary of being made to feel bad or let down.

If a youth is ambivalent about using TM, he or she may show this in a variety of ways. One is avoidance: being elsewhere when the Therapeutic Mentor arrives, claiming to feel ill, or coming

up with competing obligations to attend. Another is hostility, either overt or covert, enough to keep the TM at a distance and test the TM's patience and understanding. Yet another is by trying to control the interaction through bossing, nagging, begging, or limit testing. Indeed, even an apparently cooperative youth is likely to engage in some testing to find out where your limits are, and how you will respond to various aspects of his or her persona.

Communications of ambivalence, such as these, can be frustrating for Therapeutic Mentors. Sometimes it feels "personal." Sometimes the overt or covert resistance of the youth can make the TM enterprise seem like it cannot succeed. In situations like this, it can be helpful to remember that many youths who come to Therapeutic Mentoring have been hurt or felt unsuccessful in relationships. The behaviors that may alienate the TM may be the very behaviors which the youth needs help in changing. Progress with some youths will take time. For young people with a long history of difficulty in social relationships or self-management, things did not get this way overnight and they cannot improve overnight.

TM supervision can play a critical role in helping you understand the behavior of the youth, and to remember that puzzling or uncooperative behaviors can usually be understood as nonverbal communications about the youth and his or her experiences. Sometimes the nonverbal communications speak more deeply than anything the youth is able to put into words. Making sense of the young person's behavior is part of the TM role in the ongoing assessment of the youth.

Youth who have experienced trauma in their neighborhood or family can sometimes react in unexpected ways, as environment stimuli trigger their overactive emotional alarm systems. Alternately, some children and adolescents with a history of trauma may appear excessively risk-taking or emotionally shut down. If you know that a young person with whom you are working has a trauma history, it is important to discuss with your supervisor how to work with the youth in a way that is appropriate and does not trigger or reactivate a trauma response. Of course, a young person may have a trauma history that has never been disclosed or that has not been shared with the TM. Supervision can help you respond appropriately to the youth's behaviors even when the full history is not known.

It is true for everyone, not just traumatized youth, that the nature of relationships in growing up is often predictive of the nature of relationships in adulthood. Young people who have grown up in homes with lots of conflict tend to play out that conflict and have high emotional levels in their relationships. Some youth will be overtly grateful for your time; others decidedly less so. Be prepared for ambivalence—youth wanting help, while also resenting it to a greater or lesser degree. Gratitude is a very mature emotion, not within the behavioral repertoire of every youth in need of help.

Best Practices for building a relationship as a Therapeutic Mentor

In general, the best way to build a relationship, as well as to get a head start on skill building, is to model good social and self-management skills. Here are some reminders.

Really listen and seek to understand. Pay full attention. Do not preach. In the early stages of the relationship, use the tool of "suspension of disbelief," i.e., believe the youth's reality even if you know it not to be the full reality. When you accept their version enough to really listen to them, youth begin to realize that you are listening and taking them seriously. Only later, after some trust has been developed, can you then move to the next step of challenging some of their misperceptions.

Be honest. While not all youths are good at detecting when you are not telling the truth, there is no room for manipulation in TM. Honesty does not mean lack of tact or sensitivity (see "Be kind," below).

Apologize when you make a mistake. Even the most diligent Therapeutic Mentor will occasionally make a mistake, perhaps about being late or forgetting to prepare a promised activity. Owning and taking responsibility for errors sets a good example; it also equalizes and strengthens the relationship. (Note: Demanding apologies from youth is not a good way to build trust, however. Many young people you will work with have not yet learned what it means to apologize. It is usually better to model this behavior.)

Make and keep promises (commitments). The TM process requires teamwork between the youth and TM, and teamwork is about give and take (reciprocity). Promises (whether spoken or unspoken) are the interpersonal mechanism for give and take over time. Regularly making and redeeming promises is visible evidence that trust is working in a relationship.

Use self-disclosure, appropriately. Sharing a little bit about yourself and your life, as well as your internal responses to shared experiences, is one of the ways to build trust. Self-disclosure can be tricky—it must be for the benefit of the youth, and not for the TM who wants to "vent," and it must take into consideration the youth's ability to make use of the information (and affect) that is disclosed. This is an important area for supervision. The TM supervisor will help TM staff consider whether and how best to use self-disclosure with an individual youth.

Be kind. In relationships, the little things are the big things. Not everyone has been kind to the youths with whom you will work. They, more than others, may recognize the simple but powerful truth of the plaque that reads, "To do carefully and constantly and kindly many little things is not a little thing."

Advocate. As you get to know the youth, you may see them in a way that is a little different from the way therapists and family members see them. You may have a special insight into their strengths and vulnerabilities, not based on secret disclosures but based on seeing them in action. Communicating this perspective to others, when the youth cannot, is part of your responsibility as a TM.

Seek to understand the youth's world. Listen to his or her music or learn about their peer culture. Get to know family members and others who are important to the young person. Learn about his or her religious or ethnic heritage. As the youth trusts more, he or she will make more information available.

Be consistent. Being regular, reliable, and available must be a hallmark of the relationship. Many youth engaged in TM have experienced significant disruption and unpredictability in their environment. Consistency will helps to build the relationship by providing a sense of safety; it also models good self-management social skills for the young person.

Pay attention, even to the small things, behaviors, feelings, and statements of youth. What is a little thing to one person might be a big thing to another. Small accomplishments are the seeds that can grow into larger ones when nurtured. Small communications can be an invitation to a follow-up about a big subject.

Keep your cool. Maintain a low level of what is known as expressed emotion. That is, keep cool and do not get too excited, even when the youth is displaying a high level of expressed emotion.

Use humor, especially in tough spots. It is a good coping mechanism to teach. It can surprise and defuse an upset, angry young person. It models a good coping mechanism. **Never** use sarcasm.

Use effective behavior management. Positive behavior management is the technique of collaborating with the youth to facilitate his or her self-control. It involves identifying situations that challenge the youth, developing strategies for dealing with those situations, and reinforcing the successful use of those strategies. It often includes allowing cooling-off periods when a youth's behavior escalates, and using discussions and fair consequences to help youth learn from mistakes.

While negative behavior must be stopped before anything too destructive happens to a youth or someone else, punishment is not generally the most effective way to change behavior. It is far more effective to work with youth to establish motivation for acting in healthy and safe ways and provide rewards for positive behavior. While coaching parents to use more effective behavior management approaches with their child is out of the scope of Therapeutic Mentoring, positive and accurate feedback about the youth's strengths and accomplishments can help parents to see their child from a different perspective, and the TM can communicate observations about what works to the family and treatment team.

Maintain empathy. Do this for you to stay "in the game." Seek to understand the youth's situation, feelings, and motives. When you get frustrated or angry (and you will, sometimes), take time to revisit the reasons you are involved with the child. Talk with your supervisor about your feelings and reactions when working with challenging youth; your supervisor can help you gain perspective and renew your capacity to work effectively with youth.

Examples of skills that youth may need to develop

Perceived competency. It is fairly simple to sit down and say, "What are you good at? What do you want to be good at? Let's work on it together." When linked to the hub goals, this effort then becomes a cornerstone of the plan.

Building interpersonal skills. Helping the youth learn to be likeable, have empathy, and get along with others can be a goal in the hub plan. Skills in this area can easily grow from the planned activities within the youth's relationship with the TM.

> *As 10-year-old Adam develops a meaningful relationship with Josh, the Therapeutic Mentor, he learns how relationships can be more successful. Apologizing to each other, seeking to truly understand, getting to know each other, being honest, and making amends are ways the youth learns to get along in relationships.*
>
> *Therapeutic Mentor Josh is intentional in helping Adam develop interpersonal skills. Prior to each meeting, Josh makes a list of interactions to practice that typically occur in a social relationship, which Adam struggles with. Josh designs situations in which to practice. A particular concern is how Adam can respond more successfully when he wins or loses at a game. His tendency to boast excessively when he wins and to throw game pieces when he loses has distanced other children at his afterschool program. Josh plans games, rehearses with Adam ahead of time, and then coaches him through responses as the game proceeds.*
>
> *As appropriate responses become habit, Josh tries including Adam's mother in a game. He sets up a "homework" assignment for Adam to play a game at home with his mother, without Josh's presence, and for both Adam and his mother to report how it went. As Adam's skill level grows, they test his responses with other children (a cousin, a neighbor) with coaching, and eventually without coaching, and finally in the busier, less structured setting of the afterschool program.*

Finding and engaging positive peers. Hub goals often include strengthening the skills needed to develop and maintain relationships with positive peers. Through the TM relationship, the Therapeutic Mentor can learn about the youth's peers, and use the youth's interests to help establish and strengthen connections with positive peers. The TM can also coach the youth on the skills he or she needs to develop and sustain healthy relationships with friends and other important people in his or her life.

> *At age 15, Maria is involved in high-risk behaviors that are a source of great concern to her family. She is sexually active but lacks the maturity to discern the emotional impact that her sexual encounters have on her. She has been drinking alcohol fairly regularly for the past year, she smokes cigarettes whenever she can get them, and more recently she has been experimenting with "party drugs" when out with friends on the weekends. Some of the young people she associates with have known criminal involvement, and almost all of them are several years older than Maria.*
>
> *Maria's treatment team is large (family, professionals, natural supports, state agencies) and carefully coordinated (regular meetings, strong communication among all parties) to build a safety net around her. Goals of treatment include helping Maria to make healthier choices by ensuring that Maria understands the risks of sexual activity, drinking, smoking, and drug use, and by offering her replacement strategies for social companionship. The hub provider has engaged TM to work on replacing the peer connections that are encouraging Maria's risky behavior with a more positive peer group.*
>
> *Luisa, Maria's TM, works with Maria to foster interests in areas that Maria has not yet explored. Luisa exposes her to possibilities through discussion, Internet sites, and in-person visits to get*

information. Over time, Maria gains new interests and masters new, more productive skills than she had previously shown.

At least as important are the ongoing interactions between Maria and her TM Luisa. Luisa treats Maria with respect. She asks Maria about preferences and listens with full attention to what Maria has to say. Luisa offers choices; she never orders or dares Maria to do anything. Luisa shows kindnesses in many small ways—showing up on time, asking Maria how she is feeling, admiring any accomplishment that Maria has demonstrated, and using gentle language with her. She keeps Maria's confidences, never "trash talks," and shares some of her own challenges that she has struggled to overcome. In other words, Luisa models for Maria what a healthy relationship can be.

Working with Maria poses many challenges and choice points for Luisa, who uses supervision to help her examine her responses to Maria and to think about her future interactions with her.

When Maria has had sufficient exposure to Luisa's modeling–enough so that Maria comments on how Luisa treats her–then Luisa moves on to specific practice sessions in which Maria identifies what characteristics in their interactions are positive and how those compare with the peer interactions to which she is accustomed. They look for ways that Maria can practice asserting herself when others pressure her to do something that she knows is risky. They talk about Maria's work on incrementally building healthy relationship habits, and they share progress with Maria's treatment team so that the TM work can help to inform other aspects of the effort.

Positive family relationships. Therapeutic Mentoring can help mediate conflicts between the youth and family members by supporting the work of In-Home Therapy or Outpatient family therapy, by practicing specific types of interactions that the youth will have with family members. This aspect of skill building would closely mirror the actions in building interpersonal skills (above) and would require careful coordination with the IHT or outpatient family therapist in order to maintain clear, consistent messages. (With IHT, it would be important to ensure that the TM is not duplicating or inadvertently interfering with, work being done by the paraprofessional component of IHT, Therapeutic Training and Support).

A sense of belonging. In some situations, the TM will search out available community resources that might be of interest to the youth and encourage him or her to participate. As noted in previous examples, this is likely to be a gradual process. The TM may participate initially with the youth or support him or her in the activity in a visible way, and then gradually reduce the extent of TM staff involvement, as the youth is increasingly able to function independently in various community settings.

Natural mentors. The Therapeutic Mentor relationship can assist youth in establishing relationships with natural mentors in the community. Interpersonal relationship skills are transferrable. Since the TM will transition out of a youth's life, there is value in encouraging the youth to develop natural mentors within his or her sphere of acquaintance—a high school teacher, the mother of a positive friend, extended family members, an employer or athletic coach or other person who shares an interest in the youth's success.

Getting and using help. The Therapeutic Mentor relationship is in a unique role as an adult who is in a position to encourage and even persuade the youth to use help at school, therapy, substance abuse services, and so on. The relationship may also provide impetus to advocate for additional or different services when needed, as the TM will have access to a different

perspective of the youth than other team members have. TM engagement both receives insight from and provides insight to the treatment team.

An important function of the TM working with older youth is to assist them in finding their voice for productive self-advocacy, in line with Wraparound principles.

> *Sara, who is 17, has not had positive experience with expressing her needs. She needs help in framing what she wants to say in a polite and clear way. She needs help to overcome her anxiety when she is speaking to a group of adults, and she needs support in expressing emotions constructively (without swearing or crying). The TM can coach and practice these skills with Sara prior to her treatment team meetings so that she has a stronger voice in setting goals, choosing services, reporting on progress, and guiding the course of her recovery.*

A positive vision of the future. Because shared hope for a positive future is one of the most important ingredients of resiliency, the TM must join with the youth in developing a vision of his or her future, hopes, and positive expectations. The Therapeutic Mentor's commitment and realistic beliefs about even a few good things that may happen will make a difference in instilling hope.

Preparation and Transition Out of Therapeutic Mentoring

Planning with a youth for the day when he or she is thriving independently is a powerful statement of hope for the future and respect for the youth's resiliency. Discussions in the early meetings about the youth and family's vision (what the youth is doing when he is doing well, how the family looks when they are doing well) is the start of transition (also known as "discharge") planning.

On the other hand, suggesting to the youth or family that they have only a set number of months or "authorized" hours in which to accomplish the progress that they need has a countering effect of discouragement and worry. There is **no set limit on the time** that a youth can use Therapeutic Mentoring. The service is intended to support treatment for as long as the youth meets the Medical Necessity criteria that he/she is age 20 or younger, has MassHealth, and consents to participate in service. An arbitrary time limit is contrary to MassHealth rules and is **never** an acceptable reason for terminating TM services.

Transition planning begins at the start of services in order to give the youth, family, and treatment providers a sound, shared understanding of the outcomes to expect when they all fully engage in a family-driven, youth-guided, and clinically appropriate process. Therapeutic Mentors are encouraged to join conversations with the treatment team and the family as early in the treatment process as possible (depending on when the TM service is added to the hub plan) to frame their work in light of the overall goals and to help plan for sustainable supports following the completion of the Therapeutic Mentoring service.

If the Therapeutic Mentor has established a strong relationship with the youth, bringing the relationship to an end may cause a feeling of loss for the youth (and often for the TM, too—a good issue to talk about in supervision). If the youth has a history of unresolved losses and disruptions, the end of the relationship may be particularly challenging for the youth and may

result in "acting out" behavior, such as withdrawing or rejecting the TM, showing a resurgence of old problem behaviors, devaluing the progress made together, or "forgetting" new skills. The youth may not acknowledge the pain in words, but the return of his or her old negative behaviors may lead the Therapeutic Mentor "to share the pain"!

Alternately, the youth may deny the loss, refuse to talk about ending and pretend that everything is just fine, when it is not. While endings can be tough, and may sometimes make you wonder what all the hard work was for, it is important to realize that they can also be opportunities for youth to learn strategies for dealing with future losses. Skills such as identifying and verbalizing feelings, reminiscing about good times and accomplishments, understanding how the current relationship can be a model for future relationships, and strategies for refocusing attention and self-calming can all be coached and reinforced by the Therapeutic Mentor. Supervisors can help TMs think about how to make the ending phase an important part of the therapeutic work with youth. As a hub-dependent service, the TM also has the full treatment team to help guide and prepare for the transition.

If a youth becomes more symptomatic or slides back into old behaviors, the TM needs to evaluate whether this a simply part of the termination process, something short-lived to be worked through, or whether it is a sign that the plan needs to be revised. Again, relying on the treatment team, which has the youth and family at its center, is best practice. Team decision-making, driven by family vision and taking into account the full range of stakeholder perspectives, is the core of Wraparound and informs all CBHI services. The team together can evaluate whether positive outcomes are solid, whether more time and practice are needed, whether a reduction in service intensity is a sensible interim step, or whether emerging needs demand a major review of treatment planning.

Below are recommended strategies for promoting a positive discharge process.

- Establish a vision for healthy functioning with the child and family at the start of service to guide and inform progress along the way
- At the beginning of the service discuss what the family would like to have accomplished in order to be ready for transition
- Continually talk with the youth about his or her achievements and the progress made toward his or her goals (this is a way to reinforce the youth's use of new skills and gives the youth new language to describe himself or herself, a way to "name and claim" new behaviors)
- Frame discharge in a positive way—recognizing it as a graduation and an occasion for celebration of the youth's ability to handle life stressors
- Identify what naturally occurring activity will replace the Therapeutic Mentoring service after transition
- Use the TM to assist in the transition to the replacement activity

- Plan a transition time frame that allows for setbacks and relapses as the youth functions with increasing independence
- Use a simple survey (which can be an individualized tool you construct based on the treatment goal or specific CANS items) at regular intervals for the youth to give feedback and report on his/her own progress
- Remind families that if new goals are identified or if old challenges recur, they can be referred to the Therapeutic Mentoring service again in the future
- Make it clear that "graduating" can happen more than once and that returning to a service does not signify failure

The discharge-planning process should become more intensive and specific as the youth approaches the point where he or she has met his or her goals and no longer needs or meets the criteria for Therapeutic Mentoring services. It is expected that the discharge transition plan will be individualized based on the unique needs and age of the youth being served.

The Therapeutic Mentor participates in one or more transition planning meetings coordinated by the hub that include, at minimum, the parent/caregiver and youth. With consent, the youth, the parent/caregiver, family members, significant others, and all providers involved in care are involved in the discharge-planning process. The TM notes this involvement in the discharge plan. As noted within the Performance Specifications, the Therapeutic Mentor, in cooperation with the treatment team (or Care Planning Team, for youth in Intensive Care Coordination), writes a discharge plan that documents ongoing strategies, supports, and resources to assist youth and their families in maintaining gains, as well as the reason(s) for discharge and all aftercare plans.

According to the specification, the discharge plan is given to the youth and/or parent/caregiver, and with consent, to the ongoing behavioral health provider(s), no later than five business days of the last date of service. While the specification allows up to five days after termination to disseminate the final written transition plan, the essentials of the plan should have been circulated and discussed with all key participants long in advance of this date.

Throughout the service process, including the segment leading to ending TM, the Therapeutic Mentor contributes to the evaluation, in collaboration with the youth, family, and (with consent) significant others and involved providers, of whether the youth and family could benefit from additional natural supports and services, including other CBHI services. The Therapeutic Mentor refers to the CBHI Clinical Pathways grid (see Appendix G) as a resource in considering the appropriateness of these services for the youth and family. As appropriate and with consent, the Therapeutic Mentor includes these options within the discharge plan for the youth and family. It is the responsibility of the Hub to ensure linkage and referral to any of these potential service providers, with appropriate consent.

If youths and/or caregivers terminate the Therapeutic Mentoring service without notice, the TM provider makes every effort to contact the caregivers (or youth age 19 years and older, or

otherwise legally consenting to their own care) to re-engage them in services and to provide assistance for appropriate follow-up plans (i.e., schedule another appointment, facilitate an appropriate service termination, or provide appropriate referrals). The Therapeutic Mentor also contacts the Hub. Such activity should be documented in the youth's medical records.

Any one of the following criteria is sufficient for discharge from Therapeutic Mentoring.

- The youth no longer meets admission criteria for this level of care, or meets criteria for a less or more intensive level of care
- The treatment plan/Individual Care Plan goals and objectives have been substantially met and continued services are not necessary to prevent worsening of the youth's behavioral health condition
- The youth and parent/caregiver are not engaged in treatment. Despite multiple, documented attempts to address engagement, the lack of engagement is of such a degree that it implies that withdrawn consent or treatment at this level of care becomes ineffective or unsafe
- Required consent for treatment is withdrawn
- The youth is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care, nor is Therapeutic Mentoring required to maintain the current level of functioning
- The youth is placed in a hospital, skilled-nursing facility, psychiatric residential treatment facility, or other residential treatment setting, and is not ready for discharge to a family home environment or a community setting with community-based supports

Transition vignette: Jillian

Jillian, a seven-year-old whose focus during the Therapeutic Mentoring service was to improve peer relationships in school, has a transition plan that includes concrete examples of successful peer interactions and sustainable friendships. Jillian has met her goal of having "one best buddy" at school and having at least 10 days in a row when she can refrain from spitting, pulling hair, and pinching other children at recess. The TM has worked with Jillian to create a positive transitional object that symbolizes their time spent together (in this case, a digital "scrapbook" of pictures and notes) to help remind Jillian and her parents of the progress she has made.

The treatment team, which includes Jillian's parents, extended family members, school counselor, second-grade teacher, and the gymnastics instructor from a community program that Jillian has started attending, plans together for transition from TM. The functions that the TM performed—such as practicing with Jillian techniques for self-control and delaying gratification—are parceled out to other team members to help keep Jillian on track once TM services end.

One of the final lesson plans includes the TM working with Jillian and her parents to set up play dates with her "best buddy" in advance so they have the experience and confidence to make those happen regularly going forward.

Transition vignette: Shaun

For Shaun, a 13-year-old with anger-control issues, the transition plan is bumpier. Shaun made significant gains in verbalizing his feelings and needs instead of acting aggressively in times of anger during the Therapeutic Mentoring service. However, with the transition planning in full swing, he has been "mouthy" to the TM for several meetings and was suspended last week from school for punching another boy during an argument. This fight has alarmed Shaun's mother and the school counselor on the treatment team; they are requesting that the TM stay involved.

The team takes a step back and decides together to extend TM at a lower level of intensity to allow Shaun to regroup with support from the TM and to allow a more gradual transition than originally planned. Team members take appropriate roles around helping Shaun to process his suspension and make amends to the boy that he hit and talking with him about his past losses. Since it is important for Shaun to perceive and internalize the gains he has made, the TM builds lesson plans around repeatedly perceiving the difference in his behavior and in how others react to him when he can make positive choices and verbalize his feelings directly.

Shaun and the Therapeutic Mentor work together to create a written certificate that details Shaun's strengths, skills, and successes, so Shaun has language for articulating his achievements. The certificate will be presented upon completion of the TM service, so constructing it is a piece of preparation. The second try at transition with a slower pace and a strong, concerted effort by the team to recognize Shaun's stress over termination succeeds.

Transition vignette: Josefina

For a young adult like 19-year-old Josefina, the goal of Therapeutic Mentoring was to help her improve self-esteem, decrease promiscuous behavior, and develop useful life skills. The talented Therapeutic Mentor recognized strengths in what others called Josefina's "resistance" and "obstinacy." By reframing these qualities as a strong will and powerful self-direction, the TM tapped into Josefina's natural desire for self-advocacy. The TM coached Josefina in speaking in a calm, clear way with her treatment team. Josefina finally felt "heard" when she was able to advocate more effectively for herself. She then set her own goals of enrolling in community college and obtaining a part time job.

The Therapeutic Mentor assisted Josefina with her life goals. In the process, they worked on improving self-esteem (celebrating increments of success, like completing a college application and a resume) and replacing promiscuous behavior with making solid, healthy friendships at college. As Josefina approached age 21, her transition plan centered on sustaining her positive gains. The TM helped her establish a schedule of studying with a volunteer tutor to help with college material. The TM also worked with Josefina to help her to budget her money. By the time graduation from Therapeutic Mentoring came, Josefina and her team were confident that she had developed the skills she will need to be a successful young adult.

Documenting Progress

Therapeutic Mentoring providers communicate with the Hub and the youth and family and other providers to regularly monitor progress toward the youth's goal(s). The TM provider regularly documents progress on the goals listed in the TM Individual Action plan.

Therapeutic Mentoring providers are expected to adhere to the Managed-Care Entity Children's Behavioral Health Initiative Health Record Documentation Standards, which outline the

documents that are required to be contained in the youth's health record (see Appendix F). TM providers are expected to have the following in the youth's medical record.

- A copy of the comprehensive assessment completed by the hub provider, along with applicable parts of the CANS, depending upon family consent, completed by the hub provider;
- Documentation of all contact regarding treatment planning and collaboration that the Therapeutic Mentor has had with the youth and family and all other relevant, involved parties, including the hub provider and other providers also involved with the family;
- A copy of each update of the hub provider's treatment plan or Individual Care Plan;
- The Individualized Action Plan for TM that references the goal(s) or objective(s) for Therapeutic Mentoring, which is identified within the referring hub provider's treatment plan or Individual Care Plan (for youth in Intensive Care Coordination); and
- Progress notes that document all contact and demonstrate clarity of medical necessity, (i.e., notes (a) are relevant to the action/treatment/care plan; (b) assess symptomatic and functional progress and risk, as applicable; and (c) identify what the provider did in the session.

Best practices require that Therapeutic Mentors create Lesson Plans that identify how they will address each goal in the IAP on a weekly basis. The Lesson Plans provide clear reference when completing progress notes. Progress notes should be completed immediately following each session in order to accurately document what occurred during the visit and for how long.

There is no prescribed progress note form the Therapeutic Mentoring provider must use. The Therapeutic Mentoring Performance Specifications (see Appendix D) do not require review by a Multi-Disciplinary Team. As such, co-signatures are not required on progress notes. While there is no prescribed format, all clinical documentation must be completed according to professional standards. That is, documentation must be fact-based and objective, with clear and concise writing. It is imperative that Therapeutic Mentors realize that once they have documented details on the youth, this becomes part of the youth's medical record and part of their history. Therapeutic Mentors, as with all professionals, must take great care in making sure that what they put on paper is respectful and accurate.

Providers must ensure that Therapeutic Mentoring staff adequately document medical necessity and provide ample support for such nonclinical staff to do so.

Additional documentation guidelines can be found at www.masspartnership.com/provider/index.aspx?lnkID=TMTraining.ascx and at www.abhmass.org/msdp.html.

It is the responsibility of the Therapeutic Mentoring provider to determine its own policies and procedures regarding overall documentation expectations that are not outlined within these guidelines.

Working with Hubs and Other Services

CBHI providers are responsible for coordinating, collaborating and integrating care and service delivery to meet the youth's needs as well as assisting the youth and caregiver to make informed decisions regarding care and service delivery. The Therapeutic Mentoring provider **does not** have the care coordination responsibilities of a hub provider; however, he or she has certain responsibilities as a hub-dependent provider. These include the following.

- Ensuring that the youth is currently engaged in one of the hub services (ICC, IHT, or outpatient)
- Verifying that TM is needed in order to facilitate achievement of a goal or objective identified on the hub provider's treatment plan or ICP (for youth in ICC)
- Verifying that a comprehensive assessment and CANS completed by the hub provider demonstrate medical necessity for the Therapeutic Mentor
- Systematically gathering data concerning intervention effectiveness
- Contacting the hub provider regularly (at least once a week if the hub is ICC) to provide updates on progress
- Ensuring that TM is aware of youth's safety plan, as needed and with appropriate consent

In comparison, the hub provider has the following responsibilities.

- Completing a comprehensive assessment and CANS
- Assisting the family in exploring options and making informed decisions to meet the youth's needs
- Completing a treatment plan (or ICP for youth in ICC) and engaging the family in a safety-planning process
- Ensuring that the youth and family are linked with natural supports, hub-dependent services, other behavioral health services, and other community-based supports as appropriate
- Ensuring communication and collaboration among providers. In ICC this requires convening regular face-to-face team meetings; in IHT and Outpatient, face-to-face meetings are not required but are best practices

Working with Parents

In addition to regular collaboration with the Hub and other collaterals, Therapeutic Mentors maintain regular contact with parents/caregivers in order to keep them informed about the youth's progress, as well as to ensure that the youth's new skills have resulted in sustained successful functioning. It is also important to be aware of any changes that parents are observing or of changes in the home or social environment that may affect the youth.

The following are examples of how the TM and parent/caregiver can work together.

1. At the start of the work with the youth, the TM reviews with the parent/caregiver and the youth the documented "Shared Vision" from the hub treatment plan. If no vision is stated in the plan, the TM works with the family to define a vision that identifies the changes the family would like to see and to set expectations and establish boundaries.
2. At the time of the initial visit, the TM should also review information about any allergies or medical conditions the youth has, locations or activities that they do (or do not) endorse for the youth to engage in, and any other general guidelines for the TM when with the youth in the community.
3. The parent and TM should establish a regular communication pathway, such as a brief conversation before each session with the TM to report any progress or challenges since the last session.
4. They should establish a method for consultation between parent and TM after a session in order to discuss how the youth responded to a given intervention or how the parent can help to reinforce the skills that the youth has just learned.
5. Therapeutic Mentors and youth work together to determine the specific aspects of their work to be communicated with the youth's parent/caregiver. It is not necessary for the TM to share with parents everything communicated to the TM by the youth, but TMs must never promise to keep secrets from parents.
6. Therapeutic Mentors provide feedback to the family, with the youth, about progress and skills the youth continues to practice.
7. When the youth needs to develop or practice skills in the context of his or her family relationships, the Therapeutic Mentor will work with both the youth and family to implement strategies in the home that are consistent with the youth's action plan goals and that are clearly defined by the TM and the hub provider.
8. The Therapeutic Mentor may wish to offer mini-homework tasks for completion during the week to enable the youth and parent/caregiver to practice together, and then follow up on those skills when they meet again. For the youth, learning to practice skills in the absence of the TM is an important step toward "owning" those skills.

Providing Therapeutic Mentoring to Siblings

A Therapeutic Mentoring provider may also enroll siblings within the same family when each sibling meets medical necessity for the service and each has a hub provider in place. The siblings may not be living within the same household. Each sibling must have a treatment plan (or ICP if the youth is in ICC) with a goal that will be addressed in TM. Each sibling, of course, must have a separate medical record with full documentation as required by TM performance specifications. If in doubt about enrolling siblings, the provider may call the youth's MCE to request consultation.

In some circumstances, the same staff person may serve enrolled siblings. However, assignment of the TM staff person should be based on the best staff fit for the individual youth, and on the needs of the enrolled youths. Sometimes siblings do not tolerate sharing the attentions of a TM. Furthermore, ending TM for one sibling while initiating or continuing TM for another may be confusing and problematic for youths. It is not acceptable to continue TM for a youth who no longer meets medical necessity for the service.

Although the philosophy of CBHI is to address the needs of every enrolled child within the context of family, TM is an individual service, so it is not appropriate for one or more TMs to work with more than one sibling in the same session.

Culturally Relevant Practice

Culturally relevant services include respectful recognition of differing values and culture of the youth, family, school, and other providers. This includes, but is not limited to, recognition of economic status, gender, sexual orientation, ethnicity, race, language, and the unique values and goals of each youth and family. It utilizes the strengths of all in order to provide comprehensive care to families. To ensure that the youth is receiving effective care, agency staff, supervisors, and administrators should seek consultation and additional services when necessary to overcome barriers that compromise the delivery of care. Providers should make every effort to recruit staff who represent the diversity of the youth and families served and to deliver services in the primary language of the youth and families served.

Culturally relevant practice is an ongoing learning process. Even in the strongest provider organizations there will always be room for growth. Culturally relevant practice accepts and respects differences, emphasizes the dynamics and challenges arising from cultural and linguistic differences in planning and delivering services to diverse populations, and is committed to acknowledging and incorporating the following.

- *Importance of cultural awareness*. Culture plays an important role in how families view helping relationships and how they engage with providers.

- *Sensitivity to cultural diversity brought by a variety of factors* including ethnicity, language, lifestyle, age, sexual preference, and society status. Ask questions about what language

the family prefers to use. Do not make assumptions. Ask questions and support the family in a nonjudgmental manner.

- *Bridging linguistic differences in appropriate ways*. Families may be bilingual but will typically prefer their first language during times of stress or crisis. Some types of content may be more effectively communicated in the preferred language.

- *Assessment of cross-cultural relations*. What positive experiences or negative experiences has the family had with their local school or community? How do their culture and past experiences affect their perception of potential supports in the community?

- *Expansion of cultural knowledge.* How can we help families to engage in their community and identify allies and supports for their family through understanding other cultures better

- *Adaptation of services to meet the specific cultural needs of the consumers*. Do not assume all members of a group share the same cultural values. Ask questions that will help you adapt services to be respectful of specific cultural needs of the family.

- *Access to nontraditional services*. Some cultures use and value nontraditional services such as natural healing, spiritual guides, or identified leaders in their culture. Explore family beliefs about acceptable interventions and supports and recognize the value and strength of these nontraditional services.

The following language describes provider responsibilities regarding cultural competence.

1. The program provides services that accommodate the youth, consider the youth's family and community contexts, and build on their strengths to meet the youth's behavioral health, social, and physical needs.

2. The program staff will have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of the population served. To ensure that effective care is provided, program staff, supervisors, and administrators will seek consultation and additional services when necessary to overcome barriers obstructing the delivery of care.

3. The provider ensures access to qualified staff to be able to meet the cultural and linguistic needs of all families served in their local community.

    a. Providers ask the family's language of choice.

    b. Because staff with linguistic capacity is preferable to translators, providers offer the youth a clinician who speaks his/her language of choice whenever possible, or refers him/her to a provider who can do so.

    c. The provider has access to translation services and qualified interpreters that are experienced in behavioral health care and appropriate to the needs of the local population served. In case the program must seek translation services outside the

agency, it must maintain a list of qualified interpreters to provide this service. Interpretation and translation services are provided at a level that enables a youth to participate fully in the TM program. Any written documentation should be available in the family's primary language when requested, including discharge documents.

4. Programs will provide ongoing, in-service training that will include cultural competency issues pertaining directly to the client population served.

5. Programs will include cultural competence in their ongoing quality assessment and improvement activities.

Staffing, Training, and Supervision Requirements

Supervision Requirements

Per the Therapeutic Mentoring service specification, the TM provider ensures that all Therapeutic Mentors receive weekly, individual supervision by a licensed clinician "with specialized training in child/adolescent issues, child-serving agencies (e.g., DYS, DCF, DMH, DDS, DESE), mental health, family-centered treatment, strengths-based interventions, and Wraparound planning process consistent with Systems of Care philosophy."

The specification does not require additional group supervision, nor may group supervision substitute for required individual supervision. However, from a best practices standpoint, the addition of regular group supervision is likely to be very helpful to Therapeutic Mentors. Some provider organizations that house multiple CBHI services include TMs in joint training and/or group supervision with other CBHI services such as IHT. If handled appropriately so that the needs of each group are met, this may be a good way for practitioners to understand one another's work better and from a broader perspective.

The provider also ensures that a senior licensed clinician is available for consultation within one hour to TM staff during all hours that the program provides services, including evenings and weekends.

Quality supervision must include the opportunity for the Therapeutic Mentor to discuss the following topics with her or his supervisor for each youth with whom the TM is working.

- The TM's evolving understanding of the strengths and needs of the youth and family
- The youth's progress or lack of progress towards achieving his or her goals
- Implications for lesson plan ideas and resources needed for the youth
- Clinical opportunities and challenges working with the youth and family, including ups-and-downs in the TM's relationship with both youth and family
- Administrative matters, such as eligibility and documentation

In addition, it is important to have time to focus on the TM's management of the overall clinical and administrative demands of the work, including movement toward professional development goals and assessment of the supervisory process.

Research indicates that while clinicians and supervisors claim supervision is a critical process for ensuring quality services and good outcomes, most clinical supervisors receive little training in supervision and many employ only an intuitive framework for providing supervision. In addition, clinic supervision often focuses on administrative issues at the expense of clinical issues.[12] We agree that the quality of supervision can make or break TM (the service and the person who provides it) and can deeply affect the experience of the youth receiving TM.

TM supervisors should be aware that TMs, who are generally not clinically trained, might expect that "supervision" occurs just for administrative oversight, and they may not understand that supervision is an appropriate place to explore the thoughts and feelings that arise in the course of working with youth.

We strongly suggest that TM supervisors read about supervision, seek training and supervision (as needed) in supervision, and employ a well-defined approach to supervision. Such an approach should at least include (1) an explicit statement of the goals and methods of supervision, which provides the basis for a "contract" or explicit understanding between the TM and supervisor; (2) a joint process for assessing the learning needs of the TM; (3) a way to mark progress of the TM; and (4) a method for the TM and supervisor regularly to assess together how the supervision is going and to plan changes when needed. Therapeutic Mentoring supervisors themselves may benefit from supervision, including peer-group supervision with other supervisors within their agency or with TM supervisors across agencies.

Staff Training

Please see Therapeutic Mentoring performance specifications for staff training requirements. It is up to each provider to implement training consistent with the specifications, and to document compliance with the requirements.

Cultural competence is a central value of CBHI and should be an aspect of all training.

Credentialing Requirements

Per the TM performance specifications, Therapeutic Mentors must be at least 21 years old, and have the following education and experience.

- A bachelor's degree in a human service field and one year experience working with children/adolescents/transition-age youth;

---

[12] For a review of the evidence base in supervision, see Milne, D. (2009). *Evidence-Based Clinical Supervision: Principles and Practice*. Blackwell Publishing Ltd.

- An associate's degree in a human services field and one year experience working with the target population; or
- A high-school diploma or GED and a minimum of two years' experience working with children/adolescents/transition-age youth.

Credentialing Waiver Requests

On occasion, provider agencies may have a candidate who does not meet all the credentialing requirements for a position, but who is nonetheless specially qualified for the position. Given the flexibility already present in the TM credentialing requirements, it seems that TM waiver requests would rarely be warranted. It is conceivable, however, that a waiver might be approved, for example, for a person with special language or cultural competency.

Appendix J is the CBHI Staff Credentialing Waiver Request Form that must be used in applying for a credentialing waiver. Instructions for the waiver process and supporting documentation are included in the form. The provider submits a single request to all MCEs via an e-mail address on the form; each MCE subsequently makes its own decision on the waiver. The candidate is prohibited from performing TM services for a MassHealth member until the provider receives waiver approval from the member's MCE.

Use of Interns

Managed-Care Entities provided guidance on this topic in August 2011.[13] There is no specific provision for using interns to provide billable TM services. If an intern meets the credentialing requirements for TM, that person could provide TM services.

Staff Transitions

Because staff changes alter the relationships between the Therapeutic Mentoring staff and the youth and family, TM providers must have a protocol in place for managing both planned and unplanned staff changes in ways that respect family preference and guarantee access to ongoing services as needed.

Suggestions for managing staff transitions include the following.

- Direct contact, whenever possible and positive, between the TM who is leaving and the child and family to introduce the topic of staff change
- Reassurance from the staff to the youth and family that it is changes in staff circumstances and NOT rejection of the youth that prompts the change

[13] Available at www.masspartnership.com/provider/pdf/MCEUseofInternsforAllCBHIServicesAugust2011.pdf.

- Exploration of youth and family preferences in reassigning a TM. For example, some families may prefer to end services rather than start over with a new TM, while others may be satisfied with a change
- Reliance on other members of the treatment team to assist with continuity. For example, a Family Partner (hub-dependent) with a strong connection with the family may help to ease transition to a new TM, or a TT&S worker's positive relationship with a youth may carry over to a new TM
- The supervisor joining with the TM and/or the youth and family to clarify next steps
- Whenever possible, a joint meeting of the departing staff and newly assigned TM with the youth and family
- Timely response to all youth/family questions and concerns
- Seamless transfer of documentation to the new TM to spare the family from reiterating their needs, goals, progress, or stage of planning

Therapeutic Mentoring providers must have a protocol in place for managing both planned and unplanned staff changes: how the agency supports the youth and family during acute/ temporary situations, i.e., TM staff vacations and/or sick leave, as well as how to handle more permanent transitions such as resignations or terminations of TM staff. Therapeutic Mentoring providers must be prepared to offer TM services, if the family chooses, during all types of staff transitions. The TM must plan ahead with the family during the early meetings to identify options, including another TM or supervisor, who could provide services in the absence of the assigned TM.

When a planned resignation of Therapeutic Mentor staff occurs, the TM, in consultation with the TM's supervisor, determines how best to discuss this with the affected youth. In an unplanned staff resignation or termination, the TM must notify the family immediately and discuss a plan of action for an alternative TM.

Youth (and parents) with a history of abandonment, especially if early in life, are likely to automatically experience the departure of their TM as a reflection on them—that they are unworthy of support. It is important for the TM to undermine such misperceptions or unconscious assumptions when possible, with some explanation for the departure, as well as acknowledgement of the loss, and review of positive experiences and accomplishments that the youth had with the TM. Younger children in particular may need assurance that the TM relationship is not ending because they did something wrong.

When it is not possible to assign a family immediately to a new Therapeutic Mentor, the provider must treat the family as wait-listed when updating the MABHAccess site per MCE requirements.

In addition, if the family is willing to consider transition to another organization, the provider should consult the MABHAccess website and contact other TM providers to check for availability of openings elsewhere.

Medical Necessity Criteria for Admission

The Medical Necessity Criteria for Therapeutic Mentoring are listed in Appendix E.

Any service provided to a youth and family must meet the Medical Necessity Criteria for that service; it must be requested by the youth and family and be tied to a goal in the hub provider's treatment plan (or ICP for youth in ICC). Upon receipt of a referral for TM, the provider is responsible for ensuring that the youth meets the TM Medical Necessity Criteria. TM is available to youth up to 21 years of age; per MassHealth rules, youth become ineligible for TM on their twenty-first birthday.

Throughout the course of services and during treatment plan updates, the TM provider is responsible for ensuring that the youth is reassessed for medical necessity.

Service Definitions

The Therapeutic Mentoring Service Definition in Appendix C describes the various components of the service for which TM providers can bill. For example, as specified within the service definition, as well as the TM Performance Specifications (see Appendix D), contact with other service providers or schools, by phone or face-to-face, is a function and responsibility of the TM provider, and thus is billable. Face-to-face time during which the member and staff are traveling together (e.g., in the care provider's car) is billable; however, staffing that does not occur during face-to-face contact is not billable (note that this expense is built into the current rate structure for TM). As noted within the service definition, telephone support for the youth is billable. Care coordination is a function and responsibility of the hub provider whose treatment plan (or ICP for youth in ICC) documents the goal(s) that the TM provider is addressing. The TM provider has no formal care coordination responsibility but is expected to collaborate with the members of the youth and family's treatment team (or CPT for youth in ICC) regarding care-planning activities.

Billing occurs in 15-minute units. There is no limit on billing for activities related to service components. All services billed by the TM provider must be consistent with the TM Service Definition and documented to meet the Medical Necessity Criteria for the service (Appendix E). TM providers should review the various Therapeutic Mentoring service components to ensure that their staff are billing appropriately.

As noted within the TM Service Definition, time spent in supervision and time spent preparing for sessions with youth are not separately billable activities, as they are included in the rate.

Access to Care

Youths deserve prompt access to services when they need them. Quick and flexible response to referrals helps children and their families build important skills. Responsiveness also contributes to the CBHI vision of a system that is welcoming, respectful, and able to meet the needs of children and families.

The person(s) responsible for accepting referrals (as determined by each provider agency) ensures that a youth meets the Medical Necessity Criteria for Therapeutic Mentoring (see Appendix D); is age 20 or younger; has the correct, current MassHealth coverage type for the service; has a hub service in place to support the referral; and has a clearly defined goal in a written treatment plan by the hub, which gives the rationale for how the TM service will help resolve current needs. The first and most important criterion for TM is that the parent/caregiver (for children age 17 or younger) and youth—or youth alone, if between 18 and 21—indicate that they want to participate in the voluntary service. In general, these eligibility determinations are made in the first phone contact with the Hub and/or family.

In best cases, the provider agency representative will consult as soon as possible with the family about preferences for the Therapeutic Mentor match.

> *In the Rodriguez family, for example, Anna Rodriguez may request a male TM for José whose father is absent, or a TM who enjoys outdoor sports, or an individual with whom the family worked in the past, or a Spanish-speaking TM. Ideally, the provider agency will be able to give name and contact information for the preferred Mentor right away. When this is not possible, the Coordinator communicates to Ms. Rodriguez (directly or through the hub) that a TM with the family preferences will be responding within five days to offer an initial appointment.*
>
> *In assigning a TM to work with a child and family, the provider agency must make every effort to match BOTH the skill-building expertise that best serves the youth AND the linguistic and cultural preferences of the family, as far as known at the time of referral. This requires respectful consultation with families to override possible assumptions of what might be best and a candid assessment of the provider's scope of options. Is there a male Therapeutic Mentor who enjoys playing sports and who can communicate in Spanish with Ms. Rodriguez?*

Hub providers must allow families to express their own opinions and needs about where they choose to obtain services. Because a hub provider works well with a certain hub-dependent provider is not a sufficient reason for influencing a family's choice to wait for that particular provider.

If a TM provider cannot fulfill the family preferences at present, there are options for waiting or for choosing another provider given in the next section on Waitlist Activities. If a TM provider has consistent difficulty providing access, the provider should notify the contracted Managed-Care Entities to assist youth needing access to services.

Guidelines for access to care and for contacting families can be found in the "Guidelines for Ensuring Timely Access to CBHI Services" and "Access to Care Protocol" (see Appendix K and Appendix L, respectively). These protocols are designed to ensure a consistent process for all Therapeutic Mentoring providers. Therapeutic Mentoring providers are expected to ensure that

all relevant staff are trained on all aspects of this protocol, including expectations and guidelines about access to care definitions, response time to referrals, and waitlist follow-up expectations.

Timeframes and Documentation

Upon receiving a referral from a hub or from a family, the designated coordinator of Therapeutic Mentoring for the provider agency contacts the family within five calendar days of the date of referral to offer the family a face-to-face appointment to initiate services.

At the time of referral, the hub service provider is responsible for sharing and discussing with the TM provider a copy of the comprehensive assessment, including the CANS, and Individual Care Plan or treatment plan. Therapeutic Mentoring providers must actively participate in obtaining these documents. Passively waiting for the hub to send them is not sufficient and might delay the start of services or set services in motion without sufficient information.

There is no requirement for the use of a standardized intake form for Therapeutic Mentoring. However, TM providers must gather information during the intake process that will guide their implementation of the TM portion of the overall treatment planning. This includes information pertinent to safety during any excursions in to the community. Therapeutic Mentors must document relevant medical information (i.e., pre-existing medical conditions, food allergies, asthma, prescribed medications, preferred medical providers, and current medical conditions), which might affect planning of excursions outside the home.

At intake, the TM will review with the youth and family the goals of the TM service and the skills that the youth and the Therapeutic Mentor will be working to develop. These should be well known to the youth and family based on their participation in the hub service. If the youth or caregiver has questions about why the TM is involved, what the goals are, or how these specific skills were selected, it is important for the TM to discuss these questions with the family **and** to refer the questions back to the hub provider. The questions may indicate a lapse in communication or dissension in planning, which should be addressed immediately.

Additionally, Therapeutic Mentoring providers must ensure that consent for Therapeutic Mentoring services is appropriately obtained from the youth's legal guardian. For example, if a youth is in the custody of the Department of Children and Families (DCF), DCF staff is responsible for signing the consent to services for that youth.

Waitlist Activities

If the Therapeutic Mentoring provider who received the original referral is unable to offer a face-to-face appointment with a preferred match and initiate services within five calendar days of contact with the family, the TM provider speaks with the family to determine if they would consider receiving services with other TM providers in their area. The TM provider documents the family's preference on the Referral Log/Waitlist (see Appendix M).

If the family is willing to receive services from another available Therapeutic Mentor in the area, the TM provider who received the original referral is required to assist the hub in finding

another available provider to enable the family to receive services as soon as possible. The TM provider must check availability on the MABHAccess website and call other agencies to confirm availability, while communicating the minimum necessary information to another agency. The TM provider communicates reciprocally with the hub to coordinate the monitoring of waitlist activity to ensure timely access for their referred youth and families and to ensure that any new TM provider has all the necessary documentation to commence services.

In the event that the family decides to wait for a particular provider agency or a specific TM, the provider must contact the family on a weekly basis to confirm continued interest in service and triage any imminent behavioral health needs, and to see if the family has chosen to continue waiting or has started services with another provider. If a family requests the Therapeutic Mentoring provider not to call weekly, the TM provider may call at the requested frequency.

Medical Necessity Criteria

Criteria for Admission

Any service provided to a youth and family must meet the Medical Necessity Criteria for that service and be tied to a goal in the hub provider's treatment plan or Individual Care Plan (for youth in Intensive Care Coordination). Upon receipt of a referral for Therapeutic Mentoring, the provider is responsible for ensuring that the youth meets the Therapeutic Mentoring Medical Necessity Criteria. Therapeutic Mentoring is available to youth up to 21 years of age; per MassHealth rules, youth become ineligible for Therapeutic Mentoring on their twenty-first birthday. The Therapeutic Mentoring Medical Necessity Criteria can be found in Appendix E.

All the following criteria are necessary for participation in Therapeutic Mentoring.

- A comprehensive behavioral health assessment, including the MA Child and Adolescent Needs and Strengths (CANS) developed by the hub provider, indicates that the youth's clinical condition warrants this service in order to support age-appropriate social functioning or ameliorate deficits in the youth's age-appropriate social functioning. If the member has MassHealth as a secondary insurance and is referred to services by a provider who is paid through the member's primary insurance, the provider must conduct a comprehensive behavioral assessment. A CANS is not required from the hub in this case, although it is good practice.
- The youth requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem solving and conflict resolution, and in relating appropriately to others to address daily living, social, and communication needs. Therapeutic Mentoring can also support the youth in a home, foster home, or community setting, or the youth who may be at risk for out-of-home placement as a result of the youth's mental health condition or who requires support in transitioning back to the home, foster home, or community from a congregate-care setting.

- Outpatient services alone are not sufficient to meet the youth's needs for coaching, support, and education.
- The appropriate persons have consented to the service.
- The youth is currently engaged in Outpatient services, In-Home Therapy, or Intensive Care Coordination; and the provider or ICC Care Planning Team determines that Therapeutic Mentoring services can facilitate the attainment of a goal or objective identified in the treatment plan or Individualized Care Plan that pertains to the development of communication skills, social skills, and peer relationships.

If any one of the following criteria is met, the youth does not have medical necessity for Therapeutic Mentoring.

- The youth displays a pattern of behavior that may pose an imminent risk to harm self or others, or sufficient impairment exists that requires a more intensive service beyond community-based intervention.
- The youth has medical conditions or impairments that would prevent beneficial utilization of services.
- Therapeutic Mentoring services are not needed to achieve an identified treatment goal.
- The youth's primary need is only for observation or for management during sport/ physical activity, school, afterschool activities or recreation, or for parental respite.
- The service needs identified in the treatment plan/Individual Care Plan are being fully met by similar services.
- The youth is placed in a residential treatment setting with no plans for return to the home setting.

Criteria for Continued Services

Throughout the course of services and during treatment plan updates, the Therapeutic Mentoring provider is responsible for ensuring that the youth is reassessed for medical necessity. All the following criteria are required for continued participation in Therapeutic Mentoring.

- The youth's clinical condition continues to warrant Therapeutic Mentoring services in order to continue progress toward treatment plan goals.
- The youth's treatment does not require a more intensive level of care. A less intensive level of care would not be appropriate. Care is rendered in a clinically appropriate manner and focused on the youth's behavioral and functional outcomes, as described in the treatment plan/Individual Care Plan Progress in relation to specific behavior, symptoms, or impairments; is evident and can be described in objective terms but goals have not yet been achieved, or adjustments in the treatment plan/Individual Care Plan

to address lack of progress are evident. The youth is actively participating in the plan of care to the extent possible consistent with his or her condition.

- Where applicable, the parent/caregiver and/or natural supports are actively involved as required by the treatment plan/Individual Care Plan.

As stated above, the Managed-Care Entities make case-by-case determinations as clinically necessary around the need to waive the hub requirement and the CANS in situations where a youth has an existing non-Medicaid, reimbursed outpatient therapist (paid for by private insurance, school, etc.) and is not clinically in need of either an additional outpatient therapist that is MassHealth-reimbursed or In-Home Therapy or Intensive Care Coordination. Youth with a primary diagnosis of autism or a pervasive developmental disorder are NOT excluded from receiving Therapeutic Mentoring services, provided they meet the Medical Necessity Criteria.

Bibliography

Creating a Service System that Builds Resiliency, J. Eric Vance, MD, and Horacio Sanchez, February 1998.

Relationships and Treatment: Putting First Things First, Marci White, Mentor Inc.

Definition of a Therapeutic Environment, Marci White, Mentor Inc.

Questions and Issues to Consider When Assessing Child's Needs and Developing Goals and Strategies for Plans, Marci White, Mentor Inc.

Appendices

Appendix A: Availability of CBHI Services to Members in Various Benefit Plans

Eligibility
The implementation of the Children's Behavioral Health Initiative (CBHI) signaled a major expansion of behavioral health services for children and youth who are younger than 21 and have MassHealth. MassHealth now provides health insurance for a large percentage of the Commonwealth's children.

Even if a family earns too much money to be income-eligible for MassHealth, a child in that family with a disability may be eligible for MassHealth benefits, including a child with a mental/behavioral health diagnosis. This type of MassHealth coverage, called CommonHealth, is available, regardless of family income, with a sliding fee scale for premiums.

Children and youths younger than 21* who are enrolled in either MassHealth Standard or MassHealth CommonHealth may access medically necessary MassHealth behavioral health services. Approximately 85% of MassHealth-enrolled children and youths have either Standard or CommonHealth coverage. Children and youths younger than 21 enrolled in MassHealth Family Assistance—a smaller program developed to expand health care to more individuals—may be able to access certain behavioral health services, if the service is medically necessary.

Below is a summary of MassHealth behavioral health services** for children and youths younger than 21. Next to the service are the types of MassHealth coverage available for them. NOTE: This list of services covered by MassHealth provides only general information. Parents and youth should call their MassHealth health plan for the most up-to-date, accurate information.

Behavioral Health Service	MassHealth Coverage Types
Outpatient Therapy	Standard, CommonHealth, Family Assistance*
Mobile Crisis Intervention	Standard, CommonHealth, Family Assistance*
Structured Outpatient Addiction Program	Standard, CommonHealth, Family Assistance*
In-Home Therapy	Standard, CommonHealth, Family Assistance*
Intensive Care Coordination	Standard, CommonHealth
Family Support and Training (Family Partners)	Standard, CommonHealth
In-Home Behavioral Services	Standard, CommonHealth
Therapeutic Mentors	Standard, CommonHealth

*Note: Some members younger than 19 who are eligible for Family Assistance receive premium assistance as their only MassHealth benefit. For these members, MassHealth pays the premium for commercial insurance but does not reimburse providers directly for services. These members are not eligible for MassHealth behavioral health services.

Additionally, some families with Family Assistance also have commercial health insurance coverage. As a result, their children are not eligible for enrollment in any of MassHealth's managed-care programs, nor are they eligible for community-based MassHealth behavioral health services (with the exception of Mobile Crisis Intervention). Families can call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech-disabled) to learn more.

**MassHealth lists the services and benefits currently available. To access the list, visit the MassHealth website at www.mass.gov/masshealth or call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648).

Appendix B: Suggested Resources for Building Social Skills with Youth

- *What Do You Stand For?* – Barbara Lewis
- *Coping Cat Workbook* – Philip Kendall
- *Therapeutic Exercises for Children* – Robert Friedberg
- *Stop and Think Workbook* – Philip Kendall
- *Cool Cats, Calm Kids* – Mary Williams
- *Social Thinking Books* – Michelle Garcia Winner www.socialthinking.com
- *How to Make and Keep Friends* – Nadine Briggs
- *Social Rules for Kids* – Susan Diamond
- *104 Activities* – Alana Jones
- *The New Social Story Book* – Carol Gray
- *Let's Be Friends* – Lawrence Shapiro
- *Speak Up and Get Along* – Scott Cooper
- *What to Do When You Worry Too Much* – Dawn Huebner
- *When My Worries Get Too Big* – Kari Dunn Buron
- *Temper Tamers in a Jar* – Free Spirit Publishing
- *Choices in a Jar* – Free Spirit Publishing
- *Feelings in a Jar* – Free Spirit Publishing
- *The Social Skills Game* – Life Games
- *Social Skills Board Games* – Education Treasures
- *Consequences Board Game* – TaliCor
- *Ungame* – TaliCor

- *The Talking, Feeling, Doing Game* – Creative Therapeutics
- *Mad Dragon: An Anger Control Card Game* – Therapy Game HQ
- *Feelings Playing Cards* – Jim Borgman
- *Totika Ice Breaker Self Esteem Game* – Open Spaces LLC
- *Komichis Mini Mixed Bag of Feelings* – Kimochi
- *Social Skills Lessons and Activities* – Ruth Weltmann Begun

Appendix C: Therapeutic Mentoring Service Definitions

www.masspartnership.com/pdf/TherapeuticMentoring%20servicedef.pdf

Appendix D: Therapeutic Mentoring Performance Specifications

www.masspartnership.com/pdf/TherapeuticMentoringServices-Aug23.pdf

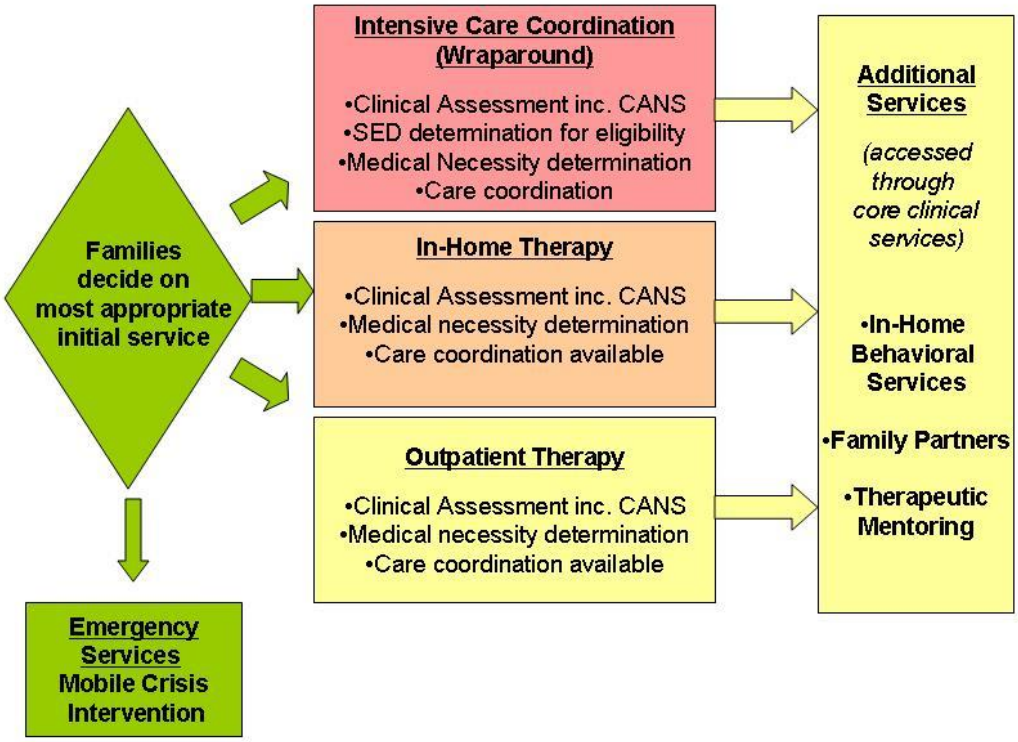
Appendix E: Therapeutic Mentoring Medical Necessity Criteria

www.mass.gov/eohhs/docs/masshealth/cbhi/mnc-therapeutic-mentoring-services.pdf

Appendix F: Managed-Care Entity CHBI Health Record Documentation Standards

www.masspartnership.com/pdf/MCE%20CBHI%20Health%20Record%20Doc%20Standards%20March%202013.pdf

Appendix G: CBHI Clinical Pathways Grid



Appendix H: Tip Sheet for Outpatient Clinicians: Roles and Responsibilities as a CBHI Hub Provider

www.mass.gov/eohhs/docs/masshealth/cbhi/op-cbhi-tip-sheet.pdf

Appendix I: Crisis-Planning Tools

www.masspartnership.com/provider/CrisisPlanning.aspx

Appendix J: Managed-Care Entity CBHI Waiver Request Form

www.masspartnership.com/pdf/MCE%20CBHI%20Waiver%20Request%20Form%2010%202014.doc

Appendix K: Guidelines for Ensuring Timely Access to CBHI Services

www.masspartnership.com/pdf/GuidelinesforEnsuringTimelyAccesstoCBHIServices522011.pdf

Appendix L: Access to Care Protocol

www.masspartnership.com/pdf/AccessToCareProtocol082012.pdf

Appendix M: CBHI Referral Log Waitlist

www.masspartnership.com/pdf/ReferralLogWaitlistTemplate090512.xls

Appendix N: Managed-Care Entities Therapeutic Mentoring Initial and Subsequent Authorization Processes

www.masspartnership.com/pdf/MCE%20CBHI%20Auth%20Processes%201%2016%2014.pdf

Appendix O: Managed-Care Entities Websites

Beacon Health Strategies: www.beaconhealthstrategies.com

BMC HealthNet Plan: http://www.bmchp.org

Fallon Community Health Plan: www.fchp.org

Neighborhood Health Plan: https://www.nhp.org/Pages/Home.aspx

Network Health: www.network-health.org

MBHP: www.masspartnership.com

Health New England: www.healthnewengland.com

Appendix P: Definition of Terms

Care Coordinator: individual who provides Intensive Care Coordination (ICC) to youth and families, using the high-fidelity Wraparound model. The role of the Care Coordinator includes facilitating the development of a Care Planning Team (CPT), including the youth and caregiver(s); convening CPT meetings; coordinating and communicating with the members of the CPT to ensure the development and implementation of the Individual Care Plan (ICP); working directly with the youth and family to implement elements of the ICP; coordinating delivery of other services; and monitoring and reviewing progress toward ICP goals, and with the CPT, revising the ICP when necessary.

Care Planning Team (CPT): in Intensive Care Coordination, includes the youth and caregivers as well as both formal and natural support people (such as extended family, friends of the youth and family, representatives of child-serving state agencies, school personnel, and advocates who assist the family in identifying goals and developing and implementing an Individual Care Plan (ICP). A CPT must include more than the youth, caregiver, and care coordinator.

Child and Adolescent Needs and Strengths (CANS): a tool that provides a standardized way to organize information gathered during behavioral health comprehensive assessments. There are two versions of the Massachusetts CANS for two age groups: birth through four, and five through 20. The Clinical Hub service is responsible for updating the CANS every 90 days. Hub-dependent service providers are not required to complete the CANS but should obtain the initial CANS and updates from the referring Clinical Hub provider, use information from the CANS to inform its work with the child and family, and provide feedback to the Clinical Hub provider to inform on CANS updates.

Community Service Agency (CSA): provides Intensive Care Coordination using the high-fidelity Wraparound model, and provides the Family Support and Training Service (Family Partners). CSAs also are responsible for convening a local System of Care meeting to strengthen local communication and collaboration. CSAs contracted with MassHealth MCEs through a request-for-proposals (RFP) process. There are currently 29 geographically based CSAs, as well as three CSAs dedicated to meeting the needs of underserved populations.

Comprehensive Assessment: a gathering of information developed by a clinician in collaboration with a youth and his/her family, which helps in understanding the youth's needs and in directing the youth's treatment. An Assessment includes the youth's strengths and current concerns, organized with sufficient detail of medical, psychiatric, and substance use history, relevant developmental history, current treatment and medications, and risk factors to provide a substantive picture of the youth's mental status and functioning and a cogent clinical formulation and DSM V diagnosis. The Assessment also includes a review of the child's need for care coordination and the adequacy of current care coordination services to meet this need. The Comprehensive Assessment includes the CANS.

The CANS is not a replacement or substitute for the complete Comprehensive Assessment, but a tool to organize the information gathered through the Comprehensive Assessment. The CANS supports communication among service providers and ensures that the child's and family's strengths and needs are identified across life domains. Providers of hub-dependent CBHI services are expected to obtain and use the most recent completed Comprehensive Assessment

for the youth they serve. *(Please note that Assessment with a capital A is used throughout this document to refer to this specific document, in contrast to other forms of assessment or the general activity of making an assessment.)*

Emergency Services Program (ESP): provides behavioral health crisis assessment, intervention, and stabilization services 24 hours per day, seven days per week, and 365 days per year. Each ESP/MCI provides ESP services for adults; MCI services for youth from birth to 20 years; and CCS services for adults (18 and older). Both ESP services for adults and MCI services for youth may be provided on a mobile basis in individuals' homes, as well as in other locations such as schools. Both ESP and MCI services may also be accessed on a walk-in or call-ahead basis at the ESP's community-based location.

Family Partner: an individual with lived experience as the caregiver for a child or youth with behavioral health or special health care needs. Family Partners are trained to assist families in either of two MassHealth services: Family Support and Training (FS&T, a hub-dependent service through a Community Service Agency), or Mobile Crisis Intervention (MCI). Most Family Partners provide the FS&T service, and while they often pair with Care Coordinators to implement the Wraparound process with families, they can work with families in other hubs, either In-Home Therapy or Outpatient. On MCI teams, Family Partners pair with clinicians to provide support to youth in crisis and their families. The Family Partner provides emotional support for the caregiver and fosters empowerment and expression of family voice. Family Partners often share parts of their own stories as an intentional way of helping caregivers develop motivation and actionable insight.

Family Support and Training (FS&T): a hub-dependent service provided by a Family Partner to the caregiver of a youth receiving ICC, IHT, or outpatient services. Building upon family strengths, the Family Partner supports the caregiver in ways that address the behavioral health needs of the youth. The Family Partner provides emotional support for the caregiver and fosters empowerment and expression of family voice. The Family Partner models, trains, and coaches the caregiver in relevant skills. FS&T may include activities such as sharing information, providing assistance in navigating the child-serving systems, assisting with linkages to parent and peer support groups, and identifying community resources. Family Partners in FS&T follow a successive process of "do for, do with, and cheer on" as caregivers become progressively able to accomplish more in support of the child.

Hub Services: Outpatient Therapy, In-Home Therapy, and Intensive Care Coordination. Hubs serve as the primary behavioral health care provider for a youth. The hub service clinician, in concert with youth and family, assesses the youth's clinical need for services, including the youth's need for care coordination and hub-dependent services, and then links youth to appropriate services to meet those needs, including Hub Services, providing greater levels of care coordination. Hubs collaborate with collateral supports and services to integrate interventions across treatment plans. Hubs facilitate treatment/care-planning meetings as necessary for coordination of care. The Hub Service with the highest level of intensity takes primary responsibility for care coordination.

Hub-Dependent Services: include Therapeutic Mentoring, In-Home Behavioral Services (except when circumstances warrant a waiver of the Hub referral), and Family Support and Training.

They provide a specialty service that augments the interventions of the hub provider. Referrals for hub-dependent services are made by one of the hub services.

Individualized Action Plan for Therapeutic Mentoring (TM IAP): In Therapeutic Mentoring, the TM IAP is developed from the goals in the hub's Individual Care Plan or Treatment Plan, and describes clinically driven skill-building interventions that the TM will use to help the youth develop target skills. The TM IAP also defines the measures for progress. The TM IAP is developed with the meaningful participation of the youth, parent/caregiver, and hub provider, and all three parties should concur with the final plan. The plan is written in nontechnical language that is understandable to the youth, and should identify all the people who were involved in the development of the plan. If the youth has a hub Safety Plan, the TM IAP should also mesh with the Safety Plan. The hub team and the TM's clinical supervisor offer input. The plan is signed by parent, youth (if age-appropriate), and TM.

Individual Care Plan (ICP): developed according to Wraparound principles in the context of a Care Planning Team with youth enrolled in Intensive Care Coordination. The Care Plan specifies the goals and actions to address the medical, educational, social, therapeutic, or other services needed by the youth and family. It incorporates the strengths and needs of the youth and family. The ICP unifies multiple treatment plans into an overarching plan and serves as the primary coordination tool for behavioral health interventions, informal supports, and Wraparound care planning.

Individualized Action Plan for Therapeutic Mentoring (TM IAP): in Therapeutic Mentoring, the TM IAP is developed from the goals in the hub's Individual Care Plan or Treatment Plan, and describes clinically driven skill-building interventions that the TM will use to help the youth develop the target skills. The TM IAP also defines the measures for progress. The TM IAP is developed with the meaningful participation of the youth, parent/caregiver and hub provider, and all three parties should concur with the final plan. The plan is written in nontechnical language that is understandable to the youth and should identify all the people who were involved in the development of the plan. If the youth has a hub Safety Plan, the TM IAP should also mesh with the Safety Plan. The hub team and the TM's clinical supervisor offer input. The plan is signed by parent, youth (if age-appropriate), and TM.

In-Home Behavioral Service (IHBS): a hub-dependent service (except when the situation warrants waiver of the Hub requirement), which addresses a youth's behaviors that interfere with successful functioning in the community. Services are delivered by one or more members of a team consisting of professional clinicians and qualified support staff via a combination of Behavior Management Therapy and Behavior Management Monitoring.

> *Behavior Management Therapy*: a component of IHBS, includes a behavioral assessment (observing the youth's behavior, antecedents of behaviors, and identification of motivators) and the development of a highly specific behavior plan with interventions that are designed to diminish, extinguish, or improve specific behaviors related to the youth's behavioral health condition(s). Both the assessment and the plan are created in collaboration with the youth and family. Supervision of interventions and training for other practitioners to address specific behavioral objectives are provided.

Behavior Management Monitoring: the other primary component of IHBS includes implementation of the behavior plan developed by the Behavior Management Therapist and the family, as well as monitoring the youth's behavior and reinforcing implementation of the behavior plan by the parent/caregiver. Also included is reporting to the Behavior Management Therapist on the implementation of the behavior plan and progress toward behavioral objectives or performance goals, so that the behavior plan may be modified as needed.

In-Home Therapy Service (IHT): a service that provides intensive therapy in the home or community, through a master's-level clinician and often incorporating a bachelor's-level person providing the service of Therapeutic Training and Support (TT&S). If the youth is not enrolled in Intensive Care Coordination but is enrolled in IHT, IHT is responsible for hub functions including treatment planning, communicating with other providers, and coordinating care. The IHT clinician develops a treatment plan and uses established psychotherapeutic techniques and intensive family therapy, working with the entire family or a subset of the family.

Intensive Care Coordination (ICC): provides care planning and care coordination using the high-fidelity Wraparound model. Collaborating with the family, ICC conducts an initial comprehensive assessment, facilitates the ongoing process for building a team, develops an Individual Care Plan to address the youth's needs and support the goals identified by the youth and family, and monitors and improves the plan until goals are met. The Intensive Care Coordinator works with the youth, caregivers, supports, providers, schools, state agencies, and others who play a key role in the youth's life, to facilitate the development of a Care Planning Team for the youth. Care planning is driven by the needs of the youth and developed through a Wraparound planning process consistent with Systems of Care philosophy.

Managed-Care Entity (MCE): an organization that contracts with the Commonwealth to provide MassHealth insurance products to Massachusetts residents. The term MCE is used by EOHHS to refer to a broad category of health plans, including specialized plans that deliver particular benefits, such as Behavioral Health services.

Mobile Crisis Intervention (MCI): the youth-serving component of an Emergency Services Program provider. Its purpose is to support youth and their families through psychiatric emergencies in ways that leave the family safe and emotionally stable. MCI provides an immediate, short-term, face-to-face, therapeutic response to a youth experiencing a behavioral health crisis. The team is mobile, travels to where the emergency is taking place, and intervenes within one hour of contact. The MCI intervention identifies, assesses, treats, and stabilizes the situation to reduce immediate risk of danger to the youth or others, consistent with the youth's risk management/safety plan, if one exists. The MCI team helps the family develop a risk management/safety plan if the family does not already have one.

The MCI service is available 24 hours a day, seven days a week. Following a crisis, MCI can provide up to seven days of crisis stabilization services, which include face-to-face therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention. The MCI team, as needed, makes referrals and builds linkages to all medically necessary behavioral health services and supports. For youth receiving ICC or IHT, MCI staff coordinates with the youth's Care Coordinator or In-Home Therapist throughout the duration of the MCI service. If

IHT is acting as the clinical hub, it must be available to coordinate with the MCI team before, during, and after the crisis event. MCI also coordinates with the youth's primary care physician, any other care management program, or other behavioral health providers involved with the youth.

Natural Supports: individuals or organizations in the family's own community, kinship, social, or spiritual networks, such as extended family members, friends, neighbors, members of faith communities, contacts at daycare, school, camp, or other community contexts that are accessible in families' daily environments. Participation of Natural Supports in the service-planning process can make it friendlier to families. The purpose of joining with Natural Supports is to find sustainable, affirmative resources that will help children and families move forward in their lives long after professional involvement ends. Connecting with Natural Supports helps youth and families connect with their community and reduce isolation.

Outpatient Therapy: a clinical service, usually (but not necessarily) delivered in an office setting, and usually (but not necessarily) delivered with a frequency and duration of not more than an hour per week. If a youth enrolled in Outpatient Therapy is not enrolled in Intensive Care Coordination or In-Home Therapy, the Outpatient Therapist is responsible for hub functions including treatment planning, communicating with other providers, and coordinating care.

Parent/Caregiver: any biological, kinship, foster, and/or adoptive family/caregiver responsible for a parental role in the care of a youth.

Senior Care Coordinator: supervises other care coordinators and is a master's-level clinician licensed at the independent-practice level.

Shared Decision Making (Informed Medical Decisions Foundation): a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's value and preference.

System of Care (SOC): a cross-system, coordinated network of services and supports organized to address the complex and changing needs of youth and families in the context of their culture, environment, and family situation. For a full discussion of System of Care, see *The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families,* edited by Beth A. Stroul, M.Ed., and Gary M. Blau, Ph.D.

Therapeutic Mentoring: a hub-dependent service that offers structured, one-to-one, strength-based support services between a Therapeutic Mentor and a youth. It is dependent on the referring Hub service and guided by the Hub's Individualized Action Plan to address daily living, social, and communication needs.

Therapeutic Training & Support (TT&S): a dimension of the In-Home Therapy service that is available to families to assist in achieving treatment goals and therapeutic objectives. The TT&S staff may coach, teach, or otherwise support the youth to develop, practice, and generalize skills to understand and manage emotional responses to family situations. He or she may assist the family in understanding the youth's emotional and mental health needs. TT&S staff may engage in skill-building activities to strengthen the youth's functioning in the family and support

family members in practicing concrete skills for dealing with the youth's episodes of disturbance. TT&S staff also help youth and families connect to Natural Supports, and they are not required to have clinical credentials for their role.

Wraparound: a well-defined planning process driven by the youth and family, which results in a unique set of community services and natural supports individualized for that youth and family to achieve a positive set of outcomes. CBHI services are designed to align with Wraparound principles. For a full description, see the National Wraparound Initiative website at http://nwi.pdx.edu/.

Acknowledgements

The Executive Office of Health and Human Services (EOHHS) wishes to acknowledge the clinicians, subject matter experts, and reviewers for their efforts and contributions to the development of these Practice Guidelines; and also Patti Donovan, MPA, for her significant contribution.