A Toolkit for Effective Collaboration Between Schools and Mental Health Agencies Providing Therapeutic Staff Support
Acknowledgements

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History of Therapeutic Staff Support

More than a decade ago, the federal Omnibus Budget Reconciliation Act of 1989 (OBRA 89) established that children up to age 21 who are enrolled in Medical Assistance are entitled to medically necessary services, including a wide range of home and community-based mental health services, even if the services aren’t included in the state plan or available for adults. Thus, each state receiving Medicaid funds was mandated to provide medically necessary services under the umbrella of Early Periodic Screening, Diagnosis and Treatment (EPSDT) in order to prevent more restrictive residential and psychiatric inpatient services.

In April 1990, Pennsylvania began implementation of OBRA 89. On January 19, 1993, the Office of Medical Assistance Programs (OMAP) issued the bulletin entitled “Accessing Mental Health Services Not Currently Included in the Medical Assistance Fee Schedule for Eligible Children and Adolescents Under 21 Years of Age”. The bulletin outlined client eligibility requirements, provider qualifications and procedures. The result was a variety of unique services developed by providers, among which were Mobile Therapy (MT), Behavioral Specialist Consultant BSC), and Therapeutic Staff Support (TSS). Together, these three modalities have come to represent the core of what have become known as Behavioral Health Rehabilitation Services, or Expanded Services, or Wraparound. At first, all of these services required prior approval of OMAP through the 1150 Administrative Waiver Process.

Before these intensive home and community-based interventions were developed, the standard array of services was available to children and families, including:

- Case management services;
- Crisis intervention and emergency services;
- Outpatient services;
- Partial hospitalization services;
- Community residential rehabilitation services (CRR);
- Psychiatric inpatient hospitalization; and
- Since 1989, family-based mental health services (FBMHS).

Residential treatment facilities (RTFs) were also made available in response to OBRA 89. In addition, the Office of Children, Youth and Families (OCYF), the Bureau of Drug and Alcohol Programs and Juvenile Justice services were in place to provide, respectively, protective services, substance abuse interventions, and residential placements for youth who are adjudicated dependent or delinquent. Supplementing these were resources such as family support services, student assistance programs, school-based mental health services and family centers.

On January 11, 1994, OMAP issued the bulletin entitled “Outpatient Psychiatric Services for Children Under 21 Years of Age”. In this bulletin, MT, BSC and TSS were added to the Medical Assistance fee schedule. TSS services were defined as “one-on-one
interventions to a child or adolescent at home, school, daycare, YMCA, emergency room, other community-based program, or community setting when the behavior without this intervention would require a more restrictive treatment or educational setting... services include: crisis intervention techniques, immediate behavioral reinforcements, emotional support, time-structuring activities, time-out strategies, and additional psychosocial rehabilitative activities as prescribed in the treatment plan (pp. 7-8). As such, TSS services served as a parallel, or alternative, to some of the interventions available through the Family-Based Mental Health Services program, allowing more flexibility and intensity than this program could sometimes offer.

TSS activities were intended to provide specific interventions to stabilize the child or adolescent, and to provide support for the family's efforts to stabilize the child and promote age-appropriate behavior. In addition, TSS workers were expected to collaborate with other members of the treatment team and professionals working with the child or adolescent in the home or community. By adding TSS (and other services) to the fee schedule, OMAP institutionalized a service modality which had actually been in use for some time previously under the 1150 waiver system. Waiver requests for TSS (as well as BSC and MT) had become so frequent that adding it to the fee schedule facilitated access to it.

A September 8, 1995 bulletin, “Accessing Mental Health Services Not Currently Included in the Medical Assistance Program Fee Schedule for Eligible Children Under 21 Years of Age”, a revision of the 1993 bulletin of the same title, further clarified wraparound requirements and procedures, including the requirement that services be recommended by a county interagency service planning team. This bulletin has become the bible of wraparound, constituting the primary set of official guidelines for the provision of services. In addition, there are a number of Medical Assistance regulations that apply to these services, such as billing and record-keeping. More recently, another bulletin has been released, entitled “Prior Authorization of Therapeutic Staff Support (TSS) Services”, which informs providers that the Department of Public Welfare now requires prior authorization of all TSS services rendered after March 1, 2001.

From the outset, by far the most frequently used wraparound service was TSS. Since use of TSS was rather flexibly defined, various providers tended to interpret the guidelines in different ways. As a result, TSS workers were soon operating in a wide range of settings, performing functions not initially anticipated. This lack of specificity, or standard of care, in TSS services, has been discussed and debated among providers. At issue was the belief that TSS services were being over-prescribed and misapplied. Some providers advocated for the development of a set of guidelines or standards to which all providers could adhere; others favored the flexibility the bulletins afforded each agency to be creative in their use of TSS.

In 1997, OMAP formed a workgroup to examine and correct problems in the delivery of TSS services. Subsequently, a draft bulletin was released and subjected to public review, revising requirements for provision of TSS, including staff qualifications, supervision and training. (The draft bulletin also addressed mobile therapist and behavioral specialist
consultant services.) A series of communications from OMAP addressed appropriate and inappropriate uses of TSS, and the PA CASSP Training and Technical Assistance Institute developed a three-day training sequence for TSS workers and supervisors which was formally endorsed by the Department of Public Welfare (DPW) in a letter to providers in June 1998. As of this writing, there are plans to make this draft bulletin the basis of new regulations for TSS, mobile therapist and behavior specialist consultant services.

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School District Involvement When Considering TSS Services in Schools

It is important to note that TSS services should not be recommended or implemented within the school setting simply because that is what the parent or mental health agency wants. The school district is a very important part of that process and should be included in all treatment team meetings, especially when the child’s school-related behavior is being discussed.

The following categories of inquiry are intended to assist interagency and school-based teams in understanding the child's school-related needs and in fostering a systematic, integrated mental health-education-family partnership that identifies goals, objectives and medically necessary services, within a psychiatric or psychological evaluation and a school-related treatment plan.

1. Current areas of school-related concerns
   A. Global functioning
   B. Functioning within specific school domains (e.g., formal classroom vs. hallway or recess functioning vs. bus behavior, etc.)
   C. Duration and history of current concerns
2. Efforts at remediation and support to date (identify which are relevant)
   A. Specific classroom strategies
   B. Teacher-parent conferences to date
   C. Other parent participation or efforts
   D. Prior educational or psychological evaluations
   E. Prior use of Instructional Support Team or Student Assistance Program staff
   F. Use of IEP, and nature of Behavior Support Plan within.
   G. Nature of Transition Plan, for an adolescent.
   H. Use of tutoring, if indicated
   I. Use of special education supports within regular classroom setting
   J. Use of psychotropic medication to date, if indicated for specific diagnosis (e.g., ADHD, depression, etc.)
3. Nature of hypothesis to explain the child's related school problems, and envisioned outcome of the child and family, as related to school functioning.
4. Relevant school-related domains for mental health services to address (as identified within the evaluation, and addressed via goals and objectives within the individualized treatment plan):
   A. Classroom behavior.
   B. Peer relationships.
   C. Use of less structured school time (non-academic subjects, homeroom, cafeteria, recess, etc.).
   D. Bus behavior.
   E. Work habits and academic follow-through.
   F. Anger controls or impulse management.
   G. Integration of school and home behavior.
   H. Promotion of extra-curricular activities and normalized community functioning.

5. Identification of specific, medically necessary mental health service(s), with proposed functions

6. Nature of ongoing collaboration, review and quality monitoring by the treatment team-school staff, mental health staff and the family.

Information copied from the Pennsylvania Department of Public Welfare Website.
Implementing TSS Services in the Schools

There are special circumstances associated with the use of Therapeutic Staff Support (TSS) in the school setting, in large measure due to mental health services being provided within a separate, independent system—the school—that has its own structure, rules, methodologies, and culture. Teachers rightfully regard themselves as experts on their children, so the manner of the TSS worker's approach to the teacher is as important as the specific information conveyed. It may be difficult for the TSS worker to know who to contact within the school, and when. The rapid pace of the school day may make it unclear when the TSS worker and classroom teacher can best debrief about the child. It may also be unclear just how much information the teacher possesses about the child and how much is appropriate, given possible confidentiality issues.

It therefore follows that school representation at the interagency team meeting—typically a sound practice, even when in-school TSS services are not being given—becomes essential when TSS is being planned for, or provided within, the school. While participation of the child's primary classroom teacher is essential, the participation of more than a single school representative constitutes best practice. In addition to the primary classroom teacher, other school representatives may include the guidance counselor, principal, vo-tech instructor, coach, special education teacher, or other teachers who know the child well.

Since TSS is never intended to function as a stand-alone mental health service, it is expected that the initial school-based contact between the TSS worker and the school be mediated by a mental health professional (e.g., a Mobile Therapist, Behavior Specialist, or outpatient therapist, or the TSS supervisor), with the participation of the family. Such a meeting offers an opportunity for all parties to clarify and come to a resolution regarding:

1. The child's most immediate needs;
2. Efforts to date by the school;
3. The current school-related goals and objectives within the child's treatment plan and/or deciding upon one behavioral support plan to ensure consistency;
4. The specific hours, school-related settings, and roles of the TSS worker (clear roles and responsibilities of the TSS, teacher, and paraeducator need to be outlined);
5. The nature of TSS oversight by a designated mental health professional;
6. Mechanisms for informal exchange of information between the teacher and TSS worker as well mutually agreeable forms for documenting student’s academic and behavioral performance;
7. Mechanisms to set up additional treatment team/IEP meetings to review student performance;
8. Other mutual expectations of school, mental health staff, and family;
9. Confidentiality issues, when applicable; and
Collaboration, Not Just Tending the Child, is the TSS Goal

The TSS role within the classroom involves not just supporting and redirecting the child, but also exchanging information and collaborating actively with the classroom teacher, in the manner identified within the treatment plan and as directed by the mental health professional. Prior to the implementation of TSS services, it will be important for the classroom teacher and the TSS to have preliminary discussions regarding how services will be implemented. Technically, this should be discusses during the implementation of the student’s treatment plan. The following are some discussion points that should be covered:

- The role of the TSS in the classroom/relationship with classroom teacher.
- How important information will be communicated.
- How the TSS will be introduced to the class.
- How information will be shared with parents.
- Specific management strategies that will be utilized (restraints, removal from the classroom, behavior plan, etc.).
- Orientation of other staff members regarding the wrap-around services.
- Addressing staff members in the presence of students.
- Discussion of the general classroom rules.

Information copied from the Pennsylvania Department of Public Welfare Website.
What Mental Health Agencies Should Expect to Provide and Discuss at Initial Meeting with the School District

Each school district has different policies and/or procedures regarding the provision of wrap-around services, particularly TSS services, in their buildings. Some common practices are as follows:

**Required Documentation from the Mental Health Agency:**

The mental health agency may be required to provide the following information at an initial meeting with the district representative:

- A copy of the release of information for exchange between wrap-around and educational agency.
- Copies of current Act 34 and 151 clearances for the TSS and any other agency employee that will be providing direct services to the student in the school setting. These documents must be no more than one year old from the initial date it was issued.
- Copies of TB tests results no more than 3 months old from the initial testing completed on the TSS and any other agency employee that will be providing direct services to the student in the school setting. Section 23.44 of the Pennsylvania Code states that all personnel are required to have a tuberculin test prior to providing direct services to students. Prior to working at the school, the individual being tested for tuberculosis shall provide to the school a form from their doctor that indicates the following:
  - A negative Mantoux test reaction, using the two-step test procedure.
  - A significant tuberculin skin reaction with a negative chest x-ray for current tuberculosis disease.
- Name of Contact Person from the Agency (to share procedures, issues, concerns, questions, and grievances, etc.).
- Verification of Workman’s Compensation Coverage from the agency.
- A copy of the student’s Treatment Plan.
- A copy of the child’s psychological report recommending wrap-round services, with parent release.
- A copy of the job description for the TSS position (may vary from agency to agency).
Discussion of General Building Rules:

The school district representative should discuss the general building rules. If not reviewed by the district representative, the mental health agency representative should ask about:

- The name and number of the district contact when issues arise or pertinent information needs to be shared.
- Sign-in and sign-out procedures.
- Introduction to the building principal(s), supervisor(s), and secretarial, and guidance staff.
- Phone usage policies/procedures.
- Fax and copier usage policies/procedures.
- Lunch and break information (location, purchases, etc.).
- Location of work environment (access to desk, storage area for personal items)
- Map of the building or provide a tour of the building.
- Parking regulations and parking passes.
- Dress code for staff (some district policies discuss visible body piercing).
- Smoking policies/procedures.
- Policy on reporting absences/substitutes (protocol on who to notify).
- District Confidentiality policy. District may require the provider’s signature on this policy.
- Identification requirements. Most districts require that individual must wear ID badge, provided by the agency or school district, which should be visible at all times.
- Fire drill and disaster drill procedures.
- Obtaining a copy of the district school calendar, discipline handbook, and staff handbook.
- Obtaining a copy of the child’s schedule.
- Where to get information regarding delays and cancellations due to weather.
- Any pertinent information regarding the child as documented in the release presented by the agency (i.e. copy of the child’s IEP, Evaluation Report, etc.).
- Location of adult rest rooms and student rest rooms.
- Procedures to be used during a crisis with the student.
School District Checklist/
Discussion Points When Meeting about
TSS Services

Required Documentation from the Mental Health Agency:
The school district should have the following information prior to the implementation of TSS services in the school:

☐ A copy of the release of information for exchange between wrap-around and educational agency.

☐ Copies of current Act 34 and 151 clearances for the TSS and any other agency employee that will be providing direct services to the student in the school setting. These documents must be no more than one year old from the initial date it was issued.

☐ If applicable, copies of TB tests results no more than 3 months old from the initial testing completed on the TSS and any other agency employee that will be providing direct services to the student in the school setting. Section 23.44 of the Pennsylvania Code states that all personnel are required to have a tuberculin test prior to providing direct services to students. Prior to working at the school, the individual being tested for tuberculosis shall provide to the school a form from their doctor that indicates the following:
  o A negative Mantoux test reaction, using the two-step test procedure.
  o A significant tuberculin skin reaction with a negative chest x-ray for current tuberculosis disease.

☐ Name of Contact Person from the Agency to share procedures, issues, concerns, questions, and grievances, etc. (See Sample A)

☐ Verification of Workman’s Compensation Coverage from the agency.

☐ A copy of the student’s Treatment Plan.

☐ A copy of the child’s psychological report recommending wrap-round services.

☐ A copy of the job description for the TSS position (may vary from agency to agency).
**Discussion of General Building Rules:**
The school district representative should discuss the following and provide pertinent documents to the TSS/Mental Health Agency (date and have MH staff initial):

<table>
<thead>
<tr>
<th>Date</th>
<th>Initials</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____</td>
<td>_____</td>
<td>The name and number of the district contact when issues arise or pertinent information needs to be shared.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Sign-in and sign-out procedures.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Introduction to the building principal(s), supervisor(s), and secretarial, pertinent teachers and guidance staff.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Phone usage policies/procedures.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Fax and copier usage policies/procedures.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Lunch and break information (location, purchases, etc.).</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Location of work environment (access to desk, storage area for personal items).</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Map of the building or provide a tour of the building.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Parking regulations and parking passes.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Dress code for staff (some district policies discuss visible body piercing).</td>
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<td>_____</td>
<td>_____</td>
<td>Smoking policies/procedures.</td>
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<td>_____</td>
<td>_____</td>
<td>Policy on reporting absences/substitutes (protocol on who to notify).</td>
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<td>_____</td>
<td>_____</td>
<td>District Confidentiality policy. District may require the provider’s signature on this policy. (See Sample B)</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Identification requirements. Most districts require that individual must wear ID badge, provided by the agency or school district, which should be visible at all times.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>Fire drill and disaster drill procedures.</td>
</tr>
<tr>
<td>_____</td>
<td>_____</td>
<td>A copy of the district school calendar, discipline handbook, and staff handbook.</td>
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</table>
A copy of the child’s schedule.

Where to get information regarding delays and cancellations due to weather.

Any pertinent information regarding the child as documented in the release presented by the agency (i.e. copy of the child’s IEP, Evaluation Report, etc.).

Location of adult rest rooms and student rest rooms.

Procedures to be used during a crisis with the student.
## TSS SERVICES INFORMATION FORM

**Student:** ______________________________  **Grade:** __________________

**Classroom Teacher:** ______________________________

**Learning Support Teacher (if applicable):** ______________________________

### AGENCY INFORMATION:

<table>
<thead>
<tr>
<th>Name of TSS:</th>
<th>Agency:</th>
</tr>
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<tbody>
<tr>
<td>Agency Number:</td>
<td>Agency Supervisor:</td>
</tr>
<tr>
<td>Other Agency Representative</td>
<td>Other Information</td>
</tr>
</tbody>
</table>

### DAYS/TIMES TSS IS ASSIGNED TO STUDENT:

<table>
<thead>
<tr>
<th>Day</th>
<th>Beginning Time</th>
<th>Ending Time</th>
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<tbody>
<tr>
<td>Monday</td>
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<tr>
<td>Tuesday</td>
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<tr>
<td>Wednesday</td>
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<td>Thursday</td>
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<tr>
<td>Friday</td>
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</table>
SAMPLE B

Confidentiality Form

Bethel Park School District
Special Services Department

I, __________________________________________ have been informed of, and understand, the importance of confidentiality of special needs students in accordance with State Regulations, Chapter 14 – Special Education Services and Programs; Federal Regulations, Part 300.572 of the Individuals with Disabilities Education Act; and FERPA, the Family Education Rights and Privacy Act. After visiting classrooms in the Bethel Park School District, I will not at any time or place discuss or mention by any identifiable means, any special needs students also in the classroom.

I agree further that should I disclose confidential information obtained as a result of the classroom observation in violation of the above paragraph, and an action is brought against the Bethel Park School District in any administrative or legal proceeding as a result thereof, I would indemnify and hold harmless Bethel Park School District, its agents, officers, officials, directors, employees and assigns as a result of such breach of confidentiality.

__________________________________________ _______________
Signature of Observer      Date

__________________________________________ _______________
Signature of Principal      Date
A Guide to Professional Behavior for Therapeutic Support Workers in School Settings

The PA CASSP Training and Technical Assistance Institute has developed a set of three core areas of professional conduct, as follows:

I. Privacy

Staff have a primary responsibility to respect the privacy and confidentiality of the family. Staff are responsible for stating the limits of this confidentiality to the child or adolescent and family and recognizing situations where the right to confidentiality is waived as in instances of child abuse and imminent danger to self or others. In addition, staff are to respect the confidentiality of the other individuals in the educational environment where they provide services (i.e. students and staff in the regular and special education classroom).

Some examples of specific applications of this principle would be:

1) Never disclose information to outside agencies or individuals without a release.
2) Never talk to unauthorized persons in any manner that could identify the child or family.
3) Never discuss the behavior of other students in the educational environment with the client’s family or unauthorized individuals.

II. Dual Relationships

Staff do not use their professional relationship to further their own personal, religious, political or business interest. Staff are aware of their own needs and their influential position in relation to children or youth and their families. Staff make every effort to avoid dual relationships (multiple roles) that could impair their professional judgment, reduce their objectivity, or increase the risk of exploiting youth or family.

Some examples of the need to apply this principle are many. Just a few might be:

1) Never engage in sexual, social or business relationships with the child or family.
2) Never take the child to staff’s home for activity.
3) Never attempt to sell any products to the child or family (e.g. raffle tickets, Mary Kay, etc.)
4) Never buy, provide or share alcohol with children or families.
5) Never borrow money from youth, families or school personnel.
6) Never use foul language in the presence of the child, youth, family, other students or school personnel.
7) Never use the child, youth or family to clean or work for staff.
8) Never compete with school personnel for authority role.
9) Never allow the youth to drive the staff’s car.
10) Never share intense personal history without prior consultation with the supervisor.
11) Never consume alcohol or illegal drugs before or during school contact with the child, youth, family or school personnel.
12) Never allow the youth to stay overnight at staff’s home.
13) Never bring (your own) friends along when transporting a client.
14) Never engage in illegal acts in the presence of the child, youth, family, or school personnel, or discuss such acts.
15) Never provide, share or buy tobacco products for the child or youth.
16) Never accept employment from school personnel during your period of employment in their school setting.
17) Always consult with your clinical supervisor before accepting gifts or giving gifts to the child, youth or family.
18) Never take the child without the parent’s or school’s knowledge of where you are taking him or her and when you will be bringing him or her back to school.
19) Never use school property for personal use (e.g. copier, fax machine, etc.).
20) Never promote personal employment agenda in the school setting during hours when working with the child or youth.
21) Never use personal gadgets in the classroom without permission (e.g. laptops, cellular phones, etc.).
22) Never discuss personal matters with school personnel during work hours.
23) Never encourage or assist with truancy.
24) Never leave the school grounds with the student without pre-authorization.
25) Never take smoking breaks against school policy or that compromise supervision of the child or youth.
26) Never transport unauthorized individuals in your vehicle.
27) Always dress professionally when in school settings, trying to adhere to school district dress guidelines.
28) Always maintain confidentiality. Always use sanctioned forums to discuss the child or youth, such as multidisciplinary team meetings, individual child and family meetings, etc.
29) Never discuss the child, youth or family in the faculty room.
30) Never discuss other staff’s performance with the child or youth with school personnel.
31) Never design reinforcement programs for the child or youth in isolation, but consult with the classroom teacher and clinician/behavior specialist consultant/ supervisor.
III. Emotionally-Charged Situations

Staff will recognize emotionally laden and charged situations and their own emotional responses to the situations. Staff will retain their ability to respond in a nonjudgmental and respectful manner and recognize every person and every situation as unique.

Examples of applications would be:

1) Never judge parents or school districts/personnel as bad.
2) Never yell, swear, use physical force or adopt a rigid, uncompromising or confrontational manner with families/schools or allow them to provoke an angry or defensive response from the staff member. Staff are obliged to be aware of their own emotional reactions to the family and avoid acting these out in ways that are counter-therapeutic.
3) Never tell the teacher how to teach.
4) Never yell or take sides when a conflict occurs with your client in the school setting. Use mediation skills.
5) Never talk down to the child, youth, family member or school personnel or be demeaning in any way.
6) Never lie to the child, youth, family members of school personnel. It is appropriate to evade personal questions.

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**The examples were originally provided by members of the curriculum workgroup for “The ABCs of TSS in the Schools” from Sara Read Children’s Center and Counseling Service, Inc.
Implementation of Therapeutic Staff Support: Practical Approaches

Introduction

TSS is a mental health support service that, when medically necessary, is guided by the individualized behavioral health treatment plan for the child or adolescent, the primary clinician as designated by the interagency team and the TSS supervisor. The behavioral health treatment plan itself is a reflection of the interagency team process, and has been developed with the active participation of the child and parents or other caregivers. The TSS worker acts to support the implementation of the behavioral health treatment plan in support of the identified child and family goals.

Implementation of TSS may involve a variety of practical approaches, in support of commonly identified goals. In what follows, practical interventions are identified that enable the TSS worker to work toward the achievement of certain commonly identified treatment goals. While, for purposes of training, a list of interventions is offered below, it must be understood that these interventions are to be used only in accordance with the child's specific treatment plan, as directed by the primary clinician and the TSS supervisor.

Common Treatment Goals and Potential TSS Interventions

1. Obtaining information about the child's problematic behaviors, in order to determine the child's behavioral patterns. The TSS worker records this information systematically, and conveys it to the primary clinician so that it can be incorporated into the treatment plan. The TSS worker may also share information with the parents and child, as determined by the primary clinician. Following are some examples of information to be obtained and documented:
   - Where problematic behaviors occur (e.g., at school, during recess, at home, during dinner, in the community, when with older peers);
   - Frequency of behavior;
   - Apparent precipitants;
   - Specific behavioral responses by child;
   - Duration of episodes;
   - Typical reactions and responses by others, and effect of these on the child;
   - Most effective interventions to interrupt cycle;
   - The child's own ways of maintaining control, problem-solving, and settling self; The child's response to TSS worker during times of emotional upset, as compared to other times.
2. Reinforcing parental roles and responsibilities with the child:
   o TSS worker discusses, with parent, the plan for scheduled contact with the child that day.
   o TSS worker obtains updated information from parent, about the child's functioning, since the last contact.
   o TSS worker highlights and verbally reinforces cooperative, respectful, age-appropriate responses by the child toward the parents (e.g., "I was impressed with the way responded to your mother's request right away, and how you looked right at her when you spoke to her").
   o TSS worker supports parental adherence to specific protocols developed by primary clinician, for use with the child (e.g., Stop and Think approaches, sticker calendars with specific tasks for the child, consistency in limit-setting).
   o TSS worker offers positive statements to the child individually, at appropriate times, about his or her parents (e.g., "Did you notice how proud your dad looked when you showed him the terrific point sheet from school today?").
   o TSS worker helps the child practice expressing him or herself to parents, using techniques as directed by the primary clinician in the treatment plan (e.g., "Do you really think your mother is going to listen to you if you yell at her like that? Why don't you try it again, more slowly and calmly?").

3. Helping the child integrate into an identified community activity:
   o TSS worker reviews with the child, prior to the specific activity, the nature of the activity to follow and likely expectations for that activity (e.g., "As you know, part of the reason that you're joining this team is to make friends and get along better with other kids. During the game, it may get intense, but that's no reason to lose your cool").
   o TSS worker observes the child's interactions with agency staff and peers, in terms of:
     ▪ Degree of attentiveness and responsiveness to the coach or other adult authorities;
     ▪ Ability to follow specific rules;
     ▪ Positive individual and team efforts by the child (e.g., the child approaches a peer and starts a conversation; the child hustles during tem play; the child offer encouragement to a teammate; the child passes the ball, rather than hogging it);
     ▪ Responses to aggressive and/or inappropriate behavior by peers;
     ▪ Degree of self-control.
   o Based on systematic observation of the child's functioning, TSS actively supports the child's participation in the community and other setting. Specific individualized TSS responses may include the following:
     ▪ Nonverbal cues of support for child's positive responses (e.g., "thumbs up" or a clap of hand, when the child scores a basket,
catches the football, or ignores an elbow by another peer during the game);  
- Nonverbal cues for the child to change an immediate behavioral response (TSS worker points at forehead, to signify "stop and think," or points at wristwatch, to tell the child to "slow down and calm down");  
- Taking the child aside momentarily, if necessary, to discuss the situation and to consider positive choices to be made;  
- Discussion about the experience afterwards with the child and parents (e.g., To the child: "I was impressed with how focused you stayed during the game, and how you didn't let yourself get angry when that other guy started trash talking you." To parents: "Your son made good progress with his treatment plan today. Bill, do you want to tell them first, or should I start?").

4. Helping the child improve interactional skills with peers:  
   - TSS worker encourages the child to identify areas of interest, competence, and familiarity, which he/she can use in social conversations (e.g., "OK, Sue, we both know you have many interests and are an interesting person. What are some of the things you can talk about with your classmates at the party tomorrow?").  
   - TSS worker encourages the child to learn to ask question with peers, and to listen actively to responses;  
   - TSS worker encourages the child to practice use of social skills (e.g., "Can you remember that one of the best ways to start a conversation is to ask the other person a question? What kind of questions could you ask Tyrone?").  
   - TSS worker helps the child build confidence in preparing for social interactions through practice of conversations with TSS worker (e.g., TSS worker engages a quiet or shy child in a conversation about an area of interest to the child, then points out how well the child did; TSS worker discusses a child's recent interaction with a peer afterwards, and offers supportive feedback).  

5. Helping the child to de-escalate when angry.  
   - TSS worker helps the child identify, even write down, specific trigger points for anger, as directed by primary clinician (e.g., "What was it that got you so angry? Do you think it had to do with his tone of voice, or what he said?").  
   - TSS worker helps the child identify the benefits of non-aggressive responses, and possible consequences of aggressive responses (e.g., "Do you realize that when you let Justin get you to lose your cool, you're giving him the power to control you? What can you do instead of punching him out?").  
   - TSS worker helps the child implement a specific protocol for decision-making/de-escalation (e.g., stop and think or others), if identified within treatment plan (e.g., "OK, Bill, this is what we've talked about. You're
starting to get ticked off. Remember what you're supposed to do when this happens?

- TSS worker cues child nonverbally and indirectly, at sign of de-escalation, or uses simple verbal cue, as previously agreed upon (e.g., TSS worker points to forehead, to encourage the child to "stop and think," or to wristwatch to encourage the child to calm down; TSS worker calls out to the child, "Remember RJ," because RJ is a positive role model whom the child has identified as a verbal cue for when he is about to lose his temper.

- TSS worker reviews the de-escalation plan with adults in the setting where services are being provided (e.g. with parents in home, teacher in school, or coach in community activity) and with child, so that implementation is predictable and consistent for child and others.

- TSS worker uses time-out interventions, as needed and as previously determined by primary clinician and parents (e.g., "OK, Mrs. Williams. Charles is disrespecting you, and you've given him three chances, just like the treatment plan says. Do you think Charles needs time-out now?").

- TSS uses verbal praise for the child when the child is showing self-control.

- TSS worker discusses the situation with the child, after a specific incident or near-incident;

- TSS worker encourages the child's keeping of a journal or diary, as directed by the therapist, for the child to record feelings or instances of positive coping.

6. Promoting appropriate attitude and decision-making by the child:

- TSS worker, building on earlier efforts by the primary clinician, helps the child identify positive role models within the family, neighborhood, or larger culture (e.g., "I really respect how hard your father and mother work to support you and your sister." "You told your mobile therapist that you respect your family's minister. What is it you like most about him?").

- TSS worker offers ongoing positive feedback for positive choices by the child.

- TSS worker reminds the child of his or her previously identified personal goals, and of the importance of making good choices in order to achieve them (e.g., "You said that you want to get off probation. What do you think will happen if you hang out with those guys who are breaking into cars?" "What's more important, getting money fast, no matter how you get it, or taking the time to earn it?").

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Dispute Resolution Process

CONCERNS ABOUT CHILD'S EDUCATIONAL PROGRAM

1) Call your child's teacher, counselor and/or the principal.
2) Discuss the situation with your school district's special education director.
3) Request an IEP meeting.

If none of these steps resolves your concern, call refer to you’re the Procedural Safeguards form or contact the PA ConsultLine for answers about special education regulations and related issues. They can be reached at 1-800-222-3353, 1-800-992-4334; TTY 1-800-654-5984. The Office for Dispute Resolution coordinates and manages Pennsylvania's special education mediation and due process system. ODR also provides help with procedural safeguards to parents, advocates, school districts, and intermediate units.

CONCERNS ABOUT CHILD’S MENTAL HEALTH SERVICE PROVIDERS

1) Always contact the child’s MCO first to see if they can rectify the problem.
2) Contact Community Care Behavioral Health at 1-800-553-7499.
3) Contact Allegheny County DHS/Office if Behavioral Health at 412-350-4456.
4) If the county agency does not give you satisfaction, you can contact the Community Services Area Manager for the state Office of Mental Health & Substance Abuse Services nearest to you. The Western PA number is: 412-565-5226.

Finally, you can file a complaint with the MCO or request a Fair Hearing with the Department of Public Welfare (DPW). You file a complaint by writing to the Complaint & Grievance Coordinator of the MCO or by calling Member Services and telling them you want to file a complaint. To request a Fair Hearing you must contact DPW in writing at:

Other resources to help negotiate a complaint: Allegheny Health Choices, Inc. at 1-877-787-2424 or Allegheny County Dept. of Human Services Director's Action Line at 1-800-862-6783.
APPENDIX OF FORMS AND RESOURCE DOCUMENTS
GUIDELINES AND EXPECTATIONS FOR BHR SERVICES

BEHAVIORAL SPECIALIST CONSULTANT

What does a Behavioral Specialist Consultant (BSC) do?
- Serves as a consultant to the Mobile therapist and/or the Therapeutic Staff Support while maintaining some direct contact with the child and the family
- Works with the family and other members of the treatment team such as school staff to design and direct a behavior modification plan that will meet the needs of the child and family
- Provides assessment, program design and monitoring of treatment interventions rather than direct therapy

A BSC does NOT:
- Work alone with the child at any time leaving the family or appropriate school staff out of treatment
- Work at anytime with a sibling or other child
- Babysit for the child or any other siblings
- Substitute for a caregiver by attending to any needs that are not identified on the treatment plan
- Perform caregiver duties such as feeding, dressing or attending to personal hygiene needs
- Prepare meals or perform housekeeping chores
- Administer medication
- Provide transportation
- Replace or substitute for the parent, teacher and educational aid
- Involve themselves with personal family activities or relationships that are separate from the child’s treatment

What are the responsibilities of the family and the child and/or educational staff when working with the BSC?
- Identify their strengths and needs
- Participate actively with the Interagency Team
- Work to regularly carry out the treatment plan in a positive, constructive way
- Provide a safe and substance-free working environment for staff
- Bring all questions and concerns to the attention of the BSC and interagency team
- Notify staff of any infectious illness in the home that could affect a staff member
- Respect the personal boundaries of the BSC staff while working with the child in the home, school or community they are not a family member and they should not be treated as one
- Inform BSC of family vacations and/or sickness which will prevent the BSC from working their regular hours

What should you expect from a BSC?
- Your child and family will be treated with dignity, respect, sensitivity and emotional care
- All rules and regulations regarding confidentiality will be adhered to
- Your family’s questions and concern will be taken seriously and responded to promptly
- The BSC will invite and encourage your child and family to participate actively in treatment and the planning process
- The BSC will conduct themselves as professionals in your home – they will keep a clear professional boundary with all family members at all times
- The BSC will arrive on time and remain for the duration of the scheduled session (unless an emergency or illness arises)
- The BSC will not bring others to your child’s home and school – such as their children, other clients, significant others, etc.
- The BSC will not engage in personal matters such as talking on the phone, running personal errands, reading a book, etc.
Milestones
Community Healthcare, Inc.
844 Centre Avenue
Reading, PA 19601
(610) 655-9845
fax (610)-655-9909

THERAPEUTIC STAFF SUPPORT

What does a Therapeutic Staff Support (TSS) do?
- Carries out specific interventions that are identified in the behavioral treatment plan developed by the Behavioral Specialist and the Interagency Team
- Helps the child avoid or eliminate socially inappropriate, threatening or dangerous behavior
- Transfers the appropriate intervention to the child, family and/or teacher by working collaboratively with them
- Supports caregivers in providing immediate rewards or consequences for behavior
- Provides emotional support to child and family
- Supports the child in their participation in activities identified by the treatment plan
- Records data and charts progress of child’s goals

A Therapeutic Staff Support does NOT:
- Work alone with the child at any time—leaving the family or appropriate school staff out of treatment
- Work at anytime with a sibling or other child – unless outlined in the identified child’s treatment plan
- Babysit for the child or any other siblings
- Substitute for a caregiver by attending to any needs that are not identified on the treatment plan
- Perform caregiver duties such as feeding, dressing or attending to personal hygiene needs
- Prepare meals or perform housekeeping chores
- Administer medication
- Provide transportation
- Replace or substitute for the parent, teacher and educational aid
- Involve themselves with personal family activities or relationships that are separate from the child’s treatment
- Utilize manual restraint or seclusion of a child (unless in accordance with the OMHSAS Bulletin issued 4/8/02)

What are the responsibilities of the family and the child (and/or educational staff) when working with a TSS?
- Identify their strengths and needs
- Participate actively with the Interagency Team
- Work to regularly carry out the treatment plan in a positive, constructive way
- Engage with the TSS during all prescribed hours so that the appropriate skills are being transferred to the long term caregiver, family and/or educator
- Provide a safe and substance free working environment for staff
- Bring all questions and concerns to the attention of the Interagency Team
- Notify staff of any infectious illness in the home that could affect a staff member
- Respect the personal boundaries of the TSS staff while working with the child in the home, school or community – they are not a family member and they should not be treated as one
- Inform TSS of family vacations and/or sickness which will prevent the TSS from working their regular hours

What should you expect from a TSS?
- Your child and family will be treated with dignity, respect, sensitivity and emotional care
- All rules and regulations regarding confidentiality will be adhered to
- Your family’s questions and concerns will be taken seriously and responded to promptly
- The TSS will invite and encourage your child and family to participate actively with treatment and the planning process
- The TSS will conduct themselves as professionals in your home— they will keep a clear professional boundary with all family members at all times
- The TSS will arrive on time and remain for the duration of the scheduled session (unless an emergency or illness arises)
- The TSS will not bring others to your child’s home or school such as their children, other clients, significant others, etc.
- The TSS will not engage in personal matters such as talking on the phone, running personal errands, reading a book etc.
- The TSS will adhere to activities only identified in the treatment plan.
MOBILE THERAPIST

What does a Mobile Therapist do?
- Identifies the strengths and needs of the child and family
- Provides individual and family therapy to the child
- Listens to the family, asks questions and provides clinical information to help the family
- Determines the need for any necessary family support services, special evaluations and/or other systems such as mental retardation, child welfare, juvenile probation, etc.
- Assists the family to promote the independence of the family in managing mental health needs and/or behavior problems
- Develop a crisis plan with other involved professionals and the family

A Mobile Therapist does NOT:
- Work with the child in isolation of their caregivers. Therapy sessions should always be conducted with another adult available to the child or clinician.
- Work at anytime with a sibling or other child, unless outlined in the identified child’s treatment plan.
- Baby sit for the child or any other siblings.
- Substitute for a caregiver by attending to any needs that are not identified on the treatment plan.
- Perform caregiver duties such as feeding, dressing or attending to personal hygiene needs.
- Prepare meals or perform housekeeping chores.
- Administer medication.
- Provide transportation.
- Replace or substitute for the parent, teacher and educational aide.
- Involve themselves with personal family activities or relationships that are separate from the child’s treatment.

What are the responsibilities of the family and the child (and/or educational staff) when working with a Mobile Therapist?
- Identify their strengths and needs.
- Participate actively with the Interagency Team.
- Work to regularly carry out the treatment plan in a positive, constructive way.
- Provide a safe and substance-free working environment for staff.
- Bring all questions and concerns to the attention of the Interagency Team.
- Notify staff of any infectious illness in the home that could affect a staff member.
- Respect the personal boundaries of the Mobile Therapist while working with the child in the home, school or community – they are not a family member and they should not be treated as such.
- Inform Mobile Therapist of family vacations and/or sickness which will prevent the Mobile Therapist from working their regular hours.

What should you expect from a Mobile Therapist?
- Your child and family will be treated with dignity, respect, sensitivity and emotional care.
- All rules and regulations regarding confidentiality will be adhered to.
- Your family’s questions and concerns will be taken seriously and responded to promptly.
- The Mobile Therapist will invite and encourage your child and family to participate actively with treatment and the planning process.
- The Mobile Therapist will conduct themselves as professionals in your home - they will keep a clear professional boundary with all family members all times.
- The Mobile Therapist will arrive on time and remain for the duration of the scheduled session (unless an emergency or illness arises).
- The Mobile Therapist will not bring others to your child’s home or school such as their children, other clients, significant others, etc.
- The Mobile Therapist will not engage in personal matters such as talking on the phone, running personal errands, reading a book, etc.
Date

Dear [Name],

In order to facilitate collaboration between school and Milestones, Milestones is enclosing the following paperwork for your review:

- Treatment Plan
- Release of Information
- Consent for Treatment
- Client Case Presentation
- Contact Information
- Guideline and Expectation of BHRS
- Roles and Responsibilities of TSS
- TSS Guidelines in School
- ISPT Guideline
- Encounter/Progress Note Information

We hope that this information will be helpful in getting to know our client and the Behavioral Health Rehabilitative Services (Wrap Around) team.

If you have any information that you would like to provide us in regards to classroom/school procedures please do not hesitate to call [Phone Number] at [Phone Number] with any questions or comments.

Thanks again, and I am looking forward to meeting you.

Sincerely,

Program Coordinator
Behavioral Health Rehabilitative (BHR) "Wraparound" Services in the School

**School Initiated**

EP/504 TEAM recommends behavioral support in school - after, & based on, Functional Cognitive Behavioral Assessment (FCBA)

School / LEA provides behavioral support

Student is MA-approved

→ Yes

Parent agrees to initiate request for BHR Service

→ Yes

Obtain consent from parent to provide information to clinical evaluator / provider

→ No

Stop*

→ Parent is successful in obtaining MA for child

→ Yes

Clinical evaluation recommends BHR Service as medically necessary

→ No

Stop*

→ Provide conducts Interagency Team Meeting and submit packet to Managed Care Org. (MCO) for authorization of BHR Service

→ MCO authorizes school-based BHR Service

→ Yes

Clinical team meets with parent and IEP/504 team to develop treatment/behavior intervention plan and to revise the IEP/504 plan, as necessary, for the provision of FAPE for student. If IEP/504 team has not already done so, enumerate BHR Service in IEP/504 plan as per BEC Behavioral Support Obligations 22 Pa. Code §14.36 issued 7/1/2003, as required for the provision of FAPE for student.

→ No

**Parent Initiated**

PARENT initiates behavioral health referral for school-based BHR (wraparound) services

With parent permission, school provides input to behavioral health provider

Clinical evaluation recommends BHR Service as medically necessary

→ Yes

Behavioral Health provider arranges Interagency Team Meeting and prescribes BHR Services

→ No

Stop*

→ Parent does not receive school-based BHR Service.

Parent may initiate request for IEP meeting and/or initiate due process

→ No

Student does not receive school-based BHR Service.

Stop MA process only.

Continue to deliver services as indicated in IEP and/or follow through with MDE process.

* Stop MA process only. Continue to deliver services as indicated in IEP and/or follow through with MDE process.