MASSACHUSETTS GENERAL HOSPITAL

Think:Kids
RETHINKING CHALLENGING KIDS

Implementation Guidelines

(Revised 11/09; © MGH and ODTC)

I. Initial Implementation Guidelines

A. Importance of Philosophy/Leadership:

1. Majority of supervisory and direct care staff understand and embrace the philosophy that "kids do well if they can"

B. Assessment:

1. Every child has an individual case formulation that consists of triggers/chronic problems and hypothesized lagging skills identified by the treatment team using the Thinking Skills Inventory. Every child receives a baseline assessment using the Thinking Skills Inventory at the treatment team meeting. The completion of the Thinking Skills Inventory is facilitated by a clinical coordinator, with a goal of team consensus on triggers/chronic problems and hypothesized lagging cognitive skills.

2. During initial implementation, the assessment and review of triggers/problems and lagging skills (through review of each child's Thinking Skills Inventory) occurs at team meetings on a weekly basis for a period of at least three months, and then as warranted.

3. During the initial three month period, the Plan B Tracking Sheet will also be completed and reviewed weekly in order facilitate Plan B discussions surrounding chronic problems to be solved.

4. Formal team review of the Thinking Skills Inventory occurs at a regular interval consistent with current Individual Client Review/Individual Treatment Plan Review timelines and guidelines – but not less than every three months.

5. For newly admitted children, specific triggers/problems and hypothesized lagging skills are identified by the treatment team no less than one week after admission.

6. In the beginning phase of implementation, the initial identification of triggers/problems and lagging skills assessment through the Thinking Skills Inventory will be through team-based dialogue and may last 45 minutes per child. As teams become more skilled and familiar with the Thinking Skills Inventory, the assessment and review of triggers/problems and lagging skills may last approximately 20 minutes per child.

7. Each staff member when asked can indicate the primary triggers / problems and skill deficits that have been prioritized for each child.

C. Intervention:

1. Proactive Plan B discussions are planned in weekly treatment team meetings and conducted regularly by staff for each trigger / problem that has been prioritized on the Thinking Skills Inventory.

2. The treatment team uses the Plan B Tracking Sheet weekly at treatment team meetings and communication meetings to outline, review, and document the progress of Proactive Plan B discussions. The Plan B Tracking Sheet includes the following elements:

    - lead adults
    - key lagging skills
    - key triggers
    - planned approach to use for key triggers – Plan A, B, or C
    - specific trigger/problem being addressed
    - child concerns
    - adult concerns
    - potential solutions
    - solution attempted
    - problem solved/status
    - next steps

3. A Plan B Tracking Sheet is used for each trigger/chronic problem that is being addressed through Proactive Plan B. Each team may decide to focus upon one or several triggers/problems during the week.

4. One to two team members (i.e. those with the best relationship with the child) are assigned through the team decision-making process at treatment team meetings to have Proactive Plan B discussions with a child over the next week. Over time, more staff participate in Plan B conversations with the child.

5. It is reasonable to expect that some solutions will require supervisory approval and this should be communicated to the child. For example,

"Looks like this sounds good for both of us, but I have to check and get back to you, okay?"

D. Communication:

1. Staff complete a communication log for significant events, family and medical issues, mutually agreed upon solutions from Plan B, and solutions needing supervisory approval. This log is used after every shift to communicate with various staff as warranted.

2. The communication logs are also available for unit staff to review and add to prior to their shift and at any time throughout the week.

3. Shift changes also require direct face-to-face communication amongst staff regarding status of current Plan B discussions.

3. The Plan B Tracking Sheet is completed, reviewed, and updated at treatment team meetings and communication meetings on a weekly basis to ensure review and updating of proactive Plan B discussions. Unit supervisor and direct care staff participation at communication meetings is required to allow for direct communication about the milieu and direct care staff perspectives.

II. Secondary Implementation Guidelines

A. Documentation:

1. Intake, treatment planning and discharge documentation uses language of the approach

B. Training:

1. All new staff receive initial training in the model as part of their orientation

2. All staff engage in regular professional development opportunities related to the model including ensuring that identified core staff have received Tier 2 training

3. Staff performance reviews include assessment of adherence to and proficiency in the model

4. Adult caretakers of children receive exposure to approach in a structured group format that emphasizes providing support necessary to adopt a new approach in home setting

5. Training and consultation is provided to community partners and referring agencies to offer continuity of care

C. Policies and Procedures:

1. Organizational policies and procedures (including job descriptions and requirements) include the approach

2. All children are discharged to setting with an aftercare plan that includes the approach

3. A systematic data collection procedure is in place to evaluate the outcomes of implementation over time