Mid-Ohio Psychological Services, Inc.

Licking County Therapeutic Mentor Program

2014

Program Background

Origins of Mentoring

Big Brothers Big Sisters was originally developed as a non-profit organization in 1902 to help children reach their potential through providing supportive one-on-one mentoring relationships with children of all ages. It is currently the oldest and largest youth mentoring organization in the United States. However, the number of children and adolescents who are in need of mentoring services far exceeds the services available to them. The Therapeutic Mentoring Program (TMP) will address this discrepancy between need and service availability by providing necessary services to such individuals.

The TMP was initially developed in June of 2013 due to an identified need for additional mentoring services for children and adolescents in the community. The program was initially developed for children and adolescents; however, due to the success of the program, the population of adults was included in the rendering of these services.

Therapeutic mentoring refers to a set of community-based clinical services provided to individuals age six and older who are experiencing difficulties with social, communication, problem solving, conflict-resolution, and/or independent living skills. Therapeutic mentors are trained professionals who work with these individuals in the community to develop and practice skills learned in session in their practical environment such as home or community. Therapeutic mentors provide one-on-one mentoring to those individuals in need of support in the community and their natural environment. They assist the individual in practicing and applying concepts learned in session through coaching, role-playing, and modeling. Therapeutic mentors also assist individuals in exploring community resources that may be available in order to increase independent and daily living skills.

Clients involved in the program are actively involved in outpatient counseling in which they are provided social, communication, problem solving, conflict-resolution, and independent living skills. The therapeutic mentor (TM) serves as the bridge between skill development and implementation as the mentor is responsible for assisting the client with generalizing the skills they learn in therapy to the community environment. The frequency of contact with the TM is based on client need and will be assessed over time based on client progress. The therapeutic mentor and the client's counselor work closely to ensure continuity of care and that learning is transferred from the counseling session to the practical application of the client's life.

Termination from the program is achieved when the minimal standards related to the client's goals have been completed. Once a client is deemed to have met the minimum goal completion standards, an exit interview will be scheduled to explore with the clients the specific skills they have learned and utilized to complete their goals for the program.

Theoretical Background

The TMP is based on the Social Support Theory (Cassel, (1976); Cobb, (1976); and Caplan, 1974). Past research has demonstrated that social support fosters positive outcomes including increased social support, positive role modeling, and learning appropriate and

meaningful life skills. In addition, positive social support has shown to decrease stress, mental health symptoms, academic problems, relational problems, and involvement with the juvenile and/or court system.

Cognitive-behavioral therapy involves the active reframing of thoughts to affect behavior change and this is an integral component of therapy that supports therapeutic mentoring. Cognitive-behavioral therapy will occur predominantly in the therapeutic office setting while mentoring services will utilize positive social support coupled with the practical application of cognitive-behavioral techniques in the real-world setting.

Program Participants

There were 48 participants for this review that met the specific criteria for the TMP program enrollment. All of the participants in the program who were enrolled at any time between 7/1/2013 and 6/30/2014 were included in the review. As can be seen in *Figure 1*, the mean age at intake was 21, ranging from six to 55. Of the adult clients, 14 were female and four were male. Respectively, of the youth clients, 14 were female and 16 were male (See *Figure 1*.)

Age	# People
06	1
08	2
09	2
10	3
11	1
12	3
13	6
14	3
15	2
16	3
17	2
18	5
22	1
26	1
28	1
30	1
31	1
38	1
39	1
42	1
43	1
44	1
45	1
54	3
55	1

Grand Total	48

Figure 1- Age Distribution

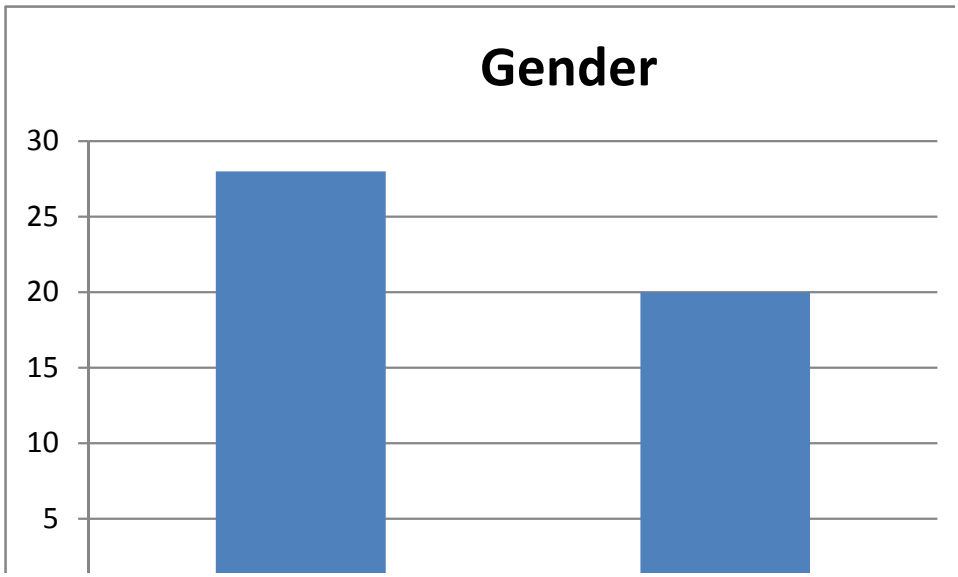

Figure 2- Gender Distribution

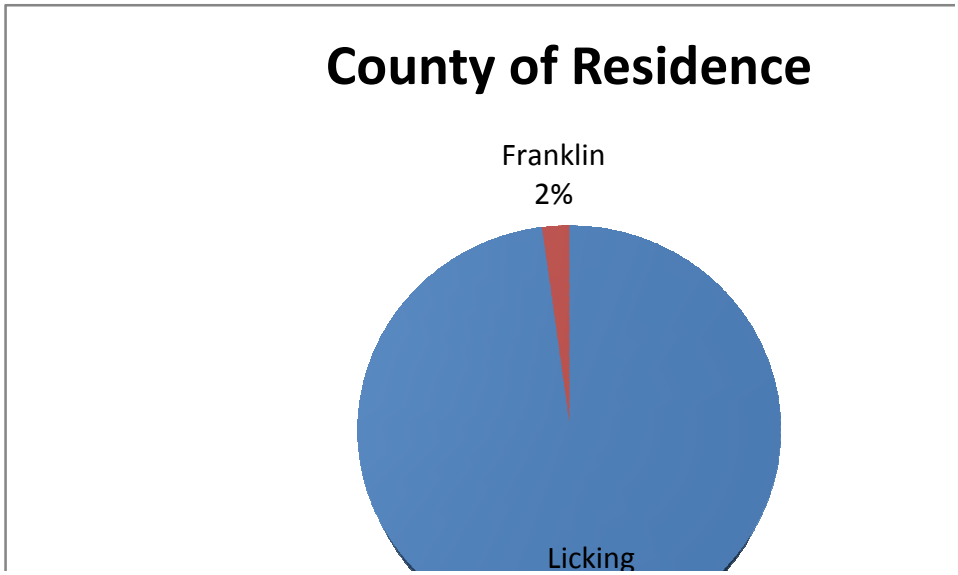

Figure 3- County of Residence Distribution

County of residence refers to the county corresponding to the county which is financially responsible for the client (ie. client is placed in Knox County but Licking County Children Services has custody). As can be seen in *Figure 3*, 98% of the TMP population were residents of Licking County at the time of their intake with MOPS while 2% were Franklin County residents.

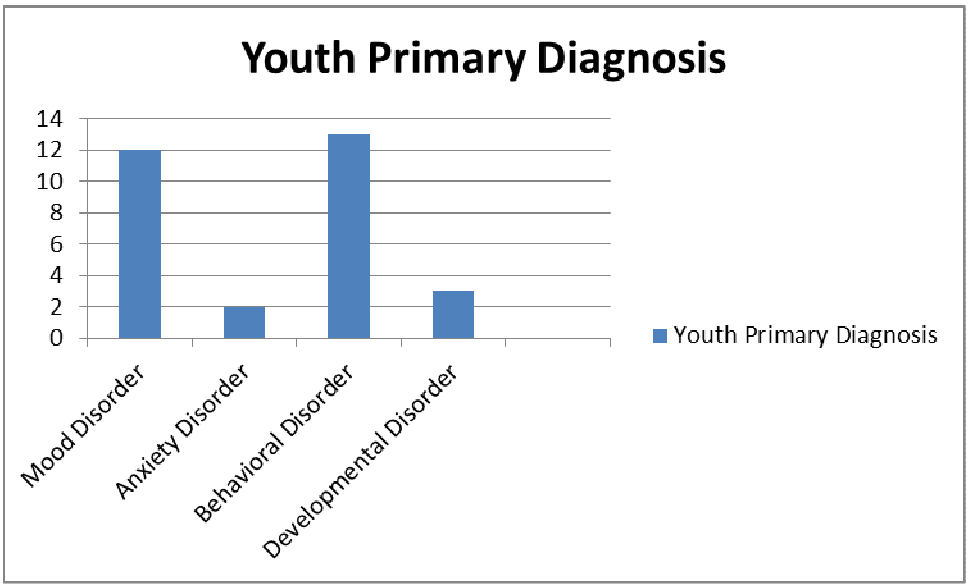

Figure 4- Youth Primary Diagnosis

The mood disorder category includes the following diagnostic classifications: Major Depression, Mood Disorder NOS, and Adjustment Disorder. The anxiety disorder category includes the following diagnostic classifications: Posttraumatic Stress Disorder and Generalized Anxiety Disorder. The behavioral category includes the following diagnostic classifications: Disruptive Behavior Disorder NOS, Oppositional Defiant Disorder, Conduct Disorder, and Attention-Deficit/Hyperactivity Disorder. The developmental category includes the following diagnostic classification: Rett's Disorder and Developmental Delay.

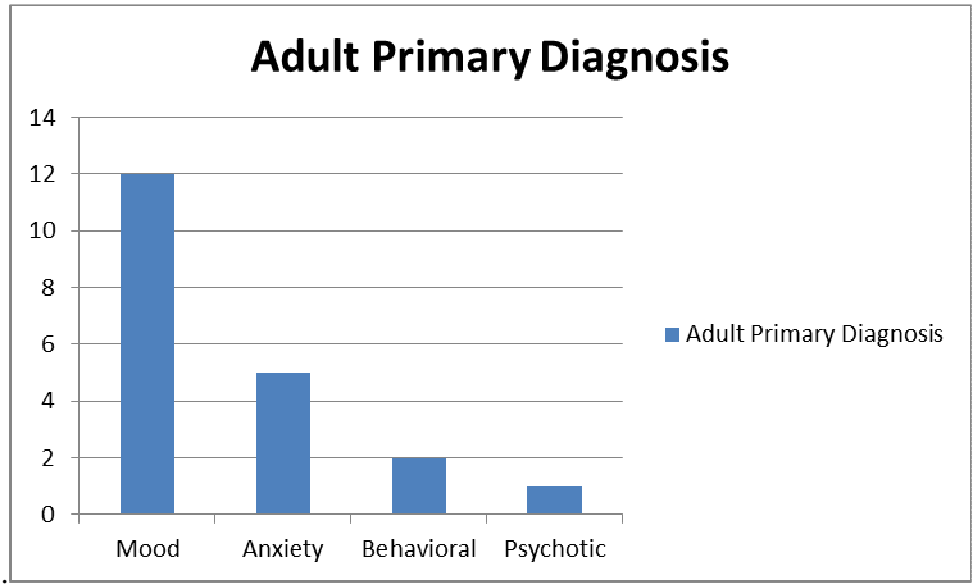

Figure 5- Adult Primary Diagnosis

The mood disorder category includes the following diagnostic classifications: Major Depression, Mood Disorder NOS, Adjustment Disorder, and Bipolar Disorder. The anxiety disorder category includes the following diagnostic classifications: Posttraumatic Stress Disorder and Anxiety Disorder NOS. The behavioral category includes the following diagnostic classifications: Conduct Disorder and Attention-Deficit/Hyperactivity Disorder. The psychotic category includes the following diagnostic classification: Schizoaffective Disorder.

Service Utilization

The following table identifies the services provided for youth from 7/1/2013 to 6/30/2014. This data includes the average amount of contacts, units, and minutes that were utilized by the 28 youth participants for the year of review. It is to be noted that it is impossible to decipher how much of the service utilization was billed by TMP versus clinicians without doing a chart review. Clinicians also provide case management services through collaborating with family members, guardians, and other service providers connected with the individual client. In this regard, it is difficult to identify what case management has been provided by the clinician versus the therapeutic mentor.

Service Type	Average Number of Contacts	Average Number of Units	Average Number of Minutes
Case management	29	26	1,567

Figure 6- Appointments from 7/1/2013 to 6/30/2014 for the year of review

The following table identifies the services provided for adults from 7/1/2013 to 6/30/2014. This data includes the average amount of contacts, units, and minutes that were utilized by the 20 adult participants for the year of review. It is to be noted that it is impossible to decipher how much of the service utilization was billed by TMP versus clinicians without doing a chart review. Clinicians also provide case management services through collaborating with family members, guardians, and other service providers connected with the individual client. In this regard, it is difficult to identify what case management has been provided by the clinician versus the therapeutic mentor.

Service Type	Average Number of Contacts	Average Number of Units	Average Number of Minutes
Case management	18	17	1,013

Figure 7- Appointments from 7/1/2013 to 6/30/2014 for the year of review

Figure 8 represents the TMP charges that were billed for Fiscal Year (FY) 2014 as well as the projected budget for FY 2015. It is important to note that clients were involved in other services at the agency such as diagnostic assessments, individual psychotherapy, group therapy, and coordination of care by the therapists. However, these services were not included in the report as they are not specifically part of the TMP.

Figure 8- Charges Billed FY 2014

Services	# People Receiving Service	Unit Definition (in hours)	Average Units/ Year	Charge/Hour	Total Charge	#Billable Hours
Case Manager and/or Mentor	48	1	40	$85	$ 163,200	1,920
Total					**$163,200**	**1,920**

Figure 9 presents the forecasted income for the TMP in FY 2015. It is estimated that approximately 55 clients will be receiving mentoring services during 2015. The forecasted income below is based on this projected estimation.

Figure 9- Forecasted Income FY 2015

Services	# People Receiving Service	Unit Definition (in hours)	Average Units/ Year	Charge/Hour	Total Charge	#Billable Hours
Case Manager and/or Mentor	55	1	40	$85	$ 187,000	2,200
Total					**$187,000**	**2,200**

Figure 10 represents the expenses that will be incurred for the TMP in FY 2015. As indicated, the projected income versus the operating expenses for FY 2015 equal zero as Mid-Ohio is a non-profit organization and therefore the income to expense ratio should equal zero.

Figure 10: Forecast Operating Expense FY 2015

Operating Expense	% Budget	Cost	Available for Pay/Hour
Payroll			
Clinical Payroll			

Direct	32.00%	$59,840.00	27.20
Indirect	6.00%	$11,220.00	40.80
Administrative	30.30%	$56,661.00	37.78
Support Staff Payroll	14.00%	$26,180.00	25.19
Occupancy	9.80%	$18,326.00	
Travel	1.10%	$2,057.00	
Professional Dev.	0.60%	$1,122.00	
Office Supplies	2.20%	$4,114.00	
Communication	0.70%	$1,309.00	
Insurance	0.70%	$1,309.00	
Advertising	0.40%	$748.00	
Professional Services	0.50%	$935.00	
Bad Debt	0.20%	$374.00	
Information Systems	1.40%	$2,618.00	
Depreciation	0.10%	$187.00	
	100.0%		
Total Expenses		**$ 187,000**	

Program Outcomes

The Outcome Measure is designed to assess how program participants have been doing in several areas of their life based on their self-reported functioning. This measure is designed to assess the participants' progress in order to evaluate treatment progress and areas for further improvement. Outcome data is collected from participants at least every 90 days, or upon renewal of the Individual Service Plan (ISP). Outcome data includes progress in the following areas: criminal justice system, child protective services, school/work, significant relationships, relationship with children, relationship with family, relationship with friends, housing, alcohol or drug involvement, emotions, bizarre/unusual thoughts, behavior, health, and overall functioning. Among the youth TMP participants for the 2013/14 fiscal year, 28 youths had outcome data completed. Outcome measures completed between 7/1/2013 through 6/30/2014 demonstrate that on average the youth rated improvement in their overall GAF score by 1.32. In addition, youth participants evidenced improvement in criminal justice (9%), school/work (8%), significant relationships (14%), parents (7%), other family (2%), friends (22%), behavior (10%), and health (3%). These improvements may be associated with the interventions utilized by mentors in assisting individuals with increasing skill implementation through practicing social, communication, problem solving, conflict-resolution, and independent living skills. However, the emotions domain (-.05%) was rated as having declined (well within the standard error of measurement). Overall, youth in the program were rated as having improved by .08%.

Among the adult TMP participants for the 2013/14 fiscal year, 16 adults had outcome data completed. Outcome measures completed between 7/1/2013 through 6/30/2014 demonstrate that on average the adult rated improvement in their overall GAF score by 3.38. In addition, criminal

justice (14%), school/work (21%), significant relationships (23%), kids (.08%), friends (14%), housing (0.3%), emotions (13%), and health (.99%) were all rated as areas of positive improvement for the adults in the program. These improvements may be associated with the interventions utilized by mentors in assisting individuals with increasing skill implementation through practicing social, communication, problem solving, conflict-resolution, and independent living skills. Overall, adults in the program were rated as having improved by 11%.

Recommendations

- All staff should be required to attend the Case management Training to learn about the history of case management and various case management models, including therapeutic mentoring. This training is designed to educate clinicians and mentors about the origins of case management, the various forms of case management, how mentoring is under the umbrella of case management, and the various services included in therapeutic mentoring. All staff should review the agency SOC, and enusure all appropriate documentation is reviewed and included in the chart.
    - Clinicians should be encouraged to ensure the Assessment for Case Management/Therapeutic Mentoring Services, Client Transfer Form, Client Guidelines, Therapeutic Mentor Domains, and Supervisory Relationship form are included in the chart. These forms were developed in order to comply with agency policy, ensure continuity of care, and estabish guidelines and consent for client participation in the program.
    - Clinicians should ensure that the TMP is indicated on the Standards of Care (SOC). The (SOC) is an agency defined, minimally accepted definition for quality service delivery and has been designed to provide clinicians with information to guide best practice in client care and treatment. Clinicians should ensure that ISP goals related to the TMP are clear, measureable, and directly connected to mentoring goals and objectives for the client .
    - Clinicians should ensure that the TM is indicated on the client's ISP.
    - All TM are required to ensure the Supervisory Relationship and CSP Guidelines are reviewed with the client, parent, and/or guardian(s) and included in the client's chart.
- Clinicians and TM's are encouraged to consistently and collaboratively work together with each other for continuity of client care.
    - Clinicians and TM's are encouraged to collaborate within the office and in session with clients to review progress and areas for continued treatment on a regular basis. Termination from the program requires consistent communication between the clinician, TM, client, parent(s), and/or caregivers in order to identify if a client has successfully completed program goals and objectives.

- An Independent Review will be conducted as a "pre" and "post" measure. Participants will be required to complete an Independent Review before receiving services in order to identify the TMP domains (Skill Implementation, Support System, Positive Environment, Stabilization, Personal Independence, and Daily Living) each participant will be working on and their skill knowledge and implementation prior to receiving services. Following completion of TMP goals, each participant will be scheduled for an Exit Independent Review in which they will be assessed on a rating scale, their progress on skill acquisition, and implementation accumulated through mentoring services.

- Clinicians and TM's are also encouraged to engage the client's family, caregiver's, and other service providers in the client's care and treatment.

- Clinicians and TM's are encouraged to actively re-engage those clients who have discontinued services to ensure successful completion of the program.

- Marketing with other community agencies needs to continue on a consistent basis to ensure the community is aware of the services provided by the agency.

  - The program coordinator will continue to market in the community and meet with various community agencies to review and discuss the program, its services, and benefits to clients of the program.

  - Clinicians are encouraged to review their active client list on a consistent basis to identify potential clients who could benefit from the program and refer them accordingly.

  - Therapeutic mentors are encouraged to maintain professional relationships with community organizations and the school system to enhance marketing and collaborative relationships within the community.

- A brief program evaluation should be conducted in one year to assess the agency's ability to implement the changes noted above.

  - Program evaluation has very little purpose if it does not lead to improved client care. The above recommendations should result in specific behavioral change on the part of the clinical staff and a brief program evaluation should be implemented, assessing at least the degree to which clinicians are complying with the SOC.

Appendix A

Assessment

Clients designated as appropriate referrals by their mental health counselor, and those who another community-mentoring program is not currently serving, are eligible for program participation. Clients who are already receiving services through Mid-Ohio Psychological Services can be referred by their counselor to participate in the mentoring program. Schools, juvenile justice system (judges, probation officers), Children Services, Council on Aging, Developmental Disability (DD), family physicians, counselors, care providers, parents and/or caretakers, and other community organizations and partners can refer potential clients to the Therapeutic Mentoring program. These referral sources can contact the office and schedule a diagnostic intake in which they will be linked to individual therapy. Once active in therapy, the therapist can refer the client to the mentoring program, with parent and/or caregiver permission. Eligible clients will then be assessed based on their current needs and will be linked with clinical staff who are appropriately trained to provide such services, a Therapeutic Mentor. Therapeutic mentoring is a special program identified under the umbrella of case management/CSP. In order to be deemed a CSP service the following criteria have to be identified as not only a need but also therapeutic services provided must address one or more of the following criteria:

The client must need one of the following:

- Assistance in developing personal independence in managing basic needs and/or development of daily skills.
- On-going assessment of needs
- On-going monitoring of symptoms, including substance abuse
- Coordination of ISP, including services identified on ISP, accessing support systems, and linkages to formal community systems/services.
- Coordination and/or assistance in crisis management and stabilization.
- Activities that increase the consumer's capacity to positively impact his/her environment.

Clinicians will utilize a referral checklist that identifies client needs and areas that should be the treatment of focus to meet these needs. Once a client's needs are identified, the checklist can also serve as a template for treatment planning. The required documents that need to be completed by the clinician include, (1) Assessment for Case Management/Therapeutic Mentor Services, (2) Client Transfer Form, and (3) Therapeutic Mentor Domains. Clinical staff who is interested in referring clients to the mentoring program will need to complete the following forms and submit to the program coordinator and/or therapeutic mentor for review.