

TREATMENT PROTOCOL

PHILOSOPHY-

Thompson Child & Family Focus believes that healthy relationships are essential to the positive development of children. TCFF has adopted Dr. Dan Hughes' Dyadic Developmental Psychotherapy model which embraces the principles of playfulness, love, acceptance, curiosity, and empathy (PLACE) as essential components of relationships between caregivers and children.

Throughout the services continuum, the relationship between the child and adult is primary. Children must learn that they are safe and that the adults they interact with will meet their needs. TCFF believes that every interaction with a child is a teachable moment and should be approached as an opportunity for growth and healing.

The "family" component is a critical part of the treatment/educational milieu. Families are required to take an active part in family therapy sessions and are strongly encouraged to spend time in the programs, working with and observing the staff. The relationship between the staff and the families creates additional supports for the child and develops an interdependent relationship that strengthens the child's capacity to trust and to flourish.

It is not until a child is able to trust the relationships they have with the adults in their lives, that true healing and growth can occur.

DESCRIPTION OF PROCESSES-

INTAKE/ADMISSION-

The initial screening material includes general information on a child, including historical information from previous treatment providers, a psychosocial history, psychological testing, and educational information. The intake team which includes directors from the different program areas (clinical, residential, community services, day treatment, and recreation) review the initial material and make a decision as to whether or not they feel our program can meet the needs of the child. If a child is accepted into the program an in-depth **Diagnostic Assessment** is completed within two weeks of admission. If a child is deemed inappropriate for the program because of low cognitive functioning, sexual perpetration risks, psychotic behavior, substance abuse/ addiction, or suicidal or homicidal behaviors the intake team may make recommendations to other programs that may be able to more thoroughly meet the needs of the child and family. At times we will suggest a stabilization period at a higher level of care before considering the child for placement. We make every attempt to screen admissions so that the child's and family's needs are met in order for them to be successful.

ASSESSMENT-

When a child is admitted to one of the Thompson programs a complete **Diagnostic Assessment** is completed by a clinician or Community support specialist. To complete the assessment the evaluator may obtain a release of information to interview any or all of the following people to get a clear understanding of the child's current and past functioning across different settings and circumstances: parent, child, Department of Social Services Case Worker, Mental Health Case Manager, past treatment providers, school personnel and/or pediatrician. The Diagnostic Assessment includes the following areas: present concerns and motivators, risk assessment, sexual behavior and attitudes, client strengths/ supports, family of origin behavioral and health history, developmental history, current placement, past placement/treatment and response (including disruptions in attachment), current and past educational functioning, cognitive functioning, social connectedness and peer relationships, cultural considerations, substance use and legal history, medical history and five axis diagnosis. This thorough assessment and interviews with multiple collaterals allows the assessor to examine and consider family and child factors in diagnosing and planning care for each child.

TREATMENT PLANNING-

An individualized treatment plan is developed for every child that is admitted to any Thompson program. Treatment goals are measurable and focus on strengths and needs of the child and family. The plan is developed in conjunction with the case manager, case worker, child, family and the various departments where the child will be involved. For example a child receiving residential care will also receive recreation services, therapy, and day treatment. Therefore, representatives from each of these program areas will participate in treatment planning and ongoing review of the treatment plan. The treatment plan is reviewed by the on campus care planning group monthly for every child in care. A quarterly review includes all of the collaterals including the child and the family. Goals are reviewed with each child on a regular basis and explained to them in language appropriate to their developmental level. If there is a service need that can not be met on campus every attempt is made to secure those services in the community (i.e. psychological testing) or to have the contracted service provided on campus (i.e. speech therapy).

TREATMENT TECHNIQUES-

Therapeutic techniques employed by Thompson's are based on Dan Hughes' Dyadic Developmental Psychotherapy and focus on the child being able to feel safe and trust adults who are responsible for their care. Families are seen as an essential part of the treatment process and are strongly encouraged to attend therapy regularly and visit with the child. The focus in all program areas is on building relationships with the children that focus on playfulness, acceptance, nurturance and empathy. When consequences are deemed necessary they are natural and/or logical and fit the developmental level of the child. Care is taken to not shame, belittle or frighten a child in any way.

SAFETY/RISK MANAGEMENT PLAN

All staff that have direct individual contact with children are trained in Therapeutic Crisis Intervention (TCI) techniques. These skills include de-escalation techniques as well as acceptable ways to physically restrain a child if the child becomes a danger to themselves or others. All less restrictive interventions are tried prior to using physical restraint with a child. Children are never restrained for non-compliance. Restraints are executed according to TCI requirements and any complaint from a child reporting pain or discomfort during a restraint is taken seriously. The staff performing the restraint will move their body to ensure that no pressure is being applied to the child's body to cause pain or injury. After a restraint the staff process with the child to re-establish a connection that is based on care and nurturance. All children in residential and day treatment services develop a crisis plan with their treatment team that addresses the behaviors that are unsafe and the plan to manage those behaviors on a continuum. During therapy sessions with the child, their cottage mentors or parents are invited to join the session to help support and nurture the child during difficult discussions. Parents play an active role in the therapy process. We offer parents individual sessions to discuss their experience with their child, to help them talk about their own feelings regarding treatment and to offer them support in the process. Touch and holding are always done as a nurturing gesture and are never used to hurt, shame or punish a child. Behavioral and clinical interventions as well as crisis plans are reviewed with a child's treatment team on an ongoing basis to insure that we keep in mind always "what is in the best interest of the child". We believe that attachment work is difficult for everyone involved. All staff receive ongoing supervision and support from their supervisors and their team. We also contract with several nationally recognized clinicians for support in working with the children in our care.

EVALUATION/ OUTCOMES/ FOLLOW-UP

All children in care develop treatment goals with their team that are measurable and observable. These goals are tracked by program staff in each service area and are reported monthly. As goals are met by the child additional goals may or may not be added. If it appears that a child is not making progress toward one or more of their goals their team will look at the interventions being used with the child and try and develop alternative interventions to help the child move forward or will develop a more appropriate (achievable) goal. In addition to the monthly progress report which tracks the progress toward goals staff also report a GAF and CAFAS score quarterly and at discharge. These scores are reported to the Director of Evaluation who tracks them across time. Follow-up at this point is informal with the families that are willing to stay in contact with the program. When a child is in the custody of the Department of Social Services (DSS) it is more difficult to follow-up long term because of HIPAA guidelines. It is our hope that as we serve more children that are not in DSS custody that we will be able to do follow-up with families at quarterly intervals following discharge for a period of at least one year.