BETTER together | A CLINICAL FRAMEWORK

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Better Together: A Clinical Framework

Abstract

The Edinburg Center's (Edinburg) *Better Together* model is a clinical framework that combines the principles of Applied Behavior Analysis (ABA) and mental health services. For individuals who present with mental health diagnoses and co-occurring Autism Spectrum Disorder (ASD), Intellectual and/or Developmental Disabilities (IDD), or high-risk externalizing behaviors, traditional mental health services alone have not always demonstrated effectiveness (Maddox et al., 2021). As a scientific approach to understanding behavior, the Principles of ABA explain how skills and actions change or are affected by the environment, and how learning takes place. By embedding the methodologies of ABA and mental health treatment holistically into all programming, Edinburg has successfully supported this target population in developing skills to replace interfering behaviors. This approach increases their likelihood of leading meaningful lives in the least restrictive settings.

Individuals with ASD and co-occurring mental health diagnoses or individuals with mental health diagnoses and high-risk, high intensity behaviors, are often unable to access traditional evidence-based therapies taught to mental health clinicians (Maddox et al., 2021). Likewise, individuals with ASD who receive ABA and other autism-based services may receive skills training to support their needs, but traditional ABA therapy does not involve mental health or trauma components that are often necessary for individuals with ASD to make lasting, life-long changes (Gilmore et al., 2022). Lack of access to appropriate interventions for these individuals leads to high rates of psychiatric hospitalizations, disrupted placements, and more restrictive levels of care (Maddox et al., 2021; Righi et al., 2018). Given barriers to accessing traditional evidence-based mental health interventions, Edinburg developed the *Better Together* initiative, a clinical framework which infuses methodologies from the fields of mental health and ABA. It is Edinburg's vision that *Better Together* will foster an environment enabling all community members to live their lives to the fullest, with dignity and respect.

The practitioner-built *Better Together* model provides wraparound, comprehensive care for the participant and their caregivers, family, and/or natural supports through a multidisciplinary teamed approach. Teams include Board-Certified Behavioral Analysts (BCBA), Mental Health Clinicians (Clinician), Therapeutic Support Staff, Peer Services, and Occupational Therapy (OT). Each participant's multidisciplinary team is determined by their expressed needs, preferences, and recommendations from assessments.

Since its implementation, Edinburg has utilized the *Better Together* model across four teams serving youth, transitional-aged youth, adults with IDD, ASD, and people who engage in high-intensity, interfering behaviors. From January 2020 to December 2023, Edinburg's *Better Together* teams served 164 youth with mental health diagnoses and co-occurring high-intensity behaviors. Of these, 150 participants partially or fully met their service goals, reflecting a 91% goal achievement rate. Additionally, only 3.5% of participants were discharged to a higher level of care.

Background

Edinburg is committed to providing services to individuals whose complex and challenging needs have been barriers to successful community living. Edinburg programming supports individuals with mental health diagnoses, IDD, ASD, and acquired brain injuries (ABI). Additionally, Edinburg has a longstanding history of delivering community-based, wraparound clinical services to youth and families through the MassHealth/Medicaid funded Children's Behavioral Health Initiative (CBHI) including In Home Therapy (IHT), In Home Behavioral Services (IHBS), and Therapeutic Mentoring (TM). Edinburg's highly

collaborative approach gained Edinburg's CBHI programming a reputation of excellence in family stabilization, mitigating the need for out of home placements, such as disruptions in foster care placements or the need for higher levels of care.

Families who do not achieve marked success with CBHI services often turn to state agencies for more intensive wraparound programming that insurance does not cover. Many youth struggle to engage or are not able to access traditional talk-based therapies as a result of symptoms of their diagnoses. Recognizing these service gaps, The Department of Mental Health (DMH) Northeast Region approached Edinburg in 2019 to develop a wraparound team that included both mental health clinicians and BCBAs. In response, Edinburg designed a model integrating aspects of mental health treatment, the Principles of ABA, and guidelines from CBHI and the Substance Abuse and Mental Health Services Administrations (SAMHSA) Assertive Community Treatment (ACT) Toolkit (2008). With funding from DMH, The Specialty Flex Team was established in January of 2020 to s erve youth, ages 7 to 22, with a range of complex mental health diagnoses, many of whom have co-occurring ASD or engage in high-intensity behaviors.

Approach

The *Better Together* approach is flexible, enabling the team to work from a person-centered lens, engage in evidence-based practices, and adapt treatment to meet the individualized needs of the participant and families. A core *Better Together* team comprises a Clinician and BCBA. Additional team members may include an Occupational Therapist (OT), Therapeutic Support Staff (TSS), and Peer Services, including a Certified Peer Specialist (CPS), Young Adult Peer Mentor (YAPM), or a Family Partner (FP). All teams are overseen by independently licensed program directors. Roles are defined as follows:

ROLE	DEFINITION
Master's Level Mental Health Clinician **(Clinician)**	A clinician who possesses a master's degree in the field of social work, mental health counseling, marriage and family counseling, or a related field, and is independently licensed, preliminary licensed, or license eligible.
Board-Certified Behavior Analyst **(BCBA)**	A behavior therapist who possesses a master's degree or certification in advanced studies in ABA and is certified as a BCBA from the Board Analyst Certification Board (BACB).
Therapeutic Support Staff **(TSS)**	A person who possesses a minimum of a high school degree or equivalent and at least 2 years' experience working with youth and families. TSS work to support the clinical and/or behavioral goals under the guidance of the Clinician and BCBA.
Peer Specialist/Young Adult Peer Mentor **(YAPM)**	A person who possesses a minimum of a high school degree or equivalent, a Young Adult Peer Mentoring (YAPM) Certification or a Certified Peer Specialist (CPS) and identifies as having lived experience engaging with the formal mental health system. YAPMs use lived experience to connect with, validate, inspire, and provide people with support to reach their goals, increase community awareness of mental health challenges, and help people cope with these challenges.
Family Partner **(FP)**	A person who possesses a minimum of a high school degree or equivalent and identifies as having current or historical experience raising a youth with emotional, behavioral, or mental health challenges. FPs have knowledge of the youth mental health system and have navigated the system on behalf of their own child or family and are able to use their personal experience to support and empower other caregivers and families.
Occupational Therapist **(OT)**	An independently licensed occupational therapist who possesses a master's degree in occupational therapy. OTs work with individuals to increase independence in all areas of their lives by decreasing barriers that impact a person's emotional, social, or physical needs.

The *Better Together* approach emphasizes collaboration with the teams meeting daily to review cases and engage in internal consultation in alignment with SAMHSA's ACT Toolkit (2008). Research supports a multidisciplinary team approach (American Academy of Pediatrics, 2017; United Nations, 2006; NICE, 2013), inclusive of people with ASD who present with high-risk, externalizing behaviors (Dillenburger et al., 2014; Strunk et al., 2017).

Using the *Better Together* teamed approach, Clinicians engage the participant and family in family therapy, individual skill building, psychoeducation, coaching, case management, and crisis stabilization. Clinicians and BCBAs often pair together at intake and work collaboratively to gather information for assessments and to discuss findings. This enables the team to work on a plan for modalities that complement all needs, while not overburdening the participant and family system.

The integration of OT into The Specialty Flex Team has further contributed to successful outcomes. Both BCBAs and OTs possess expertise with this target population. Etiology of behaviors can vary from medical diagnoses, medications, sleep hygiene, and sensory systems; therefore, by utilizing a sensory profile, an OT can better understand how a person's sensory system works, the level of sensory registration and sensitivity a person has to specific types of sensory input, and whether the person is sensory avoiding or sensory seeking. When OTs are integrated into *Better Together* teams, they can provide insight to Clinicians and BCBAs on coping mechanisms and also assist during times of escalation and emotional dysregulation. As a team, BCBAs, Clinicians, and OTs work together to proactively teach skills to participants and families outside of moments of dysregulation, as well as emphasize de-escalation in the moment.

The TSS role is flexible and addresses both clinical or behavioral goals. The TSS role is determined based upon the identified needs and preferences of the participant and family. The TSS may engage the participant or other family members in direct, strengths-based support, including, but not limited to, coaching, modeling, or skill building to increase emotional regulation, activities of daily living, or functional communication.

The integration of peer support for participants and caregivers leads to increased success, hope, resiliency, and positive outcomes. Research indicates that youth whose peer mentoring relationships have lasted a minimum of 12-months, experience reduced interfering behaviors, decreased symptoms of depression and anxiety, and have improved educational outcomes (DeWit, DuBois, & Erdem, 2016). Peer Specialists support individuals aged 14 years and older, using their lived experience to connect with, validate, inspire, empower, and instill hope toward recovery. Peers share their recovery story, build relationships, collaborate, and coach, based on the confidence and readiness of the participant. This helps the participant discover that they have a central role on the team. Similarly, Family Partners (FPs) empower, instill hope, and support families, and particularly caregivers, as they navigate complex systems. FPs often utilize interventions with roots in parent coaching, a model that is an evidence-based Practice (EBP) with demonstrated ability to help caregivers support children's development, specifically children with ASD (Straiton, Frost, & Ingersoll, 2023). FPs provide mutual support and coach caregivers to implement the interventions independently when providers are not present. According to Rocha et al. (2007), direct teaching to caregivers results in increasing the efficacy of services provided.

Engagement

During the engagement process, the team seeks to identify strengths, preferences, needs, and goals of the participant and family in order to support them to overcome challenges and attain their goals through the utilization of their strengths. The team uses Person-Centered Planning techniques, combined with the Principles of ABA, Stages of Change, and Motivational Interviewing (MI), to uphold the participant's and family's values and provide holistic, culturally relevant, and meaningful treatment options. Ongoing interactions facilitate active involvement and maximize engagement. This includes being responsive to the family's concerns, schedule, culture, strengths, and capabilities. For young adults, engagement strategies focus on a full exploration of the participant's interests and capabilities, as well as ensuring rapid engagement with a YAPM. If disengagement occurs, the team attempts to re-engage through the use of MI, reviewing treatment to show all levels of progress, and by exploring barriers to engagement, such as scheduling. Peer roles also help address barriers to engagement using purposeful self-disclosure and compassionate listening.

Assessment

The assessment process incorporates the strengths, needs, and preferences of the participant and the family, which creates a foundation for positive change. A pre-assessment conducted during intake lays the groundwork for further assessments and treatment planning. The Clinician and BCBA work in unison to complete a combined Biopsychosocial Assessment and Functional Behavior Assessment (FBA), inclusive of a complete record review, and interviews with the participant, family, and all

involved team members. The Clinician completes standardized assessments, such as the Pediatric C-SSRS and CRAFFT 2.1+N, when appropriate. If questions arise surrounding diagnoses, the Clinician may administer supplemental assessments, such as the UCLA PTSD Index to clarify diagnoses. The BCBA conducts the FBA which includes completing the Questions About Behavior Function (QABF) with as many caregivers or adults in the participants' life as possible, for all identified target behaviors. The participant is observed by the BCBA across all settings to assess where interfering behaviors occur, and engages in a reinforcer assessment to determine what is potentially motivating to the participant. Team members, the family, and the participant, as appropriate, collect Antecedent-Behavior-Consequence (ABC) data which is then assessed by the BCBA and included in the FBA. The results of the FBA explain what is happening in the participant's environment to reinforce their engagement in interfering behaviors, which in turn enables an understanding of which replacement behaviors may be appropriate and the types of interventions to use.

As part of the assessment process, the team determines whether a participant's chronological age matches their developmental age. This information is then used to develop clinical interventions that meet the clinical, developmental, and cognitive needs of each participant and family member. When working with transitional age youth, an important consideration includes supporting the participant as they prepare for increased independence. For instance, the Decisional Balance Sheet or the Values Card Sort game from MI may be used to engage transitional age youth in exploration of their own choices and values. Encouraging validated technology, as appropriate, such as a mood tracker, Insight Timer app, or the Wellness Recovery Action Plan (WRAP) app, can also be used as assessment and engagement strategies.

When appropriate, an OT administers a Sensory Profile Assessment, enabling them to understand how the participant's sensory system works and what that means for preferred and non-preferred activities, as well as coping strategies. Additional assessments include the Canadian Occupational Performance Measure (COPM), the AOTA Occupational Profile, Routine Task Inventory (RTI), and the Allen's Cognitive Levels (ACLs). Upon the identification of areas of growth, the OT works with the participant and family to set goals and may set short term and/or long-term goals depending on the participant's current strengths, preferences, and needs.

Risk Assessment and Safety Planning

Prevention is a significant component of crisis planning and this process begins proactively with a comprehensive risk assessment. Clinicians complete a full risk assessment, often inclusive of the Pediatric C-SSRS at intake, and as needed throughout treatment. Preliminary Safety (Wellness) plans are developed at intake with participants and families to identify baseline behaviors, safe behaviors, warning signs, escalated behaviors and to identify crisis prevention services, inclusive of accessing programmatic on-call support, available to participants and families 24 hours/day, 365 days/year. Wellness plans are intended as fluid documents which include interventions to assist the participant and family through the identification of warning signs to decrease the risk of crisis. Within a week of intake, the team works collaboratively with the participant and, as appropriate, the family, to develop a more comprehensive plan which includes concrete measurable steps based upon specific behaviors, warning signs, and risk level. When working with transitional age youth, the team may help the participant create a Wellness Recovery Action Plan (WRAP) and, with consent, share it with providers to ensure the participant's choices are considered during a crisis, reducing the risk of trauma-related feelings. Based on their needs and preferences, young adults may also be given access to warm lines, the Crisis Text Line and other crisis chat services. In order to remain proactive and collaborate as needed, releases are often requested at intake for crisis teams and local police departments.

Treatment Planning and Care Coordination

Participants and their families are at the forefront of services. Clinicians, BCBAs, and OTs partner with each participant and family to create a treatment plan, which is inclusive of both clinical and behavioral goals, based on the participant's and

family's identified priority needs. The discharge planning process begins at intake through the incorporation of a preliminary assessment which assists in defining participant and family visions, strengths, supports, and barriers. This tool, along with the use of MI and the FBA helps guide participants and families in identifying their prioritized needs and facilitates discussion regarding indicators and readiness for discharge. In working with young adults, this assessment is often conducted in a separate meeting to fully incorporate both the caregiver priorities, as well as the voice of the participant. Building upon natural and community supports is prioritized early, as it provides a foundation to sustain the participant and family post discharge (DeWit et al., 2016; Gilmore et al., 2022; SAMHSA, 2008). Based on prioritized needs, the team, in collaboration with the participant and family, as appropriate, develops concrete, Specific, Measurable, Achievable, Realistic, and Time-Bound (SMART) goals to help the participant and their family feel successful, even when progress is small. Progress is monitored through data. The BCBA instructs the team and family on the data collection system and also encourages participants to self-monitor in order to empower them in their treatment.

With the collaboration of the participant, family, and other identified team members, the *Better Together* Team creates a cohesive Community Support Plan (CSP) that encompasses multidisciplinary goals. The Behavior Support Plan (BSP) and OT Treatment Plans are not stand-alone documents; rather, they are integrated into the CSP along with clinical goals. The CSP identifies antecedent strategies to decrease the probability of interfering behavior occurring, teaches replacement behaviors, and provides responses to interfering behaviors to decrease the probability of the behavior occurring again in the future. Baseline data is collected prior to implementation of any intervention and is included in all CSPs. Progress towards goals is measured by taking data, analyzing it, and reporting the results once interventions are implemented. If the data shows that interventions are not effective, changes are made accordingly. The BCBA and OT provide guidance ensuring that SMART goals take the environment into consideration. Environmental modifications may include the use of technology, such as setting personal reminders to engage in self-monitoring, use of visuals, or by integrating supportive sensory equipment. Interventions are then developed to support the participant in practicing and utilizing skills to accomplish the goals and obtain an increased sense of well-being and quality of life.

Therapeutic Interventions

The team uses EBPs and promising practices based upon the needs and priorities identified by the participant and family. MI is used to increase engagement, Cognitive Behavior Therapy (CBT) strategies are used to decrease depression and anxiety, and Dialectical Behavior Strategies (DBT) strategies are used promote healthy interpersonal relationships and mindfulness. Other EBPs incorporated into treatment may include but are not limited; to Solution Focused Brief Therapy (SFBT), Acceptance and Commitment Therapy (ACT), or Trauma Focused-Cognitive Behavior Therapy (TF-CBT). The team utilizes sensory equipment in the home and community aimed at supporting the participant's natural ways of regulating their arousal states, following the Sensory Motor Arousal Regulation Treatment (SMART) model (Yochman & Pat-Horenczyk, 2019). All team members work from a strengths-based and trauma-informed framework and routinely incorporate Attachment, Regulation, Competency (ARC) into treatment. ARC GROW, a caregiver skill building intervention based on the ARC framework, is often utilized as a psychoeducation model for caregivers aimed at increasing resilient outcomes for families impacted by chronic stress or trauma. Some interventions, including, but not limited to, caregiver coaching and GROW, have been implemented successfully using telehealth.

When selecting interventions, the team explores individualized needs and modifies interventions, as needed, based upon the participant's chronological age, developmental levels, cognitive abilities, and by incorporating their preferences and interests. When working with people with ASD or IDD, the team utilizes EBPs incorporating universal design for learning to ensure accessibility. The team promotes generalizability of content and skill usage across multiple people, objects, and environments. In addition to incorporating the Principles of ABA and OT, to ensure accessibility, promote generalizability of content, and

promote skill usage, modifications are made to CBT, DBT, and mindfulness-based techniques. Visuals and social stories are created, as appropriate, to increase comprehension and retention of therapeutic content and skill usage, and to assist families in reinforcing learning strategies across all environments. Typically, when working with a young adult, goals and interventions will target skills that the young adult needs to live their life more independently.

BCBAs are educated in the principles of ABA which is an EBP. The FBA determines which interventions are appropriate for the participant and their family. BCBAs model and coach caregivers and the team. For example, if a participant did not know how to tie their shoes, the BCBA would model for the caregiver and team so that others could teach and reinforce the skill. o Other common interventions BCBAs may use, include but are not limited to, scripting, sensory integration, direct teaching, roleplaying, and the creation and implementation of schedules of reinforcement. BCBAs continue to gather and analyze data throughout the course of treatment and adjust interventions as needed.

OT interventions are meant to be creative, dynamic, and supportive of the participant and their needs. As such, the OT travels with a variety of tools, including but not limited to, body socks, spin discs, weighted blankets/vest/lap pads, arts and craft activities, and various small fidgets which target all aspects of the sensory system. Additional interventions include the Zones of Regulation and How Does Your Engine Run? These programs allow the participant to better understand how their body is feeling and what their behavior looks like based on the way they are feeling.

Better Together teams support educational and vocational goals. In a longitudinal study that examined a combination of vocational and mental health interventions in young adults, those enrolled in both the mental health and vocational interventions showed statistically significant positive increases in empowerment and quality of life 12-months post-treatment. Results also indicated decreased depressive symptoms for those enrolled in both interventions (Liljeholm, Argentzell & Bejerholm, 2020). Using the *Better Together* model, all staff support executive functioning skills, vocational, and educational goals, often with primary support from the TSS, YAPMs, or FPs. Vocationally, staff may engage participants by exploring their strengths, interests, and hobbies to identify possible volunteer positions or jobs of interest, assist in resume development, learning interview skills, or applying for jobs. Educationally, staff help participants and families navigate the 504 or IEP process or explore post-secondary educational opportunities, inclusive of navigating accommodations in a college setting.

Continuity of Care

Care coordination is essential to continuity of care. Upon intake, the team requests releases for PCPs, prescribers, involved state agencies, schools, crisis services, the local police department/Jail Diversion Clinicians, current and past behavioral health providers, other providers (e.g., attorneys, probation), other adults in the household, and as appropriate, other identified natural supports. As part of the assessment process, the team immediately engages in care coordination when there is a written consent to collaborate.

Engagement with the police department, such as a Jail Diversion Clinician or a designee within the police department occurs, as needed and with consent, to ensure that the police understand the participant's diagnoses, strengths, and needs. Additionally, as needed and with consent, a designee from crisis services is often incorporated into treatment team meetings to create mutual understanding and to engage in proactive crisis planning. Additionally, with consent and as needed, wellness plans are proactively shared with crisis teams and police departments.

If a person is struggling, and the team or family anticipates that a crisis evaluation may be needed, the team assists the family by alerting the crisis team. Treatment Team Meetings are held within 1-month intake and follow-up meetings are scheduled minimally at 3-month intervals, with increased frequency as appropriate. Fluid contact is maintained with all involved collaterals

and natural supports throughout the course of treatment. Collateral meetings are regularly held that include the participant, whenever possible, and their family. When there are multiple systems and services involved, weekly care coordination meetings may occur to ensure consistent use of strategies across all environments. If the participant requires a higher level of care, the team immediately begins the coordination process by contacting the crisis team and the receiving emergency department. This level of engagement continues throughout the placement process by immediately reaching out to the receiving facility to provide additional background information and to coordinate a mutually convenient time for their initial treatment plan meeting. The team engages in outreach when a participant is hospitalized, prioritizing in-person support to telehealth, when possible, while continuing to work with family members in the home environment. Regular communication is maintained throughout the entire length of stay in order to obtain updates, help plan visits and based upon the level of care and program policies, to coordinate day passes, trial days at school, and overnight passes. The team engages in discharge and safety planning with the program, while supporting the family through discharge, often going out to the home on the same day to provide additional support.

Case Examples

Cameron

At the time of referral to Youth Brief Treatment, an Emergency Department (ED) Diversion Program, Cameron was an 11-year-old, biracial (Black/Caucasian), biological male, identifying as non-binary using, they/them pronouns. Cameron was residing with his adoptive mother, who identified as Caucasian, in an affluent town comprised primarily of individuals of Caucasian descent. Cameron was adopted as a newborn via an open adoption, facilitated by Child Protective Services (CPS) in a southern state, to a single mother residing in a mid-Atlantic state. Cameron's biological mother was incarcerated throughout her pregnancy and Cameron's birth, and she received minimal prenatal care. Cameron had minimal visitation and contact with his birth family until the age of 2. Cameron allegedly experienced physical and sexual abuse perpetrated onto him by his maternal grandparents between the ages of 4 to 6. Upon his mother addressing these concerns with her family, no one believed Cameron, so she moved to Massachusetts to protect her child, and as a result, they no longer had contact with any family members.

Cameron was referred to Youth Brief Treatment by a local ED. At the time of referral, Cameron's mother was afraid to take him home due to Cameron's ongoing physical aggression toward her which included shoving, choking, hitting, and throwing objects at her. Additionally, Cameron had recently choked a female peer at school and touched her breasts, which resulted in a restraining order against Cameron and the school district not allowing Cameron to return to school. At the time of referral, Cameron was diagnosed by the crisis team with (F41.9) Anxiety, Unspecified, (F43.89) Other Specified Trauma and Stressor Related Disorder, (F90.9) Attention Deficit Hyperactivity Disorder (ADHD), Unspecified, and (F91.3) Oppositional Defiance Disorder (ODD).

Cameron was exhibiting physical aggression toward his mother, as well as peers, sexualized behaviors, irritability, intrusive thoughts, memories, and flashbacks, sleep disturbances, night terrors, high levels of reactivity surrounding the traumatic events, negative emotions associated with events which impacted his relationship with his mother, as well as avoidance of bathrooms and taking baths. Through the intake and assessment process, which included a thorough biopsychosocial assessment, inclusive of an FBA, Cameron's diagnoses were modified concurrent with his presentation and symptoms to (F43.1) Post Traumatic Stress Disorder (PTSD), (F34.81) Disruptive Mood Dysregulation Disorder (DMDD), (F41.9) Anxiety, Unspecified, and (F90.9) ADHD, Unspecified. Through collaborative treatment planning, the team prioritized goals including safety and stabilization, increasing coping strategies and distress tolerance, and psychoeducation and coaching Cameron's mother on how and when to respond to behaviors. The core team was identified to include a Clinician, BCBA, and TSS.

The Clinician and BCBA engaged the mother by coaching with alternative ways to respond to behaviors, as well as when not to respond. Working together, the BCBA and Clinician engaged the mother in psychoeducation surrounding the use of coping

strategies, co-regulation, and identifying strategies that worked for Cameron. The BCBA engaged in coaching with the mother regarding her response, tone of voice, and sensory interventions were put in place, including the creation of a "rip box" for Cameron which contained paper that he could shred. Cameron continued to struggle throughout treatment and went for multiple evaluations at the local ED. The team collaborated with the crisis teams and EDs in order to continue to divert Cameron from higher levels of care. Additionally, the team engaged with Cameron's school, the family's educational attorney, and attempted to support Cameron in returning to school. Three months later, at discharge, Cameron was able to increase his distress tolerance when his mother was absent from the environment. Cameron had a history of not engaging with providers; however, using this teamed approach, Cameron ultimately engaged with the TSS and was able to discuss his mood and experience. Additionally, Cameron was able to open up to the TSS, whereas he had previously not engaged with any providers.

Sam

At the time of referral to The Specialty Flex Team, Sam was a 17-year-old, Caucasian, male using he/his pronouns, who resided with his mother and younger sibling. Sam had a history of aggression toward family members including biting, punching, scratching, kicking, and throwing objects. Sam was diagnosed at age 3 with (F84.0) ASD due to stereotyped speech, highly restricted interests, repetitive play, labile mood, and aggressive behaviors. At age 5, Sam was diagnosed with (F31.12) Bipolar Disorder, and (F90.9) ADHD. Sam has had ongoing clinical interventions throughout his life, including multiple inpatient hospitalizations. Sam was referred to DMH due to lack of success accessing traditional-based CBHI and outpatient services. Prior to the referral to DMH, Sam choked his Therapeutic Mentor (TM) in the parking lot following eating a meal at a preferred restaurant with his team, which he earned as an incentive.

Through the intake and assessment process, which included releases for key providers in Sam's life, a thorough biopsychosocial assessment, inclusive of a FBA, and through person-centered planning, the team identified resources and natural supports. Sam further identified that he wanted to increase social communication skills in order to initiate and maintain conversations so that he can make friends. The BCBA engaged in observations, data collection, and instructed Sam, his mother, and the team on how and when to teach replacement behaviors to decrease aggression and to increase Sam's independence. To manage his intrusive thoughts, the Clinician and TSS worked with Sam on coping strategy utilization, both proactively and in the moment. As a result of direct teaching, Sam learned to express his thoughts, and was supported in identifying appropriate ways to communicate those thoughts and find alternative solutions. His mother gained skills to support Sam with his communication. The BCBA additionally engaged Sam in roleplaying scenarios to increase functional communication skills.

Upon transitioning out of Specialty Flex Services, Sam was able to maintain his living situation, attend school in the community, and make significant gains in his independence, functional communication and emotional regulation. At discharge, Sam had graduated high school, obtained his first independent job at a local grocery store, demonstrated the ability to navigate town by bike, and successfully transitioned to a lower level of care, which included insurance-based ABA and outpatient therapy.

Limitations

Data collection included The Specialty Flex Team, Youth Brief Treatment, and the Beth Israel Lahey Health (BILH) Better Together Community Behavioral Health Center (CBHC) Team. However, only The Specialty Flex Team integrates OT services, and the TSS role exists solely in The Specialty Flex Team and Youth Brief Treatment. The absence of these roles in the BILH Better Together CBHC Team may have influenced outcomes. While preliminary data suggests promising results, further longitudinal studies are necessary to refine outcome measurements and assess long-term impact.

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