

In-Home Therapy Services

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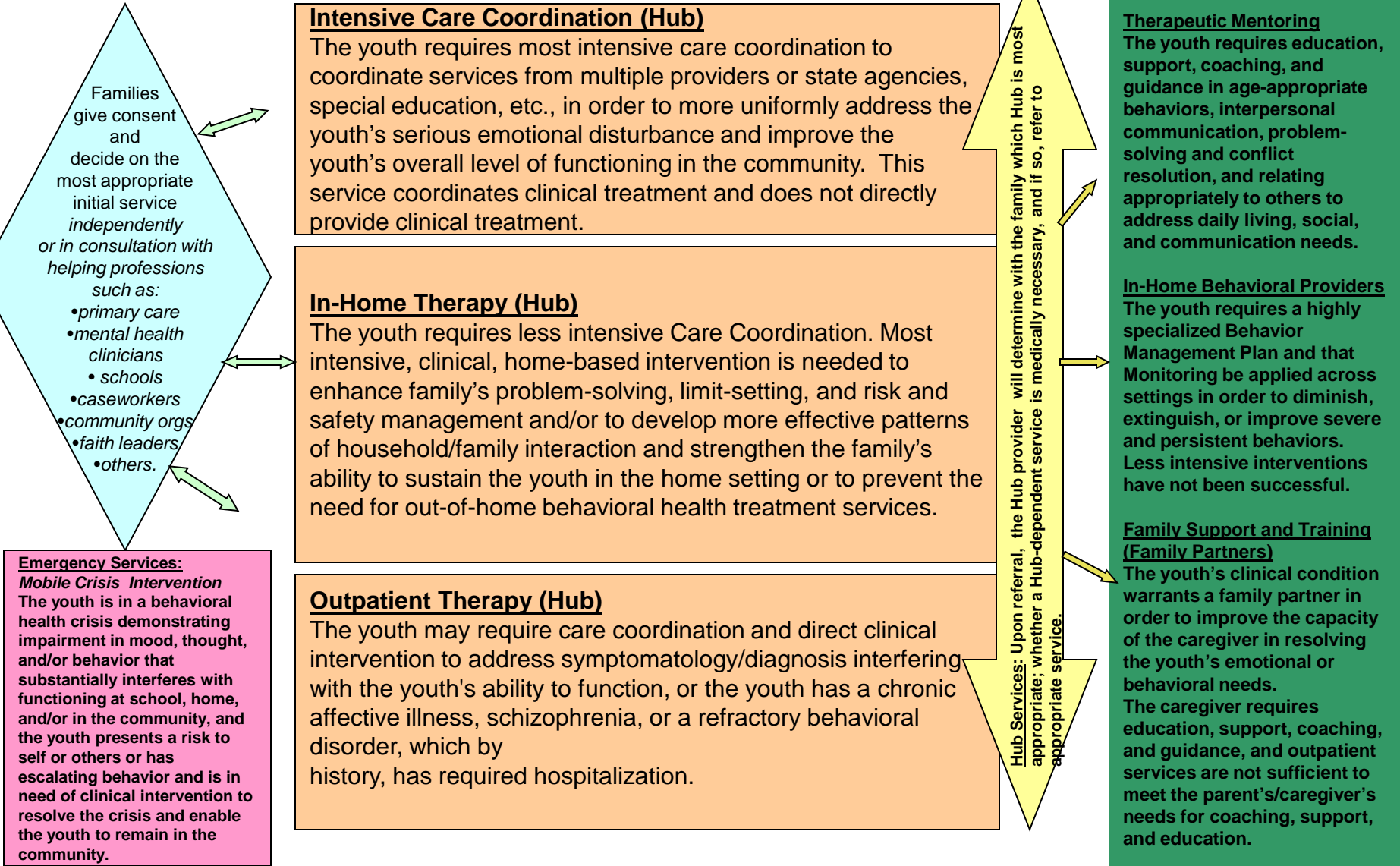
“How is it possible to convince a child of his own worth after removing him/her from a family which is said to be unworthy but with whom he/she identifies.”



Maya Angelou

CARE COORDINATION

Note: All services require medical necessity criteria and are not solely determined by parent/caregiver choice.



Emergency Services:
Mobile Crisis Intervention
 The youth is in a behavioral health crisis demonstrating impairment in mood, thought, and/or behavior that substantially interferes with functioning at school, home, and/or in the community, and the youth presents a risk to self or others or has escalating behavior and is in need of clinical intervention to resolve the crisis and enable the youth to remain in the community.

Intensive Care Coordination (Hub)
 The youth requires most intensive care coordination to coordinate services from multiple providers or state agencies, special education, etc., in order to more uniformly address the youth's serious emotional disturbance and improve the youth's overall level of functioning in the community. This service coordinates clinical treatment and does not directly provide clinical treatment.

In-Home Therapy (Hub)
 The youth requires less intensive Care Coordination. Most intensive, clinical, home-based intervention is needed to enhance family's problem-solving, limit-setting, and risk and safety management and/or to develop more effective patterns of household/family interaction and strengthen the family's ability to sustain the youth in the home setting or to prevent the need for out-of-home behavioral health treatment services.

Outpatient Therapy (Hub)
 The youth may require care coordination and direct clinical intervention to address symptomatology/diagnosis interfering with the youth's ability to function, or the youth has a chronic affective illness, schizophrenia, or a refractory behavioral disorder, which by history, has required hospitalization.

Hub Dependent Services (accessed through Hub)

Therapeutic Mentoring
 The youth requires education, support, coaching, and guidance in age-appropriate behaviors, interpersonal communication, problem-solving and conflict resolution, and relating appropriately to others to address daily living, social, and communication needs.

In-Home Behavioral Providers
 The youth requires a highly specialized Behavior Management Plan and that Monitoring be applied across settings in order to diminish, extinguish, or improve severe and persistent behaviors. Less intensive interventions have not been successful.

Family Support and Training (Family Partners)
 The youth's clinical condition warrants a family partner in order to improve the capacity of the caregiver in resolving the youth's emotional or behavioral needs. The caregiver requires education, support, coaching, and guidance, and outpatient services are not sufficient to meet the parent's/caregiver's needs for coaching, support, and education.

Youth may have 1, 2, or all 3 "hub" services. Care coordination is provided by the most intensive Hub service. The most intensive service is considered the Hub.

Important to remember

- When ICC and IHT are involved - ICC is the hub and IHT is (with family agreement) part of the care planning team.
- In this situation ICC provides wraparound process & care planning while IHT provides a clinical intervention to family.
- In addition to clinical intervention, care planning team may identify care management tasks for IHT provider to carry depending on youth need and resources at the table.

In-Home Therapy (IHT)

- Clinical Hub– Core Service
- Either a Master’s level clinician or a team approach
 - Master’s level clinician can complete assessment & develop treatment plan and then based on youths needs paraprofessional on the team may be providing intervention with no further MA-level involvement directly with family. MA-level would provide oversight to the paraprofessional.

In-Home Therapy (IHT)

- Intensive family therapy in the home or other community/natural setting to:
 - Enhance problem-solving, limit-setting communication
 - Build skills to strengthen the family
 - Identify and utilize community resources
 - Develop and maintain natural supports
 - Risk management/safety planning

In-Home Therapy, con't

- Includes:
 - Assessment (comprehensive home-based, inclusive of CANS)
 - Development of a youth- and family-centered treatment plan
 - Intensive Family Therapy
 - Coaching
 - Skills training
 - Referral and linkage
 - Identification of community resources and development of natural supports
- IHT service is available to all MassHealth enrolled youth under 21 except for MassHealth Limited

IHT Therapeutic Training and Support

- A service provided by a qualified paraprofessional working under the supervision of a clinician to support implementation of the clinician's treatment plan to assist the youth and family in achieving the goals of that plan.
- The paraprofessional assists the clinician in implementing the therapeutic objectives of the treatment plan designed to address the youth's mental health, behavioral and emotional needs.
- Phone contact and consultation are provided as part of the intervention.

IHT Therapeutic Training and Support

- Teaching the youth to:
 - Understand;
 - Direct;
 - Interpret;
 - Manage; and
 - Control feelings and emotional responses to situations
- To assist the family to address the youth's emotional and mental health needs.

IHT is Grounded in System of Care Principles

- Youth-guided and family-driven, with the individual needs of the youth and family dictating the types and mix of services provided.
- Least restrictive – most normative services
- Culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.
- See System of Care Guiding Principles Handout

Typical Youth/Family Served

- Youth with serious emotional challenges with functional impairments
- Youth at-risk of placement or have significant safety issues
- Youth with multiple system involvement
- System has not engaged youth and family effectively

Typical Youth Served

- Multiple risk factors
- Fewer protective factors
- Skill set deficits: e.g. problem solving; communication; emotional regulation
- Youth who need additional supports, active facilitation, and accommodations for success (school, home, community)

Parents/Caregivers and Families

- High amount of family stressors – Low amount of resources and supports
- High levels of family conflict
- Current skill set of parent/caregiver unsuccessful in dealing with youth's mental health needs
- System trauma that is generational resulting in significant trust issues
- Difficulty with service access (work, transportation, poverty)

Differences Between IHT & Traditional Services

IHT	Outpatient
Services delivered in the home and community	Mostly clinic-based
24/7 availability & response by IHT team	No 24/7 availability by team
Frequency & duration matches need	One hour weekly to biweekly appointments
Flexible Scheduling	Appointments during office hours
Lead role in service/ care coordination	Limited opportunities for collaboration
Smaller caseloads	Large Caseloads >30
Comprehensive mix of services	Therapy only
IHT is a hub with more comprehensive level of care coordination	OP is a hub and is expected to provide less comprehensive level of care coordination

IHT: Key Service Principles

1. Access
2. Availability
3. Advocacy
4. Action:
 - Active risk management and safety planning
 - Active intervention monitoring
 - Active support to family
 - Pro-active cross-system collaboration
5. Respectful and culturally mindful partnerships with youth and family

IHT: Service of Access

- Service delivered where the youth lives and functions: home, school, and community at times that are convenient to the family
- Access to information
 - Family dynamics and interactional patterns
 - Recovery environments
- Access to people
 - Family
 - School
 - Court
 - Community
 - Natural supports
- Access for interventions: implemented where behaviors occur

Availability

- Crisis availability: 24/7 on call: *The In-Home Therapy Services provider has 24 hour urgent response accessible by phone to the youth and family, 365 days a year.*
- Immediate crisis response from In-Home Therapists with face to face response as needed

Advocacy

- Skillful advocacy efforts are promoted to assist with accommodations and system navigation - while respecting other child-serving system's mandates

Action

- Active risk management and safety planning
- Active intervention monitoring
- Active support to family
- Active cross-system collaboration

Extreme Persistence

(John VanDenBerg, 2002)

- “Communities recognize that needs can be complex, that change is sometimes very difficult to achieve, and commit to a mutual process of extreme persistence in the delivery of services and supports.
- Providers make a “commitment to never give up on the child or family, changing the plan instead of rejecting the child and family from services and support.”

Respectful and Culturally Mindful Partnerships

- IHT staff develop strength-based relationships & partnerships with youth, family, and extended family and supports.
- **Strengths and Culture Discovery** (VanDenBerg): IHT providers strive to understand and appreciate the youth and family's values, culture, strengths, and life realities.
 - What does the family need you to understand about them– so that you can best help them?
- **Mutual Expertise:** Youth and families are experts on their lives and you are an expert in your field

Phases of Home-based Intervention

Engagement and Assessment

- First session
- Engagement (youth, family, & collaborative partners)
- Ecosystemic Assessment
- Risk Management and Safety Planning

Treatment

- Individual and family treatments and supports
- Skill Building, Skill Consolidation, and Generalization

Enhancement of Positive Support Network

- Linkages, Closure, & Follow-up

Discharge

- In Ohio the average LOS for Intensive Home-Based Treatment is 4.5 months

First Session: Pre-Structuring the Relationship

- **Main goals:** build strength-based relationship with all family members and establish basic parameters and understanding for the service
- **Setting:** Home, school, and community
- **Timelines and Flexibility:** Time is based on medical necessity, and service is flexibly scheduled.
 - **Plan for termination during the first session:** If we are successful what will we accomplish in our time together?

First Meeting (Con.)

- **Expectations:** Explore the parent/caregiver's expectation of home based intervention. Clarify why you are there and purpose of IHT
- **Role and Boundaries:** Clarify your role as a home-based service provider and establish clear boundaries (nature and parameters of the service you are providing)
- **Safety:** Explore possible safety issues and review program policies around safety with family
- **Establish expectations and parameters for utilizing on-call system**

First Meeting (Con.)

- Confidentiality
 - Youth - Parent/Caregiver
 - Substance Use
 - Doing work in public places
- Reporting Obligations
 - Balancing engagement and professional duties

Engagement through resiliency lens

- **Appreciative perspective:** Families are doing the best they can do, at any given time, given their current capacities and abilities, and life circumstances.
- **Validation and Valuing:** The youth and family are validated for their courage, efforts, and persistence, knowing that progress is sometimes very difficult, and that “hanging in there” is sometimes all that is possible at any given point in a family’s life.
- **Hope:** Foster the possibility of hope and a positive future

IHT Lessons Learned: Engagement

- Aligning with one family member at the expense of other family relationships
 - Saving the youth from his or her parents/caregivers
 - Not joining with the parents/caregivers
- Not taking the time to build relationships with the family's natural support system
- Not setting clear boundaries with the family about your professional role (becoming a part of the family)
- Misinterpreting a family's self-protection as resistance

Barriers to Engagement

- **Lack of Trust:** Has the family had previous negative experiences with the system?
- **Respect:** Is provider respectful and validating of family culture and life experiences and circumstances?
- **Service Choice:** Does the family want this service at this time? Who wants the change? (The system or the family?)
- **Different priorities:** Are there unmet basic needs that are a bigger priority to the family than therapy?
- **Pacing:** Does the therapeutic pace match the family's ability to learn and integrate the new information?
- **Loss of Hope and Family Burnout:** Is the family burned out with services or behaviors?
- **Competency:** Does the family believe you can help them?

Multidimensional Assessment

- I. **Diagnosis:** (See Child Behavioral/Emotional Needs - MA CANS)
- II. **Developmental Functioning:** (See Life Domain Functioning and Transition to Adulthood - MA CANS). Lagging skill sets; self care; cognitive maturity emotional, & behavioral maturity.
- III. **Contextual Functioning:** (See Life Domain Functioning and Acculturation- MA CANS) Individual functioning in relevant life domains, including risk and protective factors, family functioning, and risk and recovery environments
- IV. **Safety and Risks** (See Child Risk Behaviors – MA CANS): Self and other harm, personal, family, and community safety

Balanced Focus

- **Balanced:** Strength-based and need focused
- **Strengths:** Resources, supports, abilities, talents, skills, knowledge, coping, etc.
- **Needs:** Mental health needs of the youth; contextual issues that relate to the mental health needs of the youth; skill set deficits

Differential Diagnosis

- Diagnosing youth is challenging
- Use timeline to map history of symptoms
- Use Genograms for family history
- Be alert to other possible explanations of symptoms: Trauma; Substance use; etc.
- Be open to changing diagnosis based on new information

Assessment:

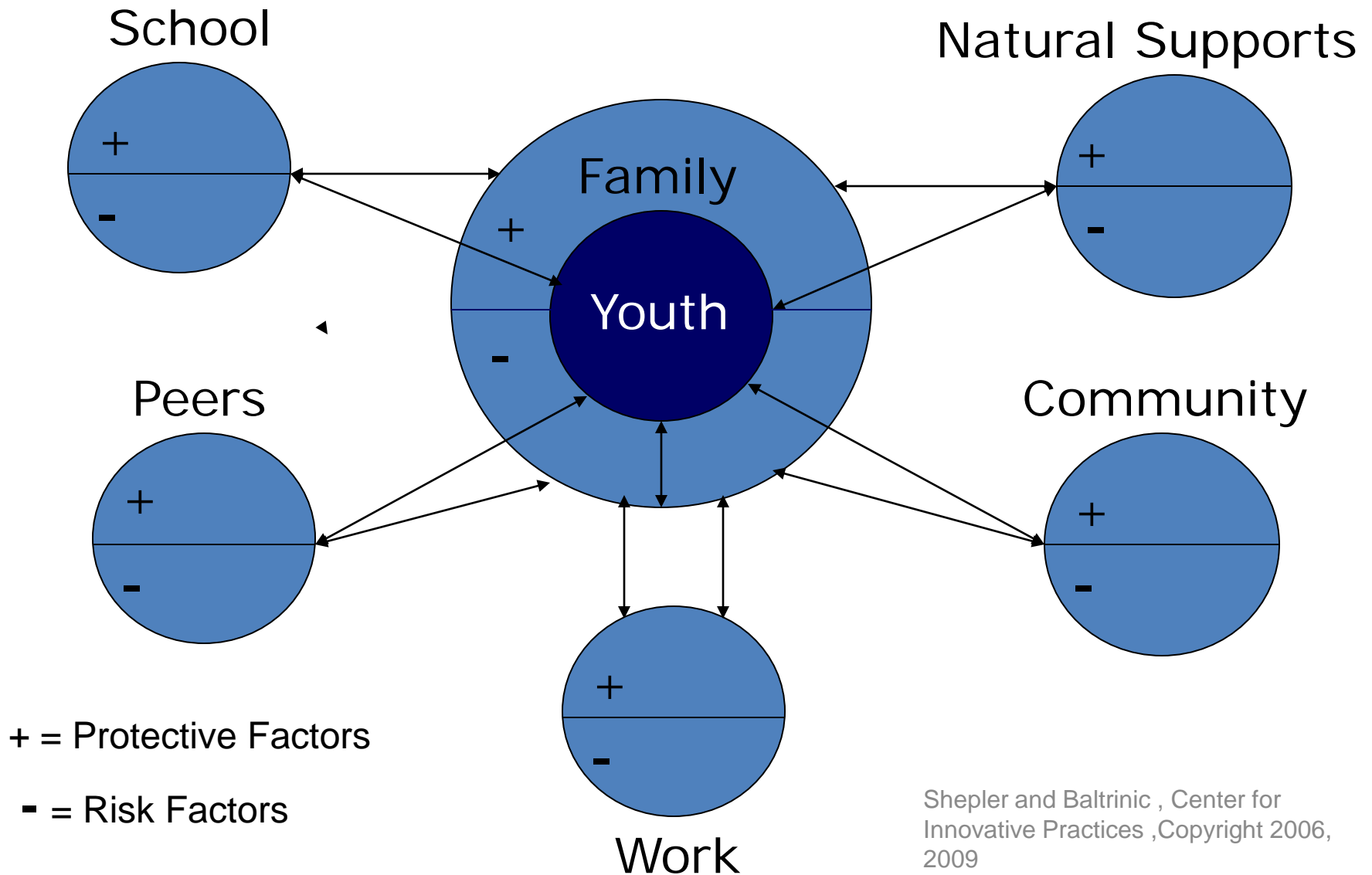
Developmental Functioning

- Skill sets: What skill sets are needed for success?
- Achievement and ability testing (Collateral information)
- Learning Disabilities (Collateral information)
- Level of emotional maturity (decision making)
- Ability to think abstractly, reflectively, and conceptually

Contextual Functioning

- How is youth functioning in major life domains?
 - Risk and protective factors
 - Recovery resources
 - Relationships (teachers, parents/caregivers, peers)

Mapping Contextual Functioning



Risk and Protective Factor Checklist

- See Handout

Assessment

Screening for Safety Risk

Self Harm Behaviors

- Suicidal ideation, gestures, attempts
- Self Injurious Behaviors

Community Safety

- To persons
- To property

Trauma

- Abuse and neglect
- Domestic Violence

Screening for Safety Risk (con.)

Personal Risk

- Runaway
- Youth Substance Abuse
- Sexual acting out
- Unrestricted internet access
- Sexting
- Cyberbullying

Ecological Risk

- Neighborhood
- Negative peer involvement: Gang activity

Destabilizing Factors

- Low parental monitoring and supervision
- Parental disabilities: MH, MRDD, SA

Assessing Youth Risk Behaviors

- The MA-CANS includes an assessment checklist in which to rate the level of need for youth risk behaviors. IHT providers are strongly encouraged to use this. Review handout – MA CANS Child Risk Behaviors.

Comprehensive Array of Services: IHT Core Services

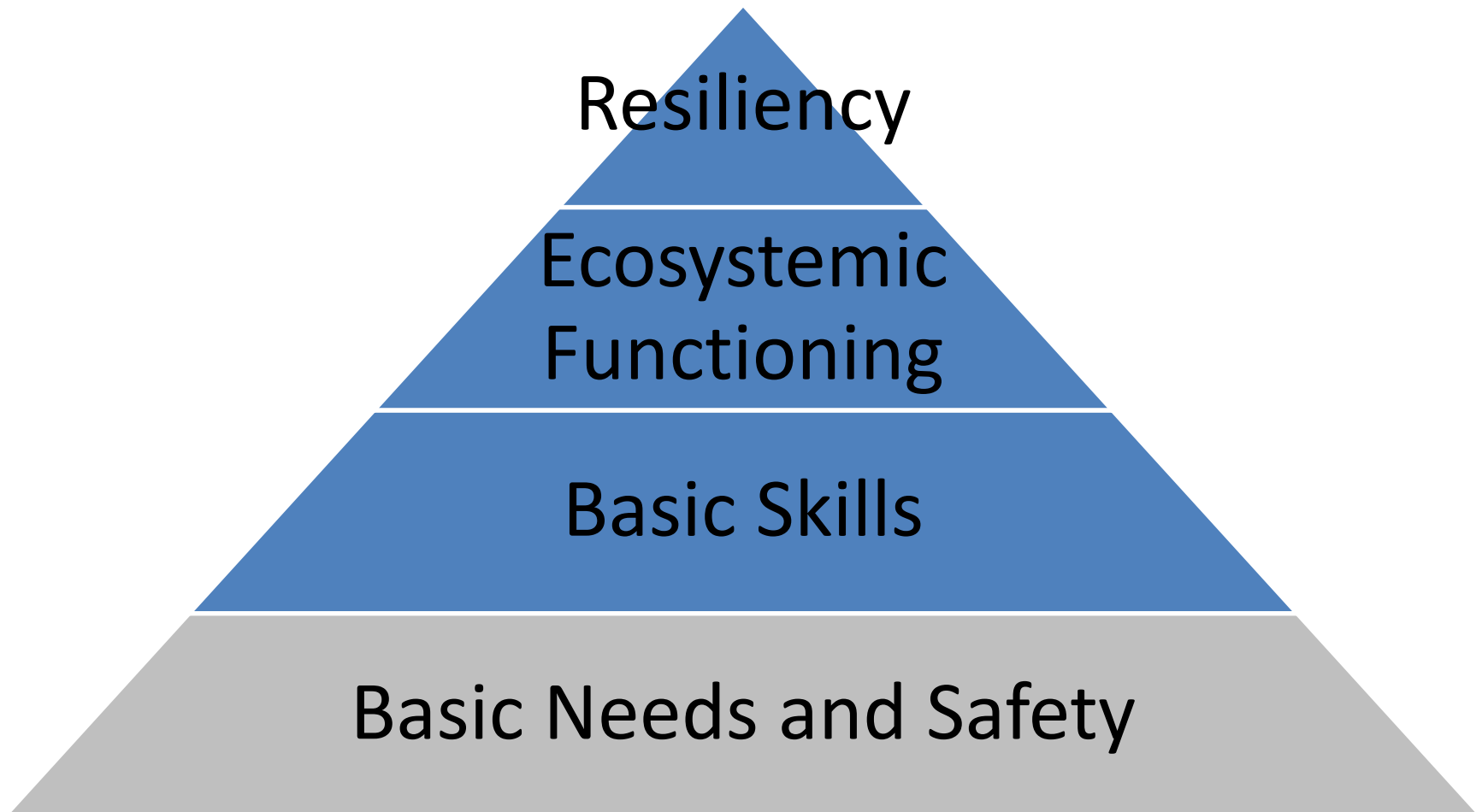
- Risk management and safety planning
- Skill building
- Individual & Family Interventions
- Cross-System Interventions and Service Coordination
- Resource and support building activities

Organizational Framework

- Need framework for organizing the myriad of information obtained in the home environment
- A family need hierarchy can be utilized to assist in assessing and prioritizing the youth's and family needs
- Strategies and interventions are matched to the most salient need, progressing to more complex needs once the primary needs are met

FAMILY NEED HIERARCHY

R. Shepler (1991;1999)



Basic Needs, Safety, and Stabilization

- Are there material needs that are unmet?
(Food; Shelter)
- Are there current safety and/or symptom concerns that need stabilization?
- Are there significant risk factors that are barriers to recovery?

Basic Needs and Safety (con.)

- **Assist with basic needs:** Active Case Management and Advocacy
- **Establish basic safety:** Risk management; safety planning; symptom stabilization
- **Risk reduction:** Reduce risk factors and environmental stressors.

Crisis Stabilization & Management

- Immediate safety
- Safety planning
- Create Safety Net (informal and formal)
- Learning new skills
 - Crisis gives family a chance to become empowered as members develop new skills

Basics of Crisis Stabilization

- Availability and Monitoring
- Stabilization
- Tracking crisis sequences
- Crisis remediation and processing
- Utilizing family as experts
- Safety plans
- Consultation (family, IHT team, and supervisor)
- Documentation
- Follow-Up

Crisis Triage and Decision-Making

- **Level of Crisis**
 - Immediate safety concern to self or others: Is there an immediate physical safety concern?
 - Escalating safety concern: Is there potential for serious incident or harm if situation is not stabilized?
 - Escalating family conflict: Is family in serious emotional distress and unable to stabilize current conflict without assistance?
- **Type of Crisis Response**
 - Emergency services
 - On site intervention
 - Phone stabilization

Level of Intervention Telephone

- Talking through steps of safety plan
- De-escalation
- Short term commitment to safety:
 - Can you get through tonight?
- Reminding family members of strengths; safety plan
- Schedule follow-up appointment next day

Levels of intervention

On-Site Crisis Response

- Immediate intervention
 - Crisis stabilization
 - Therapeutic separation
 - Contracting for safety
 - Family session
 - Respite: Arrange for short term out of home stay
 - Hospitalization or psychiatric assessment
- Supervisor consultation

Follow-Up

- Crisis Remediation: Process the crisis with family: Triggers; lessons learned; future prevention
- Crisis functional analysis (tracking sequences)
- Revisit and review safety plan
- Stepped up monitoring and intensity as needed
- Consider convening Youth and Family Team meeting if safety issues cross contexts and additional supports and resources are needed

Safety Planning Steps

- We identify the concerns
- We predict the worst case scenario
- We assess the contributing factors of the crisis and try to prevent them from happening;
- We plan for what to do if the crisis does occur

Crisis and Safety Planning

- Clearly describe roles, response, & responsibilities
 - (Who does what and when)
- Plan for 24 hour day
 - Including 24/7 availability to the family
 - Supervision and monitoring component
- Identify additional supports needed
 - Natural supports
 - Supportive/adjunct services (psychiatric; respite; one-on one supports)
 - Community controls (police; probation)

Crisis and Safety Planning (con.)

- Identify lead team member that the family calls first
- Distribute plan (Mobile Crisis Intervention; natural supports; other involved providers)
- Have a back-up plan
- Follow-up and update as needed

IHT Safety Planning and Paperwork

- Safety planning exercise
- See Risk Management Safety Plan handout

Protective Measures in the Home: Safety Walk Through

- Safety tour of the house
- Completed with parent/caregiver (and not the youth)
- Walk through each room of the house prompting the parent/caregiver with safety questions:
 - Is there anything in this room that could pose a danger to someone?
 - Think about your son or daughter and what they may have done before– is there anything in this room that we need to secure?

Items to Secure

- Knives
- Guns
- Pills
- Ropes
- Poisons (bleach)
- Other.....

Safety Strategies

- Lock boxes for medicines or knives
- Ask for gun to be kept at another house (do not tell youth where it is)
- Or keep gun locked with safety lock and ammunition locked separately
- Door alarms
- Baby monitors

Managing Risk

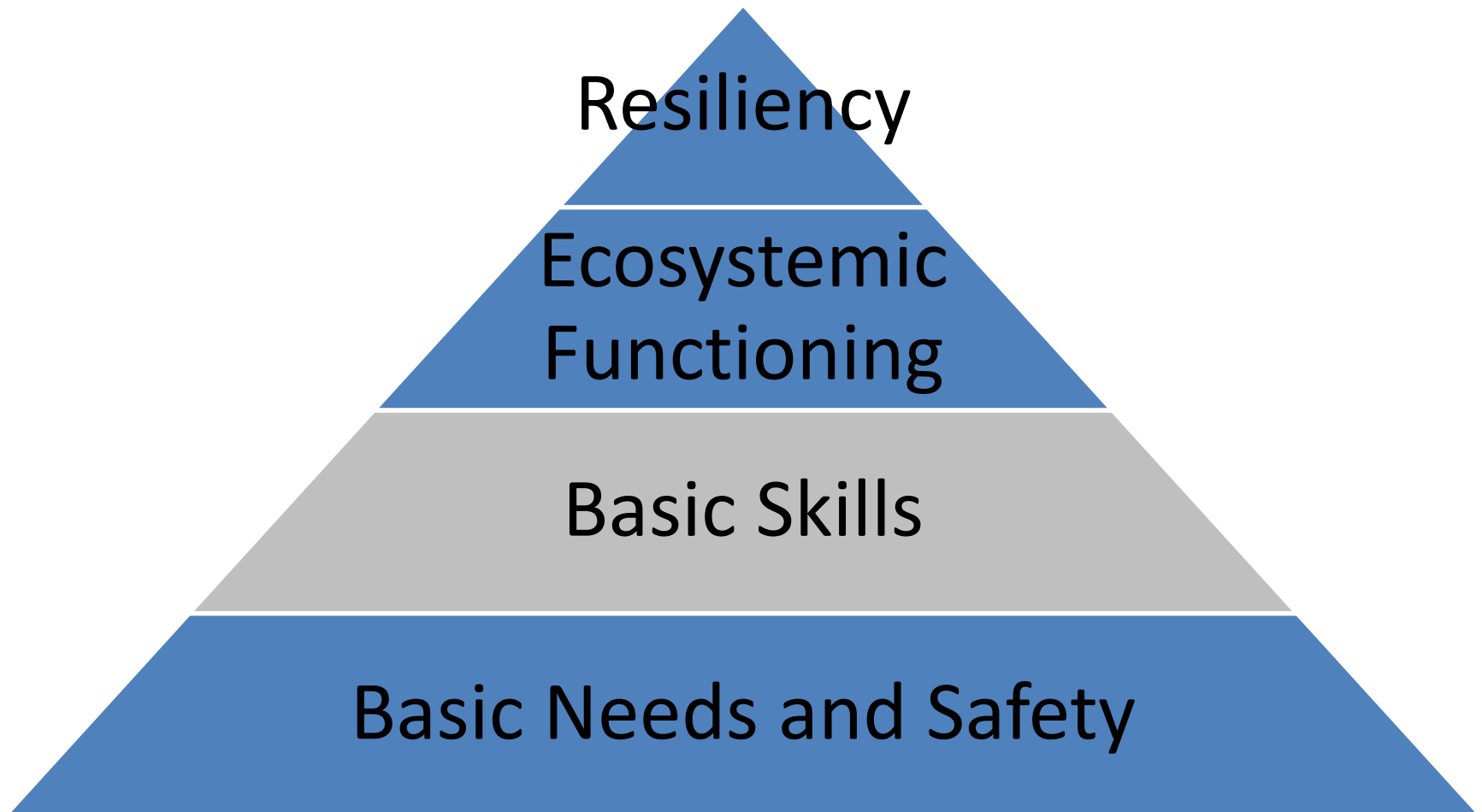
- Did you assess for it?
- Did you consult with your supervisor?
- Did you take reasonable action?
- Did you create a safety plan with the family?
- Does family have a copy? Do they clearly understand how and when to use it?
- Did you follow-up and monitor?
- Did you document all the above?

Supervisor Tasks

- Check to see if safety plan is in the chart
- Monitor plan weekly during supervision to assess status and make changes if needed
- Have staff add safety plan action steps to treatment plan goals
- Ensure that all parties have most recent risk management safety plan.
- Ensure family voice/choice was incorporated and that family is making informed consent to plan.

FAMILY NEED HIERARCHY

R. Shepler (1991;1999)



Basic Skills

- Does the youth and family know how to do what you are asking them to do?
- What skills does the youth need to be successful?

Skill Set Development

- **Emotional regulation skills:** (e.g. managing strong emotions due to frustration)
- **Communication and language skills:** (e.g. trouble processing and/or difficulty communicating clearly)
- **Conflict management skills:** (e.g. negotiation, compromise, problem solving; conflict resolution; mediation)
- **Self-knowledge skills:** (e.g. learning behavioral and emotional triggers; symptom management)

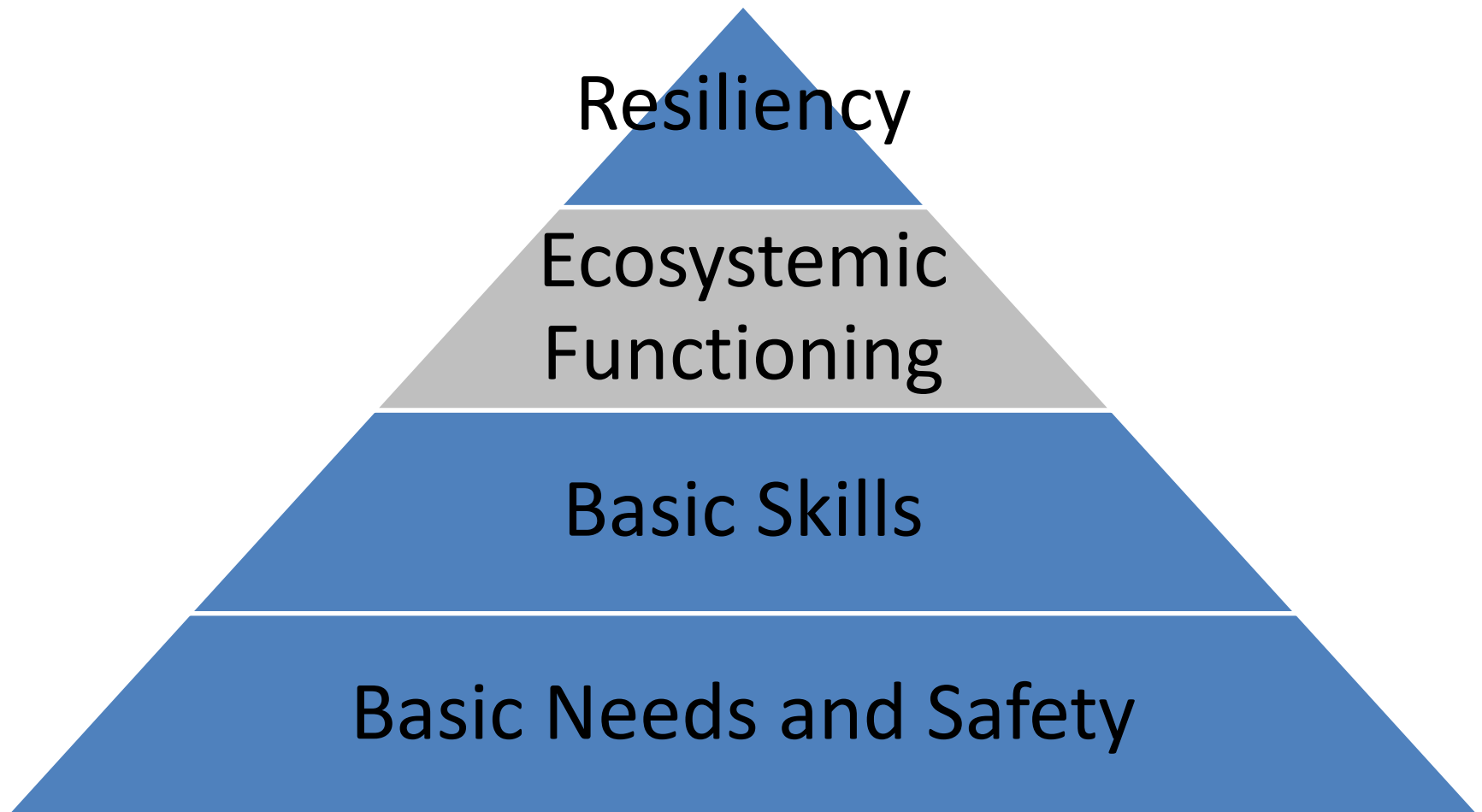
Skill Set Development

- **Personal safety skills:** (e.g. safe decision-making to prevent re-traumatization; alternative coping options to self harm behaviors)
- **Executive Functioning skills** (e.g. organizational and planning skills)
- **Cognitive Flexibility Skills:** (e.g. difficulty with transitions and deviations from rules; building accommodations to facilitate predictability)
- **Social Skills:** (e.g. not interpreting social cues accurately; appreciating another's point of view)

Skills reference: Collaborative Problem Solving (Ross Greene): <http://www.livesinthebalance.org/>

FAMILY NEED HIERARCHY

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Ecosystemic Functioning

- All behaviors have an interactive context
- What family or system dynamics are barriers to the youth and family's success?
- How do family functioning and interactions impact youth behaviors and emotions?
- How well does the youth function in key life domains: (home, school, health, social, community)?
- Goal: Improve functioning in major life contexts (family, school, community, social, vocational, etc)

Family Context: Set Stage for Change

- Create family recovery environment
- Decrease family conflicts
- Rebuild bonds and relationships
- Increase positive family communication
- Increase supervision and monitoring

Working with the Family: Reactivity & Triggers

- Turning down the volume
 - Reduce or remove triggering stimuli
- Keeping safe assured distance
 - Using people, space, and cognitive buffers
- Sanctuary
 - Scheduling and taking breaks
 - Respite and support (formal and informal)
- Working the perceptions
 - Reframing
 - CBT

Parenting Youth with Mental Health Disorders

- Requires flexibility, adaptability, and creativity
- Typically need to be weighted with greater amounts of support and resiliency factors (what the youth does well)
- Aligning expectations to what is achievable
- Less predictable results: Managing parenting frustrations
- Parent/caregiver coping skills (time out for parents/caregivers)

Parenting Adolescents

- Parent/Caregiver-Youth relationship and communication become increasingly more important in adolescence
- Change over from family authority to peer authority
- Focus on youth's decision-making and natural consequences
- Creating safety nets for youth
- Match structure and monitoring to need and behaviors

Finding Solutions and Building Accommodations

- *“Children do well if they can”* (Ross Greene)
- Requires understanding of the youth’s mental health challenges: Strong education component about the nature of mental health disorders
- Think mental health functioning, promotion, and wellness
- Can create success environments

Solution-focused approach

- Strength-based: Focus on what families are doing right
- Goal-oriented
- Resiliency-orientation: All people are capable of change
- Small change leads to larger changes (Erickson). Small change is more manageable.
- No problem happens all the time (Selekman, 2005)

Solution-Focused Language

(Berg, 1991; Selekman, 2005)

- **“When”- not- “If” language.**
 - Begin questions with “when”– implies that change will happen in time. Also allows for hope.
- **“Difference” language:** What would be different; what would “change” ...?

Scaling/Percentage Questions

(de Shazer, 1985, 1991)

- Quantitative measure of where they are and where they want to be
- On a scale from 1 to 10 with 10 meaning (the best) .. and 1 meaning (not so much) ...Where would you put Bill's emotional control this week?
- Specify a time limit or it gets confusing (today, last week, during the past month)

Coping questions

- How come things aren't worse?
- How are you doing to keep things from getting worse?
- How have you survived this well given all that you have gone through?

Exception Finding Questions (Berg, 1991)

- Find times when the problem does not occur
- Examine “who, what, how, when and where” that facilitated youth or family’s success
- Examples:
 - “You said you didn’t fight with your parents last week. How did you do it?”
 - “Tell me what is different for you at those times when you are not fighting with your parents?”

Community Context: Building Connections

- Educate community professionals (schools, juvenile court, youth services, etc) on the impacts of mental health challenges
- Facilitate reasonable expectations
- Facilitate accommodations
- Facilitate connections and opportunities

Youth Welfare

- Extensive safety planning
- Regular, ongoing communication with case workers
- Roles clarification: IHT staff are not investigative workers for Youth Welfare
- Maintaining strengths-based stance
- “Nothing about me without me” (families should be included in all meetings that concern them)
- IHT helps Youth Protective Services achieve safety and well being for youth and family

Schools

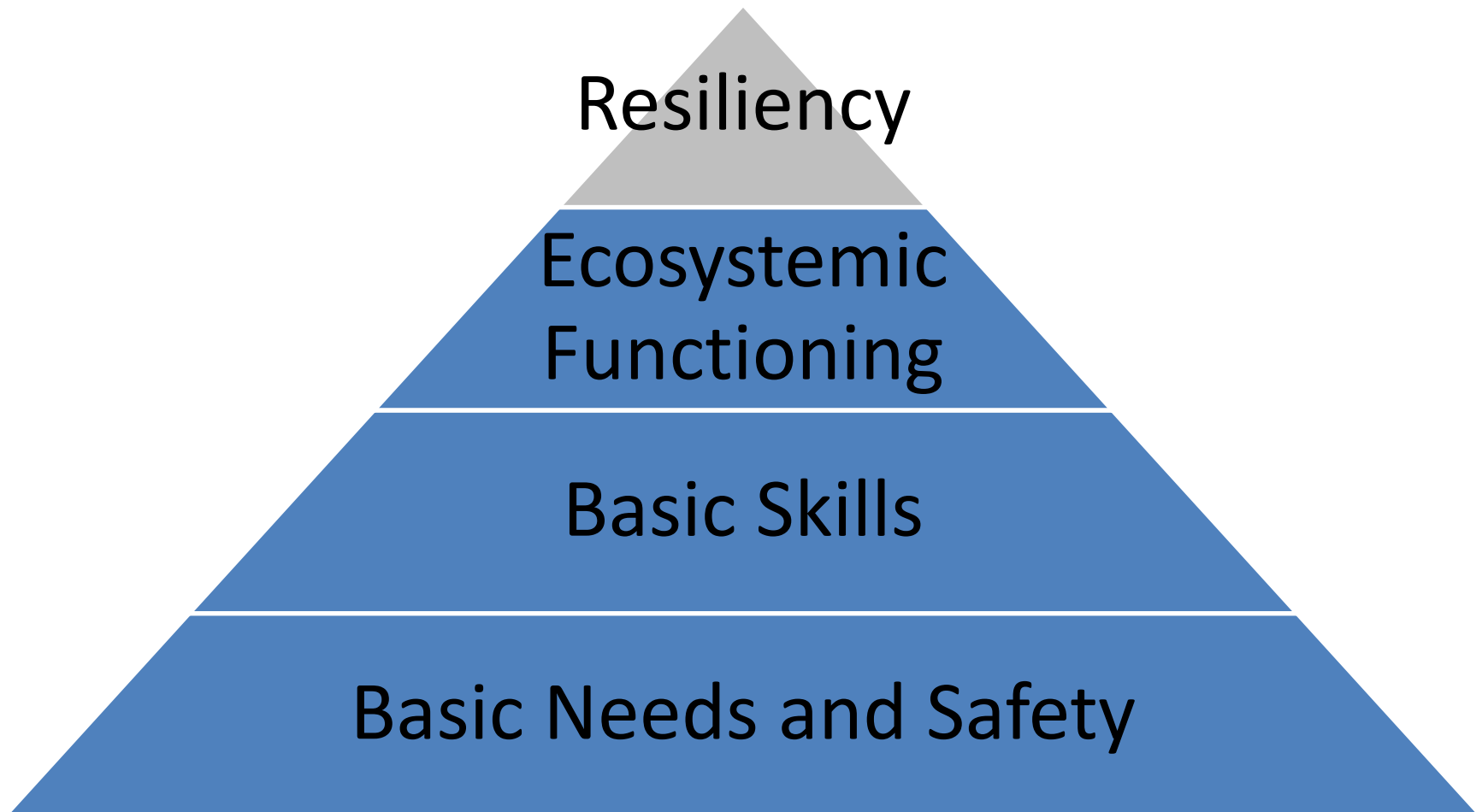
- Increase the youth and family's connection with the school
- Educate the school on the impact of mental illness
- Provide technical assistance to teachers and administrators on strategies to increase youth's success
- Assist in the development of adaptive school environments
- Be on-call to the school for stabilization of youth

Juvenile Justice

- Important to build credibility with magistrates and court officials by demonstrating good outcomes and reliability
- Need to be fluent in court language and process
- Be present at court hearings to support the family and inform the court
- Regular, ongoing communication with juvenile court staff
- Don't make court the de facto parent/caregiver

FAMILY NEED HIERARCHY

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Resiliency

What resources and supports are necessary for ongoing growth and development?

- Weave safety net of supports
- Empowered parents/caregivers
- Supports: informal and formal; for youth and family
- Positive peers and activities
- Mentors
- Pro-social activities
- Positive connections (School; community)
- Opportunities to give back
- Services: to help the youth and family sustain positive outcomes
- Wraparound process: ICC
- Possible step-down services: outpatient services, therapeutic mentoring
- Medications; Psychiatrist

Family Safety Net

- Who will be there for the family when services end?
- Think resources and supports
- Building and re-building natural support systems
- Resource-Focused Genograms:
 - Identification of potential family resources
 - Identification of potential positive family mentors for youth

IHT Closure

- When to close:
 - Presenting mental health symptoms no longer causing functional impairments
 - Youth no longer at-risk of out-of-home placement
 - Safety issues are stabilized
 - Treatment gains have reached a plateau
 - Family voice and choice
 - Youth needs higher level of care for safety
 - Treatment plan goals have been met

IHT Closure

- How to close:
 - Celebrate the strengths and successes of the youth, family & team members and the achievement of the team's shared goal!
 - Rituals
 - Dinner
 - Awards

IHT Closure

- If IHT is the Hub at the time of discharge, and there are Hub dependent services in place, including Therapeutic Mentoring or In-Home Behavioral Services or Family Support and Training (as a stand alone), that are still medically necessary, IHT and the parent/caregiver will need to develop a transition plan for the youth to have OP or ICC Hub so s/he can maintain the hub dependent service.

Lessons Learned: IHT Closure

- Common Issues:
 - Difficult for family to let go of valued service
 - Pressures from community to remain involved
 - No viable step-down options
 - Family crises at termination or as services wind down
 - There is still lots of work to do
- Keep in mind:
 - Medicaid pays for episodes of treatment
 - IHT is based on medical necessity and therefore may be time limited

Wraparound and ICC

- Wraparound meetings can be helpful to develop or solidify ongoing services and supports for youth and family
- *When the youth is receiving ICC, the In-Home Therapy Services provider participates in all Care Plan Team (CPT) meetings as a member of the CPT.*
- *The In-Home Therapy treatment plan must reflect a goal(s) on the ICP and treatment planning and delivery must be synchronized with ICC.*

Common Concerns and Challenges

- Bugs
- Contagion
- Animals
- Weapons
- Neighborhoods
- Distractions: phones; TV; visitors

- Getting comfortable so you can do the work
- Need to adopt standard safety precautions

Lessons Learned: Managing Challenges

- Remember you are a guest in family's home
- You are in control of the mental health service. The family is in control of their home.
- Be respectful of the family's values and culture
- Do not demand or challenge. Make simple request if needed.
- Relate to the family how the challenging situation affects you and what would be helpful.

Staff Safety Precautions in IHT

Pre-Home Visit Safety Assessment

Assess for weapons, animals, family violence, substance use, neighborhood gangs, etc.

Ask for family to secure what is under their control.

Develop clear safety protocols

Train staff on protocols

Cell phones

Always carry cell phones during any outreach activity

Have staff program into cell phone local police

Sign-Out/In Sheet; Weekly calendars of appointments

Always let someone know where you are

Staff Safety Precautions in IHT

Where you park

Park on the street, where you cannot be blocked in

Where you do sessions

Public visibility areas of the house, such as living or family rooms & kitchens

Avoid bedrooms or secluded areas of the house

When you do sessions

Think through the time of day that you do the session (i.e., neighborhood issues, mealtime)

Know the neighborhood

Scan your environment upon arrival (people, animals, etc)

Staff Safety Precautions in IHT

Do intakes as a team

Builds in additional safety

Family gets to meet another team member (who may be on-call for them)

Sounding board for case conceptualization

Can be the IHT supervisor

Use your common sense

Trust your intuition - if a situation does not feel safe reschedule

Allow families to help

Have family watch out for you while you enter and leave the home

Staff Safety Precautions in IHT

Family member under the influence of substances

Politely reschedule indicating that you want the family to fully benefit from your clinical services

Session boundaries & limits

Be cautious in your decision making for individual sessions in someone's home

Avoid sessions with only one person in the house if possible

What to wear and why

Type and style of clothing

Staff Safety Precautions in IHT

What to bring

Hand sanitizer

Keys and cell phone close to your body

What to protect

Valuables

Confidential information (with separate locking mechanism)

Other common home-based issues

- Invitations by family to attend family graduations, birthdays, or weddings.
- Requests for concrete services not typically included in IHT (i.e., transportation to job etc.)
- Managing confidentiality when working in public settings
- Meals with clients
- No adult home

Handling protected information

- Storing or transporting case files or parts of files in your car.
- Protecting electronic information
 - Youth or family communications via internet
 - Texting
 - Laptops: password protections

Supervisory Support, Availability and Team Consultation

- Access and availability for IHT staff when needed
- Pro-active consultation and strong clinical support
- Supervisor should have a designated responsibility to the team

Lessons Learned: Supervision

- Protect clinical supervision time: Don't let administrative supervision (productivity and paperwork) take time away from clinical supervision and case consultation
- Managing caseloads and LOS
- Build policies that support the worker:
 - Dedicated supervisor
 - Cell phones
 - Flex-time policies
 - Adjusted productivity expectations
 - Policies and trainings that support worker safety , ethics, and burnout
- Managing ethical issues

Lessons Learned: Supervision

- IHT staff need to develop skills just as the family does
- Supervisor needs to stay on top of these skills and staff training needs